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RAGPICKING - THE SURVIVAL STRATEGIES OF URBAN POOR

Bangalore holds an immense attraction for investment in industry, trade, transportation and technology due to its salubrious climate, strategic location, availability of skilled manpower, financial institutions and communication networks. It is, therefore, no wonder that child labour dominates the significant portion of urban unorganised sector.

It was estimated in 1975 (WHO Study) that the yield of solid wastes in Bangalore city was about 0.5 kg per person per week. The total yield was estimated to be around 300 to 400 tonnes per week. The task of collecting, conveying and disposing off solid wastes was managed by the Corporation of the City. It employed around 4,500 persons (sweepers and supervisors) for collecting and disposing solid wastes accumulated in about 3,000 dust bins and in all areas.

In 1987, it is estimated that the yield of solid wastes in the city is about 0.3 to 0.4 kg per capita per day. The total yield is about 1200 to 1600 tonnes per day. The total workforce of the Corporation has risen to 8,700 with a fleet of 110 lorries covering over 8300 dust bins. This means today the city is lowly manned in terms of solid waste i.e only one sweeper for every 6,000 persons as against the standard requirement of one sweeper for every 1,500 persons. While the city needs 1 lorry for 15,000 persons it has only one lorry for every 30,000 persons. It is estimated that by the year 2000AD, the city will produce around 2100 tonnes of garbage per day, necessitating the employing of at least 20,000 sweepers with 16,000 dust bins and a fleet of 300 lorries (Annual Reports of B.C.C. 85-86,86-87)

The cost of these operations will be enormous; and will have to be heavily subsidised. The city Corporation is in no way would be able to achieve this.

The increase in solid wastes are due to modern technology which manufactures more packed goods and tendency to pack most of the consumables contributing the major share of the solid waste.

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Major solid waste are glass bottles, papers, paper packs, plastics etc.

It is the rag picker who clears the additional garbage from the dust bins and keeps the city clean in many senses. We have to view the positive contribution of these child labourers and rag pickers in this direction. What are the positive contribution of ragpickers ?

a. Minimising solid waste management to the Corporation. All the dust bins in the main roads are visited by the ragpicker and cleaned than by the Corporation staff.

b. The sense of recycling - who else will go and pick the rags from dust bins which is fast catching up.

It is interesting to note that since the mid 70s many small paper mills based on unconventional raw materials such as agricultural residues, baggsse, industry waste or waste paper commenced production. The recycling industry has grown from nil during 1970 to 242 (Source : Annual Report, Directorate General of Technical Development) as on 1.1.1986. The investment pattern in them in very low around Rs.3 to 5 lakhs. These small units depend entirely on ragpickers for the supply of raw materials. Further, big mills also depend on them for paper or plastic recycling. Thus, in a way organised industry depends on these children for their operation. Therefore, child labour is not unproductive; it is the inevitable consequence of the demands putforth by the society through a complex of situation.

Children become ragpickers because of economic reasons- it is their parents' poverty which forces them to earn a living and form a part of the family labour force. The preponderance of women in unorganised sector encourages the continuance of child labour because children from an early age learn to help their mothers. eg. women construction workers - their children pick up carrying mud pots and do odd works. It is the insecurity of mother which forces these children to work. Since even the unorganised sector faces stiff competition and opportunities are less these children are pushed to streets.

From the point of ragpickers three factors virtually affect the development viz., the predominance of nuclear family and work mothers leading to little care devoted the child during its formative years; the nature of urban female occupations rarely allow them to have kids with them, and also they need to travel long distances. Secondly, in rural areas children are assigned such tasks as grazing of cattle, fetching water, wood etc. These activities are more viewed with 'dignity' since adults are also involved at times. But in urban child labour a few categories are reserved for children like ragpicking; generally, after 25 no one wishes to be a regular ragpicker and may look for some alternative even if it is less remunerative. Thirdly, in urban areas, there are several other potentially damaging elements exists for the street child.

The rural child has a traditional culture and social fabric (however bad it is yet conducive for living and growth) wide family networks. For the urban child none of these exist - there is cultural barreness and no security-structure. There are no institutional substitutes for home and for proper socialisation. However, given the situation government polices and programmes can play a role.

Child labour and problems associated with it have been a subject of concern among social planners, policy makers and researchers alike. Since street children/youth are a recent phenomenon not much has been done. The almost total absence of any organised, broad-based rehabilitation/developmental schemes in the country for the street children/youth must be considered to be among the least edifying experiences. Not that isolated efforts did not take up a few developmental programmes; in fact, a few NGOs and Government sponsored schemes are functioning with broad objectives :-

1. to prevent exploitation of child labour by providing facilities for proper sale of picked rags. This prevents the under-payment of the children/youth by the other agents;

ii. to wean the child of this hazardous occupation by providing education and industrial training in the centres set up by the organisations during the hours when the child is not required to pick rags; and

iii to protect and improve his health by providing essential services like supplementary nutrition, medical aid.

Paper prepared by the Documentation wing of the Ragpickers Education and Development Scheme, Bangalore. Presented during the workshop on " Urban Poverty" organised by ICRA 23-24 January 1988.

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WORKING CHILDREN IN BANGALORE CITY

B.R.PATIL*

Paper presented at two day workshop on "Urban Poverty" between 23rd and 24th January 1988 organised by ICRA & NCU.

Child labour is a phenomenon commonly found in all the developing countries. In India its incidence has not only been high but its magnitude is increasing from decade to decade despite rapid industrialisation and modernisation of the country. While in 1961 there were 14,469 million children as counted by the Census of 1961, their number increased to 16.3 million in 1972-73 as was estimated by the 27th round of the National Sample Survey, and to 17.36 million after another ten years as revealed by the 38th round of the National Sample Survey.

More than 80 per cent of the working children are employed in agriculture and allied occupations including plantations:the remaining live in urban society and are engaged in manufacturing and service sectors, but primarily in the unorganised, informal and small scale sectors. The variety and types of occupations and jobs in which they are employed in any industrial-urban society in India or any other developing country have established that "there is no occupation/job where a child is not employed."

Widespread poverty, adult unemployment, intermittent and inadequate family income, death or disability of the principal breadwinner of the family are some of the important causes of child labour. These are also the factors that render the efforts of the governmental and non-governmental agencies to prohibit and eliminate child labour extremely difficult. It is commonly felt that so long as child labour provides relief to the economic compulsions and continues to help the employers to derive economic benefits child labour exists.

The urban-industrial working children are confronted with the work that is often difficult to comprehend, perform, and m ster. In addition to denial of schooling and recreation more often their working conditions pose serious threats to their physical growth and expose them to various types of occupational and health hazards that shorten their working lives and often life itself. The self-employed children like the rag pickers are subjected to exploitation of the middlemen to whom they must sell their collections. They handle items like broken glasses, rusted materials, etc., that are a regular hazard to them.

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In industries like carpet weaving, match and fire works, beedi and agarbatti rolling, sari and zaradosi work, slate manufacturing, hotels and small eating places, cashewnut processing, diamond cutting, etc, either only children are employed or they out-number the adult workers. In all these industries and occupations, the exploitation of child workers is varied, extensive and intensive.

A profile analysis of child workers in Bangalore reveals that as a group they are closely comparable to their counterparts in Bombay and Delhi in respect of their age, sex composition, educational status, religion, family size and number of workers in the family, occupational status of the parents/heads of households, family income, etc., Similarly, they are comparable on work/employment related variables such as the nature of job, hours of work, wages, child-adult worker ratio, as well as their job and career aspirations.

While in Bombay 67.7 per cent of the child workers are boys (Musafir Sing et al :1980:40) in Bangalore we found a higher percentage of boys among the child workers ie. 79.67 per cent. But in Delhi only 14.7 per cent of the child workers happened to be girls (I.C.C.W:1979:28). Our survey also reveals that the percentage of girls among working children decreases with the increasing age of the child workers indicating that girls start working much earlier than boys but are withdrawn from employment as they grow old, primarily because when a family is forced to send their children to work and earn a supplementary income, it is the girl child who is sent to work and only subsequently the boys when the economic compulsions are hard. But a girl child is withdrawn from her job when she attains puberty unless otherwise she works along with either parent or any other member of the family or in exceptional cases the place of employment is safe; a grown up girl is not sent to work till she is married if there are no economic compulsions.

The age distribution of child workers reveals that while in Delhi 60 per cent of the child workers are above 13 years of age in Bang lore 65.33 per cent are of the same age; but in Bombay 71.3 per cent are above 12 years of age (I.C.C.W:28.Singh et al:40). In Bangalore 10.5 per cent of child workers are very young in age as against 4.41 per cent in Delhi and 3 per cent in Bombay.

The analysis of educational status also reveals that while 33.30 per cent of the working children in Bombay did not have schooling, 34.16 per cent of the child workers in Bangalore are illiterate. Whereas in Delhi 45 per cent of the child labourers were found to be lacking the knowledge of three 'R's. However, the child workers in Bangalore seem to have a better educational background compared to the literate working children in the three cities. In Bangalore 7.16 per cent of the child workers have studied beyond middle school level as against only 0.7 per cent in Bombay and none in Delhi (Sing et al:41:I.C.C.W:46).

This survey also reveals that the working girl children have a poorer educational background as compared to boys - 52.45 per cent of the girls have had no schooling as against 29.49 per cent of the boys, while 26.22 per cent have had middle school or secondary level education as compared to 34.5 per cent

of the boys. This poorer educational status is only due to the attitude of their parents toward their education. The poor families and illiterate parents living in towns and cities do not consider it important to educate their daughters.

Our survey further revealed that the occupational status of the parents and the educational status of the child workers are correlated. More manual the parent's occupation larger the perdentage of illiterate and poorly educated working children.

In all the three cities larger percentage of child workers belong to Hindu religion; but their percentage in Delhi and Bombay is very high. While 83.8 per cent of the child labourers in Delhi and 71.3 per cent of the working children in Bombay were found to be Hindus, only 58.33 per cent of the child workers in Bangalore city belong to Hinduism (I.C.C.W:19, Singh et al:41).

As many as 71.12 per cent of male child workers and 50 per cent of the working girl children know two or morelanguages. It was further discovered that as the educational level of the child workers increases the percentage of those knowing two or more languages also increases suggesting a nexus between the level of education and knowledge of languages.

A comparative analysis of the size of the families of working children from all the three cities suggests that a very high percentage of the child workers are from smaller families. In Bombay 91 per cent of the working children are from families having upto 8 members while in Bangalore 67.5 per cent of the child workers come from the families whose size is less than 8. Similarly in Delhi the average size of the households of child labourers was found to be 5.5. This comparative data disproves the myth that larger families contribute more to the child labour population. Our survey also reveals that a larger percentage of girls are from smaller families than the boys - 81.15 per cent as against 64.02 per cent.

While the size of the families of the working children in general is small, two-thirds of them in Bangalore have three or more working and earning members including the child workers. Among them the families of 55.74 per cent of the working girl children have three earning members and an equal numberof families of both male and female child workers have either two or more than three working and earning members. Further, the families of more than 60 per cent of the child workers with different levels of education have three or more working and earning members. Similarly in Bombay "the number of workers per family ranged from 1 to 8. The majority of the families (51.9%) had 3 to 4 workers, 40.8 per cent one to two workers and 7.3 per cent five or more workers" (Singh et al:50). This only suggests that every employed member of the families of the child workers in general is engaged in less remunerative job forcing the children to seek wage labour to supplement the inadequate income they earn.

The absence of an adult working member or the head of the household is regarded as one of the important causes of child labour. But only 5.67 per cent of the child workers in Bangalore, 4.5 per cent of the working children in Bombay (Singh et al:45) have had neither parent living. Thus the

general impression that the children take to wage labour mostly on the loss of their parents is not a common phenomenon. Further, it may be noted that 323.33 per cent of the child workers in Bangalore and 27.9 per cent in Bombay had either parents living, while the large majority both in Bombay and Bangalore had both the parents living.

The parents of child workers by and large are employed either as wage labourers or engaged in street trades and vending of vegetables and fruits, etc; hence, their occupational status in general is low. Our survey revealed that 32.17 per cent of parents or heads of households are the wage labourers and 17.33 per cent the self-employed, while 33.33 per cent are the salaried employees in government departments and private and public sector undertakings, surprisingly whose percentage increases with the increasing age of the child workers. The study by the Indian Council of Social Welfare in Delhi also found that while 8.82 per cent of the parents of the child labourers happened to be professional, technical, administrative, managerial or while collar employees, 25 per cent were business men, manufacturers, sales personnel, moneylenders, etc. (P.20 Table 3:3). This is quite balfing a phenomenon. The only explanation that could be given is the parents' desire to get their children employed before they are adult youths especially when their performance in schools is not satisfactory.

At least 43.83 per cent of the working children in Bangalore were found to have been forced to get employed and take over the adult roles of earning members due to the death, disability, ill-health and partial or total dependancy of the parents on the family and in some cases because of irresponsible parents. While 60.46 per cent of the child workers in Bangalore have 'responsible' parents, 60.66 per cent of the working girl children have adverse family conditions forcing them to work. The educated among the child workers feel that their parents are not as responsible as they should have been toward the family. As a matter of fact, 12.33 per cent of the child workers are required to shoulder major responsibilities in their families, while 77.33 per cent have to assume marginal to major responsibilities. Similarly, in Bombay the parents of 13.2 per cent of the working children had no income at all, while another 20.6 per cent were contributing less than Rs.100 per month to the family income (P.44,Table 14).

Our study revealed that in 29.17 per cent families of the child workers two or more children are employed, and that the percentage of such families increases with the increasing age of the child workers revealing the harsh reality that as children grow in age are required to take to employment at an increasing rate. The study by Musafir Singh and his colleagues in Bombay also revealed that the average number of child workers per family was 1.1 (P.50).

As for the family income is concerned, no comparison could be made since the studies in Bombay and Delhi were conducted when the rate of inflation was not high. Nevertheless it may be noted that only small percentage of the families of child workers in all the three cities have low income. The survey in Bangalore reveals that the familiesof only 11.17 per cent of the child workers have had a monthly income of less than Rs.300 while another 13.50 per cent were getting upto Rs.500 per month. But the familiesof as many as 42.37

INDUSTRIES/EMPLOYMENTS/JOBS THE CHILDREN ARE ENGAGED IN:
According to our survey 27.83 per cent of the child workers in Bangalore are employed in small scale industries or factories and workshops that are normally not covered under the Factories Act, 1948. In Delhi 67.18 per cent of the child labourers are employed in unregistered establishments (I.C.C.W:P.42 Table 5:2). Our data also brings out that 17.83 per cent of the child workers are in automobile tinkering and fuelling stations, 14.67 per cent in shops and commercial establishments, 12.33 per cent in hotels and restaurants, and 10 per cent each in construction activities, domestic services and traditional occupations like carpentry, tailoring etc. This data reveals that in anurban society both the working children and their parents/guardians prefer more remunerative jobs. Our survey helped us to conclude that the shops and commercial establishments, hotels and restaurants, automobile fuelling stations serve as the entry jobs for children.

Larger percentage of female children are employed in domestic services (32.79%), beedi and agarabatti factories but as home-workers (27.87%) and construction and allied activities (27.42%) while a larger percentage of boys are found in industrial employments (51.21%) because it was ascertained that while the girls' children are in employment primarily to supplement the inadequate family income the male children seek employments not only to supplement the family income but also to make a career out of it.

Only 15.17 per cent of the child workers were found to be in employment for less than one year at the time of t is survey as against 23.33 per cent who had been in employment for over five years; all others stated to have been employed for a period ranging from one to five years. It was destressing to note that half of the child workers below the age of 10 have had completed five or more years of service at the time of this study very vivdly revealing the economic compulsions their families had to experience and the cruel world of child labour.

Only about one-fourth of the child workers were found to have changed their employers and jobs; an important reason the change was long distance the younger ones were required to commute. But more commonly, heavy work, low wages, long hours of work, the parents' desire, and ill-treatment by the employers force the children to change their jobs and employers. A larger percentage of boys change their jobs for low wages, heavy work and due to the desire of their parents, while the girl children do so because of heavy work, low wages, and long distance.

Although 61.5 per cent of the child workers have had been in employment for one to five years and another 23.33 per cent for more than five years, only one-fourth of all the child workers were found to have been assigned independent jobs, while more than 50 per cent were working as helpers, and a little less than one-tenth doing only odd jobs. But our analysis revealed that as the age of the child increases the percentageof helpers and independent workers among the children increases suggesting that the employers seriously consider the age and experience of the child before asking them to work independently.

per cent of the child workers have been earning an income of Rs.1000 to cover 3000 per month. Our survey further revealed that large percentage of working girl children are from economically poorer families than the boys - 86.06 per cent as against 50 per cent of the boys.

ECONOMIC COMPULSION IS NOT THE ONLY REASON FOR CHILD LABOUR: It is generally believed that the economic compulsions force the child to seek employment and earn for the family. But in case of 53.67 per cent of the child workers in Bangalore, the economic compulsions are neither the immediately disposing off nor the contributory causes of child labour. Similarly, in case of 45.3 per cent of the working children in Bombay the economic compulsions were not the reasons for those children in taking to wage labour (P.78). Our survey points out that the most common reason for taking to wage labour in case of 37.17 per cent of the child workers was the need to supplement the family income while only 6.33 per cent of the child workers were required to get employed to earn a minimum living for their families. It is these 6.33 per cent of the child workers who are the sole working and earning members of their families. Another 2.83 per cent of the child workers have taken to wage labour on part-time basis to finance their own education besides con ributing to the inadequate family income. These children go to school from morning till 3 p.m. and work as labourers between 3 and 10 p.m.

Whereas 42.33 per cent of the child workers in Bangalore have been in employment because their parents wanted them to be employed for reasons other than the economic compulsions. These reasons include: stagnation of the child in schooling, loss of interest in his studies, his illiterate status, desire of the parents to get their children employed and trained in supposedly lucrative trades and occupations, desire to wean away their children from the influence of deviant children in the neighbourhood, and the idleness of the child. Among these, the threat of probable unemployment when children grow into youth/adults is a strong one. It is this threat which forces many a parent to get their children employed while they are still in their childhood or teen-age. The study of working children in Bombay also lists similar reasons for the children being employed (Table 44 p.78).

It was an interesting finding that 5.33 per cent child workers in Bangalore have got employed out of their own desire to be employed and earn for themselves. So also in Bombay 2.8 per cent of the working children got employed out of their own will.

Our survey further revealed that while a larger percentage of younger children and girl children work for earning a living for the family, a larger percentage of older children and boys are working to earn additional income for their families. And a larger percentage of younger children and girls are working because their parents wanted. The survey also reveals that with the increasing level of education children from poorer families become more sensitive to the problems of their families and take up jobs on full-time or part-time basis.

HOURS OF WORK: One common form of exploitation of child workers is excessively long hours of work. Our survey reveals that about two-thirds of the child workers are required to work for 8 to 12 hours a day, and 10 per cent work for still longer hours or do not have any fixed time to work revealing the fact that the children are put to excessively long hours of work and the consequent exploitation. The hours of work, however, decrease with the increasing age of the children, perhaps because the employers feel that they could extract better work from the children only for about 8 to 12 hours a day.

In small scale industries, automobile workshops, shops and commercial establishments the hours of work of children do not exceed 10 per day since these types of organizations are covered either under the Factories Act of 1948 or the Karnataka Shops and Commercial Establishments Act of 1965. A little more than 40 per cent of the child workers felt that their employers are always interested in work.

It is this type of employers who do not have any consideration for the tender age of the child workers. They extract work from the children as long as they could. It was also found from 12.67 per cent of the child workers that their employers ill-treat them and are rather harsh to them. Similarly, about two-thirds of the working girl children and 50 per cent of the boys felt that their employers are unkind to them. Hence, about 45 per cent of the boys and girls and the children working as helpers, learners, and doing odd jobs want to change their present jobs and employers.

Child-Adult Worker Ratio: Children are employed primarily because of the economic advantages that are far greater than the advantages of employing adults. Vulnerable, flexible, and unorganised child workers are used for reducing labour costs and maintaining competitive advantages and as a means of adapting and responding to economic uncertainties and fluctuations in demand. Yet no employer can afford to hire only children unless he himself works along with the children asking them to do all odd jobs or when he closely supervises their work and gets the desired results through them.

Thus our survey revealed that 17 per cent of the child workers do not have any adult colleagues in their employments, while 27.5 per cent have equal number of adult colleagues with a ratio of one child to one adult. Only children are employed with varying numbers in all occupations but construction industry; among them, however, domestic services, shops and other commercial establishments, traditional occupations, small workshops, etc., predominate. It is also in these employments that 1:1 ratio between children and adult workers exists. One the other hand, 30.5 per cent of the child workers are employed in occupations where the ratio between the two is 1:2 and another 25 per cent in those occupations where the ratio is 1:3 or more. Similarly, the study by Musafir Singh et al found that the "percentage of child workers to adult workers was as high as 1:1.67 in households, e.e. for every 6 adult workers the households had employed 10 child workers. Similar seemed to be the case with small hotels and restaurants. Here for every 100 adult workers as many as 156 child workers had been employed. These figures indubitably demonstrate that households and small hotels and restaurants prefer children to adults for employment

purposes. The percentage of child workers to adult workers ranged from 8.7 to 29.5 in other kinds of establishments, the minimum characterising commercial establishments and the maximum the construction work" (p 90-91).

The children in employment are exploited not only by their employers but also by the fellow adult workers. At least 19.33 per cent of the child workers admitted that their fellow adult workers are not kind to them. These children are subjected to physical abuse by adult workers both in and outside the work situation.

Low Wages and Earnings: The economic compulsion or the need to earn a wage to supplement the family income in many cases and a living in other cases generally forces the children into labour market. More importantly, child labour persists because the employer finds certain advantages in employing children. It is due to these two factors that the children have been unable to earn 'adequate' wages. Our study revealed that a large majority of the child workers are paid very low wages and that they have to work for quite a few months without any wages before they are put on pay rolls. We could gather from these working children that almost everyone has to go through a stage of wageless employment for several months. The employers have adopted the practice of keeping every child worker under a period of 'probation' for the first few months when the child is expected to 'learn' the job. Hence no wages during the period of probation. Even after the expiry of this probation period the children are paid only nominal wages for some more months.

Our survey revealed that while 4.17 per cent of child workers are paid no wages about 20 per cent are paid only a nominal wage of less than Rs.50 per month and another 15 per cent receive Rs.50 to 100 per month. But a little more than 45 per cent of the child workers are paid a monthly wage ranging from Rs.100 to 300, which rather seems to be the common rate of wages of children in Bangalore - 45 to 70 per cent children employed in hotels, shops, small scale industries, domestic services, and traditional occupations are paid these rates of wages.

It was, however, gratifying to note that a little more than 10 per cent of all the working children get wages ranging from Rs.300 to 500 per month, and 3.17 per cent earn more than Rs.500 per month, and 3.17 per cent earn more than Rs.500 per month. The "high wages' are earned by the children in construction activities, traditional occupations like carpentry, small scale industries including the automobile workshops and fuel stations. In fact, in construction industry 38 per cent of the child workers employed earn Rs.300 to 500 and 24 per cent more than Rs.500 per month. But the employment in this industry is seasonal and irregular. In automobile fuel stations children engaged to blow air in wheels of motor vehicles are not paid any wages; they are allowed to collect tips from the vehicle owners. It was gathered from these children that they collect a minimum of 10 paise from the owners of two wheelers and 25 paise from the owners of motor cars and other light vehicles, and that their earnings often exceed Rs.20 per day.

Further, more than 95 per cent of the girls have been able to earn wages only upto Rs.300 per month as against three-fourths of the boys. Butno girl works without a wage and without a

knowledge of how much is paid to her. Wherever boys are working as learners no wages are paid to them for the first few months. But once they are assigned independent work they receive better wages.

About half of the working children get only wages while nearly one-third get wages and allowances such as transport and food allowances; and another one-eighth get tips from the customers in addition to wages and allowances.

Share of the Child Workers in the Family Income: The wages earned by the working children constitute a substantial part of the income of their families - 6.33 per cent earn 100 per cent of the family income being the sole earning members of their families; 18.33 per cent earn more than 50 per cent of the family income and another 21 per cent have been able to contribute 26 to 50 per cent of the monthly family income. These contributions are no doubt a good supplement to the inadequate and intermittent family income. It is because of such a contribution that the families of these children want them to continue injobs.Hence, no wonder why children are sent to work.

Child Worker's Interest in Education and Vocational Training: Child labour means denial of education and training, denial of opportunities for growth and development, and the denial of childhood experience. The children who are forced to work do cherish a strong desire to get educated and trained like any other child. Our survey revealed that 58.83 per cent of the working children not only have an interest in continuing their education but also a strong desire to go back to schools. Among them majority are the children below 10 years of age, the teen-aged ones, the girls and those who have already acquired some amount of formal education but were forced to discontinue their education. Thus the child workers in Bangalore are not a lot different from those in Bombay where 66.29 per cent had expressed their desire to continue their education (Musafir Singh et al: 173).

Among the child workers of Bangalore who are interested in continuing their education 45.25 per cent are interested in taking up their education on a full-time basis, 24.78 per cent on a part-time basis, and 17.58 per cent through non-formal methods of education, while 12.39 per cent prefer self-study methods. Among girls 68.27 per cent are interested in continuing their education on a part-time basis, through non-formal methods and self-study.

As for job aspirations and career interests are concerned, 23.33 per cent of the child workers want to continue their present jobs. But 25.67 per cent want to change to better jobs, and 22.67 per cent want to set up their own trade/ workshops to be self-employed. Among girls 31.88 per cent want to change to better jobs and 25.52 per cent like to set up their own business. Our data indicates that better the educational background of the working children higher the percentage of the child workers interested in better career.

Lastly, 70.33 per cent of the working children are interested in vocational training. Older children, larger percentage of boys, and the better educated are more interested inundergoing vocational training. All but 18.65 per cent of the child workers have a fairly good idea about the vocations they are

interested in. Only 13.09 per cent want to continue in their present vocations, 21.46 per cent are interested in becoming machinists, 16.50 per cent in automobile tinkering, 9.60 per cent in welding/fitting trades, 7.07 per cent in electricals, 5.57 per cent in carpentry, 7.6 per cent in tailoring, and about 3 per cent in electronics. But only 27.75 per cent areinterested in vocational training on a full-time basis. And 43.98 per cent are interested inundergoing the training on a part-time basis and 28.27 per cent in 'on-the-job' training revealing their concern for a regular income for their families and improvement of their skills to become good workers.

Our data further reveals that every male child working in hotels and restaurents, shops and commercial establishments, or working as domestic servant expressed his desire to become automobile tinkers, tailors, radio and television mechanics or electricians.

Many child workers, though have a desire to have education and vocational training, did not want to give a positive answer to our question seeking their willingness to pursue education and training. They stated that they would consult their parents/ guardians in the matter and act according to the will and wish of their parents,guardians.

About 15 per cent of the child workers stated that they do not find free time to pursue their education and training. They are always engaged in their occupations so that they could earn a little more money to have better income for the family. In case of many of these children, it was gathered that, their employers do not allow them to have weekly holidays.

The broad conclusions of this survey are that the economic compulsions are strong reasons forcing about 46.33 per centof the child workers to seek wage labour, the remaining children are in employment for other reasons, the important among them being their parents" concern to see them employed when they become of age.

Whether it is the economic compulsions or the threat of unemployment, the children are subjected to different kinds of exploitat on b their employers. The employers, out of their concern for maximising the advantages of employing children, always try to extend the frontiers of exploitation. But more inhuman is the exploitation of the child by his family. It is the compulsions of survival, the desire to have an 'adequate' income for the family, and the fear,threat of unemployment that maintain the steady supply of child labour in the informal, the unorganised small scale sector and often ensure higher supply than the demand for it, enabling the employers to exploit the nchildren in their employment. Hence, so long as the supply factors continue to exist or are not eliminated, we would never be in a position to prevent the exploitation of child workers, and least to eliminate child labour. Till such time it is more advisable and preferable to protect the interests of child workers by regulating their employment and working conditions and by providing for their education and vocational training.

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WORKING CHILDREN IN BANGALORE CITY

B.R. PATIL

According to the 38th round of the National Sample Survey there are 17.36 million child Labourers.

50% of the working children are employed in agriculture and allied occupations.

In any developing country "there is no occupation/job where a child is not employed."

important causes of child labour :-
- widespread poverty
- adult unemployment
- intermittent & inadequate family income
- death or disability of the principal breadwinner.

Most of the children work under the conditions which pose serious threats to their physical growth and expose them to various types of occupational hazards.

In Banglore 79.67 percent of child ~~Lab~~ workers are boys.
34.16 percent of the child workers in B'lore are illiterates

- 43.83 percent of the working children in Bangalore were found to have been forced to get employed and take over the adult roles of earning members due to death, disability, ill-health, total dependency of the parents, irresponsible parents.
- 12.33 percent of the child workers are required to shoulder major responsibilities.

while 77.33 percent have to assume marginal & major responsibilities.

- 42.33 percent of child workers in Bangalore have been in employment because their parents wanted them to be employed for reasons other than the economic compulsions. These reasons include: stagnation of the child in schooling, loss of interest in his studies, his illiterate status, desire of the parents to get their children employed and trained in supposedly lucrative trades and occupations, desire to wean away their children from the influence of deviant children in the neighbourhood, and the idleness of the child.

5.33 percent child workers in Bangalore have got employed out of their own desire.

- 77.83 percent of the child workers in Blore are employed in small scale industries, factories, workshops.

working hours: 2/3rds of the child workers work above 8-12 hours a day & 10% even more than that.

- 58.83 percent of working children have an interest in continuing their education.

70.33 percent are interested in vocational training.

whether it is the economic compulsion or the threat of unemployment, the children are subjected to different kinds of exploitation by their employers. But more inhuman is the exploitation of the child

A Report on Sr. Marina Kalathil's work in Bangalore slums
11/03/94
DEV 3.25

S L U M P R O J E C T

Responding to the needs of the needy .....

As I was in the Family Welfare Centre - St. Martha's Hospital, assigned to counsel couples for NFP (N atural Family Planning) and thus frustrated assignment led me to go out and share my little knowledge and experience about life and its wellbeing with the people especially w ith the women in the slums. First, it was an extension NFP counseling programme for couples in their own houses so~~me~~ that ~~poor~~ the poor people may benefit our counselling. Very soon, Jayamma, the staff and I were forced to respond to the needs of the women and children, malnurished infected with various communicable diseases due to unhygienic surroundings and inadequate drinking water facilities and above all ignorance about their situations. Diarrohea, disentry, typhiod, jaundice, polio, scabies, T.B etc.. were their day to day problems. As we began to responding to their needs in educating to prevent and to cure with home-remedies and locally available herbal medicines , and referring cases like typhoid , T.B etc.. to the hospitals We also learned that many of our women suffering with atrocities, harassments, sexual abuses from their husbands, in-laws and from other members of the society. Many young women have to encounter with gang rapes, suicides, killings, abortions, alcoholism, drugs, gamblings, moneylenders, oppressionfrom local leaders and politicians.

Very soon, KSDF (Karnataka Slum Dwellers Federation) came with a request to start mobile clinics in their slums. I said No and it took five months to explain them and make them to understand that their people need more awareness of their own situations and helping them to decide what steps they need to take to solve their problems as such, instead of giving quick remedies for their pains and aches, and such remedies were not lacking for them in the cities.

The first training, we began in January 1991, at St. Marth's Hospital for 32 women and 2 men who were brought by KSDF. After having two phases of each in duration of 2 weeks training with an interval of 1½ months , they realised the importance of having such wholistic approach towards their problems where they have to take responsibility as individuals and as a community. They requested to give same training to the unmarried young girls, and they themselves brought 22 girls to St. Martha's. After that they began to ask to conduct such programmes in their own localities so that many more women can benefit.

Though we found no privacy and much of inconvenences we began to conduct trainings where ever we got a little place to sit either on the varantha of a public building or infront of a temple / a chapel or under a tree. Some times it was very difficult as we had to talk and discuss certain gynocological/ social and political problems they are facing.

We call this programme WEEPs (Women's Education and Empowerment Programmes. We are happy to say that we have given such training in a duration 6 days to 1200 women in 17 slums. It is an ongoing awareness creating and empowering programmes,

	1.	Health training (6days)	1200 women
	2.	Health seminar (1 day)	700 "
	3.	Health seminar (1 day)	children
	4.	Mahilasamajas	11 slums
W E E P s	5.	Savings	8 "
	6.	Mental health& Marriage counselling	
	7.	Legal aid seminars	
	8.	Adult literacy centres	5
	9.	Balawady	1

Mahilasamajas : During training trining programme we introduce the importance of having a mahilasamaj where we can get them together for futher discussion about various matters when we meet them again. Also for any benefit from the government they need to register the samaja.

Savings.All our women do some small bussiness like vegetables or flowers selling or some eatables after their household work. To get them for training for 6 days it is not possible unless we give some incentives. We give Rs50for 6days if they attend with out failing. We ask them to put another Rs20 more each and start savinngs. They rotate this ~~meny~~ capital among members on intrest what ever amonnt they have. In one of the slums, our women have saved up to 30,000Rs/- within 8 months time. In all these slums women do not take money from moneylenders. We also help them to get loans to do some bussiness from Working Women's Forum. Our women have to take responsibility for running all these programmes. They are the office bearers and managers of their development.

As a result many of them ~~going~~ reduced or even stoppd going for movies using toom much flowers in their heads, drinking too much coffes/teas and chewing tobaco. They leamned to save and aware of the evil of the moneylenders.

Impact on health : In every slum, we have 2/3 volenteers to take responsibility of the area. The sick people who are really need of hospital care are to be brought to the hospitals by these women leaders. We contact them to orgaise any programme conduted by us or any other organisations. There are a lot of improvement in the personal and surrouding hygiene, and also nutritional status,concened. They are capable of handling diarroeas, disentries, jaundice, cold &cough with home remedies and herbal medicines. There would have been better result if government could have given proper houses, drinking water, and sanitary facilities. It needs more organisational efforts and political approach.

Impact on mental health: During the six days health programme, we discuss and in the mahilasamaj meetings, we discuss about mental health, and how to recognise their emotional problems, and how to channelise their emotions for a better purpose. Many women say that they if they had this sort of training earlier they would not have made this much of blunter in their lives. Now many of them know how to resolve their anger, anxiety, resentment, and fear and thus help them to prevent unnecessary misunderstandings and quarels. It helps them to build up a better self-esteem and courage and motivates them to be helpful to others. We do counselling to the people esp. to women when they are in need.

Marriage Counselling. The women themselves have realised that WEEPs (Women's Education and Empowerment Progs.) are not enough for their liberation and development. They have requested to have a programme for their husbands too. As a result, we have conducted a day counselling session for 20 couples and 10 singles at I.S.I. We are thinking such sessions more and more during this year in joining to work with the international theme for the year of the family. If families are set right the whole society will be in order. We have helped 6 fam broken families to come together and live as couples.

Adult literacy : It is very difficult to get women for adult literacy. They do not have much time after their household work, and also they have to maintain the homes since their husbands spend everything on their drinking and their own self-enjoyment. Yet, we have 40-50 women in 3 centers who have learned to read and write. Many of them realised the value of literacy and send their children to the schools, and also they take responsibility for their education and proper upbringings.

Legal literacy : To create awareness on legal rights among women is a part of WEEPs. Sometimes, we invite lawyers to our slums and other times, we bring women to I.SII to discuss about legal matters. We helped a few individual cases with proper guidance and advices.

In one of the slums called Nagasandra colony, the women were treatend by some gundas in the night and we helprd the women to write an application and submit to the police station. The S.I took a real interest and send the police men for protection. There was peace for a few months. Again the problem began our women themselves got organised with out our help and went to the police station. The S.I agreed to help them and was happy for their courageous action.

Our Impression : Jayamma & I recall often the first batch of women who were so shy and shivering. To-day, most of those women are working mostly as volenteers and take lead for their developmental programmes. They have brought back a few couples who were seperated for years and helped them to live as happy couples. They are capable of organising, holding the meetings, addressing certain gatherings, managing with saving shemes and so on. Four of them addressed to the conventoin held 1993 by religious men &women of Justice & Peace Forum of Karnataka, at I.S.I. on women's liberation struggles.

Perhaps our attempt helps to buid a foundation. We encourage

them to cooperate with anybody who helps them with other activities for their development. In mamy of the slums, besides KSDF &the governmental and non-governmental like [illegible], Peoples Education Society began with tailoring night classes for drop outs etc.. The Family Planning Association of India has started doing the similar health programme like ours in the same localities and we are planning to go to other area where there is nobody help the people. we thought of visiting these slums where we had alkinds of programmes only ocasionally.

Though our approach looks like a few drops in the ocean, we do belief that our programmes enbled them to respond many ways to solve their problems. With out having a proper foundation no body can build walls and roof. We are happy to look at the achivements throuh our little input.

Reported by,

Sr. Marina Kalathil rgs.

Spiritual Well being : Spiritual health / well being is a part of total well being accordin g to WHO. According to my own experience ~~with myse~~ as well as the experience with others with whom I work I can say health is not completed with out a spiritual well being.

We discuss about the superstitious beliefs and certain religious taboos and practices that create many physical,mental,social,and economical problems. At the same the need to Have a right belief and attitude towards the God Almighty the Creator,who is supernaturally powerfull and who is mercyfull; ~~who who is~~ who forgives our mistakes; who inspires right things; who gides , provides and cares for us;whom we can trust so that we do not need to live in anxiety and fear.~~which again affects our health.~~ We need to avoid selfish desires and ambitions and search for truth, peace and harmonye ; and to see good in others and do good ~~others~~. for others.

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BACKGROUND PAPER - II

THROUGH THE URBAN LOOKING GLASS

THE IMPACT OF URBANISATION ON HEALTH*

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INTRODUCTION

Cities, the cradles of human civilization have existed for atleast the last 6000 years. Few ancient cities were large by modern standards - only one achieved the size of a million people. In 1950, there were 10 metropolitan areas with population size of 5 millions or more. By 1990 there were 33 cities with size of 5 million people or more, 15 with 10 million people or more and 6 with 15 million people or more. The greatest increase in urban population growth today, stems from high birth rates with rural-urban migration playing only a secondary role.

In a study conducted by the Population Crisis Committee in 1990, 58 of the world's 100 largest metropolitan areas have been found to be in the developing world and of these 9 are in India. All 9 were ranked "poor" using a cross-cultural Urban Living Standards Score.

* under publication of Physician's Update : Dec 1991

The Impact of Urbanization on Health

How does rapid urbanization impact on health? Rapid growth in cities leads to:

- *increased demand for resources*
- *increased utilization of available resources*
- *increased pressure on the physical environment*

This results in 3 main groups of health hazards:

1) *Those that are economic in origin*

   Large income disparities, limited education, poor dietary practices, over-crowding and insanitary conditions, all of which increase the risk of malnutrition as also diseases of infective origin such as gastroenteritis, typhoid, cholera, acute respiratory infections, tuberculosis.

2) *Those that are related to the man-made urban environment*

   Industrialization, pollution, traffic, stress, alienation which increase the risk of diseases such as chronic respiratory problems, allergies, traffic injuries, chronic multifactoral diseases and psychological disturbances and breakdown.

3) *Those related to social instability and insecurity*

   Promiscuity, prostitution, child labour, alcohol/drug abuse leading to high rates of child deaths and illnesses, sexually transmitted diseases including AIDS and alcohol & drug dependence.

THE GENERAL PRACTITIONERS' VIEWPOINT

From the point of view of the General Practitioner, this rapid urbanisation may throw up a greater number of the following kinds of cases:

1) Communicable Diseases

It must be understood that the Urban Community forms a single ecosystem with intimate interconnections between the affluent and poorer sections. Thus while on the surface, the likelihood of such diseases as TB, Cholera & Dysentery and Measles appears to be less amongst the affluent, these possibilities cannot be ruled out. Certainly amongst the marginalised urban poor, infectious diseases constitute the bulk of all cases seen. In fact, viral infections are often superceded by bacterial infections in those groups because of greater exposure and lowered immunity.

2) Malnutrition

The incidence of malnutrition (both undernutrition and overnutrition) in urban areas is high. The urban poor suffer from undernutrition because of reasons of poverty and ignorance. The urban elite often suffer from overnutrition and diseases relating thereto. In both, this is the result of a fast changing lifestyle, consumerism and a break from traditional dietary practices.

3) Lifestyle Diseases

Though urbanisation appears to increase the occurence of lifestyle disease, this may not strictly be true. Early

and easy access to better diagnostic and therapeutic medical facilities may have a lot to do with this seeming increase. However, it cannot be denied that urbanisation does affect a number of parameters which may increase the possibility of developing lifestyle diseases eg. ischaemic heart disease. cancers, diabetes, stroke etc.

4) Problems of women and children

Statistics show us that indices such as infant mortality rate are much better for urban centers in India than the rural areas. This is with good reason. The care facilities of urban areas as well as the tendency of women & children to present themselves to a medical practitioner is much higher than in rural areas. The problem is really one of continuity. Having a greater variety to choose from, urban patients tend to drift from doctor to doctor with predictable impact on the quality of care received.

5) Sexually Transmitted diseases (STDs) including AIDS

Owing to greater promiscuity and the establishment of prostitution secondary to poor social networking in urban slums, the incidence of sexually transmitted diseases in these groups tends to be much higher. Given the natural connections between this group and middle class and affluent groups - STDs are not uncommon in the entire urban community. One study in Vellore revealed that HIV positivity rates among the general antenatal clinic population was as

high as 0.45/1000 as against the estimated national prevalence rate of 0.64/100,000.

6) Chronic irritant & Allergic Respiratory Problems

As the city grows in population, congestion and pollution increases. In the Population Crisis Committee Study, rankings for air quality of Indian cities were amongst the lowest in the world. Consequently many disease eg.bronchitis, asthma etc. are endemic to large urban centers.

7) Traffic related injuries

Increasing motorization and poor town planning in association with large disparities in travel modes results in large numbers of road traffic accidents. While the pedestrian is the most vulnerable, motorcycle accidents are fairly common. Many of these are amenable to primary care by the general physician. With the Supreme Court ruling regarding the primacy of medical treatment of victims over the processes of law, care of road traffic accident victims has become less onerous for the general practitioner.

8) Alcohol/Drug Dependence & Psychological Problems

These are related to breakdown of traditional social networks and the rapid rate of change in urban life. Very often, these cases may present themselves to the general practitioner under the guise of other more easily defined physical symptoms. It would require a high index of suspicion and a sensitivity on the part of the practitioner to identify these problems which may require referral to specialist institutes.

CONCLUSION

Urbanisation in India is proceeding at an unprecedented rate. Rapid growth puts inconceivable pressures on the infrastructure and physical environment of urban areas leading to a demand for resources unmatched by their availability.

This results in the genesis of 3 main groups of health hazards leading to an increased risk of malnutrition, communicable diseases, lifestyle diseases, problems of women & children, sexually transmitted diseases, chronic irritant & respiratory diseases, traffic related injuries, alcohol & drug abuse and psychological problems.

A high index of suspicion and a concern for these diseases and their impact on the lives of their patients would help make the urban practitioners' practice of medicine a more meaninful one.

Suggested Reading

1. Population Crisis Committee: Cities - Life in the Worlds 100 Largest Metropolitan Areas: 1990.
2. I.Tabibzadeh, A.Rossi-Espagnet, R.Maxwell: Spotlight on the cities: WHO:1989.

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First National Conference of Health Officers of Municipal Corporations And Major Municipalities 1987

SOUVENIR

20th & 21st February 1987

ASHOKA HOTEL

Kumara Krupa Road, Bangalore

CORPORATION CONCERN ON HEALTH FRONT

Dr. G. N. DASAPPA
M.B.B.S., D.PH.
Deputy Health Officer, Bangalore Mahanagarapalike

Bangalore City which has grown by leaps and bounds during the last decade is fast loosing its reputation as "GARDEN CITY", "AIR-CONDITION CITY" AND "PENSIONEER PARADISE". A combination of factors came into plans and city leap-frogged to the population peak of 30,40,573 (1986 Mid-year) from its previous 16 lakhs in record time.

The fifth largest City in India and the Capital of Karnataka which is located 931 meters above sea level (latitude 12.58' North and longitue 77.36' East) has attracted people from far and near. It is also the base for several industries large and small. The rise in numbers has in turn caused the invitable growth in residential and commercial buildings, entertainment out-lets like theatres, clogged the city roads with more vehicles and lead to the virtual dis-appearance of ponds and lakes in the City.

Yet another complex factor in the multi-dimensional growth of the city is influx of people from neighbourlng states making the city into a melting pot of the culture.

Viewed against this background the task of the Bangalore City Corporation to provide amenities to the citizen is quite formidable. The range of its service is vast and varied, water supply and sanitary facilities, illumination for roads, formation of foot-paths, parks, play-grounds, markets, schools and health services. Besides it has to ensure clean environment. All these services it may be stressed and fulfilled through the financial resources of Corporation itself.

Foremost among the services of the Corporation is in safe guarding the health of the citizens. This is done through the department of health. Following are the highlights :—

M.C.H. & Family Planning Services are given to the People of Bangalore City through qualified doctors. There are 29 Maternity Homes and 38 Family Welfare Centres in the Corporation to provide M.C.H. Family Planning Services to the people in addition to the services given in five Govt. hospitals and four private hospitals.

In these Maternity homes & Family Planning Centres, Health-Education, Antenatal Care, Natal Care, Post natal care and laboratory services are given to the people. 40% of the total delivers of the city are taken place in the Corporation maternity homes only. Much attention has been given to the Family Welfare Planning Work, as it is a National Programme wherein the pregnant women are supplied with iron and Folic Acid preperations to prevent Secondary Anaemia. Immunization of expectant mothers and infants/children are done and Terminal sterlisation and other spacing methods are given. For the year 1985-86 the Government of Karnataka has awarded the prize to the Corporation having achieved 103 5% of the sterlization target.

To achieve this target special campagin was taken up and publicity materials were made available. The press, T.V., AIR and Cinema slide advertisements were given and additional incentive were given by the Corporation to the acceptors and motivators. There is a full pledged hospital for M.C.H. Care where major surgical procedures are taken up. Two paediatric Centres are functioning with the qualified doctor to provide services to the children.

100 Anganwadi Centres are established in southern portion of the City where primary health care is given to children in each Anganwadi. Slum children of 0-6 years age group are given milk and bread every day with the assistance of social welfare department.

Universal Immunisation Programmes :

Bangalore has the distinction of being the First City to launch Mass Immunjsation drive in the Country, in joint collaboration or Government of Karnataka, Rotary Internal Dist 319 and Medical Colleges of Bangalore during the month of November, December '86 and January '87, Though the compagin was a partial success it generated sufficient awarness among parents to get their children immunised.

Statement of MCH Work :

Years	Anc. Examination	Deliveries Conducted
1984-85	62147	56085
1985-86	97037	51425
1986-87 Apl. to Jan. 1987	73325	41685

Statement of Family Welfare and Immunisation Work :

Year	VC/TO	LTO	IUD	DPT/POLIO	TT (Preg)
1984-85	20216	1293	12271	77844	49965
1985-86	27379	2418	14361	74542	60206
1986-87	24414	1690	13932	60524	47061

April to January

Preventive Health work is being carried out by qualified doctors in 12 Sub-Health Centres, wherein Anti-cholera, Anti-typhoid, Anti-Rabic innoculations are given, Birth and deaths are registered. The certificates are issued in these centres.

Immunisation work against Six diseases, D.P.T., Polio, B.C.G., and Measles are given in routine in all the M.C.H. and Family Planning Centres including 14 Corporation dispensaries.

People of Bangalore City are getting their Medical services in 14 allophatic; 1 Ayurvedic, 1 Unani Corporation dispensaries, 25 local fund dispensaries aided by the Corporation in addition to the 12 Govt. Major Hospitals and 4 private hospitals.

Slum population are getting their medical service through 4 Mobile dispensaries.

The communicable diseases occured in the city are admitted and treated at Isolation Hospital and Sanitoria. All communicable diseases are investigated and appropriate measures are taken to arrest further spread of diseases in the City. Throughout the year Gastro enterities and a few cholera cases are common in the City.

Statement of Communicable Disease

Year	Gastro Entorctis		Cholera		Jaundice		Tetanus	
	A	D	A	D	A	D	A	D
1985 Jan. to Dec.	1458	38	153	9	40	9	148	53
1986 Jan. to Dec.	2508	53	248	–	19	–	155	58
1987 January	38	–	1	–	–	–	12	3

Year	Encephatilis		Diphitheria		Hydrophobia		Chickanpox	
	A	D	A	D	A	D	A	D
1985 Jan. to Dec.	1	–	128	1	31	14	189	1
1686 Jac. to Dec.	23	10	82	2	34	8	63	–
1987 January	1	–	5	–	4	2	6	–

Year	Measles		Musuges		Dhooping Cough	
	A	D	A	D	A	D
1985 Jan. to Dec.	113	2	–	–	–	–
1986 Jan. to Dec.	29	–	6	–	–	–
1987 January	7	–	–	–	–	–

Prevention of Food Adultration has been done as per P.F.A. Act. The knowledge of food adultration has been convened to the people through demonstrations, lectures and film shows in different localities of the city. In Mahila Samaja's and Schools. Regular food samples are collected from different establishments by qualified 12 food inspectors. Each Food Inspector has been given a target of 20 samples per month.

These food samples are being analysed in the Corporation food laboratory by the qualified Public Analyst. Food samples given by private agency are also analysed in the laboratory. The laboratory is helpful in detucting the food adultration launching cases.

Statement of Food Adultration :

No. of Samples Received	No. of Samples analysed	No. of Samples found Adultration	REMARKS
	From August 1983 to March 1984		
1200	1200	54	
	From April 1984 to March 1985		
1854	1854	100	
	From April 1985 to March 1986		
2234	2234	100	
Total 5288	5288	426	

No. of Samples received : 5388
No. of Samples analysed : 5388
No. of Samples found adultrated : 426

Mosquito

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Mosquito Control And Urban Malaria Control :

Under this scheme the anti-larval and anti-adult methods are adopted throughout the city regularly.

1) Weekly larvicidl like (MLO Bytex, Abate, Paris Green) spray are done to eliminate Mosquito breeding places in and around the city.

2) Regular desitting of small and big storm water drains are done to maintain the free flow of water in the drains.

3) Deweeding of water Hyacinth and other vegetations is being carried out in the tanks.

4) Gambusia Affins and Hebistes reticulatus are introduced into the Drinking water wells, and pools and ornamental tanks and fountains.

5) Filling up of ditches abondend wells, queries are also done.

6) Pyarethrim spray has been taken up in some of the localities where the adult mosquitoes density is more.

Under the Urban Malaria Scheme Active Survillance has been carried out in the slums by the Dist. Health Staff. Passive survillance has been carried out in all the dispensaries M.C.H. Centre by the Corporation and local Fund dispensaries. The blood films are examined and data of blood smear collections and positive cases of the major hospitals and Nursing homes in the cities are also coilected and recorded. All the positive cases are treated radically either by the Staff of the Bangalore City Corporation or by the Staff of the District Health and F.W. Officer, Bangalore depending upon the jurisdiction of the case. Majority of the cases were found to be imported on investigation.

Year	B.S. Collected and Examined	Malaria Parasits Positives		Tota
		P. Vivase	P. Vivase P. Faliparem.	
1984	46,692	32	4 –	36
1985	50,008	31	1 –	32
1986	57,610	40	2 –	42

Entomological Work :

Assessment of the Antilarval operation work is being carried out, independently by 20 Insnct collecters working under the Sr.Biologist, Adulters Mosquite collection is being carried out for two hours by each insect collector every day and the mosquito- breeding places are checked for the presence of larve, covering the whole area under the Mosquito Control Operation once a week. The following Species of Mosquitoes are prevailing in the City.

(1) A. Culicifacies, (2) A. Stephensi, (3) A. Fluvistilis, (4) A.Subpictus, (5) A. Vagus, (6) A. Hyricanus, (7) A. Turkhudi, (8) C. Quimquifasiatus, (9) C.Hellidus, (10) C.Vishnui, (11) Armigees, (12) Lutizia, (13) Mansonoides species and (14) AC.Aegepti. The highest density of mosquito is noticed between August and November, the density of malaria vectors is below the critical density.

Conservency Services:

Keeping the city clean is one of the responsiblities entrusted to the Health Department. The people of Bangalore city are provided a clean environement by keeping the city clean by regular sweeping of roads, foot paths, drains and markets and transporting the rubbish away from the City. This work has been done by 12 Asst. Distriot Health Officers of the Corporation. 1500 to 1800 tons of rubbish is generated everyday in the City. Out of which 200 tons of rubbish is utilised by Karnataka Compost Plant for the manufacture of manure. The rest will be dumped in the low lying areas on the out-skirts of the city. In recent years, the Mechanical Sweeper has been itroduced to clean the major roads in the City. Mechanical Compactor Machine and 55 Tipper trucks have been introduced for the quick transport of rubbish from the city. Financial constrant have in the way of going modern. Small tillers are also used to collect the rubbish from the narrow lanes and by-lanes of congested localities.

An agency has come forward to make use of the rubbish generated from the City in producing gas. This project report has been submitted to the Government for its approval.

Another agency has come forward to make use of the rubbish in preparing pallets. This pallet can serve as cheap fuel substitute.

Bangalore City Corporation has constructed twelve "SULABAH SOUCHA-LAAYS" Public latrines and Bath Rooms in important places like Bus Stands and slum localities to provide sanitary facilities to the Public. In addition to this a number of public urinals have been provided in the City wherever it is necessary.

Rabies is one of the deadly diseases transmitted to the human beings by the bite of Rabid dogs. Stray dog nuisance and their bite to the public is one of the problems of the city which has been tackled and controlled by catching stray dogs throughout the city. every day an average 90 stray dogs

are caught by means of 4 dog catching squad and these dogs are kept for 3 days in the dog pound and then elecicuted. An agency has been entrusted to take the skin of the dogs for the manufacture of leather goods.

Statement of Stray Dogs :

Year	No. of Dogs Caught	No. of Dogs killed
1985		
Jan. to Dec.	23,072	22,238
1986		
Jan. to Dec	32,660	32,373
1987		
Jaunary	2,594	2,557

The growth of parthenium plant in vacant places in the City has posed a big problem to the people of Bangalore City. The parthenium plant is not only a nuisance but also produces allergic reactions like Allergic Rhunitis. Allergic Boonchitis, Bronchial Asthma contact dermatitis in some of the people.

This has been tackled by the health authorities as much as possible by up-rooting the plant and burning. An attempt has been made to kill this plant by using chemicals like Glycilbut, it is very expensive. Now a new approch has been taken up by sowing an harmless "Cassia Serecia Seed" found and developed by the Sciantists of University of Agricultural Sciences, Bangalore, to control and curb parthenium growth in Bangalore City.

The City Corporation has provided Ambulance Services to carry Sick people to different hospital on nominal charges. Hearse Van services are also provided to carry dead bodies to the burial grounds and burning ghats. There are 4 Ambulances abd 6 Hearse Van for the use of public. 26 Burial grounds and burning ghats including 3 electric crematoria are maintained by the Corporation, Health Department.

GROUP DISCUSSION ON COMMUNITY PARTICIPATION DURING THE WORKSHOP ON IPP VIII PROJECT FOR BANGALORE CITY SLUMS TO GARNER THE VIEWS OF THE PVO'S & SLUM RESIDENTS ON 13-1-1992 AT MAYO HALL, AFTERNOON SESSION.

GROUP	RESOURCE PERSON	REPORTER	PVO'S	SLUM REP	SUBJECT
Group I	Dr.G.LOKESH DR Rajanna	Dr.DEVAKI	K.K.N.S. BOSCO Nellurlahalli Habitat Committee		Felt needs of slum dwellers: a) Identify the felt needs of people. b) What is the proority in these needs. c) What is the Health needs.
Group II	Dr.S.D.NAGARAJ	Dr.S.B.NAGARAJ	INTACH CUC Women's Voice		Project Proposals: a) What are your proposals to achieve their needs. b) Review the current propcsals. c) Is your proposal is included in the current proposal- Do you want any change.
Group III	Dr.KUMARSWAMY DR. Padmakumaraswamy	Dr. DAS	Nirmala Trust. CCF		Planning & Evaluation: a) How to implement this proposal. b) Inputs for implementation c) What is your role in this?
Group IV	Dr.GOVINDARAJU	Dr.S.M.KALLIGUDD	Community Health cell MILT		Implementing authorities: a) Who are the implementing authorities? b) Local committee formation-involving corporate staff. c) Officials of corporate staff PVO's and other agencies d) What should be the functions of local committees e) Do you suggest any changes.
Group V ✓	Dr.~~SUSHEELA SHEKHAR~~ DR. Sundar	Dr.THADAVAMURTHY	FPAI RSDS Physically Handicapped		Funding: a) Who is to fund for this project. b) What is your contribution. c) Who has to operate the fund.

DEV 3.28

PLAN FOR DELIVERY OF FAMILY WELFARE SERVICES IN SLUMS

BASED ON THE NEED ASSESSMENT OF SLUM DWELLERS(IPP - VIII)

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EXECUTIVE SUMMARY

The Urban population of India is growing at an alarming rate. By the year 2000 AD it is estimated that about 350 million population will live in urban areas. Out of which, about 40 percent will live in slums with characteristic over crowding, poor environmental conditions, non availability of drinking water, absence of proper drinage system and minimum level of residential accommodation.

Bangalore is a fastest growing city in India with a total population of 41 lakh. This uprecedented, unplanned growth has resulted in the growth of many slums (401) and lack of basic civic amenities. Health facilities due to lack of resource and lack awareness about effective utilization, have not kept pace over time. Thus prevantable and communicable diseases are still a major health problem in slums. This reflects the paucity of organized and planned health services provided by the net work of hospitals, health centres, maternity homes and dispensaries. Out-reach services of these institution do not exist or are inadequate to meet the primary health care needs of the slum dwellers. Bangalore City Corporation covered only 64 slums. Remaining 337 slums are left uncovered.

An IDA team of the World Bank visited the slums on October 12th 1991 of Bangalore city along with officials from the Department of Health, Government of Karnataka and the Health and Engg. departs officials of the Corporation. they were able to sense the magnitude and nature of the problem on a first hand basis and had thread bare discussions with the concerned implementing officials. In response to these problems, a plan for health care delivery has been prepared. This is based on an attempt to satisfy the felt needs of the slum dwellers.

At this juncture, it is necessary to make a thorough introspection into the health care delivery system of Bangalore City Corporation, so as to over come dificiencies and meet the challenges of "HEALTH FOR ALL BY THE YEAR 2000 AD. This may require a little restructuring of health services. In the present proposal efforts are made to identify problems to strengthen the delivery of integrated family welfare and primary health care services to urban poor. This is consistant with the objective of the " National Health Policy" which aims at taking the services nearer to the door steps of the people and ensuring

full participation of the community in health development process. It is proposed to reorganize and strengthen the existing facilities as per the requirement. **Strengthening of out reach services and dynomic involvement of community in taking care of its health development needs are the main points of the present proposal.**

Various objectives and strategies for improving the delivery of integrated family welfare and primary health care services are:

Specific Objectives:

1. To improve the quality of the family welfare, MCH and primary health care services to the slum population.

2. To strengthen the existing health and family welfare delivery services in city and establishing new facilities.

3. To involve the Non-governmental organisations and Private Medical Practitioners in the delivery of family welfare services in urban slums.

4. To provide integrated services of MCH & FW by involving the community in decision making planning and implementing.

5. To provide quality of training to staff by comprehensive and regular inservice programme.

6. To provide quality of training to staff by comprehensive and regular inservice programme.

7. To provide health education to community through the involvement of local leaders and voluntary organisation.

8. To expand the family welfare and MCH services in Bangalore City.

Strategies

The following strategies will be used to achieve the above stated goals and objectives:

1. Development of effective out-reach services;
2. Strengthening of infrastructural facilities;
3. Involvement of private medical practioners and PVOs;
4. Intensive IEC campaign.
5. Improving the Meternal and Child Health Services by providing a comprehensive health care for 50,000 population by strengthening the existing centres and opening new centres.
6. Improving the antenatal services by utilizing the services of link workers/50,000 population.
7. Stream lining the management information system.
8. Strengthening the training and in service training facilities
9. Monitoring and evaluation and operational research.

A Health Centre will cover a population of 50,000 and will be located in the slum or periphery of slum for its optimum utilization by slum dwellers or likewise population. This community based services backed by an effective outreach and referral services will provide preventive, promotive and simple curative health care, leaving a small quantom of curative problems that will require referral to hospitals. Most of these centres will be located near to or within slum areas so as to improve the physical accessibility and utilization.

Family welfare and Primary health care services will be provided through link workers, domiciliary visits of ANM/LHV. To back up the services, one out of every four health centres will be upgraded to have in-patient facilities with 25 beds. For this purpose, some of the existing maternity homes will be selected. The services will include:

1. Care of pregnant women including treatment of specific nutritional disorders

2. Safe deliveries.

3. Post natal care including care of new born

4. Nutritional care upto the age of five.

5. Immunization against vaccine preventable diseases.

6. Advice, supplies and facilities for Family Welfare.

7. Health and nutrition education especially the need for breast feeding and weaning practices, immunization, nutritious diet during pregnancy and lactation, etc.

8. Treatment of minor ailments of women and children.

9. Knowledge of vaccine preventable diseases and diarrhoeal diseases.

10. Detection of suspected cases of TB and Leprosy and their referral and follow-up.

SETTING UP OF NEW HEALTH CENTRES AND UP GRADED HEALTH CENTRES

It has been estimated on the basis of projected population i.e. 48.78 lakh by 1995, that 97 health centres and 24 upgraded health centres will be required. The breakup of health centres and upgraded health centres is as follows:

STATUS	HEALTH CENTRE	UPGRADED H.C.
Required	97	24
Existing	37*	30 Mat.Home
Addl. requirement	60	24**

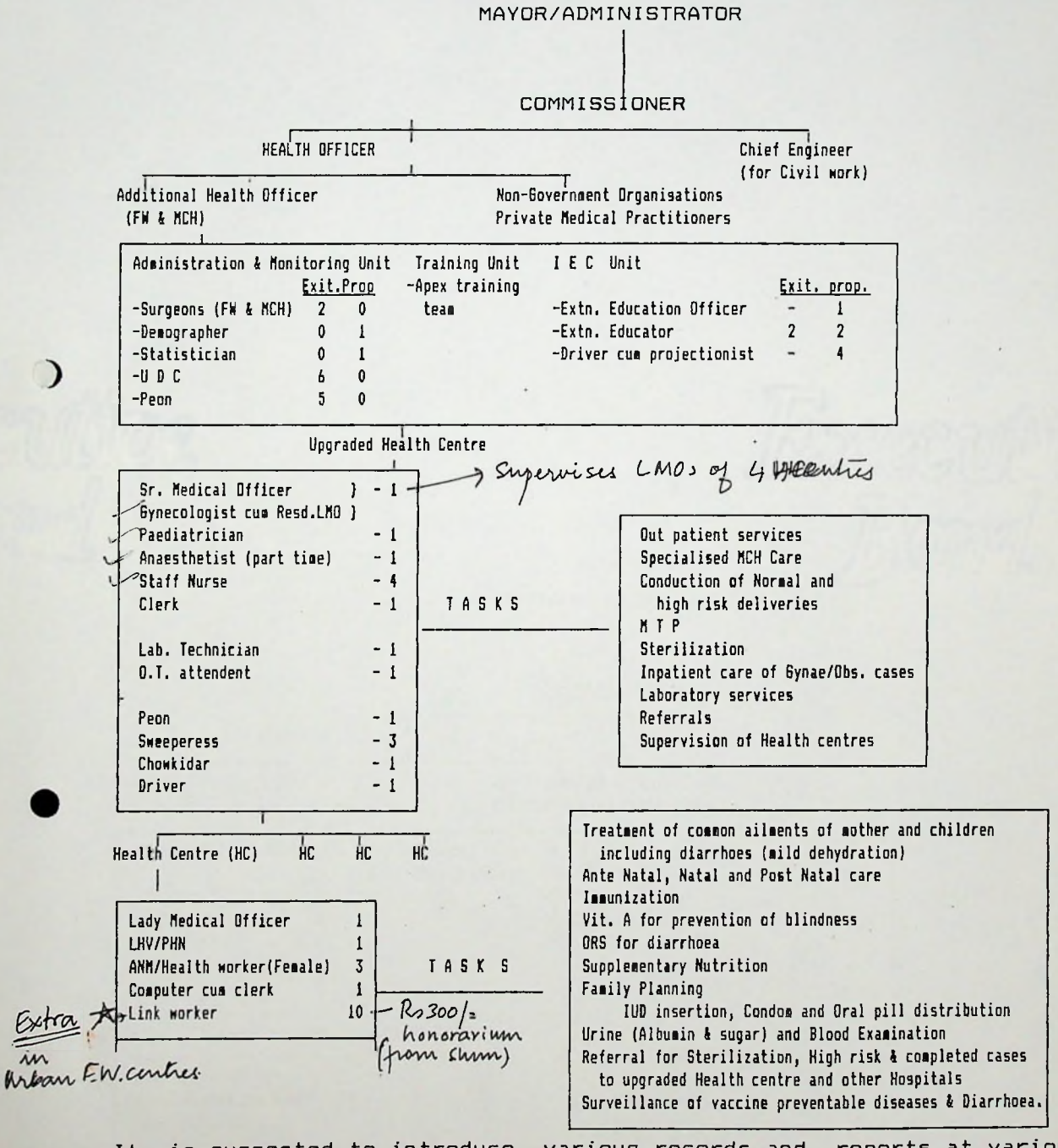
* Strengthening in terms of staff, equipment, drugs and contingencies.

* Strengthening in terms of staff, equipment, ambulance, drugs, staff quarters(only fof 6 centres) and contingencies.

Strengthening of existing centres and setting up of new centre will be taken in phased manner as follows:

YEAR	I	II	III	IV	V	TOTAL
New centres (60)	25	20	8	7	0	60
Strengthening of 37 HCs	12	10	7	4	4	37
Strengthening of 24 UHCs	9	8	4	2	1	24

Strengthening of existing HCs and UPHCs and setting up of new centres will be taken up from the periphery of the city.



It is suggested to introduce various records and reports at various levels, right from the field staff, HC and UPHC, to monitoring unit. So the information can flow both ways i.e. from field staff to the decision maker and vice versa.

Training is an improtant component of the proposal. Its major objects is to instal an out-reach/extension bias in the health functionaries. Training will be carried out at different levels for different categories of Health workers.

T R A I N I N G P L A N

CATEGORIES	VENUE OF TRAINING	TRAINERS	DURATION	TRAINING NEEDS	TRAINING METHODOLOGY
1. Apex training team	National Institute of Health and Family Welfare Services, NEW DELHI.	Faculty from NIHAFWS	3 working days	a) Emerging Urban Health needs and problems of slums. b) Project strategy for delivery of Family Welfare Services. c) Communication Technology d) Planning and organisation of training programmes and management techniques.	Lectures/discussions and group discussions
2. Sr.Medical Officers, specialists, Gynaecologist Paediatrician	H.F.W.T.C.	Faculty from H.F.W.T.C.	2 working days	a) Motivational technology with special reference to Family Welfare. b) Inter personal communications	Lecturer/discussions Demonstration and Field training
3. Extension Educator	H.F.W.T.C.	Faculty from H.F.W.T.C.	4 Days	a) Planning, organisation and evaluation of training communication techniques in health and family welfare, production and testing of training & communication materials. b) Extension techniques, planning, organisation and testing of training/communication centres.	Lecture/discussions group discussions and field training.
4. LMOs, PHNs, LHVs.	H.F.W.T.C.	Faculty/ H.Officers SMOs, Extension education officer	5 Days	a) Problems of Urban Primary Health Care, new approaches. b) Use of communication strategy in training. c) Awareness creation, motivational technology. d) Management techniques e) Clinical update f) Monitoring and supervision	Lecture/workshop, group discussions and field experience.
5. Health worker	Health centre	SMO/MO Extension Educator	5 days	a) Update in prevention and promotive health care. b) Antenatal checkups, deliveries Postnatal check-ups. c) Identification of high risk mothers	Lecture/workshop field experience and practical training/ demonstration.

CATEGORIES	VENUE OF TRAINING	TRAINERS	DURATION	TRAINING NEEDS	TRAINING METHODOLOGY
				d) Care of new born & infants e) Motivational techniques person to person communication f) Maintenance of various records and reports.	
6. Link workers (Dai)	Health Centre	PHN/LHV,ANM Extension Educators	30 Days	a) Contacting community for awareness creating. b) Motivating women particularly pregnant women. c) Update on delivery method, aseptic delivery, care of pregnant women, postnatal care, care of infnats and care of minor ailments in the community.	Lectures/group discussion Demonstration, Roleplay Field observation and practical training in real situation.
7. Private practitioners, NGOs and Karnataka Slum Clearence Board (KSCB) workers.	Health Office	Health Officer consisted by extension educators	1 day orientation /seminar.	a) Orientation to innovation approach/extension approach	Lecture,individual presentations and discussions
8. Anganwadi worker	Health centre	LHV/PHN Extension Educators	1 day orientation	a) Contacting community for awareness creating. b) Motivating women particularly pregnant women for ANC and T.T. Immunization.	Lecture/Role play.

A survey conducted in slums of Bangalore revealed that 85% of population is availing the services of Private Medical Practitioners(PMPs). It is because of fact that they are in large number and have high level of local acceptance and respect, particularly in slum areas. So, the success of implementation of the programme of strengthening of family welfare services in urban areas will also depend largely on the involvement of PMPs and NGOs providing these services.

During the interviews with PMPs, all PMPs expressed their willingness to participate in the Government Health programme. So, it is proposed in the plan to identify the PMPs and NGOs and involve them in the following activities:-

Suggestions

- Health Educn. camps
- 87% go to PMPs in Emergency.
- Use of home remedies etc - 5 to 6%

- Health Educn. mainly in centres as ⟨films. slide shows.
  NIL in community in past 5 to 6 mos.
- Info. from TV / Radio - Fr 30% } on child immunizn] + Mala-D etc.
  Rural 21% } + Suppl. diets etc.

Health functionaries as source. — 12% of respondents

Gap between [Health services provided] & [needs of people]

No info. on female literacy.

PLAN FOR INVOLVEMENT

AREA	INSTITUTION	TASK	SUPPLIES (free)	RECORDS	REPORT TO
Immunization (free)	Nursing Homes Polyclinics clinics/ dispensaries	Immunization of eligible children attending institution	Vaccines Cold chain equipment	List of Immunised children dose wise Mothers TT	UFWC/ area ANM
Family Planning	Nursing homes Poly clinic clinic/ Dispensaries	F.P.services including MTP(only Nursing homes)	IUCDs Oral Pills Condoms	Appro- priate register of servi- ces done	Area UFWC/ ANM
MCH-ANC, Natal PNC	Nursing homes Poly Clinic Clinic/ Dispensaries	Motivation for regis- tration & referral to appropriate institution	Iron and Folic acid and TT	Appropri- ate regis- ter of work done	Area UFWC/ ANM
ORT	Nursing homes Poly clinics clinics/ dispensaries	Assessment of degree of dehydra- tion and treatment	ORS Pkts.	Appropri- ate regis- ter of work done	Area UFWC/ ANM
Health Education	do	Motivation & advice on Preven- tive Measures	Leaflets Posters etc.	----	---

To strengthen the communication support of training activities and inter-personnel communication for attitudinal changes it is proposed to establish one IEC unit. This unit will be responsible for planning and organization of Health education activities in the city and coordinate with ANM/LHV and male worker in the conduction of health education activities.

Mode of Funding the Project:

Government of India will give 90% grant-and remaining 10% will be provided by State Govt of Karnataka. State Government has committed to make a budgetary provision.

As. Mohd's survey:

Started in 1982 - chairman's - S.K. Krishnan - PLAN FOR CITIES
pop - 5 lakhs & above.

In IPP-8 - 4 cities taken up.

B'lore - April 1991. study in slum areas - 401 slums
64 Corpn. / 64 BDA.
rest uncovered.

Divided B'lore into 9 parts - 12 slums selected.
(N.A.L. map). ★ 600 households proportional to size of slum.

★ - Fly. shd. have young couple 15-45 yrs - at least 1 living child.
Avg. family size - 5.5
56% popln. < 40yrs age. } 49% utilize services/aware of.

Medical care / usage / satisfn. / distance / illness / TB & Malaria.
MCH services details. / Vital info. registrn.
Health Educn. source / Water supply / Environmental sanitation.

- 84% - going to PMPs - 78% satisfied ē services.
- All slums surrounded by PMPs.

Services not used because (142 families) - overcrowding / long waiting
- Lack of attention
- Non-availability of medicine - 41%
- Behaviour of health staff not good - 42%

Focussed interview - women (e.g. delivery after false labour)

Ante-natal services - poor. - only in 3rd trimester.
T.T. immunizn. - 53%.
Deliveries — 85% - unbooked - came as emergency.
Post-natal care - NIL. in 151 births in last year.
Services - Immunizn. / child exam. / Fe + Folic acid / Vit A / Curative services.

- 47% Respondents aware of preventable dis.
- 45% → 2 children ideal family size.
- 48% - → Effective Couple protection rate.
- Registration of Vital events → poor.

PMPs: - Antenatal care / Post-natal care / Immunizn. /
- 10% MTP facilities.
- Distribution of oral pill only. / No condoms etc.

Areas of co-opern. - Immunizn. / Curative / FP. / ORT.
- peoples participn.
- identifying lacunae in services
- motivate community to utilize services.
- T.B. referred to Govt. hospital / Investigation

Suggestions: - Health facility near community - 85%
- Accessible / available at low cost.
- Lady doctor needed ē Specialists in OBG / Paed.

Project Implimentation :

It is proposed to establish Project Advisory and Coordinating committees (PACC) at state and corporation level. The Committees will include the representative of Key Ministries / Departments, PVO's and slum Communities. A committee of resource persons is also proposed.

With the objective of community participation Local committees will be formed where in the community members will participate in decision making, planning and implementation of the project. Functions, Roles and participatory management of various services by local committees are given in Annexure - I, II & III

Chaired by Corporator of the area

DEV 3-29

ಭಾರತೀಯ ಜನಸಂಖ್ಯಾ ನಿಯಂತ್ರಣೆ (ಕುಟುಂಬ ಕಲ್ಯಾಣ) — 8 ಲಕ್ಷ
ಜನ ನಾವಾನಿಕರ ಸಹಭಾಗಿತ್ವ ವಿಚಾರದ ಕಾಂತರ್ಗಾರ.
13-01-1992.
IPP-VIII < Family Welfare >

ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ನಿಯೋಜನೆಯಲ್ಲಿ ಕೊಳಗೇರಿ ನಿವಾಸಿಗಳ ಅಗತ್ಯಗಳ ನಿರ್ಧಾರ ಮತ್ತು ಕಾಂತರ್ಭರಣೆ.

ನಿಯೋಜನೆಯ ಸಾರಾಂಶ :

ನಗರ ಪ್ರದೇಶಗಳ ಜನಸಂಖ್ಯೆಯು ದಿನೇ ದಿನೇ ಹೆಚ್ಚುತ್ತಿದ್ದು ಬೆಂಗಳೂರು ನಗರದಲ್ಲಿ ಈ ಒತ್ತಡದ ಕಾರಣದಿಂದ ಕೊಳಚೆ ಪ್ರದೇಶಗಳು ಬೆಳೆಯುತ್ತಿದೆ. 2,000 ವರ್ಷದ ಅವಧಿಯಲ್ಲಿ ಶೇಕಡಾ 40 ರಷ್ಟು ಬಡ ಜನರು ಕಲುಷಿತ ಪರಿಸರದಲ್ಲಿ ಬದುಕ ಬೇಕಾಗುತ್ತದೆ. ಬೆಂಗಳೂರಿನಲ್ಲಿ 401 ಗುರುತಿಸಲು ಪ್ರದೇಶಗಳು ಇದ್ದು; ದಿನ ನಿತ್ಯದ ಅತ್ಯಗತ್ಯದ ಜೀವನ ಸೌಲಭ್ಯಗಳಾದ ನೀರು, ಒಳಚರಂಡಿ, ಮನೆಗಳು, ರಸ್ತೆ, ದಾರಿದೀಪ ಮತ್ತು ಶಾಲೆ, ಆಸ್ಪತ್ರೆಗಳು ಇಲ್ಲದೆ, ಅಲ್ಲಿ ವಾಸಿಸುವ ಸುಮಾರು 6 ಲಕ್ಷ ಜನರು ಹುಲಿಹಕ್ಕರು ಬಗೆಯಂತ ರೋಗರುಜಿನಗಳಿಂದ ನರಳುತ್ತಿದ್ದಾರೆ. ಪರರಿ ಪರಿತಿ ನೀಡಲಾಗಿದೆ.

ಈ ಕೇಂದ್ರ ಸರಕಾರವು ನಗರದ ಕೊಳಚೆ ಪ್ರದೇಶದ ನಿವಾಸಿಗಳ ಆರೋಗ್ಯ ಸುಧಾರಿಸಲು ಮತ್ತು ಜನ ಸಂಖ್ಯಾ ನಿಯಂತ್ರಣಕ್ಕಾಗಿ ಎಂಟನೇ ನಿಯೋಜನೆಯನ್ನು ಹಾಕಿರುತ್ತಾರೆ. ವರ್ಲ್ಡ್ ಬ್ಯಾಂಕಿನ ಸಹಾಯದಿಂದ ಈ ನಿಯೋಜನೆಯ ಕಾಂತರ್ಭರಣೆ ಮಾಡಲಿರುತ್ತಾರೆ. ಈ ನಿಯೋಜನೆಯ ಉದ್ದೇಶಗಳು ಕೆಳಗೆ ನಮೂದಿಸಿದೆ :—

1. ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮವನ್ನು ಇನ್ನೂ ಉತ್ತಮ ಪಡಿಸುವುದು.
2. ಸ್ಥಳೀಯ ಸೇವಾ ಸಂಸ್ಥೆಗಳು, ಖಾಸಗಿ ವೈದ್ಯರ ಸಹಕಾರ ಮತ್ತು ಲಿಕ ನಿಯೋಜನೆ ಯನ್ನು ಕಾಂತರ್ಭರಣೆಗೆ ತರುವುದು.

::2::

32 crores

ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪಾಲಿಕೆ ಜನಸಂಖ್ಯೆ ಆಧಾರದ ಮೇಲೆ ಬೇಕಾಗಿರುವ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು 97. ಈಗ ಹಾಲಿ ಇರುವ ಕೇಂದ್ರಗಳು 37. ಅಧಿಕವಾಗಿ ಈ ಯೋಜನೆಯಲ್ಲಿ ನಿರ್ಮಿಸುವ ಹೊಸ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು 60. ಉನ್ನತ ಶ್ರೇಣಿಯ ಹೆಸರಿನ ಆಸ್ಪತ್ರೆಗಳು 24 ಮತ್ತು ಅಭಿವೃದ್ಧಿ ಪಡಿಸುವ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು 37 ಇರುತ್ತದೆ.

ಯೋಜನೆಯ ಕಾರ್ಯಾನುಷ್ಠಾನ :

ಭಾರತೀಯ ಜನಸಂಖ್ಯೆ ಯೋಜನೆಯ ನೆಲಹ ಮತ್ತು ಸಹಾಯ ಸವಿತಿ.

ಕರ್ನಾಟಕ ಸರಕಾರ ಮತ್ತು ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪಾಲಿಕೆಯ ಮಟ್ಟದಲ್ಲಿ ಯೋಜನೆಯ ಅನುಷ್ಠಾನಕ್ಕಾಗಿ ನೆಲಹಾ ಮತ್ತು ಸಹಾಯ ಸವಿತಿ ರಚಿಸಲಾಗುವುದು. ಇದರಲ್ಲಿ ಸಂಬಂಧಿಪಿದ ಖಾತೆಗಳ ಅಧಿಕಾರಿಗಳು, ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳು ಮತ್ತು ಕೊಳಚೆ ಪ್ರದೇಶದ ಪ್ರತಿನಿಧಿಗಳನ್ನು ನೇಮಕ ಮಾಡಲು ಸೂಚಿಸಿದೆ.

(ಲೋಕಲ ಕವಿಟಿ) ಜನಸಾಮಾನ್ಯರ ಸಹಭಾಗಿತ್ವಕ್ಕಾಗಿ ಸ್ಥಳೀಯ ಸವಿತಿಯನ್ನು ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳ ಮಟ್ಟದಲ್ಲಿ ರಚಿಸಲಾಗುತ್ತದೆ. ಇದರಲ್ಲಿ ಗುರಿಸಲು ನಿವಾಸಿಗಳ ಪ್ರತಿನಿಧಿಗಳು, ವಿಭಾಗದ ನಗರ ಸಭಾ ಸದಸ್ಯರು, ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಯ ಪ್ರತಿನಿಧಿಗಳಾ ನೇರಿ, ಆರೋಗ್ಯ ಕೇಂದ್ರದ ವೈದ್ಯಾಧಿಕಾರಿ ಮತ್ತು ಇತರ ಸಿಬ್ಬಂದಿಗಳಿರಾಡಗಾಡಿ ಯೋಜನೆಯ ಧ್ಯೇಯದ ಮತ್ತು ಗುರಿ ಸಾಧಿಸಲು ಸಹಕಾರ ಮತ್ತು ಭಾಗಿತ್ವದ ಕಿರಿಯಾ ಭಾವದಿಂದ ದುಡಿಯಬೇಕಾಗುತ್ತದೆ. ಪರಿಸರ ನೈರ್ಮಲ್ಯ; ಸಾಂಕ್ರಾಮಿಕ ರೋಗಗಳ ನಿಯಂತ್ರಣ; ಪ್ರಾಥಮಿಕ ಸ್ವಾಸ್ಥ್ಯತೆ ಕಾಪಾಡುವ ತಿಳುವಳಿಕೆ; ರೋಗಗಳನ್ನು ಪಾರಂಭಿಕ ಹಂತದಲ್ಲೇ ಪತ್ತೆ ಹಚ್ಚುವಿಕೆ, ತಡೆಗಟ್ಟುವ ಕ್ರಮಗಳು ಮತ್ತು ಅವುಗಳ ಚಿಕಿತ್ಸೆಯಂತ ವಕ್ರವಸ್ಥಿತ ವೈದ್ಯಕೀಯ ಮತ್ತು ಶುಶ್ರೂಷಾ ನೇವೆಗಳನ್ನು ಒದಗಿಸುವುದು ಮತ್ತು ಪ್ರತಿಯೊಬ್ಬ ಪ್ರಜೆಯು ಉತ್ತಮ ಜೀವನ ನಾಗಿನುತಾ " ಆರೋಗ್ಯಕ್ಕಾಗಿ ತವಕ್ಕ ಜನಸಿದ್ಧ ಹಕ್ಕು " ಎಂದು ಮನಗಾಣಲು ಸಾರ್ವಜನಿಯ ಯತ್ನಂತ್ರವನ್ನು ಅಭಿವೃದ್ಧಿ ಪಡಿಸಲು ವಕ್ರವಸ್ಥಿತ ಸವಿಯ ದಾಯ ಶಕ್ತಿಯಂತ ಮತಾಲಕ ಹೋರಾಡ ಬೇಕಾಗಿದೆ.

DEV 3.30 (102)

Documented Reference: Draft

From: Karnataka Kolageri Nivasigala Samyukta Sanghatane, B'lore.

III.1.1 Committee Dr. Mani Kathiall

URBANISATION:

Comm. dev. Support Prog. for Housing Projects
- A problem solving Approach
— Mike Slingsby

- Developing countries do not have the resources available to meet t. shelter needs of their growing & migrating popn. in the form of large scale govt. construction prog.

- Most households solve their own housing problems - however doesn't enable to improve living conditions
- no security for permanent house
- no basic amenities or services.
water, sanitation, health, education, employment

Ref: 'Housing & Development'
- Kirtee Shah. Ahmd. Study Action Gp.
- Dr. W.J. Cousins, Urban Adviser, UNICEF

'The present crisis in the housing sector is largely the crisis of inappropriate invention. The major fault lies in ignoring people's skills, genius & resources. Therefore, policies, prog & projects need to be

re-oriented to put people in the centre of the housing process.

Questions raised:

1) what are we trying to achieve by Comm. dev. support for housing projects
2) how is comm. support cmp.?
3) how to dev. a prob. solving approach.
4) who should do what?

Mike

'The ultimate goal of ~~Comm~~ CD support projects is the integration of slum & poor comm. into the econ. & social network & phy. fabric of our towns & cities. The slums should not only physically improve but as part of this process an important psychological change needs to take place. People living there should no longer consider themselves a 'slum dwellers' & more importantly officials & other citizens should no longer think that 'those people live in a slum'. The integration of those comm. into the life of the city can be described as the absorption of newcomers'.

- Integration — regular employment.
  - access to health.
  - education & recreation facilities.
  - adequate housing.
  - access to basic services / amenities.

an ability to pay for these

(S) Much of our urban planning has been for the urban-rich, ignoring the urban-poor.

Very few land-use & dev. plans indicate the areas occupied by the urban poor. & almost none show activity areas essential for the livelihood of the majority of the citizens.

Eg: cycle shops, shoe repairs, informal markets, small tea shops do not feature on our western model dev. plans.

CDS Prog: converts households from a group who need & use services into people who can demand them.

(S)

Comm. based Support Prog: can help. Comm. identify their problems & priorities, use their awareness of what can be done & help them select from a range of components. The prog can ; act as a ~~educator~~ facilitator of a comm. needs not as an implementor of preconceived proposals. The very poor families who are pushed aside by the relatively better off when it comes to access to newly provided facilities, can also be protected.

Planning & implementing agencies have seen the solution to housing problems in physical terms. eg the provision of infrastructure & the construction of houses, a linear process = a defined beginning & end.

(2) A problem solving approach involves a cyclical process of prob. analysis, identification of resources, synthesis, dev. of objectives & strategies, implementation of prog. & project monitoring & evaluation. Performance is measured agt. objectives & not the previous years achievement & the problem is redefined as situation changes. One of the greatest resources in relation to housing problems is the people themselves & therefore the management of human resources becomes a critical component in the strategy.

Adoption of above → identification of for counting projects
a set of objectives

Areas where
- objectives
- comm. awareness gen.
- encouragement to dev self reliance

a) assist households to solve their own shelter problems
b) to assist households in improving their health
c) Assist households to use their income
d) to improve educational levels.

Who should do what:

3 q/s concern in CDSP for housing

1) poor urban comm. & their fly's.
   - prog. focus comm. & component fly's.
   - dev. & management of these human resources

2) Voluntary agencies offering specialist skills, facilitators management expertise or their own packages of prog.

3) Govt depts & their prog implementing agencies:
   - have financial & manpower resources to make a major impact on the prob of the urban poor.

Conclusion:

CDSP for shelter has mainly been in the form of medical action dealing with prob that have arisen during the implementation & management of physical improvements. It has not been seen as cost effective & has been given a low priority.

There is strong evidence to suggest that CDSP which focus on the achievement of comm. needs can rapidly accelerate dev of households & their rate of absp into the econ & soc network & thus fabric of the city.

not to be implemented as integrated
hsg. schemes packages.

- Paper presented at Int. Symposium on 'Implementation of a Hsg Policy for Housing Prov.' held at Dev. Planning Unit, University College London, London → Dec, '85

Mike Dingsby
- Vis. Prof., Columbia Plan Tech. Cooperation officer, Centre for Human Settlements, School of Arch & Plning, Anna Univ, Mad - 600025

(6) Article:

The Urban Shelter Problem
the Sites & Services Solution
– Pradip Bidwai

Like mass poverty, scarcity of housing has persisted as an intractable problem & has remained an abiding feature of the Indian reality. Year after year. The two forms of degradation are directly linked: lack of shelter & steady degradation is an inseparable part of poverty.

And yet, provision of shelter has never been at the core of any govt prog of poverty amelioration. The official approach to the shelter prob has been singularly unimaginative & patently unrealistic, consisting for the most part in creating a relatively small amt of expensive but low-quality housing stock which not only the poor but, strictly, even the middle class can't afford.

This approach has persisted despite the growing acuteness of the shelter prob in the cities. In the country's metropolises, the housing crisis has acquired an explosive character

– 1/2 of Bombay populus in slums
– 2/5th of Delhi — " — "
– nearly 1/2 of Madras — " —

In gen, there is evidence a growing failure of the cities to give shelter to their people.

11) Locational patterns of slums in Bl'lore city indicate that > 90% of slums are located in proximity of res. land uses & only 6% are located in indust. & comm. areas.

12) Shortage of 25 m dwelling units

Backlogs for 1985 { 19 m in rural areas / 6 m in urban

Req by 1990 16 m in all { 12 m rural / 4 m urban.

13) Est: slum & pavement dwellers constitute between 20% & 40% of various urb. centres.

6th plan est: numerical magnitude in 1985 = 33.1 m.

Due to public agency participation } - 15.6 m. dwellers benefitted by slum improv. prog by 1985

Backlog 17.5 m. people to be prov. housing

(6) In Bl'lore city: 50% slums of priv. lands
30% on govt & city corpn. lands mostly intended for comm. purposes.

(5) Refer Draft Statement on 'The Financing of the Urban Poor: Why & Whom?'
- KK.NSS. Bl'lore 22-24th Oct '85,
Nat'l Seminar on 'Financing the Urb. Poor'.

6) City villages: Having a rural outlook to life, but, juxtaposed in an urban system. These 'city villages' ..... - as dairy prodn.
- small scale agriculture
- domestic services
- labour.

Thrive right for their development

7) People can do a great deal themselves & an awareness of their own potential. To solve their own problems is an essential part of the process.

8) Locational patterns of slums in Bglore city indicate that > 90% of slums are located in the proximity of res. land uses & only 6% are located in indust. & comm. areas.

9) On the basis of '81 census:

Off. est. of urban popln in 1991 would reach 236 m or 27.6% of country's popln

& in 2001 @ 315 m or 31% of country's popln.

10) # of 'million plus' cities rose from 9 to 12

a/c for 27% of urb. popln of country.

Class I' cities (> 1 lakh popln) → 60.2% of total popln

TIT-BITS

1) Bihar the 6th largest city in India .... asso' with ---- famous for its historical & architectural ---

2) Bangalore, 5th largest Metropolis of India ---
Growth rate 7.6% .... City not been able to absorb rapidly continuous & ever rising urban growth ---- lagged behind in infrastructural services, community facilities & housing ---

3) Slum Clearance efforts : ---- well-intentioned yet affected by - changes in political climate
- moods of local politicians
- indiscriminate bulldozing
& fancy expensive multistoreys.

4) Slum clearance treatments :
- Conception functional & life style interaction patterns, living habits cultural traditions coping & a transient urban culture.
- uneconomic, socio-culturally undesirable - multistoreyed Concrete boxes - highest tenpose usually defeated.

5) HUDCO provides loans at the 6½% for housing of low income families. - to be repaid in monthly instalments over a period of 20 yr.

the feelings of fatalism & inertia in attempting to tackle the most critical prob. of the poor. The time has come, & now, to bring the vast masses of the urb. poor in the framework of a Natl. policy & planning to treat them as equal & deserving citizens & to make serious efforts to bring about improvement in the quality of their lives.

Ref:

1) The Urb. poor (AM Singh & A De Souza, 1980)
2) Urb. Growth & Urb. Planning (A De Souza 1983)
3) Planning commn. task force. 1985

19) Urban land policy — Policy & Practice — KKKSS

20) Towards a policy on Slums
(Extended Synopsis)
H. Ramachandran

1) Land tenure for the urban poor
Shlomo Angel
AIT, Thailand

'Let us set a limit to the amount of land an individual may own, give the excess land to those who really need it, & put a stop to the conc. of land ownership as in the hands of the few'.

Tung Chung-shu, an official of the Han Dynasty & a contemporary of Emperor Wu (140-86 B.C.)

Slums are only one manifestation of shelter crisis. There are many others: rising congestion & growing shortage of inadequacy of water supply, sewage & sewerage; rising #'s of unsafe & dilapidated dwelling; skyrocketing rents & prices of real estate; & consequent squeezing of the middle class out of the prop. market; forced suburbs which imposes an unbearable burden on transportation systems & claims a heavy toll of India as well as social time & energy; a growing drain on household incomes & savings, an rising fraction of which is claimed by rents & repayment of housing loans; a sharp & sustained decline in the quality of life for the vast majority of the urban popln. & growing marginalisation of the poor & even the MC; & an rise in family tensions, psychological distress, insecurity & growing disorientation all around

(7) Situation of the Urban Poor: Why & Whom?
(Draft Statement) Nath. Seminar on 'Housing the urban poor. KKNSS Oct 7 85

Slum & pavement dwellers: overwhelmingly poor & rural migrants seeking less depriving econ. conditions

Services: 'I-thou' attitude.

The model of econ. dev adopted at the Natl. level favoured — concentration of public & private resources in metrop. cities so that their productive & service infrastructure presents a picture of glaring, socio-economic inequalities. Under cover of a concern in the Master Plans & planners have are regarding & urban poor, for the urban poor, & to treat them as the major obstacles to urban dev. & their envt'l improvement

level of orgns. → ~~fo~~ uneven & thin.

mainly org against eviction & demanding of housing, land ownership & tenancy rights

Alternative:. Natl. movt. demanding planned urbz. & need based models of dev.

Now most planning geared at beautifying cities, the urban poor beneficiaries of charity prog. — needed: matter of rights

Planners emphasis → (productivity) = industrialisation for urban elite.

The harmonious blending of the socio-economic prog & the spatio-environmental factor has been the cardinal distinguishing feature attracting global attention in Natl. Urban Housing policy:

(18) Housing the Urban poor - KKNSS Oct'85

The thesis that slums are an inevitable consequence of dev & that in a gen. or two everyone would catch up has now been discarded on the grounds. Time & again these perceptions have been proved to be ill-founded & misinformed as the slum dwellers are found to be as productive & law abiding as any other citizens. They keep the wheels of industry moving & provide other valuable services.

The new approach (a fashion of the day!) is to see slums & its victims out of villains, save our unenlightened Govt. Thus, the present cry in various circles is for a more sensible & comprehensive urban planning / coupled with hard laws.

Outlook: More than 60 y ago, when Mr. Gandhi was asked what had distressed him most in this country, his answer was simple & apt. He said, "the hardness of heart of the educated". His assessment was & continues to be right. For, there is no section of the Indian people that is currently more sorry for itself than the educated.

One section of the educated is taking up the cause of the poor motivated by a deep sense of conviction & radicalism, setting out to shape its efforts at developing a socio-economic & political change, to be achieved along socialist options.

Emotional outlook

The other section, not unknowingly, pushes the poor to starvation & death quoting 'democratic framework' shedding crocodile tears for the poor brethren. On one hand, this section understands the needs of the poor; on the other refuses to part with the cake.

Conclusion:

Slum dwellers: 1/3rd of urb. popln. of our cities
occupy 6-10% of urb. land
consume 3-5% H_2O
0.6 to 2% electricity.
Contribute 56 to 82% of indirect taxes
51 to 63% of GNP of cities where they live in

It must be recognised that slum & pavement dwellers are at present an integral & essential part of the urb. econ. & are engaged primarily in hawking & labour-intensive work of the lowest status & income in the urb. occupational hierarchy. Their work is essential for the efficient functioning of the urb. economy & irreplaceable

Voluntary agencies & action grps, efforts fragmented & complicated by indefinite problems.
- Role as intermediaries & govt agencies sporadic.
Barring a few ad-hoc, random, take-them or leave-them or do-it-yourself suggestions, they have not recommended any specific strategies or concrete plans of action.
Even if done, only a beginning.

It has been found that it is easy to get things done that govt for a couple or two slums; but this is not going to solve the problems as a whole (in totality). Compared to the magnitude of the prob, the contribution of the public agencies is meagre. To achieve results it is absolutely necessary that the attitudes of each of the activist group - both towards the slum dwellers & other groups, - & accordingly recast our policies, plans, progs & projects.

The immensity & complexity of the problems of urb. poor many seem to defy immediate or even long term solns., yet the action group & Vol. Ag. must be aware of

life which is often on the outskirts of the nearby urb. centre. This sort of development of relatively isolated township can be seen in Bawala, Uttara & Bhore. Water supply, Sanitation & social services for these two townships is also planned in isolation from what is happening in the urb centre. This isolation has ser consequences.

- Firstly, the township can't use effectively the service facilities available in the urb. centre, particularly in the central area. Secondly, the urban centre, cannot benefit from the facilities created to service the township. There is ∴ a need in such cases for a systematic assessment of the likely impact of the project on in-migration, gen. of direct & indirect employment, transportation & other service activities & the implied infrastructure req. The resp. for undertaking these investments have then to be apportioned betw the existing city & the proj. management. The integration will have to be ensured by

Recommendations for coordination

Lower level links:

- possibility of forging a link between industrial & urb. planning depends on the extent to which the two processes can be controlled by pub. authorities.

Steel towns.

Steel plant employs 20000 to 30000 workers
- necessary to estb. new town & arrange for planning this town in project planning exercise.

Planning exercise for such new industrial towns must (a) allow for a population size much larger than that attributable to the steel plant

(b) a large number of econ. activities linked to but not a part of steel plant.

Other towns & major projects:

Major proj. other than steel also not gen. involve the estbl. of a large new town in a region area. The cases covered under this category gen involve the estbl. of a township near the project

VI Coordination of Industrial & Urb. Growth

— It is necessary to have much greater co-ord - of industrial & urb dev than has hitherto been the case. — there is little linkage between the forming of urb infrastructure, both phy & social & that of industry

- Policies concerned w the location of industry are not coordinated w the provision & funding of urban services, most w asso' comm. & transport facilities

— imperative that industrial location measures & measures for housing & shelter for pop working for these industries should be linked to urb. dev. prog. —

Some thro' reg & sub-reg dev plans so that the needs of diff kinds of investment are coordinated.

Coordination of State & Metro Plng

— A more org dialogue needed — State plans to include a 'Metro Sub-plan' for metro cities in each state. — Sub dev plan be prep. for each state on req. lines.

Coordination of Physical, Financial & Investment Plng at the State Level.

— Due to variety of metro plng authorities, diff to provide uniform institutional recommendations for all metro cities — need for MPA.

—

City surveys:

— A crucial issue in plng is how to ensure that metro. plng caters to the need of all income grps of the popn & respect to shelter, employment as well as the distr. of public services. — need for a comprehensive household / employment sample survey which should be conducted in each of metro cities every 5 y, prep to plng exercise

independence in the hierarchy struc. of the shift ~~to~~ areas of the regn

(b) assessment of the types of industries & other activities that are more suitable for location ~~in~~ in metro areas. The present policy of banning the location & expansion of industry in cities & towns exceeding 5 lakhs can then be modified on this basis.

(c) assessment of the type of industries & institutions that should be assisted to take root in small towns of the region, that would inter-link & each other & the rural hinterland & make optimum use of locally available resources.

d) Above all, the employment that is likely to grow & the implementation of (c) & the provision of housing & shelter as close as possible to their respective places of work of the persons that will man these industries & estab. in the formal & informal sectors

2) the land-use allocation exercise & the studies used do not deal adequately & the prevailing socio-econ conditions in the city & where people live, what they do & where they work.

Net result → Master Plan retains its lofty pictures on paper & seldom capable of being effectively implemented.

- The 12 emerging metro cities are conveniently located in a mosaic of geographical regions in the country. The addition of 8 or 9 more cities into the op by 1991 will further improve their geog. distribution so that each region will then be served by a large city. It is ∴ imp that detailed geog & econ. analysis of these metro regions be initiated on the following lines:

(a) Integration of comm., transport, energy & other infrastructure in the region to bring about better

· the 'intro' of urb economics.

(ii) ~~Mid-career training~~ ;

network of institution to train personnel in.

a) techn urb. plng integrating econ. & phy. approaches
b) transportation plng
c) land management & land prices
d) municipal org, adm. & management
e) municipal finances & taxation
f) urb. inf. prep, monitoring & management.

Info' System for urb. dev plng

vi) Planning for Metropolitan Areas.

- ensure plng largely consists of land-use plng as an aid to dev. control. - suffered from 2-key prob.

i) no connection betw investment implication of a Master Plan & resource availability

c) The local level :

- Municipal bodies to be strengthened for planning needs of each town.

resp. of planning at local level rest c local body

- for planning at intra-city or zonal level Most of the city level planning has been of the top-down variety & has often become little rel. c the needs of people at the neighbourhood level.

Eg: Slum dwellers who have little say in the pattern of delivery of services to them.

- the principles of the urb. comm. dev prog to be adopted widely as a means of ensuring citizen participation in urb. planning at the sub-local level.

Training needs :

(i) Training of Neighbourers :

- Existing town planning courses in the planning schools to be made broader ; management trainings for urb. dev planning to be introd : serious consideration to be given to

Centrally Sponsored Scheme on Urb. Dev. Plng

- It is necessary to launch a Centrally sponsored scheme for fundings the dev of new urb dev plng capability such that the integration of physical, investment & financial plng capability & as envisaged can take place, the Scheme to

Urban Research:

- basic as well as applied research comm. with urbn. to be supported

b) At State level:

Coordination of urb. dev:

- Machinery be estbh. for coord. of func. comm. & urb. dev. — by consolidating various fragments scp. for urb dev under one dept of Human Settlements.

—

out the detailed sub investment implications of prot urbz at least the state level.

— the Town & Country Plng Orgz. to be reoriented & enhanced as a strong tech. arm of the ministry. Dev capability in a he resp. for.

(i) investment plng for sub. dev
(ii) appraisal of sub. project
(iii) setting & monitoring of stds in sub. projects
(iv) evaluation of sub proj
(v) constant search & review of innovative sub. prog
(vi) origin of an sub info system
(vii) training needs for sub dev plng
(viii) stimulating research on sub. sub. dev in-house as well as in other institutions.

— to stress interdisciplining ch. TCPO to be renamed as 'Human Settlements Plng Orgz'.

the Project Appraisal Div, large projects gen. direct ~~evaluation by~~ employment of over 1000 persons or over Rs 50 crore should also be req. to file "Spatial Impact" or "Urban Impact" Statement. The Statement would detail the anticipated direct & indirect costs of urb. infrastructure made necessary by these investments.

Housing & Urb. Dev. Div

- upgrade Housing & Urb dev Div technically to be able to use the info provided by the perspective plan projections & the 'Urban Impact' Statements for comments to Sp. urb. dev proj, projects & schemes

(ii) the Ministry of Works & Housing ;

- the resp. for more detailed urb planning & dev should rest w the Ministry of Works & Housing. This redesignating it as Ministry for Human Settlements — resp for working

& the Ministry of Works & Housing acting as the Nodal Ministry) & other concerned Ministries. Unlike the present ad hoc system of schemes, States should be asked to prep comprehensive State & reg. urb. dev plans to qualify for urb. investment allocation, given the overall cost standards. The latter should take a/c of diff kinds of inter-regional variation.

Recommendations for Institutional Changes

(a) Nat. level

(i) Plng Commn:

Perspective Plng: Need for Integration of Urb. Proj:

- At present there is no mech. in the plan process to work out spatial (regional as well as urb/rural) implications of the sectoral pattern of investment that is envisaged in each 5 yr plan

Urban impact of Projects

- A great # of industrial & other investment decisions have a major bearing on urb. dev. It is ∴ sug. that just as projects over Rs 10 crores are subject to project evaluation by

Magesh Bhagan.

- In towns & cities there is a much greater need for comm. participation as well as the necessity of private initiative & investment in urb. dev. than exists at present. The delivery of the basic public services to everyone is not feasible w/out such an approach. What is needed is comm. level institution building such that the needs of comm. can be expressed in an organised manner as well as services provided in this fashion.

- In order to accomplish this change in approach a number of institutional dev. have to be made to strengthen the procedures of urban dev. plng. at the Natl, State & local levels. The key to the new approach is 2-fold. 1st is the dialogue betw. phy & investment plng & second is the prep. of reg. & sub-regional urb dev. plans to make the 1st possible. What is envisaged is that one nodal

Costing & allocation of resources of urb. dev. should be done at the Natl. level betw. the Plng Commission

IV Mechanisms for the planning of Urban dev.

- Planning for urb. dev should essentially be supportive of econ. dev in the country, State or sub-region, be it in agriculture, agro-based industries, manufacturing industries or in the tertiary sector. The provision of services & infrastructure removes constraints to the growth of these sectors or in some cases, promote it.

Modes of urb. planning:

- There has been very little by way of explicit urb. policy at the Natl. level. The approaches that have been followed can, at best, be described as piecemeal & desultory. 'Integrated' schemes (IUDP) were focussed on towns of diff sizes.

- The planning of urb. dev should be done at a regional or sub-regional level, though this has to be distinguished from regional planning as a whole. Regional urb. systems can be identified acco' to the economic climate, geographical & transportation chs.

- The implications of this rate of change in urb. proptn. are very striking for the rise in urb. labour force. It is expected that while the absolute rise in annual labour force in the next 3 or 4 quinquennia will remain stable at about 22 m in each quinquennium the net additions to urb labour force will keep rising from about 13-14 m in 1981-86 to 19-20 m in 1986-2000. Thus, the net additions to rural & urban labour force will be almost comparable towards the end of the period. This reflects the rising weight of urb. proptn. rises in the total towards the end of the period, despite the relatively lower urban labour force participation rates. During the 7th Plan itself over 3 m urb. jobs will have to be created annually. This calls for special attention to the problems of urb. employment in the next 15 y. Relative to the past

TASK FORCES ON HOUSING & URBAN DEVELOPMENT

I Planning of Urban Development

Planning Commission
Sept 1983

Summary of findings & Recommendations

A. Issues in the planning of urban dev:

Reasons & objectives

- urbanisation is a phenomenon which is part & parcel of economic dev. in gen.

II Urbg in India

- India not faced with a 'urban explosion'
- 1951 – 17%
  1981 – 23.7% Urbg. – no ground for complacency
- Altho' total urb. popln. increased six-fold between 1901 & 1981, from about 26 m to about 160 m, the # of settlements rose by only about 80% to 3245. Thus most of the growth was because of the enlargement of existing towns at every level & not merely because of the addition of new towns

III Urbg in the yr 2001

(Population of India (1981 Census) 782 million)

	1991	2001
Popln.	850 to 860 m.	990 to 1020 m. (practically 1000 m)
Urbgn	27 to 28%	31 & 32 %

negotiations & collaborative efforts
at planning by the local authority
& the proj management. As for
funding there is a case for setting
up a central scheme for project-linked
sub-der which can provide
resources to the local authority
undertaking its part of the
assigned resp. The proj authority
would obtain the funds for its
resp. as part of the proj costs.

- Public sector participation little future sch. Private " involvement. housing/industry.

- Urban slum dwellers - escape tenure rest but demand greater shares in urb. civic services.
  At Natl. & State level - they are poor people at local Govt. level - wealthy citizens

Radical measures
- (1) Introd of USA system for migrant to metrop. cities & approp employ. & accomodation guarantee
  (2) approp amendments to constitution under Art 19(e) to restrict right of movt from any place to metrop. cities (out prior permission & valid documents for domiciliary purposes.

— x — 1986

- Tho' the magnitude of housing prob & infrastructure def attacks the attention of all levels of Govt, the financial burden ultimately falls on State & local Govts. Policy formulation & monitoring being the main func. of the Central Govt, its participation has remained only minimal / extra-financial assistance for metrop. & def & prop of Natl Emp. & also some funds channelled thro' State Govts for selected Centrally Sponsored Schemes.

- New approach in urb planning in major cities incl (a) prob/possibilities of growth of slums
(b) identifying loc. prone for slum formation
(c) taking suff. care to def. them into low income housing colonies.

- whether present urb pattern to be made free to grow as of now?

- a) def of small & medium cities
(b) acquiring lands around them forming concentric circles : Zonings & town planning regulation
(c) def of sat towns around metropolitan cities to reduce press on core cities & town.

Regional Seminar on Financing of Housing & Infrastructure for the Urban Poor

Inaugural Address — Prof D. Lakshmisagar
Hon. Min. for UD., Housing
Parl. Affairs
Govt of Kar.

- Urban poor — to det policies, economics & even sociology of this country in 21st cent
- Present chaotic trends in this group.

- The migratory patterns in the recent past do not justify the thadickonas theses that migration & slum forms, on the effects of industrialisation.
- major reasons for migration during past 2 or 3 yrs is cumulative effect of diff classes of people settling in urb. areas & constituting a major part of tertiary sector involving trade, commerce, banking, transport, & very little industr. base & finally domestic & informal services

- Many studies have shown — imm. effects of rapid urb. & migrants on housing, toll by urb. civic services

National Commission on Urbanisation — Dr. S.C. Jain, Mr. Kirtee Shah

Stats

- The share of poorest 30 percent in the consumer expenditure has remained nearly stagnant during 1958-78

It was 13.2 percent in 1958-59 and 13.6 percent in 1977-78.

Population below poverty line might have gone up from 32 to 58 million.

Recent new responses, for urbanisation problems are

- Sites and Services
- UCD [Urban Comm. Development]
- ICDS [Integrated child Development Services]
- Basic Service approach
- Mid Day Meal
- Small & Medium Town Development

~~The~~ are not even reaching a small fraction of the people they are meant to cover; are often floundering on implementation front; are showing signs of malfunctioning

P-5 - According to 6th Plan 1/5th of the total urban population may be currently living in slums.

The urban population below poverty line would be 62.9 million.

Suggestions on the Urban Poverty theme for the Commission

In order to : (a) clarify perceptions
(b) remove prejudices and misconceptions
(c) raise awareness and build up National consciousness
(d) Develop appropriate policies, strategies, approaches programmes and projects.
(e) design suitable agencies for planning and implementation.
(f) and organise effective action.

CONTENTS

Technical skills of Hygeia and Pankeia (godess who taught how people could stay well and one who used medicines to heal the sick) are not enough. Among the most important determinants of the success or failure of work in health are government and community.

1. Urbanization in India

1.1 Urban Scenerio (1991 Census)

- Total population	844 million
- Total urban population	217 million(26%)
- Total urban agglomeration	3768
- Decadal growth rate (1981-91) percent of urban population	36
- Absolute Increase since 1981	58 million

1.2 Million Plus Cities

- Number of Cities	23
- Population	7.067 crore
- Percentage of total urban population	32.5 %
- Decadal Increase in population	37.88 %

1.3 Class I cities

- Number of cities	300
- Population	12.0 crore
- Percentage of total urban population	64 %

2. Situation of Urban Poor

2.1 Urban Poor

- Official estimates	51[illegible] million (20.1%)
- Alternate estimates	83[illegible] million (40.1%)

Part I

Status of Urban Poor in Indian Cities

CHAPTER 1 - URBANIZATION IN INDIA

According to the provisional figures for the 1991 Census, the total population of India is 844 million (as of March 1991). The total urban population in 1991 spread over 4689 towns and cities is 217 million. Some of the smaller towns (called census towns) are in fact constitutents of larger urban agglomerations. There are 3768 urban agglomerations in 1991. The absolute increase in the urban population during 1981-91 decade has been of the order of 58 million that is decadal growth of 36 per cent. The urban population in 1991 is 26 per cent of total population. Even in 1991 the urban population of India is just over a quarter of the total population. But in absolute terms the total urban population is very high - 217 million. Inspite of the low level of urbanisation in India, the urban population of India is almost the same as total population of USA.

There are significant structural shift in the economy with the share of primary sector declining to nearly one third in the economic output. In the past two decades there has also been a noticeable shift in the structure of employment away from primary to secondary and tertiary sectors. The urban population has grown from 106 million in 1947 to 217 million in 1991. The total urban population of 217 million resides in 3768 urban centres. But 23 metropolitan cities (cities with population above one million) account for 33 per cent of the total urban population. These metropolitan cities alongwith other 23 cities above 1 lakh population each account for 64 per cent of the urban population. Inspite of slower rate of urban growth officially revealed by 1991 census, the population in Mn cities has shot up from 26.4 per cent to 32.5 per cent, as the number of such cities increased from 12 in 1981 to 23 in 1991. NCU report argued that one should take a positive view of urbanisation in India, and the cities should be regarded as engines of economic growth and generators of income and wealth. In fact the NCU coined the acronym "GEM" to denote generators of economic. The objective spelt out by NCU was to make GEMs of as many cities as possible and in their prelimiary exercise NCU identified 329 GEMS spread over 49 SPURS (spatial priority urbanisation region).

2.5 Manifestations of Urban Poverty

- Proliferation of Slums and Bastees
- Fast growth of an informal sector
- Increasing casualisation and underdevelopment of labour
- Crushing pressure on Civic Amenities
- High rate of educational deprivation and health contingencies
- Retarded growth of physical and mental capacities A growing sense of hopelessness among the urban poor resulting in rising crime rate and grou violence

2.6 Reasons mentioned for Programmes not Reaching the Poor

Reasons	Poor (N=190)	Total sample (N=335)
- Corruption	31.6	43.0
- Lack of proper publicity	13.2	19.1
- Lack of administrative commitment, inefficiency	1.6	28.1
- Poor implementation	10.5	23.0
- Political interference	1.6	9.2
- Lack of funds	-	7.5
- Beneficiary if defined	6.8	5.7

CHAPTER 2 - SITUATION OF URBAN POOR

2.1 While the urban centres contribute to nation's prosperity, this prosperity is not equally shared amongst the urban residents. The urban centres present a strange contrast of wealth and poverty. The economic dominance of urban centres is accompanied by widespread poverty, deprivation and marginalisation. The urban poor residents are amongst the worst affected segments of the urban population. Their relative deprivation of income, employment and shelter is likely to be further exacerbated in the initial phase of macro-economic reforms.

Inadequate shelter is one of the most vivid indicators of relative poverty in urban areas. It is estimated that 21.2 per cent of urban population (51-2 million persons) lives in slums. In larger cities 35-40 per cent of population lives in slums. Bombay and Calcutta also have a large number of pavement dwellers who are denied even their basic rights of being recognised as a legitimate resident of urban area for want of an address.

2.2 Urban Health Data

While no systematic urban health data exists at present, the information on urban poor's health and intra urban differentials is still more difficult. The slum based benchmark surveys have been undertaken by UBSP in selected slum pockets of all UBSP cities but the final compilation and analysis of data is still awaited. Sample surveys in slums have also been done under National Institute of Health and family welfare in 'Million Plus Cities' of Madhya Pradesh, Rajashtan and Uttar Pradesh in the year 1991. Preproject studies including Baseline surveys have been done in the slums of cities of Calcutta, Bangalore, Hyderabad and Delhi in the Year 1992. These surveys throw some light on the various health indices of the population living in the slums.

i. NIHFW Study: A sample of 400 households having at least one infant was selected in each city (Bhopal, Durg, Gwalior, Jabalpur, Indore, Jaipur, Jodhpur, Agra, Allahabad, Lucknow, Meerut and Varanasi). The findings reveal that a significant portion of surveyed households in all the selected cities of 3 states have 5 or more family members. Awareness about family welfare services is lowest in Rajasthan. Immunization coverage in M.P. cities was more than 75% for BCG DPT and Polio but only 57% for measles. In Rajasthan and UP it was around 50% except for measles. Effective couple protection rate was 40% in MP, 40% in Rajasthan 33 percent in UP. The major reason for non-adoption of any family planning method was lack of awareness and because they wanted more children. Majority of respondents in all states were for opening of new facilities in their areas for providing family welfare services and providing free medicines at these facilities. Some of the cities also mentioned regarding behaviour of, staff posting of lady medical officer, counselling regarding various FP methods and provision of emergency services at the FW/MCH centres in the area.

ii. IPP VIII Preproject Surveys - were done in the cities of Calcutta, Hyderabad, Bangalore and Delhi. Results have been available from all the cities except Calcutta.

The results show wide variations in the health indices of the slum population in 3 cities. MCH Case Indices - Infant mortality rate was 100 and under 5 mortality rate was 146 in JJ clusters of Delhi. The same was not calculated for other cities. Delivery by untrained Dais was in 74% cases in Delhi while other cities reported 20% and 23%. Maternal tetanus toxoid coverage varied from 57 pr cent to 88 per cent and maternal care from 55 per cent to 89 per cent. Immunization coverage for BCG DPT and Polio was around 60-70 per cent while for measles it was 45 to 60 per cent. The couple protection rate varied from 35 per cent to 50 per cent. Age at marriage was around 15 yrs and at 1st child birth around 16 yrs.

iii. Results of Benchmark Surveys in one of the States

Mother and Child Welfare - Bulk of the females are married before 18 yrs of age. 40-50 per cent of women conceived before 18 yrs of age. Less than one fourth of the wives and one tenth of the husbands reported using family planning methods.

Summit Goal - 1 - Infant and under 5 mortality

Diarrhoea and ARI diseases have the highest incidence in children. In age group 12-23 months 8-43 per cent males and 10-39 per cent females have not been immunised. There are wide variations from town to town with regard to use of ORS to prevent dehydration from diarrhoea (2 per cent to 76 per cent)

Summit Goal II - Reduction of Maternal Mortality Rate

In some of the towns the report of pregnant women availing antenatal services was as low as 2 per cent or 22 per cent. In others it ranged between 46 to 76 per cent. The consumption of iron and folic acid was also on similar pattern. More than half of pregnant women had not been immunised for tetanus. In most of the towns the assistance of trainded person for conducting delivery was availed by nearly half to two third of women. However proportion was quite low in some towns (3 per cent; 14 per cent). Live births with less than 2.5 kg weight were less than 10 per cent in most towns. But in some towns it was 68 per cent, 34 per cent and 45 per cent.

Summit Goal III : Nutrition

Extent of severe malnutrition amongst children below 5 years ranged between 3% and 29 per cent. It was relatively higher in girls than boys. Moderate malnutrition was reported in the range of 19 to 35 per cent in most Towns. The proportion of children reporting use of supplementary nutrition was quite low.

Summit Gola IV - Water Supply and Sanitation

Household water supply was available to around 50% of households in some towns and less than 50% in other towns. Generally open space was used for defecation. Community Toilet facility was virtually non existent.

Summit Goal V - Universal Access to Basic Education

Enrollment at primary level ranged from 41 per cent to 58 per cent. Drop out was very high. At primary level it ranged between 47 per cent to 87 per cent. Enrollment of girls was distintively lower than boys. Drop out rate was quite high. Non formal education did not seem to have made significant impact.

Summit Goal VI - Adult Literacy

The enrollment percentage varies between 0.35 per cent to 5.65 per cent. The proportion of adults enrolled and still attending adult education centres is disappointing.

Summit Goal VII - Protection of Children in 6-14 years.

The number of children who reported working in 6-14 yrs age group was quite low and insignificant in all the towns/urban nits physical disability is the most important handicap from which children suffer. The incidence of handicap in 1-2 per cent.

2.2 Status of water supply and sanitation facilities

- Population covered by water supply system (%) 82.88% - 1988

- Percentage of population covered by sanitation (Latrine only) 43.51% - 1988

- Percentage distribution of households by latrines

No latrines	36.82
Using shared latrines	57.60
Having excessive latrines	42.40

- Type of latrines

Service latrines	28.62
Septic tank	32.72
Flush system	31.86
Others	6.80

2.3 Accessibility of Water Supply in Bastees (NIUA - 46, 1991)

- Average number of persons per facilities

Shallow handpump	523
Mark II handpumps	1661
Taps	315

- Percentage of Bastees having access to (total 589 in 16 states & UTs)

Shallow handpump	27%
Mark II handpumps	39%
Taps	59%

2.4 Sanitation and Garbage Disposal facilities in Bastees (NIUA - 46, 1991)

- Percentage of Bastees with Community Toilets

Men	28%
Women	29%

- Percentage of bastees with rubbish depots 41%

3. Family Welfare Facilities in Urban Areas (MOHFW GOI)

3.1 Urban Family Welfare Centres

-	Type I	455
-	Type II	153
-	Type III	933
-	Central Sector	208
	Total	1749

3.2 Health Posts for Slums

-	A	77	
-	B	84	
-	C	169	
-	D	549	
	Total	879	City FWBU 10

3.3 Category of staff required in health posts

-	Lady Doctor	509
-	Public Health Nurse	509
-	Nurse Midwife	2539
-	Mullipuspose worker(male)	2462
-	Class IV	509
-	Computer	509

3.4 Other facilities

- All India Hospitals Post partum Programme at district and state levels
- India population project - V & VIII
- PVOs supported by MOHFW
- Health component of CUDP III
- UDA slum improvement projects

CHAPTER - 3 FAMILY WELFARE FACILITIES IN URBAN AREAS

3.1 Urban Revamping Scheme :

A working group on reorganisation of family welfare and primary health care services was constituted by Govt. of India to give their recommendation for additional requirements for improving the outreach in urban slums. The recommendations of the working group were accepted by Govt. of India and were sent to various State Deptts. for consideration and approval. As per the recommendations of the working group, the urban areas have been categorised into 4 types of Health posts to be established according to the population. Similarly city FW Bureau have also been categorised into 4 types according to population of the cities. The cities of Bombay and Madras are being assisted by World Bank under IPP-V project. Under this 139 health posts in Bombay and 123 in Madras city have been approved. Urban revamping scheme was initiated in the year 1983-84 and upto the end of 1990-91 adminsitrative approval of Govt. of India for establishment of 936 Health posts and 14 city FW Bureaux has been conveyed to various state Govts. The respective state Govts. have sanctioned a total of 879 Health Posts and 10 city FW Bureaux upto 31st March 1991. In addition to these health posts 1749 urban FW centres old type are also functioning in the country. It was felt that programme was not picking up to the extent it should have been. So it was decided to assess the FW/Primary Health care needs of urban population (especially slums) and formulation of suitable proposals for their strengthening. To start with cities with population over two lakhs (1981 census) were selected for formulation of proposals for strengthening the Primary Health care, FW & MCH Services. NHFW was assigned with the job. The institute conducted workshops in various states for collecting necessary information required to frame proposals for the cities under reference. NIHFW has been requested to frame the proposals for the cities under reference as per GOI norms (Krishnan Committee Report). Other programmes like All India Hospitals Post partum Programme at Distt. and Sub Distt. Level Hospitals; IPP VIII; Health component of CUDP - III; are also providing services in urban areas.

3.2 Problem and issues of Family Welfare Programme in Urban Areas

3.2.1 Lack of outreach : Slum dwellers themselves are reluctant to visit the hospitals and other health facilities which are available in all metropolitan areas. Ignorance of Services available; The cost of travelling to these institutions; negative attitude of health workers to the urban slum clientale have been identified as major reasons for underutilization of government supported urban health facilities. Unregistered private medical practitioners who provide mainly curative care for fees. The lack of an outreach capability, especially one saffed by Medical and para-medical staff who are not alien to slum population, and who are willing to visit and counsel precnant and lactating women and younger couples in their homes in slums, is a major underlying constraints.

COVERAGE DIAGRAM

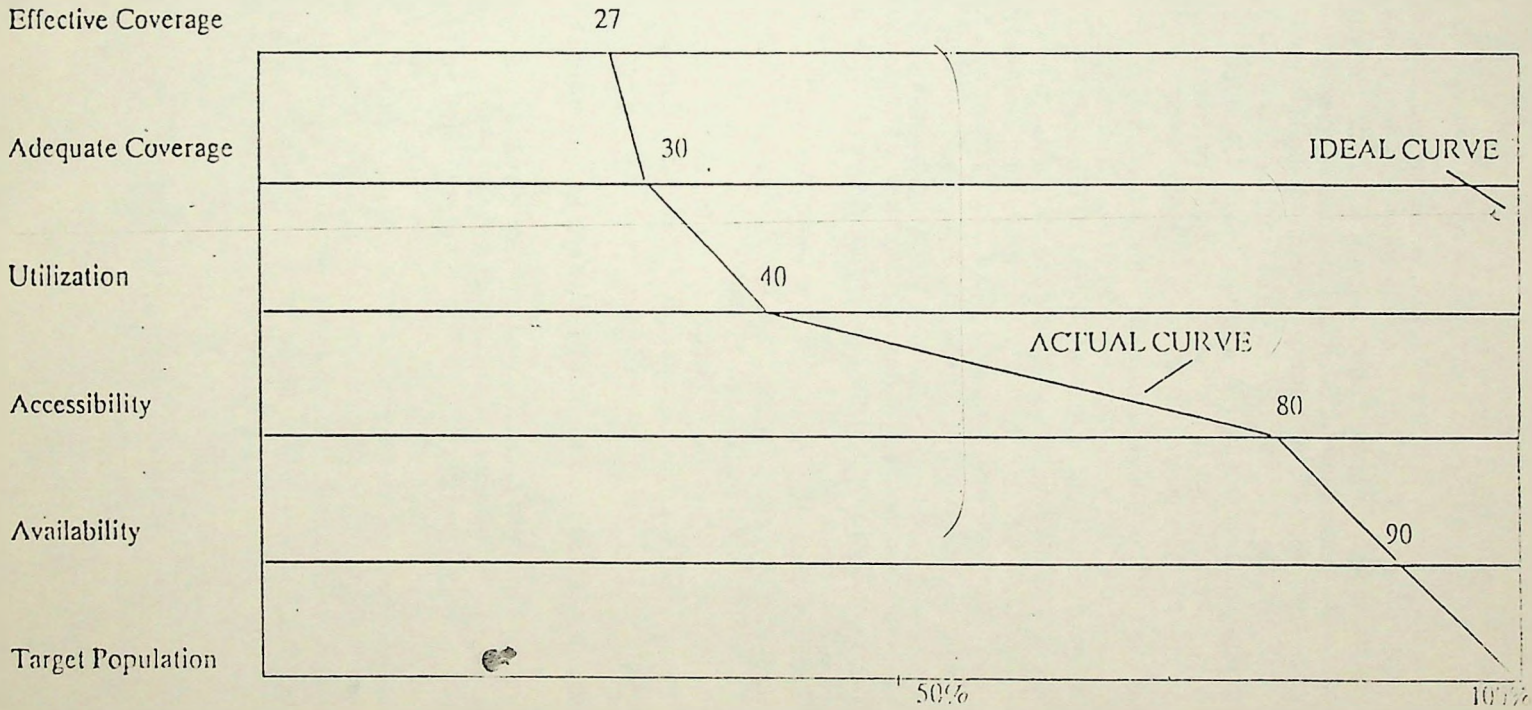
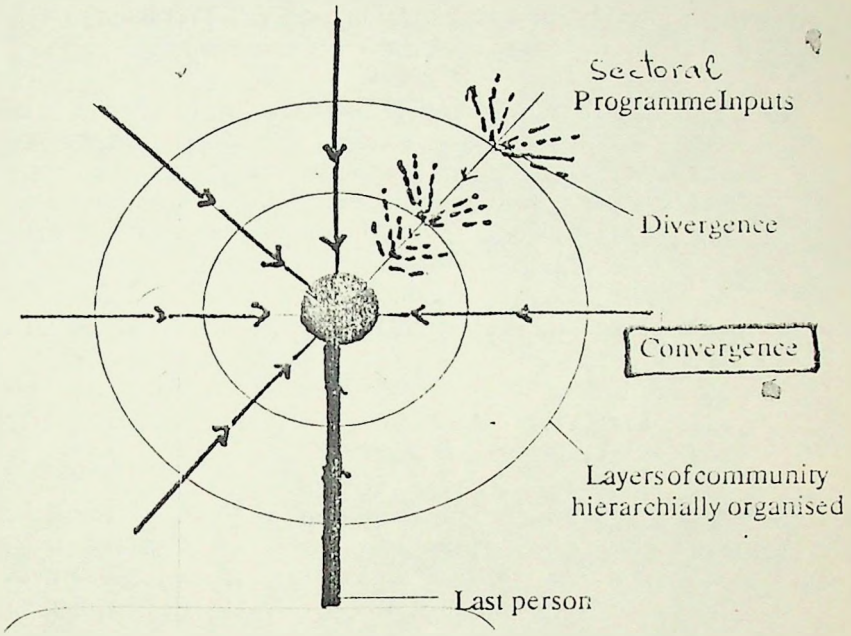


Figure 9
(shows the interrelationship of Availability, Accessibility, utilization and Coverage.
The ideal curve should be vertical. The actual curve differs according to situation)


Sectoral
Programme Inputs
Divergence
Convergence
Layers of community
hierarchially organised
Last person

3.2.2 Inadequate Training : Pre service training is designed and carried out without reference to the particular problems of urban slums such as STD, trauma from violence, alcohol and substance abuse, chronic rather than seasonal bacterial infections interactions, and rapid spread of contagious diseases (plague, cholera, typhoid, intective hepatitis). Recurrent inservice training for health workers and volunteers in upgrading clinical skills, outreach, focussed care priorities or liason with PVOs and PMPs have not taken place. The major focus of Family Welfare Programme's training efforts has been to develop health workers and managers for rural India. The HFTCS, SIHFW (IPPs) and ANM Trainign Centres all have a rural orientation.

3.2.3 Lack of Community Participation : The design and delivery of health and family welfare services in urban slums has been typically done on the basis of norms established in the center, modified by the states, and adapted for implementation by the Municipalities. This top down directive approach which develops predetermined services to targeted beneficiaries, has meant that recruitment of staff and location of facilities are determined with little reference to the needs and preference of the urban slum dweller. This lack of community participation in programme design and implementation has led to under utilization; Problem of maintenance and ultimate sustainability of the programme. The revised strategy of family welfare programme (1986)
calls for more community participation. What is required is formation of slum dwellers groups to give voice to their legitimate demands for health and family welfare services UBSP is an initial step in this direction.

3.2.4 Constraint to participation of PVOs : Bureaucratic hurdles constrain the transfer of resources from Government to PVOs. The range of problems is so large and complex that the typically small PVO can only tackle single or smaller dimensions of urban slum condition. Even when a PVO is successful, replication of their experience on a larger scale is difficult to achieve.

3.2.5. Weak Information, Education and Communication Programme: IEC interventions utilizing social marketing and other approaches can increase the demand for and utilization of health and other social services as well as promote increased acceptance and use of family planning methods. To do this IEC programme must go beyond awareness generation among target groups to promoting desired behavioral change. There is also a need to adopt more focussed, target specific approach to the use of IEC and social marketing intervention. This involves the development of strong institutional capability to design and execute meaningful IEC programes; Clearer definition of the roles and functions of various service delivery functionaries in conducting inter personal communication and utilizing mass medial support; greater understanding of various sociocultural barriers client use of health services; acceptance by programme implementers of a comprehensive approach to planning and implementation of IEC programes; better IEC intervention with a strong focus on social marketing approaches proved particularly effective in urban audience.

The ideal curve should be verticle The actual curve differs according to situation)

3.2.6. **Limited Female Education Opportunities :** Poor urban slum girls are having more limited access to schooling than do upper and upper middle class non slum girls. The problem of primary education for females are compounded by the fact that only 30% of all school teachers are female and only 15% of the schools in country dedicated to females. Girls school suffer from a paucity of trained teachers, facilities learning materials, equipment and inconvenient location even when girls are enrolled, several factors operate against successful completion and achievement. These include; competing demands on their time; early marriage and pregnancy; lack of positive role model; poor quality of education of women; direct cost as well as opportunity cost of schools.

4. 1995 Goals (MID-DECADE GOAL)

4.1 Infections

1. Achieving and Sustaining Immunization coverage >80%

2. Elimination of Neonatal Tetanus

3. Reduction of Measles mortality by 95% and measles morbidity by 90%

4. Elimination of poliomyelitis

5. Achievement of 80% usage of ORT

6. ARI - Access to correct case management in all health facilities

4.2 Nutrition

7. Making all hospitals and maternities "baby friendly" as defined by the ten steps to successful breastfeeding

8. Virtual Elimination of Vit A deficiency

9. Universal Iodization of Salt

10. Reduction of 1990 levels of severe and moderate malnutrition by 20% or more

4.3 Safe Water and Sanitation

11. Increase water supply and sanitation so as to narrow the gap between 1990 levels and universal access by the year 2000 of water supply by one fourth and of sanitation by one tenth

12. Eradication of guinea worm disease.

4.4 Education

13. Strengthen basic education so as to achieve reduction by one third of the gap between current primary school enrollment/retention rate and the year 2000 goal of reaching universal access to basic education and achievement of primary education by atleast 80% of school age children and reduction of gender gap in primary education by one third

14. Awareness of HIV/AIDS among > 50% of the population

4.5 Maternal Care & F.P

15. Family planning services including birth spacing methods available in all immunization points

16. Effective emergency obstetric care accessible to pregnant women in 50% districts

4.6 17. Significant progress towards reduction and elimination of child labour in 80% of the states

18. Ratification of convention on the rights of the child

CHAPTER 4 - MID DECADE GOALS

4.1 HFA and Primary Health Care approach :

International conference on Primary Health Care jointly organized and sponsored by World Health Organization and United Nations Children's Fund was held from 6-12 September, 1978 in Alma Ata of the Kazakhistan (formerly USSR). The conference declared that health status of hundreds of millions of people in world today is unacceptable, particularly in developing countries. More than half the population of world does not have the benefit of proper health care. In view of he magnitude of health problems and the inadequate and inequitable distribution of health resources between and within the countries and believing that health is a fundamental human right and world wide social goal, the conference called for a new approach to health and health care, to close the gap between the 'haves and have note', achieve more equitable distribution of health resources, and attain a level of health for all the citizens of the world that will permit them to lead a socially and economically productive life. Conference affirmed that primary health care approach is essential to achieving an acceptable level of health care throughout the world in the foreseeable future as an integral part of social justice. Thus the goal of Health For All by the year 2000 would be attained.

The package included at least 8 essential elements:

i) Immunization ii) MCH & FW iii) Nutrition iv) Health education v) Control of major communicable disease vi) Environmental sanitation and personal hygiene vii) Availability of essential drugs. (Also: Treatment of routine ailments)

The primary health care methodology meant the following :

i) Universalization and equitable distribution of health services.
ii) Community self management - Planning, implementation and evaluation
iii) Inter sectoral contribution
iv) Appropriate and low cost technology.

The total package could never become the prime concern of the health functionaries. Different sectoral departments have been involved in implementation of different activities. To monitor and evaluate the progress of its member states towards the Goal of health for all by 2000 A.D., WHO has developed 12 Global indicators which have been adapted for South East Asian Region :

i. Health for All is continuing to receive endorsement as policy at the highest level.
ii. Mechanisms for involving people in the implementation of strategies are fully functioning or are being further developed.
iii. Percentage of gross national product spent on health.
iv. Percentage of the national health expenditure devoted to local health services.
v. Resources for primary health care are becoming more equitably distributed.

vi. The amount of international aid received or given for health.

vii. Population coverage by primary health care for all identifiable sub-group, with at least the following :

- Safe water in the home or within reasonable access and adequate excreta disposal facilities available;
- immunization.
- local health services, including availability of essential drugs, within one hour's walk or travel; and
- attendance by trained personnel for pregnancy and child birth, and care for children upto at least 1 year of age.

viii Percentage of Newborn weighing at least 2500 grams at birth, and percentage of children whose weight for age and/or weight for height are acceptable.

ix. Infant, maternal and under five mortality rates in all identifiable subgroups.

x. Life expectancy at birth, by gender, in all identifiable subgroups.

xi. Adult literacy rate, by gender, in all identifiable subgroups.

xii. Per capita gross national product.

Goals for Health & Family Welfare Programme; Levels as Quoted in National Health Policy - 1983

Infant Mortality Rate	Below-60	(80, urban) 5%, 1990	Immunization Status % Coverage .		
Perinatal Mortality	30-35	49.6 1990	TT for Pregnant women	100	78.16
Crude death rate	9.0	9.6 1990	DPT (children below 3 years)	85	98.19
Pre school child Mortality (1-5 yrs)	10		Polio (infants)	85	98.86
			BCG (infants)	85	101.51
Maternal Mortality	Below 2		Leprosy percentage of disease arrested	80	24.66
Life Expectancy at Birth (years)			Cases out of those detected		
Male	64	58.1			
Female	64	59.1	TB percentage of disease arrested cases out of those detected	90	66.00
Babies with birth weight below 2500gm(percentage)	10				
Crude birth rate	21.0	29.9	Blindness incidence of (%)	0.3	
Effective couple protection (percentage)	60.0	44.1			
Net reproduction rate (NRR)	1.00				
Growth rate (annual)	1.2	2.03			
Family size	2.3	4.0			
Pregnant mother receiving antenatal case (%)	100	60			
Deliveries by trained birth attendants	100	40-50			

4.2 Goals and Components of National Child Survival and Safe Motherhood Programme:

Infant Mortality rate - from 80 to 75 by 1995 and 50 by 2000
child (1-4 yrs.) mortality rate - reduced from 41.2 to < 10 by 2000
Maternal Mortality rate - from 400 to 200/1,00000 by 2000
Polio eradication by 2000
Neonatal Tetanus elimination by 1995
Measles - Prevention of 95% deaths and 90% cases by 1995
Diarrhoea - prevention of 70% deaths & 25% cases by 2000
Acute Respiratory Infections - prevention of 40% deaths by 2000

4.3 World Summit for Children 1990 :

On Sunday, September 30th, 1990, 71 Presidents and Prime Ministers come together for the first World Summit for children. In this largest global summit meeting in history, representatives from 159 nations made a world declaration on the survival, protection and development of children. A commitment was made to try and end child deaths and child malnutrition on the prevalent scale by the year 2000 and to provide basic protection for normal physical and mental development of all the world's children. This overall goal was refined into more than 20 specific targets. The plan of Action for Implementing the Goals of the World summit of children in 1990's mandates appropriate mechanisms for regular and timely collection, analysis and publication of data required to monitor relevant indicators relating to the well being of children. These are intended to record the progress being made towards goals set forth in the global plan of action and corresponding national programmes of action. This global monitoring is expected to fulfill the following objectives (i) Advocacy for improving the well being of children (ii) Resource mobilization (iii) International Corporation and (iv) Management of National progremmes. A minimum set of common indicators have been suggested by the UNICEF-WHO joint committee on Health policy for each of the health related aspects of the child summit goals. It was recognized that 2000 (HFA) would be a major source of monitoring information. WHO has agreed to incorporate the summit indicators into its third HFA monitoring in order to facilitate reporting on summit goals and reduce duplication. Wherever feasible, HFA indicators which are already in place have also been adopted for monitoring the summit goals. Efforts are also on for suggesting appropriate strategies for desegregating the data on occasional or regular basis. This is important for monitoring gender and other disparities like urban/rural residence and identifying the urban under privileged.

4.4 National Plan of Action - Govt. of India : India joined the community of nations in the successive reaffirmation of global commitment to the cause of children in 1989-90. The UN convention on the Rights of child in November 1989, the World Conference on Education for All at Jomiten in March 1990, the global consultation on water and sanitation in autumn of 1990 and the SAARC summit on children soon after the world summit were all part of this reaffirmation process which transcended national barriers. India is a signatory to world declaration (September 1990) in the survival, Protection and

Development of children and the plan of Action for implementing it. National Plan of Action of India identifies quantifiable targets in terms of major as well as supporting sectoral goals representing the needs and aspiration of almost over 300 million children in spheres of health, nutrition education and related aspects of social support. The goals for children are promoted necessarily within the broader framework of national development planning. The social development objectives of the 8th Five Year Plan (1992-97) are population control, employment generation and basic human needs particularly health care, literacy including elementary education and drinking water which is closely linked to sanitation.

CHAPTER 5 - UBSP APPROACH

While the India's population has more than doubled since 1947 to nearly 840 million in 1991, the urban population has grown almost twice as fast. Today over 200 million people live in about 3600 cities and towns in India. Nearly one of every three urban resident live below the poverty line and their ranks grow each year by about 15 million. About 50 million of these people live on pavements, in poorly serviced tenement houses, in unhygenic slums and illegal squatter colonies. They work as street vendors, domestic servants, scavengers, small-time mechanics, rag pickers, and perform a host of other activities comprising the informal sector. About 68% of urban poor are women and children. They are both vulnerable and exploited. Their large numbers and unacceptable conditions challenges both government and private sector to find solutions to break the cycle of deprivation. It is accepted that a most critical point at which to begin is with the mother and child. Their survival, development and ability to secure a respectable place in society is vital. Ensuring that they have access to basic social services such as health care, nutritional supplementation, education, employment and income is key to the success in overcoming urban want and exploitation.

While the issue of community participation and community self management (planning, implementation and evolution has been given adequate emphasis by health planners, the same has not been seen in practice. The reason is that, during the education and training the health functionaries have acquired a narrow biomedical or technocentric view point on the health interventions and the larger issue of behavioral aspects of health has not been grasped by them. Wherever, there is failure in this, respect, the blame is always passed on the otherside. The poorest and disadvantaged groups become the special largest of the criticism of health functionaries.

It would be important to reiterate here that improvement in the environmental sanitation and personal hygiene, Nutrition and family planning which are essential components of the primary health care require comprehensive behavioral change at the community level. For this the implementation structures require a proper communication planning and strategy. Such is totally lacking today. the present structures are totally misfit for such a task (see figure). It is important to realise here that the health functionaries still claim their responsibility till availability of services only. Their mental make up is not geared towards reaching the last person in order to achieve effective universal coverage. The present location and timings also suit the upper strata and the convenience of the providers not of the beneficiaries. Hence there is a large gap in availability, access, utilisation coverage and effective coverage.

In order to meet the alone challenges the 'bottoms up' strategy of formation of community structures in UBSP becomes most important. In the initial stage the community is dispersed.

The Community Organiser in interacts with a group of households and asks them to identify volunteers amongst them who will be ready to voice the needs of the

5.1 Philosophy of Basic Services Approach for Achieving the Middecade Goals

a) Mckeown - Dramatic decline in IMR and CSMR in 1st half of 20th century, especially those due to infectious diseases occured before the advent of modern chemotherapy or effective immune prophyeaxis. Major causes of death were diarrhoed, pneumonia and other critical infectious diseases. Their decline followed trends more consistent with better nutrition, improved hygiene and sanitation and voluntary birth limitation with relatively little help from medical establishment.

View - Health will come as a result of development

b) Child survival package

- riding GNP band wagon towards improved national income does not necessarily lead to improved health
- economic growth is slowing in developing countries
- we have the means in our hands to reduce infant and child deaths by 50% or more. The road to health has short cuts low cost and appropriate technologies
  - ORS
  - Immunization
  - Family planning
  - Antebiotics for infections
  - Measures to prevent low birth weight

c) The UBSP approach is a MIXTURE or MIDDLEPATH of the above two. Its ultimate goal is to improve the quality of life. In the process it also aims to achieve MIDDECADE GOALS.

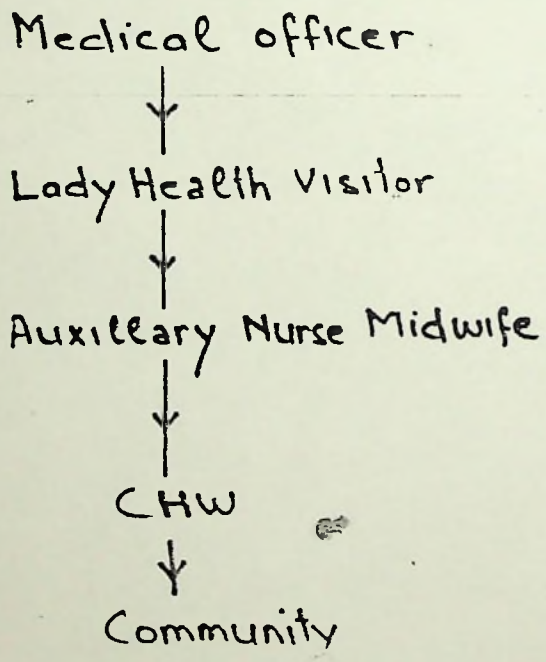
5.3 The community participation continuum

i) The 60s Model Passive
ii) The 70s - 80s Model Interactive
iii) The 90s Model Dynamic

communities and take the important messages to them. In this way one RCV is identified for 20-40 households and she acts as two way communications channel between the residents and the providers. These RCVs are provided the necessary training and orientation. 10 RCVs form a neighbourhood committee (NHC) and elect its governing body. These leader RCVs become the representatives and spokes persons for the community, and articulate the needs and demands of the community in different forums and with technical help, make mini plans for the NHC. Depending on the geographical location the different NHCs may come-together to make a community development society CDs and pool their miniplans to form a community plan. Thus a ground is prepared for rational action by different sectoral departments for efficient investment of their resources according to the needs of the community, the maintenance of the assets by the community, community contribution and not merely quantitative inputs but improvement in quality of the goals. Without simulating the above process at the ground level, the planners grope in the dark, and leads to inefficiency allocation and utilization of resources, no maintenance and low quality.

HEALTH DEPARTMENT STRUCTURES

Present



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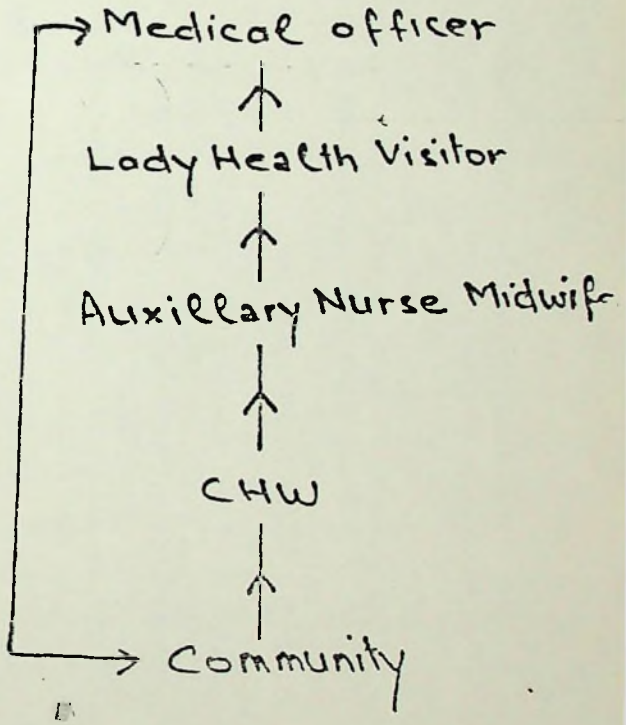
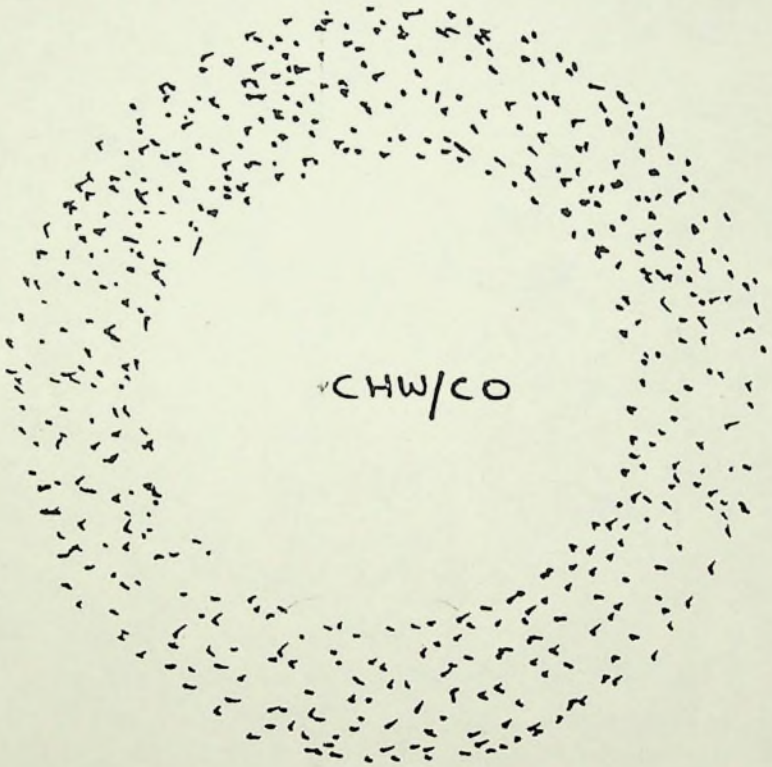
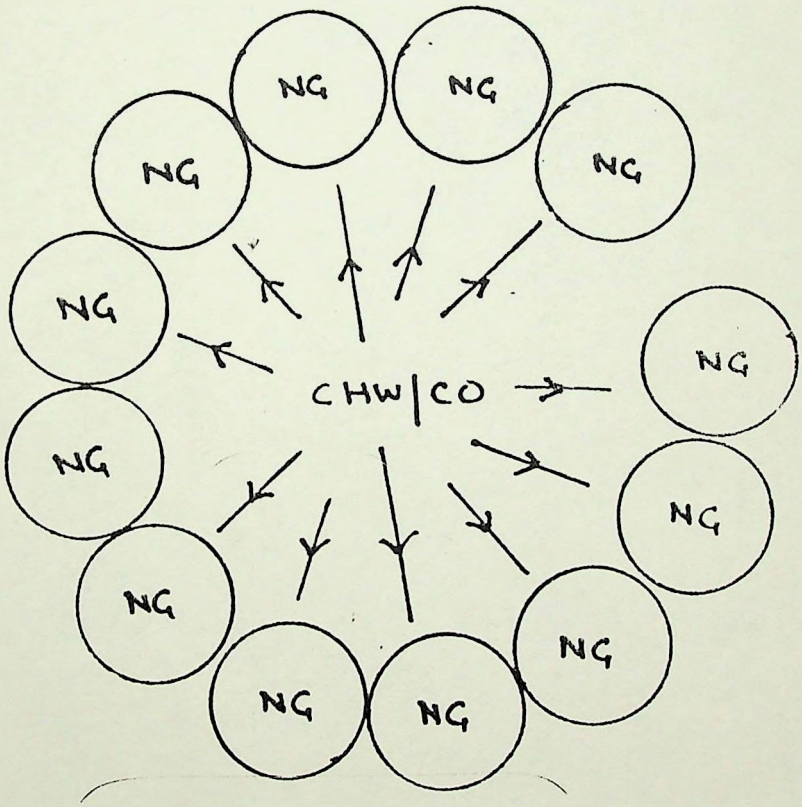


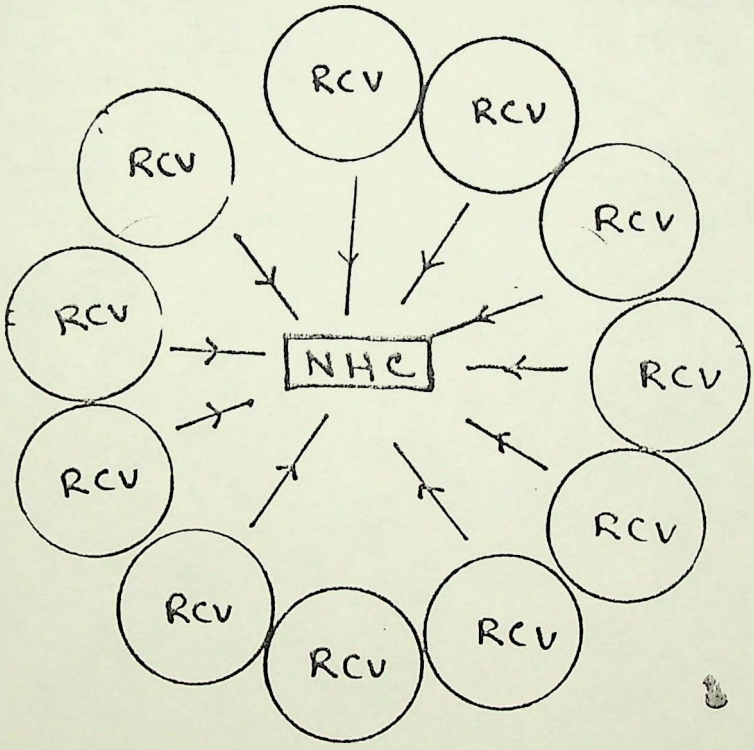
UBSP STRUCTURES-I



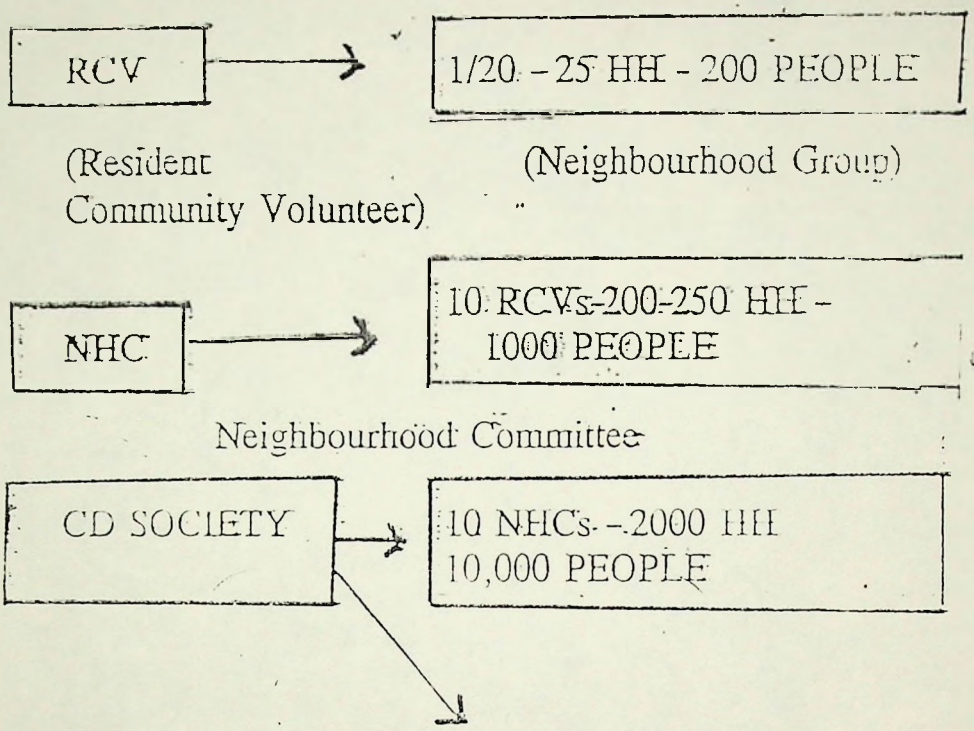
UBSP STRUCTURES - II



UBSP STRUCTURES-III



UBSP OUTLINE : STRUCTURE



AIMS OF UBSP

AS PER THE REVISED GUIDELINES, OBJECTIVES OF UBSP ARE:

1. TO EFFECTIVELY ACHIEVE THE SOCIAL SECTOR GOALS INCLUDING THE NATIONAL PLAN OF ACTION AND THE MID DECADE GOALS.
2. TO ESTABLISH AND SUPPORT SELF-RELIANT COMMUNITY BASED WOMEN'S AND OTHER ORGANIZATIONS.
3. TO PROMOTE CONVERGENCE THROUGH SUSTAINABLE SUPPORT SYSTEMS.
4. ALL ACTIVITIES SHOULD ENSURE PARTICIPATION OF THE TARGET GROUPS IN IDENTIFYING NEEDS, PRIORITIZATION, PLANNING, IMPLEMENTATION, MONITORING AND FEEDBACK.
5. CONVERGENCE OF APPROPRIATE GOVERNMENT SCHEMES AND PROGRAMMES TO ENSURE THAT THE URBAN POOR ARE SPECIFICALLY TARGETTED AND REACHED.
   (THIS INCLUDES CONVERGENCE OF ALL URBAN DEVELOPMENT/UPA PROGRAMMES).
6. CHILD-MOTHER FOCUS TO ENSURE THAT THE MOST VULNERABLE AND POOREST GROUPS ARE TARGETTED.
7. PROGRAMME COVERAGE TO BE EXTENDED TO REACH ALL URBAN POOR, INCLUDING THOSE LIVING IN SMALL SCATTERED CLUSTERS AND COLONIES, UNDEVELOPED SETTLEMENTS, PAVEMENT DWELLERS, STREET CHILDREN AND ANY OTHER RELATED CATEGORIES WHICH ARE UNDERSERVED BY ONGOING PROGRAMMES. SPECIAL ATTENTION TO SC/ST/BC AND OTHERS AS IDENTIFIED IN RESPECTIVE STATES TO BE ENCOURAGED.

UBSP OUTLINE: STRUCTURE

- EACH SLUM COMMUNITY, BASED ON THE LOCAL NEEDS AND RESOURCES, PREPARES MINI-PLANS AND IMPLEMENTS THEM AFTER APPROVAL FROM THE HIGHER LEVEL BODIES. BY INTEGRATING THESE MINI-PLANS OF ALL SLUMS, A CITY PLAN OF ACTION IS FORMULATED. AT THE TOWN, DISTRICT, STATE AND NATIONAL LEVELS, THERE ARE COMMITTEES FOR COORDINATING AND MONITORING THE PROGRAMMES REGULARLY. HOWEVER, THERE ARE WIDE VARIATIONS IN THE NATURE AND COMPOSITION OF THESE COMMITTEES AT VARIOUS LEVELS IN DIFFERENT STATES.
- CENTRAL TO THE UBSP PROGRAMME IS THE NEIGHBOURHOOD COMMITTEE, THE NHC, SERVING EVERY 200 FAMILIES. THIS COMMITTEE IDENTIFIES THE NEEDS OF THE COMMUNITY, PRIORITIZES THEM KEEPING IN VIEW THE RESOURCES, PREPARES AN ACTION PLAN AND IMPLEMENTS IT AFTER GETTING APPROVAL FROM THE CITY COMMITTEE.
- THUS, DECISION-MAKING IS BASEDON THE COLLECTIVE WISDOM OF THE PEOPLE. THE NHC ASSUMES LEADERSHIP AS WELL AS RESPONSIBILITY ON A SELF-HELP BASIS FOR THE WELL-BEING OF THE COMMUNITY. ONE RCV FROM EVERY 15-20 FAMILIES REPRESENTS THEM IN THE NHC. EACH MEMBER OF THE COMMITTEE LOOKS AFTER AN IMPORTANT ACTIVITY LIKE HEALTH, EDUCATION, NUTRITION, ETC. AND TRIES TO ARTICULATE THE PROBLEMS OF THE PEOPLE AND THEN ENSURE ITS IMPLEMENTATION.

EMPOWERMENT OF COMMUNITY, ESP.WOMEN

ONE OF THE MOST IMPORTANT FEATURES OF THE NHC IS THAT THE WOMEN MEMBERS OF THE COMMUNITY CONSTITUTE THESE COMMITTEES. THIS WAS A CONSCIOUS DECISION TAKEN, BASED ON THE FOLLOWING:

- THE HEART AND SOUL OF UBSP IS THE ORGANIZATION OF WOMEN AND THERE IS NO UBSP IF THIS IS MISSING.
- UBSP EMPHASIZES IMPROVING THE QUALITY OF LIFE OF THE URBAN POOR, WITH SPECIAL FOCUS ON WOMEN AND CHILDREN, WHO CONSTITUTE 68% OF THE URBAN POOR.
- THE PROBLEMS OF WOMEN & CHILDREN ARE BETTER UNDERSTOOD AND MANAGED BY WOMEN THEMSELVES.
- WOMEN ARE THE POOREST OF THE POOR AT THE FAMILY LEVEL AS THEY ARE SUBJECT TO EXPLOITATION AND DOMINATED BY MEN IN POOR FAMILIES, DUE TO THEIR LACK OF EDUCATION AND FREEDOM.
- STATUS OF WOMEN CAN BE IMPROVED EFFECTIVELY BY EMPOWERING THEM.

COMMUNITY INVOLVEMENT AND PARTICIPATION

KEY AREAS OF COMMUNITY PARTICIPATION ARE:

- FORMATION OF NEIGHBOURHOOD GROUPS
- SELECTION OF RESIDENT COMMUNITY VOLUNTEER (RCV)
- DETERMINING NEEDS AND PRIORITISING THEM.
- DECIDING INPUTS (SERVICES) AND WHO SHOULD PROVIDE, I.E. CONVERGENCE/COMMUNITY/AND/OR UBSP
- FINALIZING MINI-PLANS
- IMPLEMENTING THEM
- MONITORING AND EVALUATION

6. Municipal Government As Nodal Agency

6.1 Historical role of Local City Govts. to the health of the cities

- Health of the towns movement 1840s & 50s bottomsup affair
- Role of Municipal Govt. in Independence movement

6.2 74th CAA and devolving of powers and functions to municipalities

6.3 Orientation to municipal officials and corporators in

- Middecade goals to be built up in decision making process
- high degree of public participation and control in decision making
- sensitization to the needs of urban poor

6.4 Preparation of city plans for urban poor

CHAPTER 6 - MUNICIPAL GOVERNMENT AS NODAL AGENCY

The major institutional requirement for city health care seems to be to accord primacy to municipal authority, with supportive roles for the central and state governments, voluntary agencies and major employers. It is necessary to formalise these interests under a City Health Authority with responsibilities for planning coordinating, financing and evaluating a medium term city health plan drawn up in tune with government planning cycle. The nodal administrative agency for implementing city health plan should be the city municipal corporation with responsibilities for diverse services such as : service provision (environmental and preventive health), facilitation (primary health) and coordination (curative health). It would be necessary to have a legislative back-up to cover the planning regulation and implementation tasks of city health care services in tune with social development under item 3 of the 12th schedule of 74th CAA.

Similar approach is adopted through the creation of a community development wing within the municipal corporation, working under the technical staffing, materials and other parameters of cognate municipal funacional departments, such as water supply, engineering, health, education and so on. The obvious level of decentralisation of city services is the municipal wards with a population of 30,000. The municipal community development department need to be located at the ward level to mobilise political support (councillor) with administrative and functional back up from ward officer. All neighbourhood (and slum area) services need to be coordinated from the ward offices of city community development department. At the neighbourhood level, there is a need for networking with a number of community based organisations and voluntary workers to supplement the extended municipal services (one ANM and two VHWS suggested by K. committee for urban PHC).

The multipurpose community development for undertaking urban PHC is preferred in view of demonstrated success of the urban community development experiments in Hyderabad under UNICEF assistance and in Indore under British ODA support in responding to the needs of urban PHC. This is also borne by International experience as summarised below:

- community development approach can be effective in meeting the social and health needs of the urban poor in a cost effective manner
- despite poverty, it is often possible to mobilise resources from the slum community by sensitive community workers
- the key to success in community development is the staff who are to be properly selected and trained
- need for coordination is critical for most effective use of community, local government and external resources
- the importance of certain basic linkages among physical and social programmes, voluntary organisations, the communities and slum residents with formal financial institutions.

7. Convergence in terms of intersectoral collaboration

7.1 Intersectoral collaboration is inherent in all sectoral programmes today:

i) ICDS

ii) Health - (Eight essential components, primary health care methodology, stress of female education and empowerment in family welfare programmes)

iii) Education - Basic learning needs - besides literacy, numeracy, health education, education for skills training, cultural tradition & ethos)

iv) SCP - 10% of all departments expenditure on reaching the poor

But it is not the actual perspective of implementers today. This needs to be recognized and changed

7.2 One department may be given explicit recognition as voice of urban poor by all other departments

7.3 Area level planning, at wd level should become part of every departments administrative activity

Part III

UBSP Programme

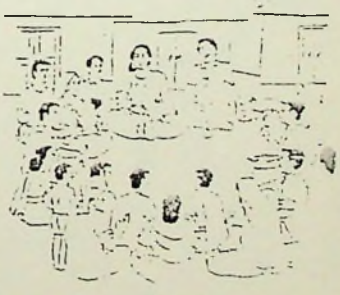
8. UBSP structures at Community Level

The Neighbourhood Group is the smallest community level within the UBSP programme framework. It comprises of 20 to 25 households. There are 33568 such groups in exsistence.

Each Neighbourhood Group selects one Resident Community Volunteer, usually a woman. A total of 33568 RCVs have been selected so far.

Ten RCVs comprise a Neighbourhood Development committee. There are 3409 such NHCs in existence.

A slum unit of about 2000 families forms a Community Development Society. There are 247 CDS registered till 1994. 460 Community Organizers, 93 Project Officers



Chapter 9 - UBSP Programme Coverage

In order to achieve the universal and equitable coverage of 240 million urban population in India the urban health planners must focus on the 54 million slum population in the 3696 cities and towns in India. In this overall context the following, information about the UBSP will be important for the urban health planners at the National, State, District and City level.

9.1 Extent of Programme :

UBSP at present is intensively working in 280 cities of the country in slumpockets having a total population of 5 million which is 9.4% of the total slum population of the country.

9.2 UBSP Functionaries

Besides the grassroot voluntary workers UBSP has the support of full time paid functionaries which are called community organizers and project officers. At present there are 460 community organizers, each covering about 10,000 population and 93 Project Officers. It is expected that in nearfuture, in many of the slum areas the NHCs and CDs will take over partial responsibilities and COs will be free to move to newer areas for formation of community organisations.

9.3 The Bench Mark Surveys

The reports of Bench mark surveys are being aggregated at the state and central levels, it would be interesting to have a look at some of the trends which show large gap which exists in the health status of slum population and the coverage of the National Goals. The benchmark data have become a ground of discussion in several cities and states between state departments of UBSP and health deptts. However in many instances the health deptts. have yielded ground and tried to extend the necessary help to UBSP to improve immunization coverages in these areas (see case studies).

9.5 Municipalization of Progrmme: The preventive and promotive health have been the traditional responsibilities of the Municipalities. The Municipal structures have played a big role in sanitation and provision of clean drinking water to urban citizens. Each municipality have sanitation and CD departments under them.

In many cities, the UBSP is trying to work directly with the municipal system and this approach has paid rich dividends.

9. UBSP Programme - Coverage

9.1 Coverage of Class I-VI cities

City	Total no.	UBSP coverage
Class I	300	145
Class II	345	58
Class III-IV	3051	77
Total	3696	280 Slum pockets 2742

9.2 Coverage of Slum Population in Different Class of Cities

City	Percentage (Total)	Percentage (UBSP Cities)
Class I	9.6	20.7
Class II	10.6	56.8
Class III-IV	6.7	76.5
Total	9.4	23.7

Total Urban Population - 23,87,65,122
Total Slum Population - 5,35,43,982
Population Coverage in UBSP - 50,17,237

CHAPTER 10 - CONVERGENCE EFFORTS IN UBSP

10.1 The City Plan for Poor : From its focus on selected clusters in selected cities in the inception stages, the UBSP is gradually progressing to the City level approach to prepare city level plan for the urban poor such plans have already been prepared in many cities and other cities are in the process. A National Consultation on city plan for poor was held at NIUA on May - 1994 to have a look at this process. In the revised National UBSP guidelines, the recommendation has been made for adopting a city level approach in order to achieve total coverage in the city. The city level plan aims to analyse the present availability and distribution facilities in order to set up an agenda. It aims to bring together all the sectoral inputs at city level in order to attain the universal coverage.

10.2 Training and Communication (UNICEF support)

In order to train the 30100 RCVs to become 2 way communication agent, network of Training Institutions has been created all over the Country. To date 11 FTIs have been functioning. Two national Institutions NIUA and RCEUS Hyderabad have been assigned the task of Trainers the trainers for UBSP.

The FTIs are responsible for training a Network of TOCs - 'Trainers on calls' in each of the 280 cities who in turn will train the RCVs to spread the messages to the last households.

10.3 Advocacy and Convergence (UNICEF support)

STIs are responsible for inviting the middle level and senior officers, municipal officers and municipals councillors to orient then in UBSP. These STIs have been instrumental in mobilizing the support and level for the programme.

10.4 Research (UNICEF support)

Important research studies have been conducted and documents have been brought out on Urban Poor, women and children.

In addition communication material has been prepared for the RCVs in the form of flash cards.
Audiovisuals in different languages have also been prepared. An operational manual of UBSP and Training Manual are the next on agenda.

10. Convergence efforts in UBSP

- Community level - Mini Plan and Community Plan
- City level - City Convergence Plan
- Distt. level - DUDAs
- State level - SUDAs
- Central level
    - National consultation on coverage of programmes for urban poor - Feb. 1994
    - Formation of Interministerial task forces (pending)
    - UPE programme of P.M.

CHAPTER 11 - CASE STUDIES IN UBSP

It will be important to give some examples of the UBSP activities in selective cities to create a live picture of the UBSP strategy:

11.1 Kanpur City: 16 Community Development Societies and 160 Neighbourhood Committees have been formed in Notified slums of Kanpur in order to reach 32,000 households or 1,60,000 population. NGOs are being promoted to work in the unauthorised slums. One of the most discesnible feature of the programme is construction of Jansuvidha Complexes of a very innovative design made by the Non-conventional Energy Development Authority (NEDA). Till date 13 such complexes have been made operational, where none had existed earlier. This effort has the potential to provide total solution to a problem which had defied all solutions in the past. The maintenance of these complexes is excellant, for this household pays Rs.15 per month. The RCVs have been given training in immunization, nutrition and family planning. The pre-school education and non-formal education is being given in newly constructed community centres in these slums. The local Dais have also been trained. The women have been given skills training to improve household income. The management of environmental sanitation in slum bastees is being slowly taken over by CDSs. Part-time Medical Officers have been recruited to provide facilities of treatment of minor ailments and easily accessible regular health checkups. Encouraged by the success of the programme in reaching the Slum Bastees, the City Municipal Commissioner has i.given the USAID family welfare programme for planning and implementatin in Kanpur City to UBS deptt. ii. entrusted them with responsibility of pre paring and implementing a development plan for Valmiki Bastees in Kanpur. iii. Even in Non-slum Areas, the UBSP deptt. has been asked to help in formation of community groups for management of environmental sanitation.

11.2 Bhopal: The CDSs formed in squatter settlements of Bhopal by UBSP have been instrumental in improving the provision of drinking water in slums by installation of India Mark II handpumps and water tanks. The low cost sanitation scheme for constructing double pit latrines is being implemented by 'Sulabh' in Bhopal and CDSs have been playing active role in motivation of residents. Other activities like immunisation and preschool education are being promoted. The CDSs provide the route for health Deptt. to improve immunization coverage in these scattered squattered settlements.

11.3 Jaipur: Benchmark surveys done by UBSP provided the data indicating low immunization coverage in the slums of city of Jaipur and other cities of Rajasthan. After initial hesitation Health deptt has accepted the fact and now immunization camps are being organized in the slums jointly by health department and UBSP department. UBSP is not only providing the vital support of motivation at community level but the gap in provision of medical personnels etc. are also filled in by the medical officer attached with the department. The presence of a Medical Officer in the UBSP cell of State Government has facilitated the convergence with the health department.

11.4 Guwahati: The Resident Community Volunteers and Dais are being trained by the local NGOs and thereby the health messages are reaching to every household in the slums of Guwahati and nearly townships. The CDSs members have contributed money to improve wooden pavements in a slum bastee located in marshy land. Low cost community toilets have been constructed.

11.5 Shillong: The RCVs have been trained in Diarrhoea management in scattered and outlying slum areas of shillong city. This knowledge has proved vital in prevention of deaths during outbreaks of gastroentities

11.6 Pulse Polio in Delhi and Ranchi

Inspite of almost 70% coverage of UIP, the city of Delhi had continued to report new cases of polio in recent past. Inspired by the success of 'Pulse Polio Strategy' in making Latin America a Polio free region, the newly elected Government of NCT of Delhi decided to try this strategy in Delhi. Perhaps for the 1st time in the history of the city, a team of about 50 Doctors launched a programme of direct mass contact with the residents of the city to build up a campaign. They went around contacting the MLAs, the NGOs and social organizations, local resident Associations, Schools etc to give orientation on the campaign. The UBS department of Delhi Goverment with its network in Delhi JJ Clusters provided the vital linkage to reach the slum households. Another important initative was taken by National Institute of Urban Affairs and a group of NGOs to press upon the idea of Zonal Planning for Pulse Polio. The Co-ordinating officer of pulse polio in south zone set down with NGOs, resdents associations, CBOs and Government Doctors to divide responsibilities on area Basis in the entire Zone. This exercise was found very useful in proper implementation, motivation and avoiding unnecessary dupication and confusion. It is estimted that on 2nd October and 4th Dec. 90% coverage of Children with polio vacine was achieved.

Inspired by the response to this programme other states and cities have also shown keen interest. The most interesting features was the voluntary effort undertaken by the Bastee Vikas Manch of Ranchi. Watching the advertisement on television, the leaders of this Manch which had been formed under UBSP programme in Ranchi decided to undertake pulse polio programme in all the slum bastees of Ranchi having a population of about 2 lakhs. Since the Manch has its network in all the slum Bastees, it incurred no expenditure on the programme. The vaccine was provided by the health department This is one extreme example of a true 'UBSP effort' by community participation and convergence.

11.7 Other efforts in Delhi

In post epidemic phase of 1988, the Area volunteers of UBSP programme undertook the gigantic effort of building a campaign for prevention of diarrhoea deaths in JJ clusters of Delhi (population 2 million) by health education and provision of chlorine tablets and ORS packets. They have also been instrumental in improvement of immunization coverage and monitoring of Environmental sanitation of JJ clusters. At present in 11 JJ clusters the CDSs have been formed and efforts are being made to adopt a city level approach for JJ clusters in collaboration with IPP-VIII project. Training in working with Community has been given to Medical Officers and ANMs of IPP VIII in Delhi by NIUA. Efforts are being made to promote the idea of mini plan at Neighbourhood level, community level at Bastee level and Area Plan at the level of Municipal Zone instead of present centralised planning for one crore population.

CHAPTER 12 - OPERATIONALISATION ISSUES

12.1 Urban Information:

12.1.1. The fact that urban information base are virtually non existent in our country, is a symptom of a morphous nature of our current urban planning practice including urban health planning. It is important to realize that this specific and systematic definition of urban health planning process must come before an information base can be created. It is not possible to create an integrated information system which can help to make urban health planning systematic. Data or observation which comprise an information system do not exist in vaccum, they are purpose specific. They have to be gathered with reference to a view point, a specific frame of mind-paradigm. Information for urban health planning, therefore can only be obtained when this framework is defined, that is act of planning is made explicit and each task of planning process identified.

Good basic health information should be seen as a resource for health and not as unnecessary expense. A shared agenda needs to be developed between public and health workers based on real information and raising of public awareness with the help of mass media educational institutions and cultural and social centres.

Information about diseases, health and quality of life can be major driving force for change. The little information currently available is often not used effectively to fuel the dialogue that should take place between politicians managers, health care professionals and public about most appropriate services and their location. There is a need for appropriate local level epidemiology and the aggregation of information to different levels for different purposes.

12.1.2. Intracity differentials

Health problems of urban poor have a complex etiology but they are rooted in poverty itself. Relevant information that would make it possible to assess the extant of various problems and take adequate remedial measures is not available in most cases. Data concerning urban poor are either omitted from official statistics or aggregateed with data from more affluent areas. The use of city wide statistical average often hides enormous variations between different neighbourhoods. More local intracity comparisons should be developed to enable interventions to be more effectively targeted.

12.1.3. Disaggregation of disadvantaged people

There is need for positive and selective identification of vulnerable individuals and families. There is a wide heterogeneity of disadvantaged groups. Not all of the urban poor live in slums and not all who live in slums and shanty towns are poor. Information should be specifically built up for the following disadvantaged groups.

Part IV

Operationalization issues for total coverage

i) low paid and unskilled workers
ii) unemployed and underemployed
iii) multichild families
iv) Orphaned families
v) chronically sick and elderly persons
vi) mentally or physically handicapped

12.1.4. Relevant issues Regarding Monitoring of Summit Goals

a. Most developing countries do not possess inbuilt monitoring systems. Large surveys at periodic intervels are hence unavoidable. Cost effectivity of these surveys, quality and sample selection are important issues which require attention.
b. Adequate political and administrative will is required to absorb truth and institute remedial action.
c. When such surveys are planned, there is generally a mixing up of process indicators (coverage) and outcome indicators like IMR and nutritional status which require a time lag to improve.
d. In order to monitor progress, concrete markers to define *** change are urgently requested.
e. It is difficult to monitor all indicators in all countries. Prioritisation should be considered in situation specific manner.
f. In the context of community participation, the alterntive approaches need to be searched for Monitoring and evaluation.
g. Averages mark the true picture and needs of most disadvantaged groups. Disaggregation of information is important. Separate micro sample needs to be drawn for *** disadvantaged group in surveys.

12.2. Role of Health Centres

For health centres to fulfill their commitment to catchment area and population coverage, it is essential that they should be based in accessible places which are appropriately networked to both community activists and other salient community facilities. Well located facilities are well used by local populations. However, cultural acceptability is also an important aspert of this question and participation of local population in Health centre construction and development should ensure optimum cultural relevance and population involvement and coverage. Health centres should have criteria such as travelling time by foot or by motorized transport - and should be concerned with reaching out to population as much population being able to reach them.

i health centres should be at the heart of equitable health development for their catchment populations in the context of district and national health system.
ii. they should have medical and health staff who are adequately prepared and motivated for leadership and community focussed health development, and should be centres for multiprofessional training
iii. they should involve community/users as equal partners in planning, management, resource use and decision making (co-management)

iv. they should provide high quality service from a judicious mix of national and local priorities established in dialogue between the health system and community/users

v. they should receive priority financing from all available sources with public funds directed at addressing problems affecting equity

vi. they should be able to attract and retain local resources, including community/user financing

vii. They should manage an appropriate information system which allows regular feedback and monitoring sessions with community/users and be a priority location for research into service performance, disease/problem surveillance and household health behavious based on a set of specific indicators

viii they should promote involvement and actions of other sectors in health improvement

ix. they should be supported by district level teams endowed with sufficient skills and resources and by an enabling and legal framework

xi. they should evolve towards addressing broader social and environmental problems as the local epidemology changes and as resources allow.

12.3 Link Worker: Three options are available

i) CHW paid (just as in urban revamping scheme & IPP projects)

ii) ICDS teacher

iii) The NHC formed by a group of Resident Community Volunteers. Without prejudice to the virtue of any of the above, it must be said that from the point of view of community participation the NHC approach appears to be the best bargain. An experience with CHW has brought out their following limitations:

i) isolated from the community, propagate the point of view of medical establishment

ii) press for more curative work

iii) the honorarium does not satisfy and demand more,

iv) get bog down in record keeping.

Though at the initial stages these community health workers may be used, but only temporarily, since most of their responsibilities can be taken over by the NHC easily. ICDS teachers have the same limitations in this respect. So the NHC approach can be the only bargain in the long run. The time and effort spent in community to stimulate the process is worth the output.

12.4 Municipal Level

a) It is important that Municipal system is involved especially at ZHO level/sanitation linkage.

b) City level/Zone leave/ward level plans should be prepared.

c) Involvement of citizen's committees, all the citizens of the city is sought in the health efforts.
(The pulse polio efforts has proved that it was possible).

12.5 Distt.Level

i) The sectoral deptts. should make the necessary efforts for convergence

ii) A Distt. Plan for urban population should be prepared

iii) disaggregated data base for Distt. level should be prepared.

12. Operationalization for total coverage of urban poor

12.1 Intersectoral coordination - central state and distt. level

- MOHFW (esp.)
  - Urban revamping scheme
  - All India Hospital Post Partum Programme
  - Urban Family Welfare Centres
  - India Population project (V & VIII)

- MOUD (esp.)
  UBSP programme, Slum Improvement projects)

- MHRD (esp.)
  - Primary education
  - Non-formal education
  - Adult education

- Department of women & child
  - ICDS in urban areas

12.2 Municipal Level

Sensitization on Mid decade goals. Z HOs and Sanitary Inspectors to play more active role in working with communities. EIUS - engineering depts to involve community

Primary teachers: Parent Teachers Associations
Formation of citizen's groups at ward, zone and city level on the issues of women and child

12.3 Community Level

a) UBSP functionaries to sensitize other field functionaries (ANMs, ICDS teacher, sanitary inspectors, primary teachers, Jr. engineers) on working with the community.

b) other field functionaries to provide technical support in UBSP areas (orientation of RCVs by Doctors, Teachers, engineers, anganwadi teachers)

c) Sectoral Deptt. at Distt. level to ensure supplies (Immunization, Dai kits, ORS packets, oral and conventional contraceptives, blackboards & chalk, ironfolic acid tablets, vit A, weighing machines)

d) specific messages and concrete tasks with reference to each middecade goal to be defined at community level and responsibilities assigned

e) involve NGOs, PMPs, social activists and non-poor citizens of the city.

Community level : Implementation activities

	Health Education	Other specific tasks
1. Neonatal Tetanus	Awareness of Neotanal Tetanus in community	availability of sterlised blade and thread with each pregnant woman, training of TBAs
2. Immunization Measles Poliomylitis	Stress on total coverage in community for the immunization to be effective esp. for poliomyeltitis	- follow up visits after immunization - distribution of Crocin for fever - Care of abcess etc.
3. Vit A	locally available cheap sources of Vit A	availability of Vit A solution in community
4. Use of ORT	ORT as preventive of dehydration use of home made fluids appropriate refessal	availability of ORS packet community
5. Baby friendly Hospitals	Need for continuing breast feeding as long as possible	breast milk doners(?) in community creches at work site
6. Malnutrition	stress on nutrition of adolecent girl, pregnant mother locally available weaning foods	availability of weigning scales and regular growth monitoring/iron folic acid
7. Family planning	counselling on use of specific spacing methods	community based distribution of contraceptives
8. Em. Obst. Care	awareness of high risk conditions antenatal, natal & post natal); where to go in emergency	common fund for transport in case of obstetric emergency
9. ARI	Identification of Pneumonia in children	availability of septran tablets at community level

Part V

Recommendations

12.4 Information

a) Rapid assessment methods to be used for collection of disaggregated information in the city (slum and non-slum areas) and intra-city differentials to be highlighted for advocacy of the poor

b) Quantitative and qualititative information to be used for micro and meso planning

12.5 Training and Communication

a) All sectoral functionaries to be specially oriented on the situation, special needs and perspectives of the urban poor so that planning is done on that basis e.g.

- location and timing of facilities
- emphasis on nonformal education
- choice of contraceptive by urban poor women

b) Messages to take the perspective of urban poor women in account

c) The emphasis on theatre, role play and mass action techniques to restore the self image of oppressed urban poor women, break the silence and restore self expression

12.6 Resources

a) Restructure the patterns of expenditure tertiary care to primary care; brick and mortar to nonformal methods in education

b) mobilization of community resources (labour, time, place)

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NR/(-): Not Reported/Not Available.

TABLE 15 INDIA: REVENUE RECEIPTS/EXPENDITURE OF MUNICIPAL BODIES (NON-PLAN), 1986-87*

States	Total ('000 Rs.)		% Distribution of Receipts					Per Capita (Rs.)	
	Receipts	Expenditure	Internal Sources		External Sources			Receipts	Expenditure
			Taxes	Non-taxes	Grants-in-aid	Shared Taxes	Others		
Andhra Pradesh	674084	585193	26.29	23.63	26.50	11.23	12.34	134.38	116.66
Assam	6134	8447	29.49	61.84	5.20	2.64	0.78	11.12	15.31
Bihar	12390	21560	30.48	16.59	38.86	NR	14.09	19.56	34.04
Gujarat	750948	721832	64.41	10.54	13.98	4.35	6.62	256.83	246.87
Goa	10376	5998	21.95	21.05	38.45	NR	18.56	211.79	122.43
Haryana	125877	109593	49.89	20.70	21.98	0.67	6.75	115.46	100.52
Himachal Pradesh	36835	32075	31.56	29.79	10.86	NR	27.79	450.91	392.65
Jammu & Kashmir	105991	66383	33.59	7.29	58.55	NR	0.57	121.74	76.25
Karnataka	421526	482331	54.81	19.76	2.84	7.75	14.83	123.62	141.45
Kerala	130655	170992	63.42	20.20	5.82	10.56	NR	66.07	86.47
Madhya Pradesh	134591	175387	42.05	14.41	22.87	2.00	18.67	102.39	133.43
Maharashtra	1914041	1677297	59.54	7.42	15.80	4.91	12.33	335.63	294.12
Manipur	1144	NR	2.79	76.33	NR	20.87	NR	5.59	NR
Meghalaya	9667	9576	29.67	11.18	52.54	NR	6.62	77.54	76.81
Nagaland	NR	507	NR	NR	NR	NR	NR	NR	11.17
Orissa	176566	149450	56.57	8.14	24.06	0.47	10.76	154.72	130.96
Punjab	544499	486574	78.54	13.08	2.79	NR	5.59	208.20	186.05
Rajasthan	243013	213006	74.61	11.33	7.03	0.15	6.88	81.82	71.72
Tamil Nadu	304951	345095	25.29	34.71	9.24	28.67	2.09	105.70	119.61
Tripura	30946	27807	2.69	2.42	79.21	NR	15.69	198.33	178.22
Uttar Pradesh	533653	583956	52.57	9.37	28.25	0.91	8.90	82.33	90.09
West Bengal	51478	35469	33.09	3.74	34.11	29.06	NR	49.94	34.41
Total	**6219365**	**5908529**	**54.29**	**13.45**	**16.72**	**5.81**	**9.73**	**150.68**	**143.14**

Source : NIUA, Upgrading Municipal Services : Norms and Financial Implications, 1989.

* Data Relate to 157 Class I Municipal Bodies.
NR - Not Reported/Not Available.

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TABLE 18 INDIA: PATTERN OF REVENUE EXPENDITURE IN MUNICIPAL BODIES (NON-PLAN), 1986-87*

States	Total Expenditure ('000 Rs.)	% Distribution of Expenditure						
		General Administration & Collection of Revenue	Public Health	Public Safety	Public Works	Education	Recreational Activities	Miscellaneous
Andhra Pradesh	585193	11.30	41.53	3.89	11.87	21.71	1.10	8.61
Assam	8447	33.60	40.63	1.68	22.64	0.96	0.49	NR
Bihar	21560	7.04	57.63	12.62	10.75	NR	5.03	6.93
Gujarat	721832	19.24	26.84	11.82	6.87	18.19	2.62	14.41
Goa	5998	NR	49.31	4.93	45.76	NR	NR	NR
Haryana	109593	16.27	48.67	6.26	8.38	0.23	3.54	16.65
Himachal Pradesh	32075	12.61	44.06	NR	6.93	0.31	NR	36.09
Jammu & Kashmir	66383	47.18	36.19	4.39	8.53	NR	1.49	2.21
Karnataka	482331	9.05	54.23	4.44	14.23	0.11	2.07	15.87
Kerala	170992	16.15	41.22	14.17	17.78	2.47	4.68	3.52
Madhya Pradesh	175387	10.48	28.59	4.23	12.19	3.88	1.49	39.15
Maharashtra	1677297	12.26	33.49	4.42	12.41	16.01	1.82	19.60
Manipur	NR	NR	NR	NR	NR	NR	NR	NR
Meghalaya	9576	22.32	65.07	0.70	10.78	NR	NR	1.13
Nagaland	507	NR	100.00	NR	NR	NR	NR	NR
Orissa	149450	9.62	32.71	5.10	23.87	10.53	0.41	17.77
Punjab	486574	5.02	43.53	4.53	20.32	0.03	2.37	24.20
Rajasthan	213006	25.51	30.33	8.75	16.65	0.43	2.85	15.48
Tamil Nadu	345095	8.55	40.37	9.54	6.27	16.43	5.10	13.74
Tripura	27807	15.96	42.15	4.19	30.01	NR	0.08	7.61
Uttar Pradesh	583956	9.68	47.41	5.45	22.63	1.31	1.21	12.30
West Bengal	35469	27.20	55.40	4.38	8.62	2.58	NR	1.83
Total	5908529	12.75	38.43	6.16	13.67	10.51	2.12	16.36

Source : NIUA: Upgrading Municipal Services; Norms and Financial Implications, 1989.

* Data Relate to 157 Class I Municipal Bodies.
NR - Not Reported/Not Available.

DEV 3.3i

TABLE 9 INDIA : ESTIMATED URBAN POPULATION AND SLUM POPULATION, 1990

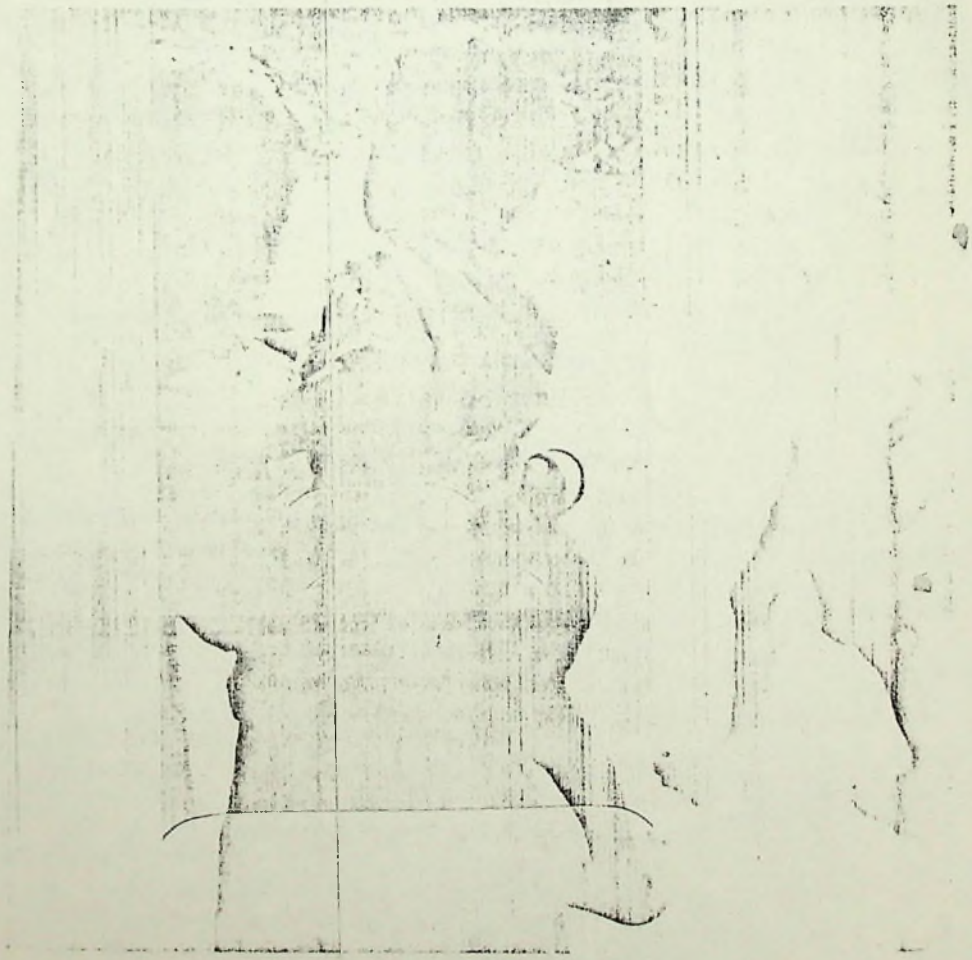
(Persons in Lakhs)

States/ Union Territories	Urban Population 1981	Identified Slum Population 1981	Estimated Urban Population 1990	Estimated Slum Population 1990
INDIA	1,597.27	279.14	2,415.44	512.28
States				
Andhra Pradesh	124.88	28.58	190.37	38.07
Assam	20.47	1.24	33.14	6.63
Bihar	87.19	32.70	137.72	32.70
Gujarat	106.02	15.32	155.05	31.01
Haryana	28.27	2.74	45.86	9.17
Himachal Pradesh	3.26	0.76	4.58	0.92
Jammu & Kashmir	12.60	6.27	19.44	6.27
Karnataka	107.30	5.74	165.62	33.15
Kerala	47.71	4.10	68.16	13.63
Madhya Pradesh	105.86	10.75	168.81	33.76
Maharashtra	219.94	43.15	312.55	62.51
Manipur	3.75	0.17	9.61	1.92
Meghalaya	2.41	0.66	3.99	0.80
Nagaland	1.20	-	2.75	0.55
Orissa	31.10	2.82	53.02	10.60
Punjab	46.48	11.67	68.93	13.79
Rajasthan	72.11	10.25	115.69	23.14
Sikkim	0.51	0.02	1.29	0.26
Tamil Nadu	159.52	26.76	213.78	42.76
Tripura	2.26	0.18	3.24	0.65
Uttar Pradesh	198.99	25.80	326.54	65.31
West Bengal	144.47	30.28	198.57	49.64
Union Territories				
Andaman & Nicobar Islands	0.49	N.A.	0.93	0.19
Arunachal Pradesh	0.41	N.A.	0.93	0.19
Chandigarh	4.23	N.A.	7.65	1.53
Dadra & Nagar Haveli	0.07	N.A.	-	-
Delhi	57.68	18.00	92.84	38.25
Goa, Daman & Diu	3.52	0.24	5.45	1.09
Lakshadweep	0.19	N.A.	-	-
Mizoram	1.22	N.A.	3.80	0.76
Pondicherry	3.16	0.94	5.13	1.03

Source : A Compendium on Indian Slums, Town and Country Planning Organisation, 1985.

MAJOR GOAL 9: URBAN CHILD

ALL SECTORAL GOALS TO BE ACHIEVED IN URBAN AREAS WITH SPECIAL EMPHASIS ON SEMI POPULATION LIVING IN NOTIFIED SLUMS, UNAUTHORISED SLUMS, SLUM AREAS, RECLASSIFIED MUNICIPAL AREAS AND MORE SPECIFICALLY AMONG "AT RISK" URBAN CHILDREN



A. SPECIFIC GOAL 9: URBAN CHILD

i. All sectoral goals to be achieved in urban areas with special emphasis on slum population living in notified slums, unauthorised slums, fringe areas, reclassified municipal areas.

ii. Special attention to be paid to urban "at risk" groups. "At risk" children to include children both from

(a) economically disadvantaged "at risk" groups, viz. slum dwellers, pavement dwellers, street children, migrant groups and construction workers.

(b) economically advantaged "at risk" groups, viz. children under the pressure of stress and competitive stress, children at risk for drug abuse/child abuse, children losing their childhood pleasures due to lack of recreational & play facilities and relaxation.

B. PRESENT SITUATION:

Karnataka has an urban population of 13.85 million spread over 254 cities and towns. The State ranks fifth in the degree of urbanisation and accounts for 6.3% of the total urban population in the country. There are 17 Class I towns with a population of more than one lakh each and accounts for 72% of the total urban population in the State. 4.91 million of the urban population lives in 237 towns with a population of less than one lakh. The rate of growth of urban population in Class I and Class II towns was 42% and 47% respectively during the 1981-91 decade. The rate of growth and migration to the metropolitan city and other major towns is creating acute problems of housing, traffic and transportation. It has to be recognized that by 2011 A.D., more than 50% of India's population, and specially child population would be living in the urban areas.

Children in urban areas suffer from multiple disadvantages in the areas of nutrition, health, sanitation and access to facilities and services appropriate for their requirements of balanced growth, which problems are further compounded by the existing social inequities. It is evident that the pressures of urbanisation have been such that the urban children have gradually lost their rights to food, shelter, education, health and other services. It is estimated that at least 25% of the urban children belong to the economically disadvantaged "at risk" groups, and are situated in dispersed urban pockets, and any strategies planned to reach the disadvantaged should take such dispersal into account.

C. MAJOR STRATEGIES:

The main long-term strategy for urban development in Karnataka is to focus on alternate development by providing for planned growth of the peripheral and suburban areas adjoining the metropolitan areas where the problem is most acute, through locating employment generation activities, infrastructure investments for urban development in small and medium towns, as well as incentives and disincentives such as taxation measures of subsidies etc. Current strategies also include priority attention to housing and environmental improvements, specially for slum and pavement dwellers, through sites, services and housing etc., as well as improvements to the lighting, water, sanitation, latrines, drainage etc.

Implementation of these strategies requires to be re-examined especially in views of the socio-cultural and political realities, to ensure community participation and access to these services on an equity basis. This would also require a greater level of co-ordination and convergence among the various departments of the Government under different programmes with the people being given a role or power in planning for their development.

There is a pressing need for immediate implementation of minimum services for delivery to every disadvantaged urban child. The minimum services should include health care, pre-school education and primary education, non-formal education, programme for school drop-out, health & nutrition education services for mothers, supplementary nutrition programme for children (6 months - 6 years of age) expectant and nursing mothers, and community awareness programme to involve community cadre for implementation and monitoring.

The on-going programmes for implementation of various activities are Urban Basic Services for the poor (UBSP), IPP-VIII, ICDS urban based programme, NGOs efforts and other government schemes.

The components of these programmes require special attention towards training for the government personnel implementing the programme, through capacity building, awareness amongst the community, space for multipurpose center, and complementing the effort with mobile programmes.

UBSP could be identified as the approach through which all schemes of the government can converge with community involvement.

There is need for preparation of an overall "City Action Plan" to focus attention on the poorest of the poor in urban areas, laying emphasis to the following aspects.

(a) *Identification and mapping of locations and areas where the poorest population groups are found, including slum and pavement dwellers, street children and rag pickers. This ought to be done by the ward committees of the local urban bodies.*

(b) *Assessment of the status of children and women living in these areas in terms of health, nutrition and education and access to basic facilities such as shelter, drinking water and sanitation for the family, and opportunities for human resource development of the child.*

(c) *Targetting available basic services and programme coverage to those most critcallly in need, and ensuring access to health, nutrition and education facilities.*

(d) *Preparation of city/town action plans by the ward committees of the municipalities in consultation with NGOs to focus on vulnerable groups for the achievement of sectoral goals through convergence of existing programme and services specifically with respect to the following elements:*

(e) **Health And Nutrition:**

- *Birth and Death registers to be maintained at the ward committee level*

- *Establishment of a health identity card system on a mandatory basis for the disadvantaged group which should have the same serial numbers as ration cards.*

- *Providing outreach services for families "at risk" under IPP-VIII or other such programmes.*

- *Undertaking periodic training and skill upgradation programme for all municipal health officers under CSSM Programme.*

- *Creating awareness about use of ORS. Providing adequate supplies of ORS packets for urban "at risk" families through IPP-VIII, ICDS, UBSP and commercial channels.*

- *Addressing household food security needs through better targetting of the PDS system to reach urban "at risk" children.*

- *Ensuring proper provision of ration cards and access to fair price shops to urban 'at risk' groups and maintenance of records of the same at the wards committee level and location of fair price shops within the areas where the poorest population groups are found.*

- *Making available iodised salt through fair price shops at affordable prices*

- *To recognize the role of stress on emotional and psychological development of the urban child and to identify and provide counselling and support services for the same within the identified areas.*

(f) **Education:**

- *Undertaking school mapping with community support to ensure access to education by all the "at risk" children by the Education Department.*

- *Initiating systematic Non-Formal Education activities for school drop-outs.*

  - *to set targets through text books, where content matter is relevant,*
  - *through teaching methods that are child-centered and culturally familiar to the child,*
  - *to introduce a modular system of teaching and learning,*
  - *to decrease number of hours education,*
  - *to do away with age wise admissions for each level, and*
  - *to increase resources to this system.*

- *Establishing linkages between Anganwadi and other Non-formal pre school centers to the primary schools to ensure that children from anganwadi centres enter and complete the stage of primary education.*

- *To ensure evaluation of children's performance for identified Minimal Levels of Learning for each year/stage of education. This is relevant both for the formal and the non formal methods of education.*

- *For purposes of admission declaration of age by the parents should be enough for (a) school purposes, as well as (b) the municipal authorities for issue of birth certificates.*

- *To encourage schools, community halls and other available government and community buildings to be utilized for non-formal education, before and after school hours, as well as National Literacy Mission activities through voluntary organizations.*

- *To encourage child to child programme for teaching of primary education skills for the urban disadvantaged child, by secondary school children under the National Literacy Mission and other parallel programmes.*

- *To make available recreation and playground facilities for all children.*

- *Mobilising community support for improving school facilities, including buildings, water and toilet facilities, and basic teaching equipment (including play equipments) as well as voluntary teachers.*

- *To insist upon the private schools to allow their school buildings and playground facilities to be used (by NGOs with prior tie ups) for non-formal education and adult education, etc. after their regular school hours.*

- *To provide career data banks of employment opportunities for each level of completed education, for school drop-outs and for those going through the non-formal system of education.*

- *To improve community facilities to school, centers, and child safety in and around schools (monitor availability of drugs, road accidents, sexual abuse, etc.,)*

(g) ***Water Supply:***

- *Ensuring the achievement of the urban norm of one drinking water source for 100 persons (20 families) through development of alternate systems (like handpumps and wherever possible by providing additional storage capacity)*

(h) ***Land and Housing:***

- *The rights and requirements of the disadvantaged urban child should be recognised allowing the family to have access to land on which they are living or a house on ownership basis, with security of tenure and proper civic facilities.*

- *The pavement dwellers/slum dwellers should be provided with land and/or shelter in proximity to their employment areas.*

- *Planning and decision-making on providing shelter, land showing provision of proper community spaces like parks, play areas etc. should be done with community participation keeping the requirements and rights of the urban child in view.*

(i) Environmental Sanitation

- *Covering all urban poor, with special facilities for pavement dwellers under the existing programme of Low Cost Sanitation (LCS) and Environmental Improvement of Urban Slums (EIUS)*

- *Developing community maintenance systems for water, sanitation, drainage and solid waste collection in UBSP project areas.*

- *Providing space for smaller community latrine units for better access to 'at risk' communities under Slum Clearance and Slum Upgradation Schemes with provision made for their maintenance.*

- *Developing special designs for group community latrines to meet the basic needs of women and children.*

- *In urban slums there is no sanitation or proper disposal of solid waste. Community education and proper disposal of waste with the help of municipal bodies requires to be taken up urgently.*

(j) Communications And Media:

- *Preparation of programmes that use audio visuals, mass media, folk media, puppetry, street theatre, etc.*

- *Preparation of data banks that are accessible to NGOs for planning.*

E. PROCESS INDICATORS:

- *Preparation and operationalisation of town plans at ward committee level.*

- *Coverage levels of health, education, water and sanitation in urban areas (quantity)*

- *Formal and non-formal centers for education (number)*

- *Number of health cards issued*

MAJOR GOAL 10: CHILDHOOD DISABILITY

PREVENTION, EARLY DETECTION, INTERVENTION AND COMMUNITY-BASED REHABILITATION OF DISABLED CHILDREN BY 2000 A.D.

STATE LEVEL WORKSHOP OF "HEALTH OF THE URBAN POOR": 26-28th May, 1995

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DEV 3-33

THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA
(CHAIKA) Karnataka.

Ref. No. : Date.....

Workshop

on

Health of the Urban Poor

26 - 28 - May, 1995

Organised by

The Catholic Hospital Association of India, Karnataka Region

in Collaboration with

Govt. of India, UNICEF and other Voluntary Organisations

Venue: Indian Social Institute
24, Benson Road
Bangalore - 560 046

8.30 A.M.	=	Registration
9.00 A.M.	=	Inauguration
10.00 A.M.	=	Tea
10.30 A.M.	=	Key note Address Dr. C.M. Francis Special Advisor - CHAI
11.10 A.M.	=	Workshop Dynamics Dr. Mani Kaliath Head - Community Health Department CHAI
11.20 A.M.	=	Situational Analysis - I Dr. Vasundhara M K Former Prof and Head of Dept of Community Medicine - B.M.C.
11.55 A.M.	=	Situational Analysis - II Dr. Halagi - Additional Director (Projects) and Ex-officio, Additional Secretary to Govt. of India
12.25 P.M.	=	Vote of thanks - Mr. Chandar - C.H.C. -
		Moderator: Dr. Daramar - Vice-Principal & Head of Community Health Dept. St. John's Medical College
12.30 P.M.	=	Lunch
01.45 P.M.	=	Group discussion

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THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA
(CHAIKA) Karnataka.

Ref. No : *Date.....*

3.45 P.M.	=	Case Study - I Dr. Mala Ramachandran - Medical Officer incharge, Health & Family Welfare & M.C.H. Bangalore City Corporation
4.00 P.M.	=	Tea
4.30 P.M.	=	Case Study II Dr. Maya Abreu Community Health Department St. John's Medical College Bangalore

27-05-1995 Day-II

8.30 a.m.	=	Pleanary Session
10.00 A.M.	=	Tea
10.30 A.M.	=	Case study - III Ms. Pankaja and Ms. Selma Directorate of Municipal Administration Karnataka
11.00 A.M.	=	Case study - IV Mr. Joy Maliekal & Ms. Philomena R.L.H.P. Mysore
11.30 A.M.	=	Group discussion
12.30 P.M.	=	Lunch
01.30 P.M.	=	Plenary Session
02.30 P.M.	=	Panel discussion
4.00 P.M.	=	Tea
4.30 P.M. - 6.00 P.M.	=	Group discussion

28-5-1995 - Day III

8.30 A.M.	=	Plenary Session
9.30 A.M.	=	Summary of Previous two days Proceedings
9.45 A.M.	=	Tea
10.00 A.M.	=	Plan of Action - Group discussion
11.30 A.M.	=	Plenary Session
12.30 A.M.	=	Lunch
01.30 P.M.	=	Statement - Action Plan
3.30 P.M.	=	Valedictory Function
4.30 P.M.	=	Tea
5.00 P.M.	=	Departure

102B.4 27/3/89 DH

Foreign panorama

DEV-3-34

How Bangkok is tackling its slums problem

By Philip Smucker

ON the banks of a contaminated channel boards of pressed wood are piled precariously one on top of the other, searching for support.

On these half-rotted gangplanks that connect houses to each other, old people and the unemployed are waiting, selling fried chicken heads and other tidbits of Thai cuisine. Small children run barefoot, dodging rusty nails and splinters, on this network of homemade bridges that extends over the stagnant water, where rats and bacteria multiply among trash and human excrement. On hot days, boys go swimming in the channel.

More than a million slum-dwellers in Bangkok refuse to "make way" for development. Together with social organisations and community workers they fight against eviction for the right to shelter and a little piece of their own urban land.

Most men and many women spend most of the day away from this sordid place, laying bricks or mopping floors for a daily wage that is rarely enough to feed the average family of five or six.

Despite the horrifying conditions in which they live, the residents of Bangkok slums refuse to move from the centre of the city to less congested areas on the outskirts. "Last year I decided to move because the landlord promised me 7,000 bahts (US $ 350) if I would leave, but to this day, I've yet to see a cent," said one woman who left the slum only to return.

"He lied to me, and besides, I couldn't stay (when I went). It was a barren field. There was no work. There was only more poverty," added the disillusioned slum tenant.

The population of metropolitan Bangkok, now standing at 6 million, will reach an estimated 12 million by the year 2000. In an effort to reduce the number of slum-dwellers from the current 1.2 million to a more manageable size, authorities are doing everything possible to convince them to leave.

But while the battle between municipal officials and slum-dwellers continues, some innovative ideas are emerging about how to provide them with shelter, according to an expert in human settlements from the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP).

Bangkok, with unequalled housing problems thanks to the slums that run along its contaminated channels, is having some success with the two-pronged policy of slum improvement and land distribution.

Through the land distribution programme, squatters who live in the slums turn over a portion of the land to its legal owner, who then permanently rents a plot to them at a reasonable price.

"We have seen that people prefer to improve their own homes instead of moving into housing provided by the Government," said the ESCAP representative. Based on this assumption, ESCAP has put into action a series of self-help housing programmes throughout Asia, offering an alternative to subsidised programmes on the western model.

In Thailand, only 17,000 houses had been constructed by public entities by 1973. The National Housing Authority (NHA), founded that year, added fewer than 50,000 units in the subsequent 10 years — filling but a small portion of the city's housing needs.

NHA functionaries admit that some of its programmes were over ambitious and that they were not prepared to accommodate the lifestyle of Thai slum-dwellers. NHA Government Suchet Sitthichaikasem said that until recently some NHA housing units went unsold for lack of water and access to public transportation.

Other officials point out that poor slum-dwellers often sell their new homes to better off middle-class families and return with their earnings to where they came from.

Nevertheless, the population of Bangkok's slums has been dropping in relative terms — from 25 per cent of the city's population in 1974 to 20 per cent in 1984.

The most significant advances in the housing situation have been realised through improvements in existing slums, where field workers make sure that people are prepared to make an investment and improve their houses — provided they will not be threatened with eviction.

Initiatives undertaken by the residents themselves, combined with a strong organisation and negotiating capacity, have proved to be the most meaningful for these people. "There is no reason why slum-dwellers can't stay where they are in the majority of cases," said one expert.

But since 1980, housing opportunities have diminished for the poor of Bangkok. The growing privatisation of entrepreneurial activity has allowed large companies and developers to penetrate deeply into real estate markets. Land in downtown areas is being purchased by commercial firms, forcing low-income employees to live in neighbourhoods 30 kilometres from their workplace, according to ESCAP reports.

One ESCAP proposal points out that slum-dwellers have to organise themselves to improve their power to negotiate and enable them to confront the challenge of real estate developers and speculators.

The Government rarely furnishes information about how to deal with eviction orders or get money together to fight them. It is non-Governmental organisations (NGOs) that take on the task of organising urban communities and providing them with a platform so that the poor can air their grievances. ESCAP estimates that these forums can fill the communication gap between the Government planning machine and the people.

Despite these steps forward, Bangkok slum-dwellers often remain at the mercy of landlords determined to regain control of their land for commercial use. Landowners have won several lawsuits recently over real estate occupied by marginal housing.

However, there exists a small but determined oppositoin to the landlords and developers. "Every human being has the right to a place to live. It is a necessary condition for existence and pre-empts all laws," pointed out Duang Prateep, whose work in defence of the human rights of Bangkok's poor is funded by Thailand's royal family.

— Third World Network Features.

Commuting problems the world over

LONDON:

IT can take longer to cross modern London by car than it did by horse carriage a century ago. Some New York commuters are spending 200 dollars a month on fares and six hours each day travelling. Japan is offering long distance "Bullet Train" commuters a tax break on their fares.

The inability of some modern cities to provide adequate transport for the millions who work in them poses an economic challenge for the 1990s. "Without action now, London risks losing its pre-eminence as the financial and business centre of Europe," says John Banham, Chairman of the Confederation of British Industry.

Worldwide, huge sums will be spent on transport. Firms may have to spend money moving outside city centres, subsidising fares or buying more computers so that people can work at home. Or they may just go to places like Paris or Frankfurt which can apparently handle their transport problems.

Reuter correspondents around the world took a look at the plight of commuters:

In New York, where nearly 3.5 million people stream daily into Manhattan, some have dreamed up new ways of avoiding the crowds. Wealthy executives from neighbouring New Jersey formed a helicopter-pool to fly in. A ferry company, Direct Line, last year proposed to moor floating parking lots on the Hudson River. New Jersey commuters could drive onto these lots, park and then take a ferry to work. Housing close to Manhattan has become so expensive that many face a three-hour bus ride to get to work.

In London, the world's oldest underground rail network is groaning under the daily strain of three million commuters, while traffic jams last more than half the working day. "We are now a first world city with Third World standards," said Professor Peter Hall of Reading University.

Many professionals have moved out to smaller cities where they earn less but enjoy a better quality of life.

Tokyo commuters endure some of the most crowded trains and longest rides of any. And a dramatic rise in land values has forced people to travel further and spend more on commuting. A one-day train fare of more than eight dollars is common, while the Transport Ministry reckons that some 100,000 people commute from places more than 100 kms away. The government and big firms are now encouraging people to live way outside Tokyo and commute by Shinkansen "Bullet Train."

Zurich shares some of London's worries. A survey of banks, insurance and financial firms revealed several problems over the next few years because of parking space. Sixty per cent of employees commute to work from outside the city, many by car. Some firms have moved to less crowded areas, which may risk Zurich's expansion as a financial centre.

Paris, however, looks set to enter the 1990s with a big advantage. A fast, efficient transport system is led by the RER, suburban express railway, which carries 600,000 people a day. "Not many other European capitals have such developed public transport systems as Paris, said Roger Dubreuil, traffic consultant for the police. Traffic has grown over the last 20 years but one-way systems and ring-roads have helped keep it flowing.

Some 300,000 people commute to Frankfurt, a city of 600,000, travelling up to 60 kms. Plans to erect high-rise office blocks promise more jobs but two new local rail lines are already planned to cope with higher demand and should be ready by 1994.

In Hong Kong commuters often spend an hour-and-a-half travelling in. An average journey from the outlying new towns, built in the early 1970s, can cost about a US dollar each way. The Mass Transit Railway, Hong Kong's underground, carries 80,000 people an hour in one direction during the morning rush. Some go three stops the wrong way just to be able to get on.

— PTI Feature.

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KARNATAKA KOLAGERI NIVASIGALA SAMYUKTHA SANGATANAE (KKNSS)

CONTENTS

KARNATAKA KOLAGERI NIVASIGALA SAMYUKTHA SANGATANEE (KARNATAKA SLUM DWELLERS FEDERATION)

"STORY OF STRUGGLE TO SURVIVE"

> "for the poor and pauperising overwhelming mass of citizens, the Rulers have left no option within the framework of evolving social order they are erecting, except to perish or revolt.
>
> the poor, including urban poor, will not perish but will resist. The struggle of the slumdwellers, who number in millions, is not at present fighting for better amenities but for mere survival. They have to struggle if they want even to survive".
>
> (AR Desai, 1986)

KARNATAKA KOLAGERI NIVASIGALA SAMYUKTHA SANGHATANE (KKNSS) is the 'Voice of the slumdwellers of Karnataka', representing the marginalised, alienated and the dispossessed majority in our country, who toil with their blood and sweat to uphold the urban economy. KKNSS is a people-based movement representing the genuine aspirations of all slumdwellers, and provides a platform for them to express themselves, their struggles and hopes; it also serves as a means to formulate strategies for their "struggle to survive" in this society.

1.1 Housing Situation in Urban Karnataka

The number of houseless persons in urban areas has increased from 13 thousands in 1961 to 43 thousand in 1981 inspite of significant increase in housing stock from 891 thousand units to 1,723 thousands units during the same period. In percentage terms, the houseless population has increased from 0.24 in 1961 to 0.40 of the total population in 1981. It is worthwhile to take note of an observation by the study conducted by the Population Research Centre which states that "....houseless population is under-enumerated to a large extent in censuses because of their root-lessness and the apathy of the census enumerators themselves....". Thus, even the available data

is not that accurate for safe conclusions.

As against 1,817 thousand households recorded in 1981 census, the number of residential houses returned was only 1,723 thousand. The excess of households over residential houses indicates that dwelling units are often shared. It is noticed that 66 thousand dwelling units were shared in 1961 and this number rose to 94 thousand in 1981. This shows an increasing shortage of dwelling units in urban areas of the State. This is, in addition, to the houseless population who do not have even a shelter to share with others.

Of the 1,723 thousand dwelling units recorded in 1981- 1,620 thousand units were used wholly as residence. The rest were used partly as residence and partly as workshop or for commercial purposes. What is worse is that the proportion of dwelling units used exclusively as residence has dropped from 97.3 percent in 1961 to 94 percent in 1981. There is an unmistable sign that the housing situation in urban Karnataka has deteriorated with every passing year. The rapid increase in population in the urban area itself, the exodus of landless people from an indignant countryside to towns and cities in search of jobs, the lack of repair and maintenance of the existing housing stock have all exacerbated the situation.

On the quality of dwelling units in urban Karnataka no reliable data is available. The House Listing Operations of the 1971 Census revealed that 12 percent of the dwelling units in Urban Karnataka have both walls and roofs made of flimsy materials such as grass, thatch, mud etc. Another 37 percent of the dwelling units had either wall or roof made of materials which are not durable for more than a year or so. Further, as many as 5 persons live in a single room dwelling unit; in two room dwelling units on an average 3 persons live. One can easily

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imagine the extent of overcrowding and lack of privacy in such houses.

The tenure of land for households by and large is "temporary" and always at the mercy of the State Government. This is true of even new layouts which had unfortunately been built up on revenue sites (land not to be used for purposes other than agriculture); these houses stand to be demolished in the event of the Government deciding to enforce the available legislations. A recent study states that only 19 percent of the houses in the city of Bangalore have good tenurial rights. This means about 80 percent of the dwelling units do not have good title deed. This is in fact the crux of the problem in the State.

1.2 Slum Situation in Karnataka

In Karnataka we see three distinct patterns of slum settlements viz., (1) this settlement is characterised by the emergence of sprawling "industrial slums" located in and around major industrial areas such as Binny Mills, Yeshwantpur in Bangalore; KGF in Kolar. (2) "Service slums" located in and around 'residential areas' which is inhabited by domestic servants, house keepers, peddlars etc; in Bangalore this category of slums are found near Jayanagar, Jayamahal Extension etc. (3) "commercial slums" which abound near and around Commercial complexes or office complexes like Shivajinagar in Bangalore, people from these slums rely mainly on informal sector for their income. These classifications are mutually contributive and in no way strictly regulated by our definitions.

1.2.1 An overview of slums in Karnataka

The recent survey conducted by the Slum Clearance Board of Karnataka (SCB) in 1984 identified 976 slums in the State. The corresponding figure in 1977 was 792. Of the 976 slums identified 590 are so far declared officially as "authorised" under the

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provisions of the Slum Clearance & Improvement Act. Whereas the distribution of all identified slums over various towns in the year 1977 is available such a distribution data is not available for the 1984 survey except in case of Bangalore. Between 1977 and 1984 the slum population has increased from 800,000 to 922,000. The 590 slums had about 547,000 persons.

About 50 percent of the slums were located in class I cities of the State., (i.e.cities with population more than 100,000) and Bangalore alone accounted for 23 percent of the slums and 45 percent of the slum population (1977). But in 1984 the Class I cities alone accounted for almost 70 percent of all slums and 80 percent of slum population in the State. The proportion of slums and slum population in Bangalore increased within the span of seven years to 41 percent of all slums and about 54 percent of slum population in the State.

It should be noted that although in terms of absolute numbers the slum population in small towns is not considerable, the percentage of slum population is comparable to that of large cities. In fact, after the metropolitan city of Bangalore, the next largest proportion of slum population is found in towns of less than 50,000 population. This suggests that the rural migrants prefer centres of largest opportunity and also centres of proximate opportunity. Thus, moving to far-off places is kept only as a last resort when all options are closed. It is also observed that the largest proportion of slum population is concentrated in those cities that are multifunctional with industrial base, rather than those that specialise only in industrial base. Thus, it is clear that industrialisation alone do not contribute to the proliferation of slums.

Among the locational characteristics of slums within a city, the 1977 survey observed that the largest number of encroachments

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were in private lands and the preference for private land increased in Bangalore, where the growth rate of slums on private lands was 151 percent between 1972 and 1982. Also, an overwhelmingly large proportion are interspersed with residential areas. Almost 98 percent of the slum areas in Bangalore are interspersed with the residential areas and in other Class I cities of the State. Since 1980 many slums have also emerged on the peripheral parts of the city on revenue land and on land earmarked for future urban development.

1.3 Slums in Bangalore

As the data pertaining to the city is easily available and as KKNSS has established a strong base in the city we could qualitatively and quantitatively assess the slums in Bangalore City.

VL Prakasa Rao and VK Tiwari in their study titled: "Structural Analysis of a Metropolis - Bangalore" (1979) state that the Bangalore City Corporation contained 159 slums in 1971-72 with a population of about 1.3 lakhs accounting for about 10 per cent of the city population; whereas the average slum population in cities with a population of over a million is estimated to be about 17 percent (NSS, 1980). The number of 'declared slums' in Bangalore increased from 159 in 1972 to 287 in 1982 i.e. an increase of about 85 percent and identified slums (including undeclared ones) are estimated to be 420 in 1984.

These studies also estimate that the average population size of a slum was little over 800 persons. However, the range in size was between 34 to 9,000 persons - the most frequent size being 300-600.

According to NSS (1980) study slums in Bangalore occupy an area of 3,451 acres which is about 11 percent of the corporation's

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total area. Slum areas in the city centre occupy less space-mostly single room residences; whereas slums in the periphery occupy more space being of recent origin (since 1980 or so). But security of tenure-wise City core slums have better standing than that of periphery, i.e. risk of demolition, eviction etc. are more in the periphery than in the city centre (this hypothesis of ours in general proved to be wrong during 1985 demolitions carried out by the State Government; however, theoretically still this holds good!).

About 9 percent of the slum area in Bangalore containing 42 percent of the city slum population was reported to be waterlogged during monsoon. In the case of other Class I cities the corresponding figures are 47 percent of the area and 51 percent of the population. Thus, slum population in the State is also suspectible to floods, water logging etc. for a period of 15 weeks in a year.

Vinod Vyasulu (1986) in his paper on "Urban facilities in Karnataka" states that education, sanitation, drinking water facilities and medical are lacking to an extent varying from 40 percent to 80 percent of the total urban population in the various Class I cities of Karnataka.

1.4 Slum Clearance and Improvement Programmes

In view of their location three State agencies are involved in the clearance improvement of slums viz., Bangalore Development Authority, City Corporation of Bangalore and Slum Clearance Board of Karnataka. Since the responsibility of housing slumdwellers rests with three agencies this has given ample scope for the complete ineffectiveness of their carrying out any meaningful developmental programmes in any of the slums. Many a times these agencies do pass on their responsibility to the other with the result no one desire to look at the immediate work

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to be carried out in order to at least maintain the facilities provided, if any.

Interestingly, all the three agencies do not necessarily recognise the "authorisation" of the slum by other two agencies to provide facilities and amenities. This completely brings in a double burden on the slumdwellers to prove their tenure to each of these agencies in order to receive facilities from them. Also, cluttering of responsibilities has led to claims and counter-claims by each of these agencies.

1.4.1 Slum Clearance Board of Karnataka

In order to understand the roles and functions of each of the three agencies, a simple analysis of SCB is sufficient. The Slum Clearance Board of Karnataka was established in 1975 with the following major objectives:-

a. take up projects to improve environmental conditions in slums;
b. protect the bonafide slumdwellers from eviction by the landowners;
c. construct tenements for slumdwellers and
d. clear unauthorised huts and prevent emergence of new slums.

In view of the high costs involved in the clearance of slums and resource availabilities achieving all the objectives laid in the said Act became virtually impossible.

Even a charitable evaluation of the functioning and role of the SCB indicates that the Board had taken a role of a "disbursement agency" of available funds for slum improvement projects. Basic issue relating to slums or a long term perspective or a plan of action are not included in its functions. There is provision for maintaining the facilities that are provided. Many a times authorities do not know who has to maintain water supply, sewerage,

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toilets etc. built by SCB. Further, due to anomalies in the existing legislations SCB has no direct access to land for building tenements or for relocating slums demolished or evicted - it has to approach either the Revenue Department or BDA for this purpose. What is said about SCB is true for other two agencies too.

Interestingly, the prevailing confusion on the role and functions of the SCB, BDA and Corporation had led to situations like where a slum was demolished after improvement schemes have been implemented at substantial expenditure!

2.1 Emergence and growth of KKNSS

A brief background about Karnataka Kolageri Nivasigala Samyuktha Sanghatane, and the struggles it undertook since its formation is necessary here.

2.1.1 Around the end of 1982, when the previous Government led by Mr. Gundu Rao, then representing Congress (I), was the Chief Minister he proclaimed that all slums were "eyesores" and are to be got rid of, and that therefore all slumdwellers should be shifted out from the core and intermediary zones of the city to be settled in the peripherial areas in four different directions. This was something short of a la Antulay's plan to shift pavement dwellers from Bombay to be deported to their respective States from where they originally came from.

However, before Mr. Gundu Rao could initiate any action on his proclamation, elections to the State Assembly was held and in early 1983 the present Janata Party came to power. But from November 1982 itself the fear of possible evictions began to float around the city. In order to mobilise them under a singl banner and to educate them on their rights - if and when evicti

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occur - KKNSS was formed at the convention which was held for this purpose attended by various activists and slumdwellers. KKNSS, the participants felt would provide the much needed singular platform to voice their grievances and demands. It was resolved at the convention that a charter of demands be presented to the newly formed Government. Among the main demands were the provision of secure land tenure (patta), ownership rights, housing and provision of basic amenities to all slums, and re-enumeration and recognition of all existing slums etc. A mass procession of slumdwellers was organised by the Sanghatane in February 1983 and a Charter of Demands was submitted to the Government.

The hanging threats of possible evictions of November/December 1982 and the subsequent convention realised the need for a networking federation of all slumdwellers in the State of Karnataka to provide much needed strength and vitality in their "struggle and fight for survival". That was the beginning of their growing political consciousness at one side; whereas on the otherhand they were continued to be exploited, marginalised and made to,live in dehumanising living conditions. In order to give a meaning to this growing consciousness and to fight marginalisation and exploitation KKNSS was born in December 12, 1982.

Since then KKNSS has been regularly campaigning for slumdwellers rights' from various platforms, forums etc.

Objectives of KKNSS can be briefly stated as follows:-
It aims to:-

a. a platform to voice out their grievances and working towards changing the policies of the State for the benefit of slumdwellers in the State of Karnataka;

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b. act as an umbrella organisation for the local people's associations which are primarily meant to tackle local issues;

c. to undertake, execute and assist formation of local associations for the promotion of social awareness and equitable justice;

d. to create a sustainable process - a process of self-awareness by which a community could raise itself to a more human and equitable way of life;

e. to encourage and develop leadership qualities among slumdwellers, specially among women and youth, and motivate them to work for the benefit of the community;

f. to undertake, execute and assist programmes for the creation of local resources for the benefit of slumdwellers;

g. to work towards the unity and solidarity of all slumdwellers irrespective of caste, language, creed, religion etc;

h. to organise regular seminars, workshops, lectures, demonstrations etc. to highlight the problems of slumdwellers;

i. to raise public opinion on the issues to pertaining to slums and slumdwellers;

j. to impart legal aid and legal knowledge to slumdwellers;

k. to collect, collate and disseminate information, data pertaining to slums and slumdwellers.

2.1.2. On March 4, 1983 KKNSS conducted a Dharna in front of the Assembly Hall in Bangalore in order to press slumdwellers charter of demands presented to the Chief Minister after the February 1983 convention. The attitude of the State Government was unsympathetic and indifferent.

2.1.3 During 1983 the State Government carried out demolitions in at least 3 places. KKNSS protested and staged demonstrations after each of the demolitions. This in a way helped the affected people to get at least "some" compensation when the Government

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allotted land at a place 15 kms. away from the city. Both KKNSS and the dwellers refused to accept the proposal and offer.

2.1.4 On June 22, 1984 several huts located on a Government undertaking's property (Karnataka State Road Transport Corporation's property located near the main bus stand) was demolished. It was argued by KSRTC that the huts were unauthorised and illegal. It was day of crowbars, bulldozers, lathis only. Ironically, these huts were inhabited by construction workers who built the Main Bus Stand, Over-bridge etc. by the side of which these huts existed. KSRTC too in a statement admitted that all the slum-dwellers were construction workers in their project.

KKNSS with the active support of the State Construction Workers' Union condemned the demolitions, conducted dharnas, mobilised public opinion etc. These protests led to an angry editorial from the State's leading daily "Deccan Herald" to comment".... it is ironical that those people who built the entire bus stand, over bridge are today deprived of a roof over their heads and are thrown in the street....."

The relentless functioning of KKNSS and Construction Workers' Union got the affected people alternative sites. About 46 families were provided with sites whereas others either returned to the same bus stand or took abode in places nearby.

2.2 Operation Demolition of 1985

It all began with a "padayatra" of the Chief Minister Mr. RK Hegde in the cantonment area during May 1985. Walking along one of the elite shopping area he found the meagre belongings of a few pavement dwellers scattered allaround their 'homes'. Instead of realising the callousness of the society he decided that it was essential to "Bring Beauty Back to Bangalore". And the only way to do this was to evict all slumdwellers.

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2.2.1 "Operation Demolition" began on May 6th 1985 when the Chief Minister Mr. Hegde was away vacationing in Kodaikanal, and many of his ministerial colleagues were "out of station". The demolitions were arbitrary and no one knew to which direction the demolition squad would move next! The entire operation was planned and executed in a systematic way.

2.2.2 KKNSS started lodging protests to various agencies and replies were evasive and contradictory. CM claimed that slums which were in existence prior to 15 years would not be demolished; the City Corporation authorities said that they would not touch slums older than 10 years; and the Slum Clearance Board was claiming 1980 as the cut-off year. While these puzzling claims and counter claims were taking place the reality was that even slums in existence since pre-independence days were demolished. And not all the demolished slums were located on Government lands; many of them were on private lands, church and muzrai lands, along railway tracks etc.

The actions were so arbitrary that even lands officially allotted by Government agencies were also not spared. For example, Mr. P. Thangavelu, a veteran freedom fighter was allotted a site by BCC in 1954 to set up a bunk shop so that he could earn some money and support his family. His site was cleared. This in a way violates the Government's own allotments made in the past.

2.2.3 Between May 6th and July 5th 1985 around 65 slums were demolished all over the city rendering about 25,000 people homeless. Only 11 slums' evicted people were provided with an alternative site at Laggeri, 10 kms. away from the city; but again in June 1985 the Government claimed that even the alternative sites provided to these 11 slums were only temporary and they will be re-evicted soon to a so-called "better" place.

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2.2.4 Throughout the demolition period the entire State machinery and the police force were functioning with an unprecedented efficiency and effectiveness, something rarely seen at other times. The Police and Demolition Squad members many a times outnumbered the number of persons evicted. Helpless cries of the children and the aged, women and men alike fell on deaf ears. Ruthlessly the huts were razed to the ground, their meagre belongings thrownout, or in some cases, carried away by the demolition squads.

2.2.5 Initially KKNSS made many representations to the Urban Development Minister under whose jurisdiction slums came. He pleaded "helplessness" saying that the Municipal Corporation had had undertaken the demolitions. Discussions with the concerned Municipal authorities and the Mayor yielded no results as they said that were only obeying the orders of a high level committee of which the CM was the main person.

2.2.6 In view of different claims KKNSS launched a telegram campaign and over 1,000 telegrams were sent to the CM who was then vacationing in Kodaikanal.

2.2.7 On 27th May 1985 a mass rally was organised in which over 50,000 slumdwellers marched to Vidhana Soudha, picketed its portals and stormed the seat of power, before meeting the CM with a memorandum demanding the stopping of all demolitions, and provision of patta, housing and basic amenities to all slumdwellers in Karnataka. Empty promises were made and the demolitions continued without respite.

2.2.8 The Chief Minister replied to the memorandum of KKNSS presented on 27th May stating that " .....slums create environmental pollution and are a health hazard to their surrounding neighbourhood....."

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2.2.9 This blatant reply from the Chief Minister led to another delegation to the Urban Development Minister. This delegation was led a 60 years old women who all through her life has lived in various slums of the city. Her questions summed up the complete view of KKNSS which runs as follows: "is it not we, slumdwellers who keep the entire city clean? who beautifies the streets? who construct the very structures that house the Government and the rich? how then the city could survive without them?

The Urban Development Minister very sheepishly replied that the city lacked infrastructural facilities but the uneven and inequal distribution of the resources, which is the real issue, was overlooked by him. KKNSS also questioned that if slums are considered to be unauthorised constructions, then very clearly, there are thousands of other skyscrapers, apartments and such other structures which do not adhere to all construction or building by-laws, and therefore become "unauthorised" too? Why then are those building not being razed to the ground? The Minister had no answer.

2.2.10 On June 15th 1985 continuing struggles against demolitions 17 members from the Sanghatane went to Yercaud in Tamilnadu where an All India Janata Party National Study camp was being held. A memorandum was given to the All India Janata Party President Mr. Chandrasekhar, and discussions were held with various leaders both from the State and National level. The Sanghatane members soon realised that many of the National leaders who opposed the demolition issue were hoodwinked into believing that all the evicted victims were given alternate accommodation. The Sanghatane members soon impressed upon them that this was a false notion, and that actually thousands of people are still languishing in the streets without a roof over their head. However, the false claims of the State Janata Party leaders prevailed upon the delegates.

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3.1 While the struggles continued in the form of dharnas, morchas, meetings etc. and organisations were mobilised, Women's Voice, a women's group working among slum women in the unorganised and informal sector in Bangalore filed a Writ Petition in the High Court of Bangalore seeking a Stay on the demolitions. The court admitted the petition but no hearing was given and demolitions continued. The matter came up for hearing on June 14, 1985, but though notice was issued, no stay order was passed nor any other order restricting demolitions.

3.1.1 On July 13, 1985, the KKNSS and others filed a Writ petition in the Supreme Court against the State of Karnataka, the Slum Clearance Board, the Commissioner of the Corporation and the BDA which argues that the provisions of Section 11, 12 and 13 of the Karnataka Slum Areas Act of 1973, on which the demolitions are based, are violative of Articles 14 and 21 of the Constitution (i.e. right to equality and the right to life). The argument goes that a person deprived of a place to reside in the vicinity of her/his place of work, under conditions of abject poverty is deprived of the right to life. It is also argued that the right to reside must be available to <u>all</u> citizens and not only to those who have means to acquire property. A stay order was issued on July 18, 1985. Ex parte interim injunction was granted and appeals and counter-appeals are going on. The final hearing is due any time now.

3.1.2 Despite this stay order the Government carried on demolitions in a novel way during December 1985/January 1986. The system was simple. BDA issues a form to the head of the household which states that the family accepts to shift to a new place and that would accept alternate provided by BDA <u>in an area where land is available</u>. Because of the mutual <u>agreement</u> between parties concerned this is not violative of law, it was contended. KKNSS conducted a thorough enquiry and found that the signatories were unaware of the contents

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of agreement and that the BDA was forcing them to sign. KKNSS mobilised the people through its local associations not to sign such agreements and BDA was forced to stop this campaign.

3.2 In order to step up their campaign KKNSS organised a National Seminar on Housing the Urban Poor on October 22-24 1985 with Justice Krishna Iyer, Indira Jaisingh, Keerthi Shah and other prominent defenders of the slumdwellers cause. The statement of the seminar made clear that slum and pavement dwellers are overwhelmingly rural migrants, mostly belonging to scheduled castes and scheduled tribes and other weaker sections of the society. They are exploited as cheap labour as well as politically used as vote banks and at the same time ostracised as "encroachers", "squatters" and "criminal elements". In actual fact they are the construction workers who have constructed the city, not being allowed to erect houses for themselves, they are the load-carriers who are branded as a burden on society, they are the domestic labourers who enable middle class housewives to go out for work, being deprived of the right to run their own household. The statement also pointed out that the crucial issue of "the right to use land" has as yet been entirely unresolved in the ongoing struggles in which the poor are constantly on the defensive. The enormous commercialisation and speculation in land has marginalised vast sections of the population and has made rational planning processes virtually impossible. Urban planning is meaningless without the participation of the marginalised masses who are at the centre of the city's economy but whose exploitation is so abysmal that the middle classes and the State see the need to make them entirely invisible. The recent (1985) remark of the Commissioner of BDA is indicative of the process the seminar noted viz., "why do you get worked up? if we evict them, people will simply vanish into thin air".

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3.2.1 In the statement of the National Seminar (1985) and in its subsequent demands KKNSS contends that it is necessary to question the "public purposes" for which slum evictions are carried out. KKNSS also reiterated its belief that vast stretches of prime land are held by public and private charitable institutions for private purposes, and that such land could be used for housing the urban poor.

3.3 KKNSS's short-term demands include: stop all demolitions; constitute a larger bench to review the Slum and Pavement Dwellers' case in the Supreme Court; Right to Housing be declared a constitutional right; provide alternative housing in the same place or in the vicinity for evicted slumdwellers in the past and provide sufficient compensation to those rendered homeless; enumerate and recognise all slums; issue patta and ownership rights to all urban poor; bar land occupied by urban poor from commercial transactions, both private and public, stop all urban land trading; provide, improve and maintain basic amenities for the urban poor; do away with cut-off dates; appoint a study team consisting of professionals, government officials, NGOs and concerned citizens to look into various aspects of housing for the urban poor and develop alternatives; stop police harassment; enact separate slum dwellers' central legislation to protect their rights.

3.3.1 KKNSS's long term demands include: comprehensive revamping of legislation affecting slumdwellers and the use of urban land; redefinition of objectives, priorities, and financial allocations of agencies like Housing Board, HUDCO, HDFC,. Slum Clearance Board, Development Authorities; people's participation in this process of redefinition is an essential pre-requisite; review of acts on land use by charitable institutions; reformulation and checks on implementation of urban

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planning; integration of rural and urban planning to reverse migration trends; right to information and public participation in planning; introduction of "self-building programmes" for urban poor; obligation on industries to provide housing for workers; reservation of one-third of extension areas for housing the urban poor.

3.3.2 KKNSS is absolutely aware of the fact that seeking recourse or relief through legal justice or presenting memorandum to the State or its agencies does not solve the problem in its overall perspective - however, it does help in (i) giving time to strengthen our struggle; (ii) suggest alternative solutions; (iii) create a deeper awareness and understanding; and (iv) such recourse-seeking functions as an educational process for the poor to understand the structures and systems in the State.

4.1 Participative process of an urban social movement: Urban problems and political processes ; a reflection

Urban problems are increasingly becoming political issues for two basic reasons:-

1. the process of consumption in an obviously unequal society and the role of the State (and its agencies) as a powerful intervening force through its REGULATORY powers;
2. the spread of an urban ideology emanating from the rich (elite!) sections of the urban milieu having close links with the State which views slums in such terms as "eye-sores", "health hazards" etc.

4.1.1 In Karnataka, the current interest and debate on urban problems, and popular struggles/initiatives is due to diffusion of a dominant policies of the State which is inherently anti-people. These policies became apparent during Mr. Gundu Rao's regime in 1981-82. These anti-slumdwellers policies gave rise to a wide range of protests generated by KKNSS. Since

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1982 KKNSS played a pivotal role in the emergence of two kinds of protest movements among the urban poor of Karnataka though independent of the policy bases and effects. They are:-

a. a form of ECONOMIC DEMAND (protests) primarily to meet immediate needs related to living conditions of the habitat - such as drinking water supply, sewerage etc. This type of protests are now part of KKNSS's organisation and have a strong internal coherence, also most prevalent type of urban social movement in many cities and is similar to what we may call "socialisation and collective consumption" of amenities and facilities.

b. a form of protest which demands for the right to live and livelihood as enshrined by the Constitution of India based on the social fabric of the slums. This we term as POLITICAL DEMAND. This type of protests or demands highlight State's oppression by various means through its regulatory and welfare polices; equitable distribution of resources like land, housing materials at nominal prices; subsidy for housing, representations of slum-dwellers in the concerned Boards and demanding room for their participation. This can be termed as an intermediary level of our mobilisation. This mobilisation has got a strong protest base and consistently question the structures and systems in urban areas, land policies legislations, schemes etc. which are deterimental to the very life and livelihood of slumdwellers.

This form of protests also help us in clarifying our perceptions, conceptual frame work aims etc. on a continuous basis. This promotes our mobilisation aspect as part of our movement in an objective level.

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4.1.2 KKNSS and the Working Class

Economy of the cities in Karnataka has two basic sectors viz.,

a. formal, non-agricultural economy covering manufacturing, commerce, administration service etc. This sector has access to the resources of the State and other facilities.

b. informal, non-agricultural economy mostly covering that of service sector. They have no access to resources of any kind. The most important is of course their wage rates are significantly lower and fluctuating.

Because of the low wage rates and unstable economic conditions people depending upon this sector live in appallingly poor living conditions; majority of them, obviously, reside in slums, pavements etc. In such a situation an organisation like KKNSS cannot ignore strengthening and linking of sectoral organisations like Construction Workers, Domestic Servants, Hawkers, Women, Youth etc. This makes possible the integration of formerly passive, popular urban informal sectors with the crucial political battle initiated by the working class movement. In this sense, we can look forward to an urban social movement as people are mobilised around crucial issues affecting their livelihood take active part in the political process in the direction of a change in social relationships and processes.

4.1.3 In order to strengthen this aspect where it is essential KKNSS functions through the respective Trade Unions or target groups. For example, when KSRTC demolished the hutments of these workers who built the Bus Station it was the State Construction Workers Union which took the initiative with the active support of KKNSS in organising protests, dharnas etc.

It was Mrs. Balamma, a 85 years old woman, who led the procession in May 1985 highlighting the double oppression suffered by women in the slums viz., (i) as any other women in the docile

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Indian milieu which is inherently pro-men; and (ii) as a slum-dwellers who is neglected and pushed around by the State.

It was children who led the procession on October 2, 1985 (Mahatma Gandhi's birthday) to focus attention on their under-nourished, unschooled status, unhealthy living conditions devoid of even minimum facilities.

4.2 KKNSS believes that even a reasonable social transformation of the Urban structures and systems are impossible without an alliance with the organised working class with the unorganised and unconscious working class who all face the same crisis in one form or the other. We have established relationships with trade unions of the informal sector and their leaders time and again addressed slumdwellers on matters pertaining to housing, amenities etc. KKNSS also urges established Trade Unions to include housing as one of the demands in their charter. Thus, the unity and motivation of the slumdwellers' did survive any possible polarisation of the political opposition which exist in other areas.

What is true of our relationship with the Trade Unions is also true of political parties in the State. Many leaders from various political parties despite their agreement with the State on the policy of demolition in the name of rehabilitation of "congested slums" had offered their assistance in condemning evictions, demolitions; they have also addressed to slumdwellers from various plat-forms seminars etc. in defence of them, their rights etc. Thus, we were able to neutralise any direct, possible opposition from political parties to our demands.

4.3 <u>Urban Planning as a Social Process: KKNSS's view</u>

The increasing complexity of the urban problems has led to a more "human" urban planning which appears as a political saviour to the crises felt by the citizens in their daily life. Thus, very high expectations are placed upon planning. KKNSS in relation to its past experiences views planning as a deliberate State

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process with only limited, defined objectives like regulation; institutional intervention; readjustment of the economic and social problems vis-a-vis social interests. To us "urban planning" is the creation of dominant interests in collaboration with the State which views slums as an "administrative problem". Thus, planning process in our view emerges to be a "net work of vested social interests" deterimental to the slumdwellers and poor in general.

To substantiate our view and analysis a recent example is sufficient. Real Estate Developers (RED) have mushroomed in the Bangalore City since 1980 and have "developed" many layouts in and around the city. Recently it was found that these layouts were built on revenue lands, not eligible for residential use. The house owners (hailing mostly from middle class or neo-rich sections) along with the REDs formed an association styled "Revenue land House Owners' Association" to get the matter "settled" with the Government. In some cases, it was learnt, the Government has imposed a nominal sum as "fine" for the mistake done for using revenue land for residential purposes and let off. Other requests for such exemption are under consideration. Government has also promised to provide basic amenities at the earliest.

Thus, mobilisation of people and the quick decisions of the Government did not occur in a social vaccum; on the contrary social base of the REDs and the House owners played a definite role in "settling" the issue. It is in this context that KKNSS demands participation of slumdwellers in the Urban planning process so that they can voice their needs in proper forums despite the limitations.

4.4 Did these struggles, protests and initiatives of KKNSS make any visible socio-cultural-economic impact and lead to

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people's movements which the third phase of our organisational work?

It would be false to claim that people's movements have taken place. But definitively such a trend has taken roots and growing. A closer scrutiny will reveal that a numerous number of small, day-to-day protests against the State's policies are taking place. Local associations, which have strong functional links with slum Federation (KKNSS) are asserting their rights in a specific way and the slumdwellers are now quite sensitive to their living conditions than in the past. To us, such a position is conducive for the growth of a political movement since in course of time people would realise that the "Small" problems they face are the side effects of bigger policy decisions of the State. Very fruitful and effective struggles can develop, and are developing, according to the conjuncture and to the classes through ideological motivation. This implies that we believe people move from general immediate day to day demands (thinking also) to a more radical, political and ideological protests aimed at the transformation of social relations if sustained efforts are carried out.

5.1 The spread and level of progress of KKNSS as a people's forum cannot be separated from the general level of consciousness in the society which progressively growing. But this is only a contributive factor that hastened their participation in our struggles and strengthened our educational activities.

5.2 Our experiences and analyses can be theorised and summarised as follows:-

a. a sustained urban movement can be an instrument of social integration which goes beyond religious, linguistic, regional, cultural barriers;

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b. the difficulty of fighting against the various mechanisms of the State and "elitist" policies of the State prove to be a good political education in course of time as people realise the limitations of the "democratic processes and structures".

c. a movement like KKNSS can definitely differentiate to people between 'immediate demands' and 'long term demands' and the stages of preparation are simultaneous.

d. a movement like ours can also destroy the social relationships created and developed by the State, say for example, distribution of urban land for real estate developers - by claiming these lands for housing the poor.

e. the so called "militants" of the slum (a mild term for 'goondas' and 'slumlords') have progressively lost their traditional base with the people. Earlier these militant leaders used to collect annual rents, conduct slum panchayats to settle most of the personal and locality matters etc. KKNSS and the local associations formed have now been exposed these militant inherent vested interests and their links with with the exploitative structures. This also happened when militants failed to generate much interest to work for the slumdwellers. During hours of crisis, such as evictions, these militants revealed their limitations. With the progressive alienation of these militants people's associations asserted their supermacy.

Conclusion:

6. The struggles of slumdwellers not only in Karnataka but all over India have assumed a greater importance by their increased levels of consciousness, demanding that they need a better deal instead of arbitary decision of the Government to demolish their houses, in the pretext of "beautification drive" development of cities.

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The time has come that the slum dwellers have realized that Housing is a Fundamental right to all citizens and they too have a due share in urban cities. The time has come to bring the vast masses of urban poor within the frame work of national policy and planning to treat them as equal and deserving citizens and to make serious efforts to bring about improvement in their quality of their lives.

APPENDIX I

In section 3.1.2 we referred to a letter distributed among slumdwellers for applying alternative house sites. The English translation of this letter is as under:-

"Addressed to the Commissioner
Bangalore Development Authority
Bangalore

Sir,

In pursuance of letter given dated 28th December 1985, requesting rehabilitation, you have provided a house site numbering..... on Survey No.....in.....area, provided with all facilities, water, electricity, drainage and street lights.

I am voluntarily vacating my present unauthorised possession from HAL 2nd stage located on survey No. since there are no basic facilities available there. Viewing this rehabilitation provided to me, I will not complain to any authority or go to Court of law. Therefore, I surrender my previous possession and my right to the old dwelling and I am giving this in writing to you.

Thanking you,
Yours faithfully,

Signature of head of household".

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Note: To make matters worse, the allotted land under this scheme is under dispute since a private party is claiming its ownership and has been granted a stay by the court in regard to that particular land!

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3. H. Ramchandra in "Slumming the metropolis" (1986) in Essays on Bangalore published by Karnataka State Council for Science and Technology.

4. National Sample Survey Organisation: Survey results of the Bangalore City slums, 1980,

5. Shivalingapppa, 1979, in IIPA's journal "Administering slums and slum problems in a city".

6. Gabriele Dietrich in Economic and Political Weekly, March 1, 1986 "Housing the Urban Poor" - a commentary on the struggles and initiatives of KKNSS.

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WORKSHOP ON URBAN POVERTY

BACKGROUND NOTE

Against the 'aesthetic approach'

The official perception of the phenomenon of urban poverty has been by and large conditioned by simplified notions about differentiation of urban poor. Urban poor have been treated, in terms of methodology of policy and planning, as a homogenous entity. And generally urban poor are equated with slum dwellers. In the area of official action, the emphasis is generally laid on shifting slums to some God forsaken outskirts of a city. In other words, the problem of slum dwellers has been increasingly treated as an 'aesthetic' one which is related to the beauty of a city. We feel that such official actions signify outmodel understanding of urban poverty.

On some beleifs of official perception

In this background, we feel that there is a deepfelt necessity to initiate a comprehensive discussion on urban poverty in terms of evolving an alternative strategy to tackle the above said problem. Essentially, this means a concrete re-examination of the current beliefs and theoritical models of urbanisation trends in India.

One such belief is that urban growth in India is unbalanced because it is oriented to metropolitan cities and the small and middle size cities are very slow in growing. The belief still persists that metropolitan communities are experiencing very high growth rates because of a heavy stream of migration from the country side.

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It is further necessary to draw attention to the fact that during the decade the rate of metropolitan growth is lower as compared to growth of regional towns.[1] The above said belief results in a bias towards a big cities in allocation of resources at the cost of smaller towns and cities. The problem of urban poor is not just confined to big metropolitan centres. Even in terms of slum population, for example in Karnataka, small cities like Raichur, Shimoga, Bellary, Tumkur, Harihar have reported the existence of 12%, 7%, 7%, 10%, 16% of slum dwellers respectively. And it has registered a definite increasing trend.[2]

Another widely held misconception is that official policy in regard to urban poor should concentrate mainly on spheres of service and reproduction. Schemes like ICDS, Basic services approach, Mid-day Meal scheme for the school children essentially reflect this 'service oriented' approach in spheres of production, And in the spheres of employment urban poor are left at the mercy of 'informal sector'. Poor citizens in urban areas are forced to fend for their livelihood and income by resorting to a proliferating insecure, lowly paid relatively non-growing, more exploitative and humiliating 'bazaar' and 'informal sector' and also live in a increasingly deteriorating urban situation.[3]

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1. S.C. Jain and Kirtee Shah, A disscussion on the Urban poor, Ahmedabad - this paper draws our attention to the widely held beliefs behind official perception. (1987. P.8 a document for private circulation)
2. Source: Urbanisation in Karnataka - Seminar papers, technical section IV P.4 Institution of Engineers Bangalore - 1985.
3. Desai A.R. 'Urbanisation and proliferation of slums and Pavement dwellers, paper presented at the seminar on law, urban development and planning, organised by Lawyers collective, Bombay, 1982

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Now the task is to achieve a synthesis of 'services oriented approach' and a fundamental approach towards the problems of production and distributive Justice. The present workshop intends to provide a forum for this debate.

These are just few of the problems that we would like to highlight in the workshop. Hence, we have planned it as a congregation of social scientists, policy makers and activists.

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NATIONAL COMMISSION ON URBANISATION

A discussion note on the Urban Poor and Some suggestions for action for the Commission

By

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1.0 Situational Analysis

1.1 The management of growth of the cities - especially the metropolitan and other big cities - in a manner that would ensure (a) an acceptable quality of environment and reasonable standard of living to their inhabitants, and (b) result in reduction of inqualities is one of the formidable challanges before the planners, administrators and people of this country. A number of complex forces, operating simultaneously and often pulling in conflicting directions, constitute a stern test to our planning ability, institutional ingenuity and administrative capacity. A great vision and high degree of creativity are going to be needed in assessing problems, determining priorities, formulating solutions, finding resources and effecting durable changes.

1.2 The most demanding of the urban challanges, unquestionably, is the challange posed by urban poverty: the challange of reducing exploitation, relieving misery and creating more humane conditions for working, living and growth of the

disadvantaged sections of the urban population: the task of adequately feeding, educating, housing and employing a large and rapidly growing number of malnourished, illiterate or semi-literate, un-or semi-skilled, un-or under-employed and impoverished city dwellers struggling to make a living from low paying occupations, enterprises and jobs and surviving on pavements and in poorly serviced chawls, overcrowded and unhygeinic slums, illegal squatters and other forms of degraded and inadequate urban settlements.

1.3 If the present trends persist it is certain that in coming decades, as now, the urban landscape will continue to mirror, probably more glaringly, the contradictions and ills of the Indian Society: economic disparities, social inequalities, cultural alienation and increasing deprivation for a large number of its people. There will be more skyscrappers and in them more spacious and luxurious apartments for a previleged few. At the same time the number of those who "squat in squalor and drink from the dream" will also increase. The poor and the unskilled from the rural areas will continue to flock to big cities in the hope of employment and better life only to add to the growing number of unemployed and further deterioration in the quality of city life.

1.4 There is considerable evidence to suggest that the growth path selected by us has not led the poorest sectors of

population to better living standards nor has it led to reduction of inequalities in any visible manner. The share of the poorest 30 per cent in the consumer expenditure has remained nearly stagnant during 1958-78. It was 13.2 per cent in 1958-59 and 13.6 per cent in 1977-78. The percentage of population below poverty line had only a marginal decline from 41 per cent to 40.3 per cent during 1959-1979. The percentage of population suffering from calorie or protein deficiency was as high as 32.6, which is higher as compared to the figure of 28.8 per cent for rural areas. Since the population has expanded from a mere 380 million in 1951 to 683 million in 1981, the reduction in percentage does not mean reduction in absolute numbers. In fact the urban population below poverty line might have gone up from 32 million to 58 million. It is paradoxical that this should have happened despite the annual average rise of income by 3.5 per cent. Justice Iyer described this phenomenon sarcastically as a double process of growth of GNP, namely growth of Gross National Product and growth of Gross National Poverty at the same time! Since the accent of planning process in India, as in several other developing countries, is on improvement of living standards of the poorest groups in society and reduction of inequalities in asset distribution, the urban development policies must be viewed in this light.

1.5 The official response to the phenomenon of urban poverty and the situation of urban poor - which has so decisively altered the visual landscape, social fabric and overall character of the Indian cities - in form of policies, strategies, and programmes has been generally unimaginative, inadequate, half-hearted and sectoral. The urban poor is usually equated with the slum dweller. Housing is perceived to be the slum dwellers' main problem. Till recently providing a pucca house was perceived to be its solution (until running out of money and realising that in the numbers game it stood no chance of winning). Recent new responses like the Sites and Services, Slum Improvement, the Urban Community Development Projects (UCD), the Integrated Child Development Services (ICDS), The Basic Services Approach, the Mid-Day Meal Scheme for the school children and the Small and Medium Town's Development Programme represent a better assessment of situation, more realistic attitude to resource constraints, a broader framework, and probably a new awareness of the responsibility. However, most of them are at their early experimental stage; are not reaching even a small fraction of the people they are meant to cover, reach and benifit; are often floundering on implementation front; and some of them are already showing signs of malfunctioning. These approaches, programmes and projects are certainly hopeful signs and therefore deserve a proper try, careful monitoring and evaluation, redesign, strengthening and a fresh commitment. The fact, however,

remains that considering the scale, complexity, and gravity of the poverty situation and the threat it poses to the social fabric and economic well being of the city and its citizens, the response is woefully inadequate.

1.6 A comprehensive and well articulated policy for urban poor is yet to emerge. While slums undoubtedly house the urban poor, it would be wrong to conclude that slum improvement and urban poverty eradication are synonymous. According to the Sixth Plan document about one-fifth of the total urban population may be currently living in slums. By 1985, such population is estimated to be about 33.0 million. However, the population below poverty line was estimated to be 38 per cent of the total population in 1976. If this rate persists, the urban population below poverty line would be 62.9 million as against 33.0 million living in slum areas.

1.7 In the fifties and early Sixties it used to be a fashion to use the terms 'slums' and 'squatter colonies' to denote extremely chaotic and dilapidated 'houses' and the highly deprived and unhealthy character of the residential environment in such areas. The illegal occupation of the land on which the shacks, hut or enclosueres made of cheap and cast-away materials had been constructed was a standing challenge to the institutions of law and order. The slums were considered to be a blemish on the fair name of the

city, a blot on its social life and a parasite on its physical body. Slums and squatter settlements were viewed as dens of criminals and thieves, of pimps and prostitutes, of lepers and beggars, of bootleggers and smugglers, of the toughs and the thugs. The city commissioners frowned on any proposal for investing municipal income on the amelioration of the conditions in the slums. According to them, it was misplaced humanitarianism which amounted to punishing the law-abiding and innocent citizens. Further it constituted an open invitation to more lawlessness. Instead, they argued, they would ask the fraternity of social workers to co-operate with them to evict the illegal occupants and persuade them to be on the side of the enforcement forces of law and order and help surveillance organisations which were to be strengthened to prevent illegal occupation of lands. There were even suggestions to cordon-off the cities against infiltration of unwanted elements.

1.8 These attitudes still persist. However, a change is visible. The compelling logic of numbers could not but assert itself in a system of politics where numbers matter in gaining political power. If such a large number of persons were arrayed against the society, no police would be able to succeed in restoring law and order. The squatter settlements were seen as receiving pockets of in-migrants who had been pushed out by the rigours of deprivation and bleak prospects in rural communities, especially during the disastrous periods of famine, floods, etc. These people had been lured to the cities by prospects

of better incomes and were exploring their chances with the help of friends and relatives. The slum ~~pocket~~ was a balancing mechanism for levelling-up rural-urban disparities which had been generated by uncontrolled ~~forces~~ spin-offs of planned development and natural adversities. The slum reflected the poverty of means of in-migrants and transitional character of their involvement. Poverty and struggle, however, are neither illegal nor immoral. On the contrary, the poor ~~may have~~ are often possessed of stronger social and moral fabric than the affluent ~~ones~~ claim to possess. Such explanations dismiss the theories of 'cordoning' the cities (as practised in some socialist and military dictatorships) to keep the intruders at bay. It means freezing inequalities and injustices perpetrated by an oppressive political system. It considers all talks of 'removal' as cruel.

1.9 A theoretical analysis, as represented by urbanologist Turner, classifies slums into slums of hope and slums of despair; the latter are reception pockets of those who had met bad luck, failed or fell out. The former, peopled by the new frontiersmen, represent rising hopes. As the pioneers berthed into an economic opportunity and ~~got~~ were integrated with the economic and social structure, they could stabilise their incomes and social relations and could attend to the problems of housing and residential environment. The strategy was, therefore, of gradual~~ist~~ incremen-talism; ~~of~~ providing access to the basic resources and

structures of residential environment to begin with and hoping that the suprastructure and details would be filled in as the transients improved their incomes and started consolidating and giving social expression to their economic gains. The present 'Site and Service Scheme' derives its rationale, and not in any small measure, from this view of squatter settlements.

1.10 This position represents a marked deviation from the earlier position based on the legality or otherwise of the existence of slum settlements. It is dynamic, functional and humane. It views men and settlements changing over a period of time, in incomes, social connections and maturity. It views slums as an essential part of city's social and economic life. A slum dweller is not a parasite, hanger-on or peripherial individual on the economic margin. The services provided by him are essential to the very survival of the city as an economic entity. Besides, it views slums as people and not just places with human sensitivities, responsiveness, empathetic abilities and capacity for collective action.

1.11 The strategy of in-situ development and upgradation, especially where a slum had been in existence for over 10 years, was an important departure from the earlier policy of slum removal and mass relocation. The legislative tools are still inadequate to enable a public authority to earmark and declare an area for upgradation, carry out

necessary improvement projects and collect the cost through a suitable levy. As a result, the 'in-situ-improvement of slums' is confined to municipal lands alone; this has a very limited scope. It may be of interest to know that 78.1 per cent of the slums in Ahmedabad have been built on private land; 6.4 per cent on Government land and only 10.4 per cent are on municipal land. The unspecified 'no man's land' category is applicable to only 5.1 per cent.

1.12 Even if the legislative tools and implementation machinery are strengthened, the 'transitional settlement' approach does not get to the root of the problem. It has no answer to the problem of how the cities should cope with continuing flows of in-migrants at an ever increasing rate with a progressive reduction in the availability of developable land, rigid tax base and increasing difficulties in recycling of invested resources.

1.13 The transitional settlement's approach does not spell out the nature of intervention to guide the process of population movement. Although wage levels in the city are undoubtedly high as compared to rural areas, the industrial production activities are likely to ~~get frozen~~ freeze under the influence of current restrictive legislations and incentive polices for developing industries in backward areas. It would be a bold city government which can plan for the full employment of its own population which it adds every year. What is the

point of investing and freezing the migrants with slum improvement and Sites and Services ~~approach~~ if the future prospects of expansion of economic activities of the city ~~do not warrant~~ their full scale absorption? On the other hand, the new centres of industrial dispersal, providing economic opportunity, suffer for want of skilled labour because housing, social services and residential environments have not been simultaneously developed. A planned policy of growth dispersal, accompanied by planning of infrastructure for conservation and development of human resources and synchronisation of information and communication services can make the process of movement much more meaningful than unguided migratory movements into the cities.

1.14 A planned policy of population distribution supported by appropriate implementing powers, resources and organisation can rationalise the flow to a considerable extent, although it cannot stop migration from far off districts, other states and foreign countries in so far as it is sheltered by local relatives and friends of in-migrants. Metropolitan slums ~~is rather~~ are a national problem.

Even in a cosmopolitan city like Ahmedabad 60 per cent of the in-migrant householders in slums belonged either to the district to which the city belongs or to the neighbouring districts. In smaller cities, the proportion of population coming from the adjoining region is likely to be much larger. The area approach has, therefore, considerable potential for restraining the process of unguided migration.

1.15 There is a strong evidence that the growth of low income settlements is much higher than the population growth of the city as a whole.

The slum population of Ahmedabad is estimated to have risen from 0.87 lakh in 1961 to 4.15 lakhs in 1976. Part of the rise is no doubt due to a higher birth rate but the largely rise is attributed to in-migration. The story of Bombay, Kanpur and other cities are not much different. The in-migration rate in slums is about twice that of the city as a whole.

1.16 Dr. S P Kashyap of the Sardar Patel Institute of Social and Economic Research, in analysing Ahmedabad data (1976-77), found that as compared to the per capita monthly income of slums (Rs. 51.29) that of chawls was Rs. 121.71 and that of non-poor settlements was Rs. 378.48, excluding super-rich families. These disparaties did not necessarily reflect differences in productivity but the manner of organisation of production process and appropriation of surplus. The expanding proportion of slum population, therefore, reflects growth of impoverished masses of population. In the regional cities the per capita income of slum dwellers is smaller as compared to metropolitan city of Ahmedabad. The growing population in low income settlements, therefore, aggravates the misery.

1.17 The social composition of slum population in Ahmedabad showed that 21.0 per cent of the households belonged to scheduled castes, 12.2 per cent to scheduled tribes and 14.8 per cent Muslims. In Baroda the percentage of scheduled tribes and Baxi Panch population was 47.64 per cent in the slums as per 1976 enumeration. These percentages are much higher as compared to overall city percentage for the same groups.

If the present trends continue we may find a higher percentage of low income households and scheduled population groups inhabiting the city. The social and economic character of the city is accordingly bound to change.

1.18 The facts of life in the so called slum settlements as they are known to us today lead us to view them as unplanned low income settlements rather than as transitional settlements. A large number of settlements have existed for more than 25 years. The following table provides data about the ages of 1205 slum settlements identified in the seven major cities of Gujarat.

Age (in years)	No. of Settlements	Percentage
Less than 5	24	1.99
5-10	63	5.23
11-25	168	13.94
26-50	609	50.54
Over 50	326	20.05
N.A	15	1.25

Over three-fourth of the total settlements are more than 25 years old. Only 2 per cent of the settlements which are less than 5 years old would come in the transitional category as they are likely to be peopled largely by newly arrived immigrants, ~~are found in old slums also~~. However, the overwhelming majority still belongs to old settlers. In Ahmedabad, for example, 61.8 per cent of the households were staying in slums before 1963. If the chawls are included, some of which are more than 100 years old, the percentage would increase sharply. It is thus clear that we are dealing here not with transient migrants but with settled people who have decided to make the city their home. A settlement thus comprises persons at different levels of economic and social integration: of those with permanent intention to stay; of transient explorers and seasonals; of failures and cast-outs. The facts brought out by ~~the author~~ some's studies in Baroda and supported by other studies is that a large majority of the dwellers who have an economic base in the city have succeeded in reaching the social nexus and are determined to stay in the city for the rest of their life. The undecided ones either lack economic and social locus in the city or have improved their incomes and social status so considerably as to afford a movement to a new area ~~of~~ and a better life.

1.19 The urban poverty line has been defined as Rs. 75 per capita per month expenditure level, corresponding to caloric requirement in 1977-78 prices. Based on this the total urban population falling below poverty line expenditure level was estimated to be 38.1 per cent in the country (Gujarat figure was 29.02 per cent). For policy implementation, further differentiation is necessary so as to distinguish between the marginally poor and the very poor households. If income is taken as proxy for expenditure level, the Ahmedabad slum picture would be composed as shown in the following table:

Monthly income per capita (1976-77)	Percentage of households	Average	Gap	Income supplementation needed	
				monthly	yearly
Below 25	11.50	22.7	52.3	Rs 319	Rs 3828
25-50	45.74	39.1	35.9	Rs 219	Rs 2628
50-75	35.63	69.2	5.8	Rs 35	Rs 420
Above 75	7.13	87.5	-	-	-
	100.00	51.29	26.6	Rs 136	Rs 1632

Considering the data about families below poverty line, gap varied from Rs. 8.5 per capita per month to Rs. 52.3 per capita per month. The average gap was Rs. 26.6 per capita per month. If we take the average family size as 5.11 an income supplementation of the order of Rs. 136 per month or Rs. 1632 annually is required to bring most of the

families above poverty line. However, it has to be of the order of Rs. 3820 for very poor families and only Rs. 420 for marginally poor families.

Raising the poverty line to Rs. 85 per capita per month for his 1980 study (Planning Commission figure Rs. 88) Pichollia estimated the average gap to be Rs. 27 per capita per month which is very close to the data cited above. His percentage of marginally poor is smaller but the percentage of the very poor is quite close.

1.20 The most readily available means to raise incomes is the productive use of under-utilised manpower. The urban situation in this respect seem to have worsened during the period 1972-77 for which N.S.S. data have been analysed. The following table presents data on unemployment rates.

Years	Urban Unemployment Rates		Rural Unemployment Rates	
	Daily Status	Weekly Status	Daily Status	Weekly Status
1972 - 73	9.00	6.55	8.21	3.89
1977 - 78	10.34	7.86	7.70	3.79

While the rural unemployment rate was down during this period under reference both on daily status as well as weekly status basis, the urban unemployment rate had gone up by about 15 per cent on daily basis and 20 per cent on weekly basis.

Disaggregated figures are not available on unemployment rates amongst urban poor households on a nation-wide or statewide study scale. Picholia, however, in his case study of a ward in Ahmedabad reports the following figures about unemployment on usual status basis. See the following table:

Category of Households	Percentage of Unemployed ones		Duration of Unemployment			Total
	To population	To Labour force	More than one year	1-2 years	More than 2 years	
Poor	11.29	20.81	54.08	20.73	24.39	100
Non-poor	2.44	3.55	45.45	36.36	18.19	100
Overall	7.91	13.21	53.76	22.58	23.66	

The contrasts are clear. The poor households have relatively a much higher rate of unemployed labour power as compared to non-poor households. Even in poorer households, incidence of unemployment was found significantly higher in scheduled caste and scheduled tribe groups. Further, the severity is indicated by the period of unemployment. Nearly one-fourth of the unemployed were in that status for more than 2 years. Compared to the non-poor, the poor households had a longer waiting period.

Unfortunately, data are not available on urban under-employment rates in poorer sections. Visaria has analysed that under-employment rate amongst casual labourers is

higher as compared to other earner categories. As casual labour forms a large proportion of labour force in slums (about 1/3 of the total), the under-employment rate in low income areas is likely to be much higher as compared to the general city rates.

Income group	No. of earners	Per cent
0-100	2047	13.15
100-200	7411	47.25
200-300	3459	22.05
300-500	1044	6.97
500-700	14	0.09
N.S.	861	5.49
	15686	100.00

Not only the high rate of labour underutilisation but also the low rate of returns accounts for the poverty of an overwhelmingly large number of house-holds in low income settlements. The Baroda data throws light on the distribution of earners according to their monthly income (Survey year 1976).

The type of occupations in which this labour force was distributed was found as under:

Occupational category	Frequency	Percentage of workers
Agriculture and Animal Husbandry	340	2.22
Domestics and servants	507	3.23
Casual labour	5450	34.84
Workers in Industry, Government and Private Sector	5217	33.26
Petty business	1735	11.38
Technical	453	2.89
Retired	85	0.54
Others	1839	11.72
	15686	100.00

Data from other studies shows that domestic servants and casual workers occupy the bottom of the earning scale. Their monthly income seldom exceeded Rs. 200. In most of the cases it was below Rs. 100 per month. Next come temporary workers. Their earnings came between Rs. 100 - Rs. 200 in a large majority of cases. A few had a monthly income of over Rs. 300 but no one had more than Rs. 500. A majority of permanent workers enjoyed incomes upward of Rs. 250 per month. The self-employed persons were engaged in petty trade or small business, household crafts and services (tailor, laundry, barber, carpentry, pottery, leather work, blacksmithy, etc.), and transport services (auto rikshaw, pedal rikshaw, hand-cart pulling).

A large majority of craftsmen had less than poverty level incomes. Under transport category, the modern sector workers (Auto-rikshaw drivers) crossed the poverty line while others were having low income. Petty traders with low investment had below poverty level incomes.

The data, therefore, suggest that regularisation of employment (its de-casualisation, settled locus or de-temporalisation), its modernisation (high energy application to produce more work) and collectivisation (through unions, associations, or chambers) appear to be intimately associated with higher returns.

While higher productivity (especially in self-employed sector) is associated with higher returns, wages in the manufacturing establishments in the informal sector are about half of those in the organised sector, though labour productivity between them does not differ markedly. The unregulated hours of work and wage norms coupled with deprivation of statutory benefits account for their low wage rates.

1.21 While analysis of employment and income data may throw some light on the current state of the urban poor, we have to probe further to assess the future prospects of regeneration. Education is one of the steps that confers a title on a successful graduate to participate in relatively better paid, regular and non-hazardous jobs. Despite great strides taken by the state to universalise primary education, the high rates of illiteracy continue to stalk the areas of poverty. The literacy percentage of slum dwellers in Ahmedabad was worked out to be 10.9 per cent according to the A.M.C. Census survey (1976). The figure was 16.75 per cent for males and 4.24 per cent for females. This can be seen against the city's literacy percentage of 59.02 per cent attained five years later.

The heavy drop-out rate from school is partly due to problems of access, language background, slow progress caused by low level of mental and physical abilities, behavioural truancy and alien teaching environment. But it is mainly due to the withdrawal of students because of poverty and help needed in domestic work.

1.22 Public health services of low income sectors of the city has certainly improved lately. Malaria staff visits and small pox vaccination services are now universal. However the family planning services do not show a strong presence. According to the Ahmedabad study cited, proportion of poor

families having more than 3 children under 14 years was nearly one-third of the total while the corresponding percentage was only 3 per cent amongst the non-poor. Child and mother mortality index has not been separately documented in these studies, but it is certainly much higher than the city's average.

1.23 The housing and environmental conditions of low income settlements have been the subject of detailed enquiry in most of the city surveys. The story is the same with minor variations. An overwhelmingly large number of them have walls made of mud, wooden planks, bamboos, gunny bags or burnt bricks laid in mud mortar; ~~for~~ roofs ~~it is~~ are mostly of cast-away tinsheets, broken asbestos ~~sa~~ cement sheets, wood, grass or bamboo. Tiles and R.C.C. roofs account for less than 5 per cent of the structures. Domestic electric connections, private water supply connection or separate family lavatory units are very rare.

1.24 There is another force which deepens the incidence of the already existing poverty of slum households. It is the higher birth rate, coupled with early incapacity or death of earning members. The percentage of juvenile population (below 14 years) was as high as 43 per cent. Those who were returned as working members were only 25.8 per cent of the total population. Picholia presents demographic contrasts between BPL (Below Poverty Line) and APL (Above Poverty Line) families of the same ward in Ahmedabad city.

Age group	Below Poverty Line Per cent	Above Poverty Line Per cent
0-4 years	11.6	5.1
5-14 years	29.2	17.8
15-59 years	54.3	68.9
60 & over	4.9	8.2

The above-poverty line families carry only about 60 per cent of the juvenile dependency load and have about 14 per cent higher population in working age group. Urban living does not account for a significant rise in the adoption of family planning practices in slum areas. If the birth rate in the slum areas can be brought at par with the rest of the city it would result in reducing poverty by about 18 points. This does not require enormous investment of resources, but only education, co-operation, and co-ordination of supplies.

1.25 Since incremental housing programmes depend on the future savings assumptions about the householders, it is necessary to analyse the data on savings and indebtedness. Kashyap reports a savings-earning ratio of 10.29% for registered workers households in chawls. It is of interest to note that savings ratio is much higher in non-poor localities even within the same income group when it is compared to savings ratio of chawl dwellers. Further, contrary to the general belief it goes down as per capita income increases.

These are enigmatic findings. Although, in view of the insecure employment conditions and income fluctuations a high propensity to save is a reasonable explanation, yet all the other factors, namely asset base, earner-dependency ratio, consumption compulsives, economics of bulk purchasing, etc. militate against high savings potential. The indebtedness picture is not clear from Kashyap's data. Picholia provides a more detailed picture about indebtedness.

When other legitimate modes of adjustment to poor incomes like cutting down consumption or purchasing of inferior quality and cheaper goods fail, the low income households resort to borrowing. Here the non-migrant families have a slight advantage. Because of their long residence and experience they succeed as more acceptable borrowers as compared to newly arrived migrant families.

The data on the amount of borrowing by low-income households, especially on account of deficit, is not available for any recent year. Picholia found that 35 out of 106 households/below poverty line; that is, about one-third of the households were deficit households. The expenditure in these cases was found to be in excess of their current income. Some 30 of these households (86 per cent) resorted to borrowing to meet the deficit. The rest drew upon their past savings to meet the deficit. See the following Table:

Per capita per month income group	Per cent of BPL house-holds	Per cent of indeb-ted house-holds	Per cent of deficit house-holds	Average debt per indebted family (Rs.)	Average annual borrowing of deficit borrowing households (Rs.)
Upto Rs. 30	8.5	4.9	3.7(44.4)	1100	500.0
31-50	32.6	16.4	15.1(48.5)	2547	900.0
51-84	58.9	31.1	14.2(23.4)	4288	1125.0
	100.0	52.4	33.0	3461	1037.0

The data shows that 52.4 per cent of BPL households were indebted. The average debt per family was Rs. 3461. It is to be observed that while the per cent of deficit household and deficit borrowing went down progressively with increase in per capita income, the average debt per family increased with increased income. This was partly due to the fact that the bank loan assistance for buying productive assets was flowing mostly to the marginally poor sections. About 6 per cent of the BPL household reported such loan assistance. Even if allowance is made for such productive borrowing, the fact remains that contingency borrowing, social borrowing, and deficit borrowing accounts for a very large share of total debt.

Local authorities have been content to play only an indirect role in relation to income and employment development, social security and social welfare, especially amongst

the poorer sections of the population. Their major pre-occupation has been local works, public utilities, public health, primary education, revenues and housekeeping functions. Welfare services are being better funded now. Harijan employees welfare, women and child welfare programmes, etc. Urban planning and housing departments, however, carry mainly land-use exercises. They have hardly any goals expressed in terms of income or employment development or social integration and social security.

The alignment of municipal functioning with the basic planning goals of the country and the aspirations of the poor requires that a new orientation is accepted by the local authorities and that they are given an opportunity to participate in the area development programmes focussed around anti-poverty and employment promotion goals. The Gujarat State has already constituted District Planning Boards in which civic corporations are represented by their Mayor and commissioner. However, unlike a Zilla Panchayat, District Rural Development Agency, Tribal Sub-plan Authority, Rural Development Corporations, etc. which exclusively look after low income families, there is nothing comparable in the cities. The Urban Community Development Service has yet to grow in stature and capabilities to deal with the income and employment aspects. Its role is recognised but its contribution has been

peripheral to a few training courses and minor loan facilitation. Its working is oriented to development of some common amenities. Household and cluster approaches and resource development exercises have not been tried by it as yet.

The time has come for the local authorities to involve themselves more deeply in helping the low income settlers, solve their problems of low income, unstable employment and unhealthy environment and use the funds and facilities available to them more fully for this purpose. The State can be persuaded to earmark allocations to the District Planning Boards for being applied to the assistance programmes for the urban poor and provision of their basic collective needs like site and services.

2.0 Issues :

2.1 Frame-work of Preventive Policies :

Urban development policies essentially are part of national development policies in which basic solutions are to be sought for problems of rural and urban development together. If the national policies succeed in popularising family planning and creating substantial income and employment generation activities for rural poor, the pressures of city-ward migration would be considerably reduced in their intensity. The cities and towns can find the problems of urban development within their coping capacity. A perspective plan which ensures full absorption of new additions to labour force in rural areas is necessary. A plan with a built-in potential for heavy urban migration is inconsistent with the control of urban ward migration. The present demographic projection shows a 4 per cent rate of growth in the labour force in urban areas which is more than double the projected growth rate.

It will also require policies for the rationalisation of income, wages and prices with a view to reduce differentials between urban and rural areas and intra-urban sectors especially when such differentials are not based on productivity differences. A close

coordination of housing and industrial development policies and requiring the industry to share the cost of developing shelter and social services for its low paid employees based on national norms will have to form part of policies of planned development.

The policies regarding norms of land use, water-development, recycling of resources will have to be realistically recast in the light of perspective plan for the next 15-25 years. A set of framework of preventive policies needs to be evolved and the present framework to be examined from the stand point of consistency with this framework.

2.2 Ameliorative Policies :

The ameliorative policies embrace a wide variety of issues :

(a) Population Control

Studies show that birth and mortality rates are higher in pockets of urban poverty. The reduction of infant mortality may temporarily upset the balance but in the long run may have beneficial effect on the size of women poor to restrict the family size. The organisational efforts, for family planning adoption, however need not wait. Efforts on successful concentration of family planning will have immediate effect on the reduction of inveteracy and enhancement of saving

potential. In the long run it will reduce excess supply of labour and build up capital for investment which will raise returns from labour. Concentration of family planning and Child and Maternal Care efforts will thus form essential ingredients of amelioration work against urban poverty.

(b) Public supply of essential goods at guaranteed/affordable prices:

The public supply system needs to cover a broader spectrum of essential goods to households at subsidised rates, if necessary, so that the urban poor can have protection against the erosion of purchasing power. Edible oil, coarse cloth, kerosene, pulses, milk, onions and potatoes can be added to the existing list of food grains and other items.

The content, rate and mode of subsidisation of essential goods under Public Distribution System channels of supply are major issues. The dual price system may be necessary to ensure that PDS supplies are not misused.

(c) Affordable shelter and larger share of public utilities for poor:

Whatever perspective of income is taken of urban poor, the shelter at the minimum norms of subsistence will become unaffordable at present market rates which are showing tendencies of sharp rises. Public supply of affordable shelter is inevitable. Resource mobilisation and increased allocation of land and service resources of local authorities for urban poor would become necessary. The employers of the workers must share responsibility as principal beneficiaries. Thought and reflection is necessary for apportionment of responsibilities for contribution of resources.

(d) Decasualisation; Social Security :

In a developing economy, a number of entrepreneur initiatives for new entities and new trials are expected to blossom. To guarantee permanency in such setting is unrealistic. Risk and uncertainty are part of the venture. A number of jobs might, therefore, be non-permanent. Social security backing is necessary if the worker is not to suffer hardships. Substantial extension of coverage of social security benefits for low income households - old age pension, unemployment benefits, maternity aid, sickness insurance, etc. can relieve crisis-borrowings and thus help in reduction of debt burdens.

(e) Lowering School Drop-outs; Supplementary Nutrition :

The acquisition of productive skills requires a literacy base. The drop-out phenomenon destroys the very base on which the modern skill structure is built. Higher retention rate is, therefore, a necessary condition for advanced skill acquisition later and escape from poverty-trap eventually. Along with other methods mid-day meals might improve the retention rate. The extension of food scholarships to children from poor urban families is worth consideration.

(f) Redirection of Consumption and Savings :

Surveys show that a large part of income of urban poor is spent on alcoholic drinks and other consumption goods harmful to health. It destroys saving potential and builds social tensions. Methods for reducing consumption to the acquisition of goods for human nutrition, education and health is a necessary part of urban poverty alleviation.

2.3 Agency for implementation :

An important question associated with the implementation of amelioration policies is that of the agency to promote development of the low-income urban households.

(a) Should the Urban Community Development (UCD) agency be expanded in coverage, reoriented and retooled or a new agency is necessary ?

(b) Since health, housing and educational services have lot of complementarities and linkages, where should the urban poverty alleviation agency be located to secure co-operation, of the departments supplying these services ? Should it be municipal corporation, a new agency of State Government, an aided voluntary agency with a council type structure on which various other bodies are represented ?

(c) How should beneficiary institutions be involved. Should there be consultative co-ordination committee of workers, neighbourhood volunteers and/or ?

2.4 Technology transfer, Skill development, Productive Asset Acquisition, Credit line up :

There are technological developments in the field of appropriate technology which can increase productivity, reduce monotony and avert health risks. These items will have to be identified by a national project on "Technology and Urban Poor". Such items should be identified, demonstration projects should be set up to learn lessons, skill

development outlays and arrangements should be installed and the infrastructure, consultancy and marketing links necessary to utilise the skills should be laid out. The productivity of non-formal sector varies from operator to operator. The technology transfer, skill development and productive asset acquisition would help in upgrading the operators getting low returns from their work.

The productive asset acquisition will have to be accompanied by appropriate line-up of credit arrangements for purchasing of fixed assets and acquiring working capital. The priority sector will, therefore, include credit flow~~s to the~~ lines to be opened for urban poor.

2.5 Improvement of labour market mechanism :

Despite free services of employment exchanges, the rate of clearance is very low which shows either sluggishness in growth or imperfection of market-mechanism. Apart from gathering at a central place in the city, there is hardly an alternative mechanism to bring the openings for temporary and casual jobs to the attention of those who subsist on daily wage basis. There are several methods to improve labour market mechanism. However, the recognition of their limitations is necessary. Market information can secure better adjustment of supply and demand and provide indications for price, supply, and demand adjustments in the long run but it cannot correct distortions induced by historical inequalities and policy biases.

3.0 Suggestions on the Urban Poverty theme for the Commission :

In order to

(a) clarify perceptions

(b) remove prejudices and misconceptions

(c) raise awareness and build up national consciousness

(d) develop appropriate policies, strategies, approaches, programmes and projects

(e) design suitable agencies for planning and implementation, and

(f) organise effective action

which would help dealing effectively with the phenomenon of urban poverty and the situation created by it in the Indian urban centres, it is suggested that the National Commission on urbanisation undertake, under its auspices, the following activities :

3.1 A Situational Analysis on Urban Poverty of Indian Cities:

Based on secondary and if necessary primary data covering various categories of cities and representing different regions. To make the picture more realistic, graphic and people-based, case-studies, interviews and anecdotes may be included.

The Situational Analysis besides presenting a factual picture of urban poverty should be designed to play a rold similar to that played by Dandekar-Rathe's study on Indian Poverty. The effort should be directed towards raising public awareness and building national

consciousness of the dimensions and gravity of the problem and address all levels in the appropriate forms.

3.2 A Statement of attitude towards urban poor:

A document presenting and analysing perceptions, views, beliefs, images, opinions and attitudes of a cross-section of Indian society with regard to the urban poor - their level of existence and role in society and ways to deal with their problems.

This exercise should aim at bringing into focus the perceptions and interests of people concerning the poor and poverty. Taking this up along with the fact-based Situational Analysis will help both ways - seeing peoples' perceptions in the context of reality and understanding the role perceptions play in shaping reality.

The exercise may be so designed as to obtain views and opinions of people at different levels and playing different roles in the urban framework. It should cover the highest and the lowest in the land.

3.3 Performance evaluation and impact analysis of policies, programmes, projects and agencies designed to tackle poverty situations and improve the lot of the urban poor:

The following programmes/projects/agencies are suggested for this purpose :

(a) The Sites and Services Approaches

(b) The Environment Improvement and Shelter Upgrading Approaches

(c) The Urban Community Development Project

(d) The Integrated Child Development Scheme

(e) The Mid-day Meal Scheme for School Children

(f) The Basic Services Approach

(g) The Urban Land Ceiling Act.

All these projects have been designed to reach various urban services - housing, nutrition, education, community organisation, etc. - to specific target groups among the urban poor and have been operating for some years now. Questions like: Do they reach the really needy? Do they benefit the intended beneficiaries? Are they cost effective? and How can their coverage be extended?, are to be examined.

3.4 A position paper on preventive and remedial strategies including a ten year perspective plan dovetailed with the National Development Plan:

In doing this, the assistance of interested and competent public and private agencies - professional, educational, research, voluntary, etc. -can be obtained. A note outlining the Terms of Reference could be prepared to solicit participation and work out time schedule, cost estimates and other details.

The process of doing this exercise itself can become a useful means of building up a subject constituency.

Stage set for new urban policy

By JAGPREET LUTHRA

SIX months after the National Commission on Urbanisation submitted its final report to the Government, the Urban Development Ministry is feverishly engaged in follow-up action both at the policy and practical levels.

The Ministry is working in close co-operation with the Planning Com- ion to ensure that the report's mmendation of a hike in the Plan tion from 4 per cent to 8 per Eighth Plan is given due n. The Government has ccepted the recommendation ple but has to wait for the ord from the Planning Com- ion.

The Ministry has held discussions with State Urban Ministers and two States — Tamil Nadu and Maharashtra — have already formulated and sent their responses to the Centre. According to the Joint Secretary in the Urban Development Ministry, Mr. P.S. Sundaram, the response has been positive. The other States, he said, had also favourably received the report at the Urban Ministers' conference in New Delhi last month but the Centre is awaiting a detailed written response from them to act on the report.

Mr. Sundaram explained that it was very necessary to seek the individual response of every State as the report was basically a national document which must be tested for adaptability l needs of every State. The is also organising State-level Mars and discussions for the ne- ary feedback on the report in consultation with Unicef. "It is basically going to be a learning exercise to assess local needs before we give the States any guidelines on the subject," he said. The seminars will be held over the next two months.

GUIDELINES

According to Mr. Sundaram, the commission's recommendations are based on well-researched facts of Indian urban life and provide the Government, for the first time, extensive guidelines for a national policy on urbanisation. The report, he was confident, would effectively replace the current ad hoc and panic approach to the country's urban problem.

One of the most radical aspects of the approach, observed Mr. Sundaram, was that it considers growing urbanisation a vital input in the growth of the economy, thereby convincingly refuting the growing school of thought that advocates discouraging urbanisation and views cities as parasites on the national economy. Instead of recommending that urbanisation be stifled, the commission, he said, had shown ways to cope with it.

According to Mr. H.K. Yadav, Chief Special Projects, Housing and Urban Development Corporation (HUDCO), another positive aspect of the commission's findings has been that urbanisation can be a self-sustaining process and need not always depend on state funding. The commission has suggested involving the private sector in funding urbanisation and encouraging joint sector projects in the field.

GEMs

The most impressive aspect of the commission's study, according to Mr. Sundaram, is the list of 329 generators of economic momentum (GEMs) suggested by the commission. The list is not a definitive one but as an illustrative one, he observed, it was a major breakthrough. The commission has identified these GEMs based on the guidelines that State capitals deserve the same attention as the national capital and that five-year plans should provide support to large industrial cities, port cities and other industry-specific cities to expand and consolidate their economic bases. Most of these centres, according to the report, have high rates of population growth.

The recommendations regarding GEMs, said Mr. Sundaram, would not only supplant the urban location strategy for such centres but also the industrial location strategy.

While pointing out that the urban housing chapter of the report matched well with the National Housing Policy finalised last summer, he said the commission, had, however, not provided a definite solution to the difficult problem of urban squatters.

The commission, according to him, has also been vague in its recommendation about the 4 per cent hike for urbanisation in the Eighth Plan allocation. The suggestion, he said, was very broad and the Ministry was seeking the help of research bodies to break up the suggested hike into specific heads for a better realisation of resources. The Ministry, he said, was hopeful of formulating specific policy decisions on the major recommendations by the middle of this year.

According to Mr. Yadav, if the report is followed in right earnest, beginning with the Eighth Plan next year, there should be a perceptible change in the urban situation in the country by the end of the Plan. One would have to wait until the end of the Ninth Plan, 10 years from now, for a more definite improvement, he added.

He was confident that the Eighth Plan would mark a new stage in the policy on urbanisation. The Planning Commission, he noted, could not afford to ignore the need for correcting the urban situation in view of the political will that prompted the setting up of the commission.

S.S. DRAFT NOT FOR QUOTING!

Maternity Health Care for the Urban Poor in Bangalore

A Report Card

DEV-3.

Sita Sekhar

Executive Summary

Background

Bangalore Mahanagara Palike's (BMP) maternity homes represent the only decentralised set of health facilities in Bangalore that are accessed by relatively low-income women and children. A network of outreach centres has now been created through IPP 8 to expand and further strengthen the services of the maternity homes. While this expansion and upgradation of the health facilities for the poor needs to be applauded, it is important that careful thought is given to their proper utilisation, maintenance and effectiveness. This comparative study on Maternity Homes, Urban Family Welfare Centres and IPP Health Centres, discusses the system's maladies, concerns about the future of these facilities and presents some thoughts on how to address them.

A total of 500 patients and 77 staff of these facilities were interviewed in two phases. The major findings were as follows:

- The overall satisfaction of patients was the lowest with the services of the maternity homes. Only a third rated them as good while 71% and 60% considered IPP centres and UFWCs respectively as good.
- Only 39% of the patients of the maternity homes claimed that they received all medicines free as opposed to 63% in IPP centres and 61% in UFWCs. Maternity homes also lead in taking payments for injections. But the staff says that medicines are given free to all patients.
- Cleanliness of toilets is an indication of the standards of hygiene and sanitation. Here, patients rated maternity homes the lowest (43%) in contrast to IPP centres (83%) and UFWCs (61%).
- Maternity homes were rated the lowest also in terms of staff behaviour towards patients. But the gap between them and IPP was much smaller in this case.
- The most distressing finding concerns the prevalence of corruption. While none of the facilities seems corruption free, maternity homes stand out in terms of the severity of the problem. Payments are demanded or expected by staff for almost all services, but most of all, for delivery and seeing the baby. The proportions of people paying bribes vary from one service to another. On the whole 90% of the respondents reported paying bribes for one service or the other at maternity homes at an average of Rs 700 per head. Nearly 70% pay for seeing their own babies! One out of two pay for delivery.

- If a poor woman paid for all services, it would have cost her over Rs. 1000 for a delivery. It is reported that a nursing home might give her hassle free and better quality service for Rs. 2000. A rough estimate of the bribes being paid in all these facilities may be between Rs one and two crores annually. A similar estimate based on the finding that 90% of the women pay an average of about Rs 700 at the Maternity Homes would put the total amount of bribes paid at about Rs 1. 6 crores. The annual emoluments o the staff at the 30 maternity homes also amount to about Rs 2 crores.
- Most of the staff denies the practice of corruption. They do complain about the constraint of facilities, and shortage of staff, supplies and resources. Doctors emphasized the need to improve the awareness of patients, especially with respect to the need to be regular in their visits

The evidence presented above clearly points to the need to urgently reform the municipal health care facilities for the poor in Bangalore. At the core of the problem is the highly unsatisfactory state of the services of the maternity homes. If the present conditions continue, the newly created IPP centres will also deteriorate and become part of the pool of corruption and low quality that characterise the system. It will be a great pity if the fresh investments being made for these centres are rendered unproductive by continued apathy while paying lip service to the upliftment of the poor. On the brighter side, reforming the maternity homes should be a manageable task given their relatively small size and the compact population they serve. The Chief Minister's concern for good governance and control of corruption offers a window of opportunity for BMP to design and carry out an agenda of reform. If promptly done, reforms will have a strong demonstration effect.

Maternity Health Care for the Urban Poor in Bangalore
A Report Card

Sita Sekhar

Background/Introduction

The provision of good maternity care to poor women and primary health care to children should be one of the primary concerns of any government in a country. Since poor women do not have access to quality care in the private sector due mainly to the prohibitive costs, it becomes all the more important that the authorities ensure that proper care is made available to these women.

In the city of Bangalore, it is the City Corporation that provides a major share of these services to the poor women. This is done through a network of three kinds of health care institutions. There are around 30 Maternity Homes and Urban Family Welfare Centres, and 55 India Population Project run Health Centres.

The present exercise began with a round of discussions among NGOs working with the urban poor and officials from the IPP, following reports of poor service and widespread corruption in the provision of these services[1]. The group met to strategize for working towards an improvement in the maternity care provided to poor women. Public Affairs Centre was assigned the task of conducting a Report card study on the services provided by these three kinds of maternity health care providers run by the Municipal Corporation of Bangalore, since it would be unfair to draw any conclusions without a systematic investigation. It was decided to get feedback from poor women who have used these facilities on the quality of care provided, the level of cleanliness, accessibility, and extent of corruption in them. The purpose of the study was to get corroborative evidence on the poor quality of services provided, and the widespread corruption in the maternity homes to strengthen the advocacy work.

The rest of the paper is divided in to 3 sections. Section I describes in detail the methodology followed for this study. Findings from the surveys are presented in Section II. Section III presents the conclusions and recommendations of the study.

[1] This includes an earlier Report Card study on public hospitals which brought out the inefficiencies in the running of maternity homes and also the highlighted the prevalence of level of corruption in them.

Section I

Methodology

This survey was carried out in two phases. The first phase involved getting feedback from slum dwellers that had accessed the services of the Maternity homes, Urban Family Welfare Centres (UFWC) and India Population Project (IPP) Health Centres run by the Corporation of Bangalore. The Report Card methodology was used to collect the feedback. The sample was selected using multi-stage-sampling technique.

Phase I

Twelve maternity homes, and UFWCs were selected and 20 IPP Health Centres were selected based on relevant criteria such as size of the facility, number of patients visiting the facility and the size of the population served by the facility. Geographic representation was also ensured. Respondents were selected by visiting slums that are served by the selected maternity homes and health centres. 150 patients (women) each for Maternity Homes, and UFWCs and 200 women for IPP Health Centres were selected for the sample. These women gave feedback on the services provided by the three kinds of providers. This led to a sample size of 500.

Phase II

This was a survey of the three kinds of staff - doctors, nurses, and other staff - from Maternity homes, UFWCs and IPP Health centres. Six Maternity Homes, 6 UFWcs and 10 IPP Health Centres were selected from among those that were covered in the first phase ie the survey. One doctor from each facility, one nurse form each UFWC or IPP Health Centre and two nurses from each Maternity home were interviewed. One other staff member from each facility was also interviewed. This yielded responses from 22 doctors, 44 nurses and 22 other staff on various issues related to maternity health care for the poor. The sample size therefore was 77 staff members.

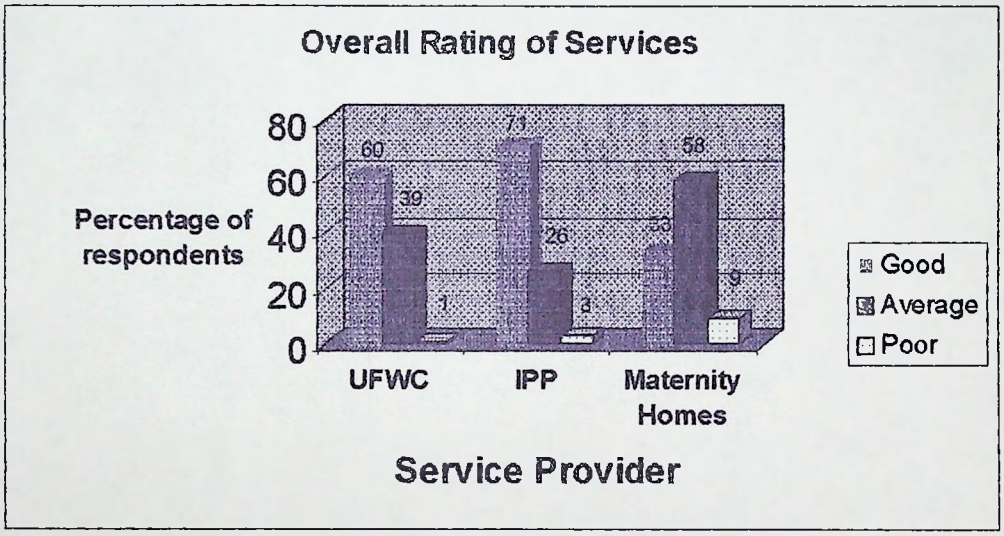
Section II

Major Findings

2.1 Overall Satisfaction with Services

The overall rating of services provided by Maternity Homes, UFWCs and IPP Health centres by people who visited them is given in Chart 1 below.

Chart 1: Overall Rating of Services



71% of the users of IPP Health Centres have rated their services as good, while 26% have rated them average. 60% of women who went to UFWCs have rated their services as good while 39% have rated them as average. 33% of the patients of Maternity homes consider the services provided by them as good while 58% say they are average.

IPP health Centres are on the whole rated better than the UFWCs and Maternity Homes. For similar services provided by all three the rating is the highest for IPP Health Centres and lowest for Maternity Homes.

2.2 Feedback on Service Delivery

A. On free supply of medicines

More of the patients that went to UFWCs (73%) and IPP Health Centres (71%) are aware that medicines are to be given free than those who have gone to maternity homes (63%).

While only 39% of the patients were given the medicine free of cost at the maternity homes, 61% and 63% were supplied the medicines free at the UFWCs and IPP Health Centres.

Money was demanded for the medicines from 11% of the women at the maternity homes while only 4 and 3 % reported being asked to pay money for medicines at UFWCs and IPP Health Centres.

The average amount paid for medicines was higher at Rs 94 at maternity homes than Rs. 30 paid at UFWCs. But the least amount was paid at IPP Health Centres (Rs. 15)

Table 1: Information related to free supply of medicines

Tablets related aspects	Percentage of respondents saying yes at maternity home	Percentage of respondents saying yes at UFWC	Percentage of respondents saying yes at IPP Health Centre
Whether advised to take tablets	84	94	90
Whether aware medicines are to be given free	63	76	71
Whether medicines given			
All	36	55	60
Some	54	39	32
None	10	6	8
How many of medicines given free			
All	39	61	63
Some	61	39	37
Whether money demanded for medicines	11	4	3
Average amount paid	Rs. 94	30	15
Whether asked to buy medicines from private shops	84	75	80

- ***All doctors, nurses and other staff at all three types of facilities say free medicines are given to all patients all the time.***

B. Feedback on tests done at Maternity homes

Table 2 : Feedback on tests done at Maternity Homes

Status	Percentage of respondents saying yes/Rs.		
	Scan	Blood test	Urine test
Whether done	8	71	65
Whether informed of result	85	70	76
Whether paid	38	13	7
Average amount paid	176	21	21

A large proportion of the women had urine and blood tests done at the maternity homes. Scan was done for a smaller 8% of them. Most of them said they were informed of the results in all the cases. Though these tests are supposed to be free of charge , 38% of those who got a scan done, 13% of those who had a blood test done and 7% of those who had a urine test done paid for the test. An average amount of Rs. 21 was paid for the tests and Rs. 176 for the scan.

The data indicates the practice of collecting fixed relatively smaller sums for blood tests and urine tests and larger sums for scans at the maternity homes.

C. **Feedback on Hygiene Related Issues**

Table 3: Feedback on Hygiene related Issues

Injection related aspects	**Percentage of respondents saying yes**		
	Maternity Homes	**UFWCs**	**IPPs**
Whether given injections	*84*	*93*	*93*
Use of disposable syringe	*52*	*70*	*70*
Payment for injections	*11*	*07*	*06*
Average amount paid	*Rs. 16*	*Rs. 16*	*Rs. 14*
Hospital facilities related aspects	**Percentage of respondents saying yes**		
	Maternity Homes	**UFWCs**	**IPPs**
Availability of drinking water	*83*	*89*	*95*
Clean & Usable toilets	*46*	*61*	*83*

Many of the women (84%) who visited maternity homes and 93% of those who went to UFWCs and IPP Health Centres were given injections. Of these 11% paid for the injection at maternity Homes, 7% at UFWcs and 6% at IPP Health Centres. An average of RS 16 was paid for the injection at Maternity Homes and UFWCs , and Rs 14 at IPP Health Centres.

As in the case of tests a certain sum has been collected for the injection though it is to be given free of charge at all three places.

Despite use of disposable syringes being mandatory, half the women who went to Maternity homes reported non-usage of disposable syringes. Usage of disposable syringes is more prevalent at IPP Health Centres and UFWCs at 70%.

- *The patients for the Maternity homes corroborate the information given by the staff regarding usage of disposable syringes.*
- *In UFWCs 40% of the doctors and 60% of the nurses reported using disposable syringes - which contrasts with what patients have said.*
- *In the case of IPP Health Centres 92% of the doctors and 33% of the nurses said they used disposable syringes. This varies significantly from what is reported by patients.*
- *However the staff do point out that even if disposable syringes are not used they do use autoclaves to sterilize the injections.*

It is to be noted that in the times of the fear of AIDS and other communicable diseases, there is an alarming level of unawareness among the patients on the issue. They have not realised that the syringes used for them are being sterilised and they are not disposable ones. That is what explains the contrast in what the patients reported and what the staff said. In fact, most UFWCs and IPP Health Centres use autoclaves to sterilise the syringes and rarely use disposable syringes.

Availability of drinking water is reasonably good at all the three facilities but the IPP tops with 95% patients saying they do have drinking water. But when it comes to clean and usable toilets maternity homes are clearly not as good as IPP Health Centres with 46% and 83% women respectively rating the toilets always clean and usable. The UFWCs are only marginally better than Maternity homes at 61%.

- *All the staff at all three facilities have said there is drinking water available and that toilets are kept clean and usable.*

D. **Satisfaction with behaviour of staff**

Table 4: Ratings on Behaviour of staff

	Percentage of respondents always satisfied with behaviour of		
	Doctors	Nurses	Other staff
Maternity Homes	73	73	73
UFWC	83	76	86
IPP Health Centre	95	81	92

Patients are generally quite satisfied with the behaviour of the staff at all the facilities (with 73% of the women reporting being always satisfied and the rest either never or sometimes satisfied). The satisfaction is however significantly greater with the staff of IPP Health Centres. While users of Maternity homes rate all three kinds of staff equally on behaviour, patients at IPP Health Centres and UFWCs find doctors and other staff better behaved than nurses.

Behaviour of staff does not figure as an issue for the respondents. Staff at the IPP Health centre is rated the best behaved by the patients.

E. **Waiting time at the facility**

Table 4: Time taken to attend to patients

Maternity home	35 minutes
UFWC	28 minutes
IPP Health Centre	23 minutes

Patients at the maternity homes have to wait for about 35 minutes to be attended to. The waiting is marginally less at UFWCs at 28 minutes. The wait at the IPP Health centre is the least at 23 minutes.

The data on waiting time indicate a certain amount of crowding at the facilities. For a centre that serves a geographically smaller area, the waiting time at the IPP health centres could certainly be brought down.

Doctors, nurses and other staff at all the three kinds of places have quoted not more than five to ten minutes as the waiting period for patients.

2.3 Extent of Corruption

Many of the patients have reported instances where they have paid a bribe for some purpose or another. The various purposes for which they have paid bribes are tabulated below. In general however, it can be said that there is corruption in various forms in Maternity homes. There is evidence of corruption in UFWCs and IPP health Centres as well but not to as great an extent as in Maternity homes.

Table 5: Extent of Corruption

Purpose for payment	Percentage of respondents who paid	Average amount paid
Maternity Homes		
For medicines	11	94
For scan	38	176
For blood test	13	21
For urine test	7	21
For delivery	48	361
For seeing the baby	69	277
For immunization of mother	13	18
For immunization of child	10	10
For family planning	10	95*
For injections	11	16
Other reasons	32	**
Total		1089
UFWCs@		
For medicines	4	30
For injections	7	16
For immunization for child	0	0
Other reasons	2	1
Total		47
IPP Health Centres		
For medicines	3	15
For injections	6	16
For immunization for child	2	13
Other reasons	0	0
Total		44

* This is those who went to a maternity home for Family planning. Some who were referred from UFWCs for sterilisation to Maternity Homes have paid as much as Rs 150/-.

** Average not worked out

@ there are people who have reported having paid for sterilization but are not included here as sterilization are done only at MHs.

The level of corruption at Maternity Homes is much higher than that at UFWCs and IPP Health Centres. One of the reasons for this could be that UFWCs and IPP Health Centres do not involve admission. The reason for which bribes are paid by most patients are for seeing the baby (69%) and for the delivery itself (48%). Other services like injections, family planning medicines etc are also provided for payment of bribe but the extent is not so large. As far as the average amounts paid are concerned they are quite large for seeing the baby and for the delivery (Rs.361 and Rs. 277 respectively) while other bribes are smaller in value.

There certainly is corruption at both UFWCs and at IPP Health Centres, and nominally more at UFWCs for most reasons. However the fact that even services such as provision of free medicines, injections, immunization and family planning are not provided free as they should be even if for some patients is disturbing.

At maternity homes even small things like providing hot water, giving an enema, cleaning the room or the patient are not done for as many as 32% of the patients without money changing hands.

- *When asked how patients express their appreciation almost all the staff at all three kinds of places said they "say thanks".*
- *When asked if there is a practice of receiving gifts or money they mostly said no (with the exception of one doctor and a few other staff)*
- *When asked if they were aware of anyone demanding money for services they all said no!(again with a few exceptions)*

2.4 Usage of the Services of Maternity Homes, Urban Family Welfare Centres (UFWC) and India Population Project Health Centres (IPP Health Centre)

Table 6: Purposes for the visit

Facility → Main purpose of visit↓	Maternity Home	UFWC	IPP Health Centre
Antenatal care	79%	67%	73%
Immunization for child	55%	62%	79%
Delivery	94%		

Among the patients who had visited maternity homes, 94% had gone there for their delivery and 79% for antenatal care. Among those who had visited the UFWCs, 67% had gone for antenatal care and 62% for immunization for the child. Of the women who visited IPP Health Centres, 79% went for immunization for the child and 73% for antenatal care.

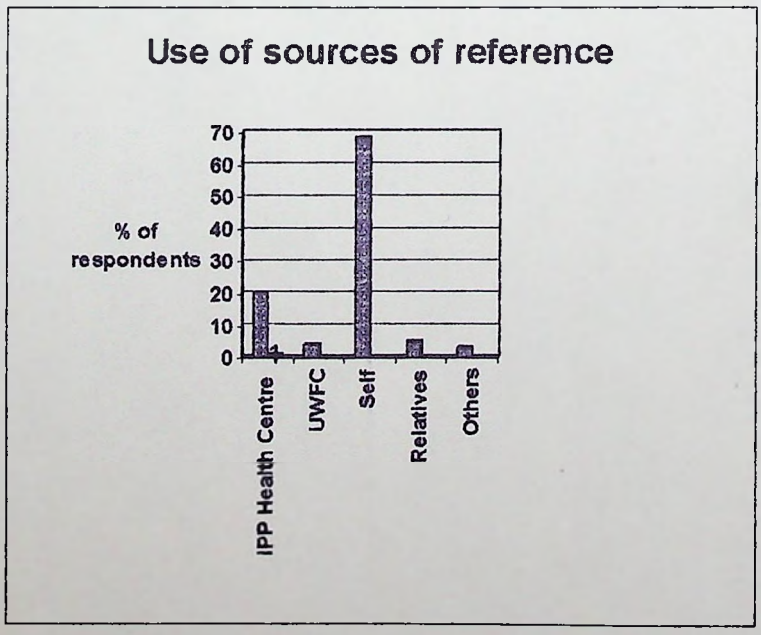
The above findings show that maternity homes are more popular among women for antenatal care than the other two providers. This indicates either a lack of awareness among the patients of the availability of these facilities nearer their residences at the IPP Health centres or a reluctance to go to a new place. In either case there is a need to educate the women on the advantages of using the IPP Health Centre.

2.4.1 Referral to Maternity homes by UFWCs and IPP Health Centres

Patients who had been to Maternity homes were asked who referred them there. The response shows that most of them came there on their own (68%), some were recommended by friends and relatives (8%) while 20% had been referred by IPP Health Centres and 4% by UFWCs.

Among patients who visited UFWCs and IPP Health Centres, 63% and 64% said they were referred to maternity homes for delivery. Of these 81% and 67 % went for their delivery to maternity homes from UFWCs and IPP Health Centres respectively.

Chart 2: Use of sources of reference



This shows that while a reasonably large proportion of those who visit UFWCs and IPP Health Centres are referred to maternity homes for deliveries, there are still many women who come there on their own. One probable cause could be their familiarity with the maternity homes and therefore the confidence in them. This calls for intensive awareness and motivational campaigns by the IPP staff among slum dwellers.

The question as to why, when 64% of the patients are being referred to maternity homes from IPP Health Centres, only 67% of them have actually been to maternity homes for delivery is also raised. Is there a block at the maternity homes or are they wary of going there out of fear that they would not get proper treatment?

2.5 Other Interesting Findings

- Most users of maternity homes went for delivery(95%)
- the main purpose for visit at UFWCs was Antenatal care and child immunization.
- The main purpose for visit at IPP HCs was child immunization and antenatal care
- most patients visiting MHs went on own(68%)
- Relatives and friends are chief motivators for visits to UFWCs
- Link workers bring 29% of patients to IPP HCs
- 7% persons refused admission at MHs
- Immunization programs users say they benefit from - mainly pulse polio (over 95%)

GIVING A FACE TO THE NUMBERS!! - 2 case studies

Nagamma had a harrowing time at a young age of 19. She went for a delivery to a maternity home expecting to bring home a baby in joy. It turned into a nightmare. Upon arrival in labor the doctor refused her attention unless she was given money. The husband in a panic went and mortgaged her jewelry and paid the doctor Rs. 1000. The rudeness of the doctor added to their misery. Once the money was paid, the doctor conducted the delivery but it was too late. The baby had died.
The nightmare did not end there. The staff would not show the dead baby to the aggrieved parents till some more money was paid. Can Nagamma be blamed if she vowed never to go to a BMP Maternity Home again?

On the brighter side, at another Maternity Home one patient was badgered in to paying a large sum for a delivery. Her family and friends got together under the guidance of an NGO and sat in dharna till the Doctor returned the money! Here's to hoping there are more and more incidents like this in the future!

Section III
Conclusions and Recommendations

It is for the BMP to decide how to deal with the problems brought out by the above findings. To assist in the process, PAC and several other experts and NGOs working with the urban poor held a discussion to think about the options that might be considered by BMP. What follows are the major conclusions drawn and the recommendations that came out of these deliberations.

3.1 Conclusions

- The study very clearly brings out the distinct differences in service quality between Maternity Homes and IPP Health Centres. While Maternity homes do not score that well on cleanliness and hygiene, IPP health Centres do. Basic medicines that are to be given free are not being given to a large proportion of poor patients at Maternity homes, while at IPP HCs most people get free medicines.

- The differences in quality of service are also indicative of poor discipline and responsiveness among the staff at Maternity homes.

- The practice of corruption is far more entrenched in Maternity Homes than in IPP Health Centres. Bribes are being demanded and paid for almost every service being provided at Maternity Homes.

- The staff are not ready to accept the prevalence of corruption leave alone trying to tackle it.

3.2 Recommendations

- A more effective oversight mechanism should be created to monitor the activities of the maternity homes. A board of visitors consisting of 5-7 persons could play this role through quarterly meetings to review the operations, needs and plans of each maternity home. A board can also check and eliminate unnecessary overlaps between the maternity homes and the outreach centres. The board should include 4-5 independent experts and activists concerned about the urban poor and health. A corporator and another official could also be nominated to the board. If a board for each home is impractical, perhaps, a board could cover about 4 homes located in contiguous wards. These boards should report to the Commissioner or his deputy.

- A patients' charter should be created for the maternity homes. It should publicise the services offered, time deadlines and terms of service, fees,

remedies in case of problems, patients' rights and duties. This could be the first service of BMP for which a charter could be designed on an experimental basis. Staff should participate in this process and be trained and motivated to implement it.

- Though the services are free, the reality is that the poor women are made to pay for them in a majority of cases. They pay, but have no assurance of quality or rights. Why not move to a system of contributions to a health fund by the women (some are allergic to the concept of user charges)? The idea is not to recover the full costs of the services, but to let patients share the costs (hence contribution) so that they have a right to receive the services. Norms for the contributions could be published. Delivery is a predictable event and not an emergency. They can save for this event and pay rather than be faced with extortion when in distress.

- The fund thus created should be used for the maintenance and improvement of the facility where it is collected. It will be an incentive for the doctors and staff if the money can be used to improve their facility. Whether a part of the fund could be used to pay a bonus to the staff is a matter for further consideration. Public hospitals in MP are already working on similar lines.

- In the case of the IPP centres, it is imperative that provision be made for the diversification of their management and control. When they revert to BMP, the issue is whether interested NGOs, foundations, teaching hospitals, etc., could be brought in to operate the services with a maintenance grant from BMP. IPP centres have the potential to become community service centres as their infrastructure could be used after office hours for meetings, teaching and even private practice and other services beneficial to the community. If this approach is adopted, the maintenance costs and BMP's burden can be reduced as additional income will be generated by the centres through the use of their facilities. Good NGOs may have an incentive to work along these lines as it will help further their own mission.

- Even if all these actions are taken, there is a need to empower the poor women to demand their rights and to stand up against abuse. The only way to do this is by creating support groups of women in different slums. Some NGOs have already agreed that they will play this role in their areas of work. They have also expressed interest in operating help desks in the maternity homes for patients. Support groups could prepare and brief pregnant women and accompany them on visits to maternity homes. This function properly belongs to the voluntary sector. IPP centres could be used as a base for organising the support group activities.

3.3 Follow-up to the Report Card

As a follow-up to the study, the findings were presented to the Officials of the BMP and the response has been very encouraging. Steps have already been taken to implement the recommendations made in this report. For more information in this regard, refer the paper by S. Manjunath that describes the complete initiative in detail.

DEV - 3.

Library

CAMHADD THE COMMONWEALTH ASSOCIATION FOR MENTAL HANDICAP AND DEVELOPMENT DISABILITIES

(SUPPORTED BY THE COMMONWEALTH FOUNDATION)

Background Document of CAMHADD One-Day Workshop on

Citizens & Governance Programme
The Trisector Dialogue (Government, Private and Civil Society) in Health

Preventive Health Care with Special Reference to Urban Poor(Bangalore)

Sponsored by
Bangalore Mahanagar Palike(Corporation)

In Partnership with
Rajiv Gandhi University of Health Sciences Bangalore

Sri Jayadeva Institute of Cardiology Bangalore

Supported by
The Commonwealth Foundation London

Venue: Sri Jayadva Institute of Cardiology Date: 11 January 2003

Prepared by
The Commonwealth Association for Mental Handicap and Developmental Disabilities

Sri Jayadeva Institute of Cardiology, Bangalore

Urban Health Research and Training Institute, Bangalore Mahanagar Palike

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Preface

CAMHADD

CAMHADD – A Professional Association and A Pan Commonwealth NGO Supported by the Commonwealth Foundation London was established in January 1983. Its main objectives are prevention (primary and secondary) of mental handicap and to strengthen health professional links between and among developed and developing countries. **CAMHADD** has arranged 27 regional workshop including 8 Pan Commonwealth workshops from 1985 to 2002 involving 1387 (Male 714 Female 673) invited participants professionals from 45 Commonwealth countries and 17 Non Commonwealth countries.

CAMHADD is in official Relations with WHO since 1990 for collaborative programmes.

CAMHADD in collaboration with WHO has developed and implemented priority initiatives for the prevention of brain damage due to birth asphyxia (lack of oxygen either before or immediately after birth) a major non-communicable cause of death and disability in newborn to prevent mental, neurological and sensory handicaps as integral component of safe motherhood and child survival. CAMHADD is a long-standing partner of WHO in a number of technical areas, in particular mental health, disability prevention, maternal and newborn health, reproductive health, prevention of injuries, prevention of childhood blindness and Unity Towards Health to Achieve Social Accountability. WHO has co-sponsored 13 CAMHADD Regional workshops.

CAMHADD is granted observer status by the Commonwealth Health Ministers to attend their meetings.

CAMHADD was accredited as Pan Commonwealth NGOs to represent at the Commonwealth Heads of Governments Meetings (CHOGM) at Edinburgh (UK) in October 1997, Durban (South Africa) in November 1999 and Brisbane (Australia) in February 2002.

Citizens and Governance Programme arose directly from out of the Commonwealth Foundation's " Civil Society in the New Millennium" project

Citizens and Governance Programme : The Tri-Sector Dialogues

Governance as distinct from government is interpreted by most to mean having an inclusive approach to policy and decision-making, and to sharing responsibility for any or all of decisions, actions, provisions among the three main social actors –the government, private sector and civil society.

The Commonwealth Foundation(CF) organised a workshop in Australia in 2001. It highlighted the importance of examining the appropriateness and impact of tri-sector approaches in concrete situations in diverse of parts of the Commonwealth, Following this discussion Commonwealth Foundation decided to initiate a series of dialogue in up to 12 diverse localities in the Commonwealth in collaboration with Ford Foundation. **One-Day Workshop on Trisector Dialogue in Health at Bangalore (India) is one in the series.**

The topic of the workshop is : Trisector Dialogue in Health : Preventive Health Care for Urban Poor (Bangalore)

This background paper is prepared following a series of meetings, workshops, and individual views. Involving government, private sector, and civil society. Details are enclosed in Annexure. [1-6]

On behalf of CAMH ADD, I would like to express our sincere thanks and gratitude to :

Mr Colin Bal,Director of the Commonwealth Foundation London for supporting One Day Trisector Dialogue in Health.

Dr Rajesh Tandon –President PRIA (Participatory Research in Asia), New Delhi ,for his guidance

Mr M.R.Srinivasa Murthy, Commissioner, Bangalore Mahanagar Palike(Corporation) for sponsoring and supporting the workshop

Professor S.Chandrashekar Shetty-Former Vice Chancellor, Rajiv Gandhi University of Health Sciences, Bangalore for his guidance

Dr Chandrashekara, Vice Chancelleor, Rajiv Gandhi University of Health Sciences, Bangalore for supporting partnership programme

Dr A.R.Prabhudev, Director, Sri Jayadeva Institute of Cardiology Bangalore for his co-operation,cpllaboration and support

Dr Mala Ramachandran and Dr M.Jayachandra Rao of the Health Department of Bangalore Mahanagar Palike for arranging pre-workshop meetings and consultations

Dr S.Pruthvish and Staff Members and Post Graduate Students of the Departmnt of Community Medicine, Ramaiah Medical College Bangalore for their active involvement

V.R.Pandurangi
Founder, Emeritus Secretary General
and International Co-ordinator CAMHADD

Consultants of the workshop
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And International Co-ordinator CAMHADD

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Rajiv Gandhi University of Health Sciences (RGUHS) Karnataka Bangalore

WHO Representative
Dr. Roberta Ritson-External Officer
Government and Private Sector, WHO Headquarters Geneva

Facilitators
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Dr Mala Ramachandran-Director, Urban Health Research & Training Institute
Bangalore Mahanagar Palike Bangalore

Dr. M. T. Hemareddy – Former Director of Health Sciences and Family Planning Government of Karnataka, Bangalore

Rapporteurs
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Dr Ganesh Supramaniam-CAMHADD

Dr S. Pruthvish-Community Medicine and Public Health, Ramaiah Medical College Bangalore

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Dr K. V. Ramani-Indian Institute of Management, Ahmedabad-360 015

Dr. M. Jayachandra Rao – Health Officer (East) and Project Co-ordinator, India Population Project –VIII Bangalore Mahanagara Palike, Bangalore.

Background to the Trisector Dialogue

The Civil Society Initiative

1. The Commonwealth Secretariat(COMSEC)

2. The Commonwealth Foundation (CF) London

3. The World Health Organization (WHO)

"Civil Society can be defined as what people and their organisations do to improve their societies.

The Commonwealth Secretariat and Civil Society

Commonwealth Heads of Government Meeting(CHOGM) Durban(South Africa) November 1999 : The Durban Communique : Para 42 - Civil Society

"Heads of Government declared that people-centred development implied that people must be directly involved in the decision making process and in the implementation of development plans and programmes through their own organizations. They noted the significance of civil society in empowering people to benefit from globalisation, in contributing towards the goals of poverty elimination, equal opportunity and fair distribution resources and in helping to deal more effectively with ethnic,racial and religious conflicts. They acknowledged the need to enable capacity-building efforts of local and regional non-governmental organizations. They noted the report of the Commonwealth Foundation on Citizens and Governance and the Communique of the Third Commonwealth NGO Forum and asked Senior Officials, at their next meeting, to study the issue of the Forum presenting its views to the next CHOGM.

The Commonwealth Foundation and Civil Society

The Commonwealth Foundation and The Civil Society Commonwealth Foundation is an intergovernmental organisation of the Commonwealth, was founded in 1966, and is based in London. The Foundation is one of three inter-governmental Commonwealth Organisations. It works along side and in co-operation the Commonwealth Secretariat and the Commonwealth of learning. **Its mission is two fold: Civil Society and the People's Commonwealth.**

The Civil Society

The Commonwealth Foundation initiated a Civil Society Project in the New Millennium to strengthen the ability of citizens and civil society organisations to work together and with government and the private sector, towards the achievement of fundamental Commonwealth purposes and values, and especially those relating to good governance, people-centred and especially those relating to good governance, people-centred and sustainable development, and poverty eradication.

The World Health Organization (WHO)

WHO established the Civil Society Initiative (CSI) in June 2001. The civil society is defined as what people and their organisations do to improve their societies. The CSI main objective is to promote more effective collaboration information exchange and dialogue with CSOs on global, regional, national and local health issues and to develop partnership to achieve its objectives.

The Citizens and Governance Programme

The Citizens and Governance Programme is a significant new initiative born of a major research and consultation study mounted by the Commonwealth Foundation in the Civil Society in the New Millennium Project. The citizens and Governance Programme is about responsible citizenship and responsive, participatory democracy. The two are mutually reinforcing and supportive; strong, aware, responsible, active, and engaged citizens along with strong, caring, inclusive, listening, open and responsive democratic governments.

This is the basis on which a good society in which needs is met, association constructed and connections established can be built. It is the connection between citizens and governance that prepares the ground to address the myriad challenges that face our societies. Poverty, marginalisation, and discrimination can only be overcome through responsive governance and active citizenship.

The Citizens and Governance Programme: The Trisector Dialogue

Governance as distinct from government is interpreted by most to mean having an inclusive approach to policy and decision-making, and to sharing responsibility for any or all of decisions, actions, provisions among the three main social actors –the government, private sector and civil society.

The key question is: *who does what?* What roles are appropriate for the state, what for the business sector (and the market more generally and what roles are most appropriate for civil society (including citizens themselves as individuals as well as their voluntary associations and more institutionalised civil society organisations)?

A second question is: *What difference does it make?* What impact is made on a society's ability to meet people's basic needs – such as the need for human security, shelter, health, and livelihood-by new tri-sector distributions of power and responsibilities? What changes to existing relationship are needed in order to increase impact?

A Preliminary discussion of these questions was held at a workshop organised by the Commonwealth Foundation (CF) in Australia in 2001. It highlighted the importance of examining the appropriateness and impact of tri-sector approaches in concrete situations in diverse of parts of the Commonwealth, Following this discussion Commonwealth Foundation decided to initiate a series of dialogue in up to 12 diverse localities in the Commonwealth in collaboration with Ford Foundation.

One-Day Workshop on Trisector Dialogue in Health at Bangalore (India)

The Bangalore one day workshop " Citizens and Governance programme: The Trisector Dialogue in Health is one of the series of dialogue on 11 January 2003. The topic of the dialogue will be " Preventive Health Care with special reference to Urban Poor (Bangalore) and venue will be Sri Jayadeva Institute of Cardiology. The Workshop will highlight some specific health issues for prevention of diseases and disabilities and also promotion of health after listening to the voices of the poor so as to achieve good health as the greatest asset of the poor.

The objectives of the workshop

- To promote Commonwealth Foundation's Project "Citizens and Governance Programme: Trisector Dialogue in Health
- The Role and responsibilities of trisectors: government, private and civil society in social development to achieve social accountability
- Strategies to develop trisect or collaboration for the benefit of citizens
- Reduction of Poverty through Health Promotion

Expected Outcome

To develop strategy for preventive Health care to urban poor (Bangalore) in collaboration with trisectors: government, private sector and civil society.

Preventive Health Care with special reference to Urban Poor Bangalore

Health : Health has long been recognised as one of the human fundamental right and is reflected in the universal declaration of human rights Yet huge disparities exist in health between rich and poor within developing countries.

Health is not mere absence of disease or infirmary but is a state of well being at the physical, Mental and Social(as well as spiritual) levels : WHO

Ill health is not simply a consequence of poverty, it is an aspect of it Better health contributes directly to diminishing poverty by improving quality of life expanding opportunities and safe guarding livelihoods

Limited health budget and growing health needs forcing developing country governments to make strategic decisions on the use of both domestic and foreign funds. Within the health sector, ministries should preferentially allocate resources to primary and secondary care rather than to tertiary care.

When public sector fails to meet the health care needs of the poor out of pocket expenditure rapidly exceeds public expenditure. Payments for private health care can be considerable up to 90% of house hold expenditure on health in India are in the private sector with the poor paying proportionately more than the rich.

The pattern of disease also varies significantly between rich and poor with disease of category I(communicable disease, maternal, perinatal and nutrition related conditions) dominate among poor and which accounts 59% of death and 64% Dalys lost among them. This does not mean that poor do not suffer from non-communicable disease they do. But they are not the principal cause of excessive morbidity and mortality.

To achieve the objectives of the workshop and to promote Commonwealth Foundation project on " Citizens and Governance Programme" CAMHADD will initiate partnership with Sri Jaydeva Institue of Cardiology and Bangalore Mahanagara Palike (Corporation) to develop this programme as Commonwealth Model.

Bangalore

Bangalore is the Capital City of Karnataka State in South India with a population of 65.02 Lakhs according to 2001 Census + Flaoting Population of 10 Lakhs ccovering an area of 226 Kms. 12 % of the population live in slum area and 30% of the population is Urban Poor.

The Bangalore Mahanagara Palike(Corporation)

The Bangalore Mahanagar Palike has 28 Maternity Homes, 6 Referral Hospitals, 19 UFWC's and 55 Health Centres, which provide Family Welfare/Maternal Child Health and Reproductive Child Health services to the urban poor of Bangalore Metropolitan area. Five maternity homes are added under the IPP VIII during the year 2001.

The Bangalore Mahanagar Palike has developed programme for control of Communicaable Diseases.

These facilities provide a range of services from day care to in patient facilities for women and children. The scope extends from preventive to promotive to curative Health Care, and are spatially distributed all over the city and are invariably located in or near the urban poor localities.

Besides this, The Bangalore Mahanagar Palike provides such services as sanitation, mosquito control, Prevention of Food Adultaration, stray dog,cattle and monkey managenet and Nirmala Bangalore Toilets.

The Bangalore Mahanagar Palike has also initiated Swacha(Clean) Bangalore concept which involves door to door collection,push carts and lorry synchronisation,source segregation and citizens participation.i

The Bangalore Mahanagara Palike has now a mandate to improve the governance in these facilities and provide quality care with a view to enhance customer perception and satisfaction in obtaining health care from the Bangalore Mahanagara Palike facilities.

Annexe -1

Annexe-1

Workshop for the Health Professionals of the Bangalore Mahanagara Palike on 26th December 2002 at the Urban Health Research and Training Institute, to prioritise the Health needs of the Urban Poor

The workshop was attended by Health Officers, Superintendent of Referral Hospital, Doctors of Maternity Homes, Urban Family Welfare Centres, Health Centres, Health Inspectors, Pharmacist, Staff Nurses, LHVs and ANMs of Health institutions of BMP, totaling 25 participants.

Dr. M Jayachandra Rao, Health Officer East welcomed the participants and spoke about the Objectives of the Workshop.
Dr. Pandurangi, explained the CAMHADD initiative and the Trisector Dialogue for preventive Health care in Bangalore.
Dr. Mala Ramachandran conducted a Brainstorming Session of the Health needs of the community and there after evolved the priorities by the consensus of the group.
The brain storming session listed out the following needs of the urban poor from the health professionals perspective.

1. Lack of a link between the facility and the community, and inter and intra sectoral coordination.
2. Access to cost effective treatment and investigations relating to Primary Health Care, including specialist services, and referral linkages.
3. Toilets, under ground Drainage and safe drinking water and problems of Gastro enteritis and Cholera. Sanitation and solid waste management
4. Housing
5. Health education, counselling, sex education, with focussed attention on child marriages and male participation
6. Education for all, Enrollment of Dropouts, Adult literacy, Child Labour.
7. Pollution both environmental and household
8. Nutritional problems, Food adulteration and Public Distribution System
9. Communicable Diseases
10. Non communicable diseases, Cardio vascular diseases, Cancers,
11. Blindness and cataract
12. Substance abuse
13. Problems of elderly and care in chronic illness
14. Care of disabled
15. Accidents and Trauma Care, Disaster management and availability of ambulances
16. Violence, Crime, safety and security, Legal assistance, Beggary destitution, Prostitution, Gambling and street children
17. STD/HIV/AIDS
18. Mental illness,
19. Adolescent Health
20. Income generation and poverty alleviation

The group then prioritised these issues by consensus

1St Priority- Access to cost effective treatment and investigations relating to Primary Health Care, including specialist services, and referral linkages.

2nd Priority- Toilets, Under Ground Drainage and Safe Drinking Water and problems of Gastro enteritis and Cholera. Sanitation and solid waste management

3rd priority- Housing

4th priority- Health education, counselling, sex education, with focussed attention on child marriages and male participation

5th priority- Nutritional problems, Food adulteration and Public Distribution System

6th Priority- Education for all, Enrollment of Dropouts, Adult literacy, Child Labour.

7th Priority- STD/HIV/AIDS

8th Priority- Accidents and Trauma Care, Disaster management and availability of ambulances
Violence, Crime, safety and security, Legal assistance, Beggary destitution, Prostitution, Gambling and street children
STD/HIV/AIDS
Mental illness,
Adolescent Health

9th Priority- Non communicable diseases, Cardio vascular diseases, Cancers,

10th Priority- Problems of elderly and care in chronic illness

Dr. Prithvish and Dr. Pandurangi summed up the discussions

Annexe- 2

Workshop for the Opinion Leaders at the Nandini Layout Slum of the Bangalore Mahanagara Palike on 27th December 2002 at the Nandini Layout Health Centre, to prioritise the Health needs of the Urban Poor

The workshop was attended by the local leaders, women's groups, Community Based Organisations, women who worked as link workers in the IPP-VIII and Health Staff of the Health Centre, totaling 35 participants.

The Lady Medical Officer of the Nandini Layout Health Centre welcomed the participants

Dr. M Jayachandra Rao, Health Officer East spoke about the Objectives of the Workshop.

Dr. Mala Ramachandran and the medical officer of the health centre conducted a Brainstorming Session of the Health needs of the community and there after evolved the priorities by the consensus of the group.
The brain storming session listed out the following needs of the urban poor from the health professionals perspective.

Issues at Nandini Layout

1. Accidents
2. Primary Health care and Referral
3. Pollution
4. Toilets and Underground Drainage
5. Safe drinking water
6. Blindness control
7. Alcoholism
8. Old age problems
9. Crime and Dowry
10. Unemployment and Poverty alleviation
11. Education/ adult education and school Drop outs
12. Street children
13. Housing
14. Non Communicable Diseases
15. Handicapped
16. Mosquito Menace
17. Child marriage
18. Transport facility
19. Physical education center

The group then prioritised these issues by consensus

1St Priority- Safe Drinking Water

2nd Priority- Toilets, Under Ground Drainage and Gastro enteritis and Cholera.

3rd priority- Accidents and Trauma Care

4th priority- Primary Health Care and Referral

5th priority- Education for all, Enrollment of Dropouts, Adult literacy, Child Labour.

6th Priority-Handicapped

7th Priority- Alcoholism

8th Priority- Transport

9th Priority- Violence, Crime, Dowry

10th Priority- Non communicable diseases, Cardio vascular diseases, Cancers,

Dr. Pandurangi, explained the CAMHADD initiative and the role the community should play to act as a pressure group to ensure their health priorities are met.

Dr. Prithvish summed up the discussions and proposed the vote of thanks

Workshop for the Opinion Leaders at the Murphy Town Slum of the Bangalore Mahanagara Palike on 27th December 2002 at the Murphy Town Health Centre, to prioritise the Health needs of the Urban Poor

The workshop was attended by the local leaders, women's groups, Community Based Organisations, women who worked as linkworkers in the IPP-VIII and Health Staff of the Health Centre, totaling 52 participants.

The Lady Medical Officer of the Murphy Town Health Centre welcomed the participants

Dr. M Jayachandra Rao, Health Officer East spoke about the Objectives of the Workshop.

Dr. Mala Ramachandran and the medical officer of the health centre conducted a Brainstorming Session of the Health needs of the community and there after evolved the priorities by the consensus of the group.

The brain storming session listed out the following needs of the urban poor from the community perspective.

1. Alcoholism
2. Housing
3. Sanitation and Garbage removal
4. Dowry
5. Toilets, Under Ground Drainage problems of Gastro enteritis and Cholera.
6. Reproductive and Child Health

7. Unemployment
8. Problems of elderly and care in chronic illness
9. Youth and Street children
10. Communicable Diseases
11. Non communicable diseases, Cardio vascular diseases, Cancers,
12. Education Adult literacy and Dropout
13. Inter caste Marriages
14. Substance abuse
15. Blindness and cataract
16. Violence in women
17. Early Marriage
18. Pre Marital Sex
19. Health Care for men
20. Child Labour
21. HIV/AIDS/STD
22. Awareness
23. Child Abuse
24. Primary Health Care

The group then prioritised these issues by consensus

1St Priority- Alcoholism

2nd Priority- Sanitation and Garbage removal

3rd priority- Toilets, Under Ground Drainage and Safe Drinking Water and problems of Gastro enteritis and Cholera

4th priority -Substance abuse

5th priority- Primary Health Care

6th Priority- Education for all, Enrollment of Dropouts, Adult literacy,

7th Priority -Unemployment

8th Priority - Child Labour.

9th Priority - Housing

10th Priority-Violence, against women

11th Priority – Child Abuse

12th Priority Awareness

Dr. Pandurangi, explained the CAMHADD initiative and the role the community should play to act as a pressure group to ensure their health priorities are met.

Dr. Gopinath summed up the discussions and proposed the vote of thanks

Annexe-3

Workshop for the Non governmental Organisations working in the slums of Bangalore on 28th December 2002 at the Urban Health Research and Training Institute, to prioritise the Health needs of the Urban Poor

The workshop was attended by 25 representatives of NGOs working in the slums of Bangalore.

Dr. M Jayachandra Rao, Health Officer East welcomed the participants and spoke about the Objectives of the Workshop.

Dr. M.T. Hema Reddy, explained the CAMHADD initiative and the Trisector Dialogue for preventive Health care in Bangalore.

Dr. Mala Ramachandran conducted a Brainstorming Session of the Health needs of the community and there after evolved the priorities by the consensus of the group.

The brain storming session listed out the following needs of the urban poor from the health professionals' perspective.

1. Awareness of General issues of importance like legal issues, health issues, availability of services etc.
2. Primary Health, Mobile services, referral services, availability of treatment for communicable and non-communicable diseases.
3. Safe Drinking Water, Sanitation, Solid Waste Management, Toilet and Under Ground Drainage, nuisance of stray animals
4. Access to cost effective services/ Lack of accountability /Corruption/Lack of information about services/Health Insurance/Lack of awareness about the rights of the community/Community ownership/ Empowerment
5. Child Marriage
6. Street children
7. Alcohol and substance abuse
8. Migrants and settlers
9. Violence against women, Sex related violence, Sex abuse
10. Child Labour
11. HIV/AIDS/STD
12. Polygamy, Multiple Partners
13. Male Participation/ Lack of gender sensitivity
14. Housing and electricity
15. Exploitation
16. Unemployment/ Poverty
17. Education-Adult and Drop outs
18. Adolescent Problems/Sex Education /Pre marital Sex
19. Malnutrition
20. Disability and Accessibility issues
21. Recreation

22. Accidents and Trauma Care
23. Area Dynamics in Government
24. Inter and intra sectoral coordination
25. Crime/Safety and security Trafficking in women, suicides and Dowry harassment
26. Nutrition problems/PDS/Food adulteration
27. Lack of City plan, lack of sensitivity among citizenry to slum problems, lack of media attention
28. Care of old
29. Pollution

The group then prioritised these issues by consensus

1St Priority- Awareness of General issues of importance like legal issues, health issues, availability of services etc..

2nd Priority- Safe Drinking Water, Sanitation, Solid Waste Management, Toilet and Under Ground Drainage, nuisance of stray animals

3rd priority- Primary Health, Mobile services, referral services, availability of treatment for communicable and non-communicable diseases.

4th priority- Access to cost effective services/ Lack of accountability /Corruption/Lack of information about services/Health Insurance/Lack of awareness about the rights of the community/Community ownership/ Empowerment

5th priority- HIV/AIDS/STD

6th Priority- Alcohol and substance abuse

7th Priority- Adolescent Problems/Sex Education /Pre marital Sex

8th Priority- Malnutrition

9th Priority- Disability and Accessibility issues
Violence against women Sex related violence, Sex abuse

10th Priority- Accidents and Trauma Care
Pollution

Dr. Prithvish summed up the discussions

Annexe-4

Workshop for the Health Professionals of the Bangalore Mahanagara Palike on 30th December 2002 at the Urban Health Research and Training Institute, to prioritise the Health needs of the Urban Poor

The workshop was attended by Deputy Health Officers, Medical Officers I/c of Sanitation in ranges, Doctors of Urban Family Welfare Centres, Health Centres, Health Inspectors, LHVs and ANMs of Health institutions of BMP, totaling 21 participants.

Dr. Mala Ramachandran welcomed the participants and spoke about the Objectives of the Workshop.

Dr. Pandurangi, explained the CAMHADD initiative and the Trisector Dialogue for preventive Health care in Bangalore.

Dr. Mala Ramachandran conducted a Brainstorming Session of the Health needs of the community and there after evolved the priorities by the consensus of the group.

The brain storming session listed out the following needs of the urban poor from the health professionals perspective.

1. Lack of Knowledge on general and health issues, legal issues their rights
2. Solid Waste Management
3. Toilets, Under Ground Drainage, surface drains and Safe Drinking Water. Sanitation
4. Communicable Diseases
5. Playground and Recreation
6. Access to cost effective treatment and investigations relating to Primary Health Care, including specialist services, and referral linkages.
7. Education for all, Enrollment of Dropouts, Adult literacy, Literacy for women
8. Apathy and lack of planning their lives
9. Problems of elderly
10. Accidents and Trauma Care,
11. Insurance
12. Disaster management
13. Stray animal nuisance
14. Non communicable diseases, Cardio vascular diseases, Cancers,
15. Care of disabled
16. Food Vendors, Street vendors, unhygienic open air food preparation, food adulteration
17. Juvenile delinquency
18. Local Dynamics
19. Child Labour
20. Debts
21. Quackery
22. Accessibility to roads

23. Alcoholism and substance abuse
24. Women empowerment
25. Housing and electricity
26. Unemployment and vocational training
27. Violence, Crime, safety and security
28. Malnutrition
29. Child Marriages/Taboos /Superstition
30. Pollution both environmental and household-Air and Noise

The group then prioritised these issues by consensus

1st Priority- Lack of Knowledge on general and health issues, legal issues their rights

2nd Priority- Solid Waste Management

3rd priority- Alcoholism and substance abuse

4th priority- Communicable Diseases

5th priority- Food Vendors, Street vendors, unhygienic open air food preparation, food adulteration

6th Priority- Juvenile delinquency

7th Priority- Women empowerment

8th Priority- Housing and electricity

9th Priority- Problems of elderly

10th Priority- Local Dynamics

Dr. Hema Reddy summed up the discussion

Dr. Pandurangi proposed the vote of thanks.

ANNEXE- 5

Workshop for the Representatives of the media on 3rd January 2003 at the Urban Health Research and Training Institute to prioritise the Health needs of the Urban Poor.

Dr. Mala Ramachandran welcomed the participants and spoke about the objectives of the Workshop.

Dr. Prithvish, explained the CAMHADD initiative and the Trisector Dialogue for preventive Health care in Bangalore.

Dr. Mala Ramachandran conducted a Brainstorming Session of the Health needs of the community and there after evolved the priorities by the consensus of the group.

The brain storming session listed out the following needs of the urban poor from the media perspective.

1. Education - enrolment and education for women
2. Lack of employment opportunities/occupational problems
3. Lack of awareness on general issues and awareness for change
4. Lack of basic medicines/lack of accessibility to services including health services
5. Lack of transport facilities.
6. Child labour
7. Problems of children of convicted parents
8. Lack of toilets, drains, lack of sanitation/safe drinking water
9. Strengthen community based organisations/empowerment of women.
10. Violence in Women
11. Exploitation
12. Education regarding rights and availability of services
13. Lack of recreational facilities like library, playground
14. Nutritional problem including anemia, vitamin deficiencies
15. Develop linkage through community workers
16. Electricity/Housing

17. Replicating successes in preventive health interventions to other areas.
18. Lack of counseling centers
19. Lack of career guidance facilities
20. No land ownership
21. Lack of access to amenities like provision stores and telephone facilities.
22. Blindness/Cataract interventions
23. Problems of old age
24. Problems of migrant workers
25. Lack of availability of creches
26. Bridging the gap between rich/poor – amongst children
27. Sustainability of changes, motivation
28. Gender discrimination
29. Female feticide
30. Lack of family ties

Provisional Programme

The Tri-Sector Dialogue Workshop on: Preventive Health Care with Special Reference to Urban Poor (Bangalore)

Venue: Sri Jayadeva Institute of cardiology, Jayanagar 9th Block
Bannerghatta Road, Bangalore-560 069
Telephone: (080) 6534466

08.30	Registration
Session I	**Chairperson** Professor S.Chandrashekar Shetty Former Vice Chancellor Rajiv Gandhi University of Health Sciences Bangalore And Consultant to Trisector Dialogue in Health
09.00	**Welcome** Dr A.N.Prabhudev Director Sri Jayadeva Institute of Cardiology
09.10	**Self Introduction of Participants**
09.20	**Purposes of the Workshop and Presentation Of Background Paper** Dr V.R.Pandurangi (CAMHADD) Consultant to Trisector Dialogue in Health
09.30	**Keynote Address** Dr Rajesh Tandon President PRIA (participatory Research in Asia) New Delhi
10.15	**Tea/Coffee Break**

Session II

10.30 **GROUP discussion: Three Groups**
Theme: Who does what?

Government Sector	Private Sector	Civil Socciety
Facilitator	**Facilitator**	**Facilitator**
Rapporteur	**Rapporteur**	**Rapporteur**

(Three Sectoral groups: Participants will discuss their sectors current and /future roles and responsibilities)

- What is it what the sector is best placed to do?
- How does this compare with the current role of the sector?
- What expectations are there of the roles that are best taken on by the other sectors (or where it is in appropriate for other sectors to be involved)?

Session III

11.30 **Plenary Session: Presentation of group reports**

Chairperson:
Rapporteur: Dr Ganesh Supramaniam

12.45 **Lunch**

Session IV

13.30 **Group Discussion " What should the Future look like"**

Government Sector	Private Sector	Civil Society
Facilitator	**Facilitator**	**Facilitator**
Rapporteur	**Rapporteur**	**Rapporteur**

Each Sector discusses

- Who should do what in relation to the identified need/issue?
- How does this differ from the present tri-sector distributions of power and responsibility?

Programme

CAMHADD One-Day Workshop on
The Tri-Sector Dialogue: Preventive Health Care with Special Reference to Urban Poor (Bangalore)

Venue: Sri Jayadeva Institute of cardiology, Jayanagar 9th Block
Bannerghatta Road, Bangalore-560 069
Telephone: (080) 6534466
Date: 11th January 2003 Time: 0830-1730

08.30	**Registration**
Session I	**Chairperson** Professor S. Chandrashekar Shetty Former Vice Chancellor Rajiv Gandhi University of Health Sciences Bangalore And Consultant to Trisector Dialogue in Health
09.00	**Welcome** Dr. A. N. Prabhudev Director Sri Jayadeva Institute of Cardiology
09.10	**Self Introduction of Participants**
09.20	**Purpose of the Workshop and Presentation Of Background Paper** Dr. V. R. Pandurangi (CAMHADD) Consultant to Trisector Dialogue in Health
09.30	**Keynote Address** Dr. Rajesh Tandon President PRIA (participatory Research in Asia) New Delhi
10.15	**Tea/Coffee Break**

Session II

10.30 **GROUP discussion: Three Groups**

Theme: Who does what?

Guidelines for group discussion and plenary session

Dr. D. K. Srinivas-Director, Curriculum Development
Rajiv Gandhi University of Health Sciences Bangalore

Government Sector	Private Sector	Civil Society
Facilitator	**Facilitator**	**Facilitator**
Prof. Chandrashekar Shetty	Dr. K. V. Ramani	Ms. Shagun Mehrotra
Rapporteur	**Rapporteur**	**Rapporteur**
Dr. Mala Ramachandran	Dr. Ganesh Supramaniam	Dr. Roberta Ritson
	Ms. Nalini Sampat	Dr. Pruthvish

(Three Sectoral groups: Participants will discuss their sectors current and /future roles and responsibilities)

- What is it what the sector is best placed to do?
- How does this compare with the current role of the sector?
- What expectations are there of the roles that are best taken on by the other sectors (or where it is in appropriate for other sectors to be involved)?

Session III

11.30 **Plenary Session: Presentation of group reports**

Chairperson: Dr Roberta Ritson
Rapporteur: Dr Ganesh Supramaniam
Ms Nalini Sampat

12.45 **Lunch**

Session IV

13.30 **Group Discussion " What should the Future look like"**

Government Sector	Private Sector	Civil Society
Facilitator	**Facilitator**	**Facilitator**
Prof. Chandrashekar Shetty	Dr K. V. Ramani	Ms Shagun Mehrotra
Rapporteur	**Rapporteur**	**Rapporteur**
Dr Mala Ramachandran	Dr Ganesh Supramaniam	Dr Roberta Ritson
	Ms Nalini Sampat	Dr Pruthvish

Each Sector discusses

- Who should do what in relation to the identified need/issue?
- How does this differ from the present tri-sector distributions of power and responsibility?

Session V

14.30 **Plenary Session: Presentation of Group Reports**

Chairperson: Dr A. N. Prabhudev
Rapporteur: Dr Ganesh Supramaniam
Ms Nalini Sampat

15.30 Tea/Coffee Break

Session VI

15.45 **Group Discussion: Three Groups**
Theme: "What we need to play our part"

Government Sector	Private Sector	Civil Society
Facilitator	**Facilitator**	**Facilitator**
Prof. Chandrashekar Shetty	Dr K. V. Ramani	Dr Francis
Rapporteur	**Rapporteur**	**Rapporteur**
Dr Mala Ramchandran	Dr Ganesh Supramaniam Ms Nalini Sampat	Dr Pruthvish

Each Sector discusses

- Their role in the identified issues
- Identifies obstacles and what is needed to overcome them including support, resources, capacity building needs etc.

16.45 **Plenary Presentation of 3 Groups**
Chairperson: : Dr Rajesh Tandon
Rapporteur: Dr Roberta Ritson
Ms Nalini Sampat

17.30 **Closing Session**

Chairperson
Mr M. R. Srinivasa Murthy
Commissioner
Bangalore Mahanagara Palike

Co-Chairperson
Dr. D. K. Srinivas
Rajiv Gandhi University of
Health Sciences Bangalore

Recommendations
Dr Roberta Ritson
WHO/HQ/Geneva
Plan of Action
Dr Ganesh Supramaniam (CAMHADD)
Chairperson's Remarks

Vote of thanks
Dr V. R. Pandurangi (CAMHADD)

Citizens and Governance Program: The Tri-Sector Dialogue Workshop on Preventive Health Care with Special Reference to Bangalore Urban Poor

11 January 2003

Guidelines for Group Discussion and Plenary Session

1. Participants will form three sectoral groups. The three groups will hold discussion simultaneously in separate places.
2. The participants will discuss their sector's current and/or future roles and responsibilities in addressing the identified need/issue focusing on during: the group discussion

I Group Discussion - Theme: ***"Who does what?"***

Discussion Points:

i. What is that the sector is best placed to do.
ii. How does this compare with the current role of the sector?
iii. What expectations are there of the roles that are best taken on by the other sectors (or where it is inappropriate for other sectors to be involved)?

II Group Discussion - Theme: ***"What should the future look like?"***

Discussion Points

i. Who should do what in relation to the identified need/issue?
ii. How does this differ from the present tri-sector distributions of power and Responsibility?

III Group Discussion - Theme: ***"What do we need to play our part?"***

Discussion Points

i. What is needed to enable the sector to play its role effectively in the future Identified in the previous session?
ii what obstacles/constraints are anticipated?
iii. What is needed to overcome them including support, resource, capacity building needs etc.

Since the dialogue is only for a day, keeping the time constraint in view, the groups are requested to focus on the issues raised in discussion points

3. Plenary Sessions

During each of the three plenary sessions, the three sector group reports are shared. Overlapping experiences, expectations, points of agreements and areas of disagreement are identified and further discussed. If necessary, plenary could break into '*buzz*' groups – small cross- sectoral or sectoral to workout solutions to dispute areas so that a final recommendation on each theme is ready at the end of each plenary session.

In the third and final plenary, the entire group discusses next steps including any related to workshop report and the 2003 international workshop.

4. Group Reports

Each sectoral group report should be brief, precise, and specific and action oriented.

The organisers appreciate your cooperation.

Happy Dialogue!

DEV-3.

गौतमपुरी से भलस्वा

उजड़ने-बसने की कहानी

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भूमिका

सत्ता और नीति के गठबंधन के ज़रिए बस्तियों का उजाड़ा जाना कोई नई बात नहीं है। परन्तु पिछले 6-7 सालों के दौरान वैश्वीकरण, उदारीकरण और निजीकरण के पसरते कदमों तले इनका कुचला जाना बढ़ता गया है। सरकार रोजगार और बसाहट की समुचित व्यवस्था तो करती नहीं उल्टे जब लोग किसी तरह जीने–रहने के कुछ आधे–अधूरे तरीके ढूंढ़ लेते हैं तो उन्हें उनके संवैधानिक और मानवीय अधिकारों से वंचित कर दिया जाता है। सफ़ाई, प्रदूषण-मुक्ति, अपराध-मुक्ति इत्यादि के नाम पर फैक्ट्रियों का बन्द किया जाना (1996) और बस्तियों का उजाड़ा जाना – इसी अमानवीय मानसिकता और इसी नीति का आईना है। पूरी दिल्ली में बस्तियाँ तोड़ी जा रही हैं। झुग्गी-झोपड़ी बस्तियों को तोड़कर लोगों को शहर के हाशिये पर फेंकने का मसला हो या उद्योग एवं रेहड़ी-पटरी बंद करने की बात– दिल्ली को ग़रीबों से खाली करने की योजना पूरी रफ़्तार के साथ लागू की जा रही है और ऐसा नहीं है कि यह काम केवल सरकार कर रही हो। बस्तियों-कारखानों के छुटभैये नेताओं से लेकर पुलिस-प्रशासन तक और रईस कालोनियों में रहने वाले सम्मानजनक नागरिकों से लेकर सर्वोच्च न्यायालय तक सभी इस साज़िश में शामिल हैं। इसी परिप्रेक्ष्य में है गौतमपुरी का उजड़ना और वहाँ के लोगों का भलस्वा में बसाया जाना।

इस कहानी में एक तरफ हैं गौतमपुरी के सीधे-सादे, मेहनतकश बाशिंदे जिन्होंने अपना खून–पसीना बहाकर इसकी जड़ों को सींचा और अपने व अपने बच्चों के लिए एक खुशहाल और सम्मानजनक जिंदगी की संभावनाओं को तलाशने की कोशिश की। दूसरी तरफ़ हैं वे ताकतें व निहित स्वार्थ जो हर कदम पर लोगों की इन कोशिशों को नाक़ामयाब करने में लगे रहे हैं। इस तरह यह 'लोक' एवं 'लोक-विरोधी' ताकतों के बीच ज़द्दोजहद की कहानी है। आई.टी.ओ. पर आज दिल्ली का प्रशासनिक केन्द्र है। आई.टी.ओ. के पास बहती है यमुना नदी जिसके दोनों किनारों पर बहुत सी बस्तियाँ बसी हुई हैं जो लाखों औरतों, बच्चों और आदमियों को आश्रय देती हैं। इन्हीं बस्तियों में से एक है गौतमपुरी।

बस्ती का बसना

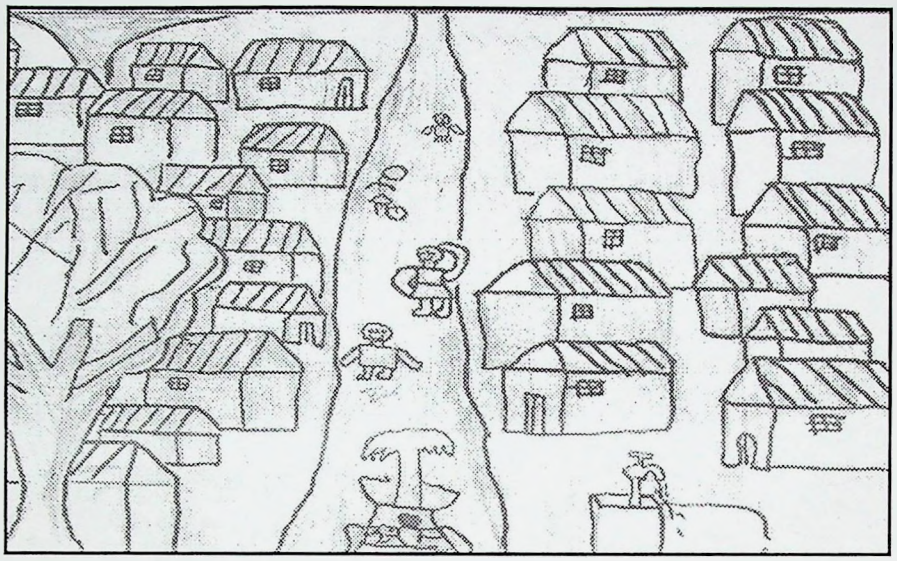
यमुना पुश्ता और उसके ईद-गिर्द के समूचे इलाके को पहले इंद्रप्रस्थ के नाम से जाना जाता था। चारों तरफ खाली ज़मीन और जंगल था। कहते हैं पहले कोई गौतम बाबा ने अपनी झोपड़ी बनाई। रोज़ी-रोटी की तलाश में दूर-दराज़ के गाँवों से लोग आते गए। पुश्ते की उपजाऊ ज़मीन पर खेती-बाड़ी करने वालों की कमी न थी। अपनी मेहनत व पैसों से लोगों ने खेती बढ़ाई। 1947 में मिली आज़ादी के साथ देश के बँटवारे का नासूर भी मिला। लाखों लोग

पश्चिमी पंजाब से भागकर दिल्ली आये। इनमें से बहुत से लोग पुश्ते पर भी बसे। धीरे-धीरे पुश्ते पर बसाहट बढ़ती गयी। हरियाणा सरकार ने अपने सर्वेन्ट क्वार्टर यहाँ बनाये। केन्द्रीय अतिरिक्त सुरक्षा बल का एक कैम्प बना। एक छोटा पावर हाउस बना जहाँ कोयले से भरी गाड़ियाँ आती थीं। करीब 250 परिवार थे जो पावर हाउस के साथ जुड़े हुए थे और इन गाड़ियों से कोयला एवं राख बाहर निकालने का काम करते थे। इनमें से ज़्यादातर लोग यू. पी., राजस्थान व हरियाणा के थे। पावर हाउस के पास ही एक सरकारी स्कूल भी बना।

1962 में दिल्ली का पहला 'मास्टर प्लान' बना। इसके तहत आई.टी.ओ. और उसके आस-पास बड़े पैमाने पर निर्माण कार्य होने लगे। यमुना के दोनों किनारों को जोड़ने के लिए पुल बनाया गया। बड़ी-बड़ी इमारतें बनीं। नदी के किनारे आने-जाने के लिए बाकायदा पक्के पुश्ते बनाये गये।

इन सब निर्माण कार्यों के चलते पुश्ते पर खेती करने वालों की ज़मीने भी छिनने लगीं। हैरान-परेशान लोग उस समय के प्रधानमंत्री, लाल बहादुर शास्त्री के पास गये। उन्होंने लोगों को एक पत्र के द्वारा आश्वासन दिया कि यमुना के पास की खाली ज़मीन पर लोग खेती कर सकते हैं। लोगों ने उस ज़मीन पर खरबूज, ककड़ी, तरबूज इत्यादि बोने शुरू किए। इस पत्र के बाद ज़मीन हथियाने की प्रक्रिया थोड़ी धीमी तो हुई किन्तु रूकी नहीं। आज से 5-6 साल पहले खेतों की ज़मीन छीन ली गई, हरित-पट्टी के नाम पर, जहाँ अब तक न पेड़-पौधे लगाए गए हैं, न खेत ही रहे। लोहे की बाड़ के पीछे दिल्ली विकास प्राधिकरण का बोर्ड भर लग गया है।

धीरे-धीरे नये-नये लोग आते गये और झुग्गियों की संख्या बढ़ती चली गयी। गाँधी दर्शन के पास के किसानों को जब वहाँ से उठाया गया तो वे भी गौतमपुरी में ही आकर बस गये। 1982 में दिल्ली में एशियाई खेल हुए। सारे शहर में बड़े पैमाने पर निर्माण कार्य हुए। पुल बने, होटल बने, स्टेडियम बने, बड़ी इमारतें बनी। आई.टी.ओ. के पास ही इंदिरा गाँधी इन्डोर स्टेडियम बना। इन सभी निर्माण कार्यों के लिए लगभग 10 लाख मजदूर शहर में लाये गए। इमारतें बनी, खेल हुए, विदेशी आकाओं ने सरकार की पीठ थपथपाई और उसके बाद सरकार गहरी नींद में सो गयी। बड़ी-बड़ी इमारतें बनाने वाले मजदूरों को अपने परिवारों के लिए एक छत भी नसीब नहीं हुई। मरते क्या न करते, मजदूरों ने जहाँ जगह खाली देखी वहीं झुग्गी डालकर बस गये। पुश्ते पर भी बड़ी संख्या में मजदूर आकर बसे। वहाँ भरी-पूरी दसियों बस्तियाँ बस गयीं जिनमें आज सवा लाख से भी ज़्यादा लोग रहते हैं।



"गौतमपुरी में हमारे घर बड़े थे। 10-12 जन आराम से रह लेते थे। पानी–बिजली भी थी। अब वहाँ से निकलते हैं तो रोना आता है।"

सरकार की नीतियाँ

इन लाखों लोगों के बारे में सरकार की क्या योजना है यह तो इस बात से स्पष्ट हो चुका है कि गौतमपुरी की 529 झुग्गियाँ यानि तकरीबन 3,000 लोगों को उजाड़कर शहर की परिधि पर स्थित भलस्वा में पटका जा चुका है। अगले एक साल के भीतर ही बाकी लोगों को भी उजाड़ने की योजना है। दलील दी जा रही है कि यमुना बहुत गंदी हो चली है और इसके सबसे बड़े दोषी पुश्ते पर बसे 'गंदे' लोग हैं। सच्चाई कुछ और है। जीवनदायिनी यमुना को कचरा वाहिनी बनाने की जिम्मेदारी किसकी है? अमीर इलाकों के ढेरों कचरे, प्रशासनिक लापरवाही और प्रदूषण-नियंत्रण यन्त्र न लगाने वाली फ़ैक्ट्रियों की न कि आम लोगों की। पर इस बहाने लोगों को दूर भेजकर नदी को 'साफ़' करने का इरादा है। नदी को साफ़ करके क्या किया जाएगा? न्यूयार्क (अमरीका) के मैनहटन की तर्ज़ पर एक 'यमुना विकास योजना' बनायी गयी है, जिस पर तकरीबन 1,000 करोड़ रू. खर्च किये जायेंगे। इस योजना के तहत यमुना के दोनों किनारों पर रईसों के लिए बड़े-बड़े अपार्टमेंट बनेंगे, खेल-कूद के मैदान व स्विमिंग पूल बनेंगे, सरकारी दफ़्तर एवं बहुराष्ट्रीय कम्पनियों के आफ़िस बनेंगे।

जून–जुलाई 2000 में गौतमपुरी के ठीक पीछे रेलवे लाइन के पार, दिल्ली सरकार की नई

आलीशान इमारत तैयार थी – 'प्लेयर्स बिल्डिंग'। वैसे इमारत का खंडहर-नुमा ढाँचा एशियाड खेलों (1982) के समय से खड़ा था। अब उसका 'सदुपयोग' किया जा रहा था। और दिल्ली-सचिवालय का मुख्य भाग पुरानी दिल्ली से यहाँ लाया जा रहा था अपने नए पाँच सितारा भवन में। ठीक सामने 'गन्दी बस्ती' है जो 'अपराध' का अड्डा हो सकती है और आँख की किरकिरी तो है ही। जुलाई–अगस्त 2000 में कुछ सरकारी कर्मचारी बस्ती का सर्वेक्षण करने आए। पूछने पर बहुत स्पष्ट उत्तर नहीं मिले कि क्यों हो रहा है यह सर्वेक्षण। पर बहुत जल्दी यह स्पष्ट हो गया कि 'हमें' उजाड़ा जाएगा।

किसी को नोटिस जैसी कोई चीज़ नहीं मिली। डर और हताशा ने घेर लिया। जीविका का, सुरक्षा का, बच्चों की शिक्षा का सवाल था। लोगों की नींद उड़ गई, चैन उड़ गया। उठते-जागते बस यही चर्चा होती रहती कि पता नहीं कब हमारी बस्ती को खाली करने का फ़रमान जारी हो जाये। आखिर फ़रमान जारी हो ही गया। उनसे कहा गया कि फलाँ दिन ट्रक, बुलडोज़र आएँगे आपको भलस्वा ले जाने के लिए। कहा गया कि भलस्वा अन्य कई पुनर्वास इलाकों से बेहतर है। महिलाएँ देखने गईं। शायद नरेला से थोड़ा बेहतर था, शहर से दूरी थोड़ी कम थी। पर शहर की उत्तर-पूर्वी सीमा के पार स्थित भलस्वा की ज़मीन पोली दलदल है। यहाँ शहर का कूड़ा फेंका जाया करता था।

23 अक्टूबर 2000 बस्ती के साधारण लोगों की ज़िंदगी का एक साधारण सा दिन था। काम पर जाने वाले लोग काम पर गये थे। स्कूल जाने वाले बच्चे स्कूल गये थे। खेलने वाले बच्चे खेल रहे थे। घर पर काम करने वाली औरतें घर पर काम कर रही थीं। अचानक एम.सी.डी. (झुग्गी झोपड़ी विभाग) के दफ़्तर का एक अधिकारी आया और एक पुर्जा पढ़कर सुनाने लगा : "तीन नवम्बर तक सब लोग अपना-अपना सामान बाँध भलस्वा जाने के लिए तैयार हो जायें नहीं तो उनकी झुग्गियाँ बुलडोज़र के नीचे रौंद दी जायेंगी।" सारी बस्ती में अफ़रा-तफ़री मच गयी। समझ में नहीं आ रहा था कि क्या करें? कहाँ जायें? होशोहवास लौटने पर कुछ लोगों ने तय किया कि एम.सी.डी. (झुग्गी झोंपड़ी विभाग) के दफ़्तर चला जाये और सारी बातें विस्तार से पता की जायें। वहाँ जाकर पता चला कि पहले चरण में तीन नवम्बर को 529 झुग्गियों को हटाने की योजना बनी है। यहाँ से हटाकर लोगों को भलस्वा ले जाया जायेगा। प्रत्येक घर से सात-सात हज़ार रूपये लिये जायेंगे जिसके एवज में उन्हें भलस्वा में प्लॉट मिलेगा। 1990 में उस समय के प्रधानमंत्री श्री वी.पी. सिंह द्वारा जारी किया गया टोकन जिनके पास है उन्हें 18 वर्ग मीटर का प्लॉट मिलेगा। जिनके पास यह टोकन नहीं है उन्हें 12.5 वर्ग मीटर का प्लाट मिलेगा।

यह जानकारी लेकर लोग बस्ती में आये। पूरी बस्ती गहरी उदासी में डूब गयी। रोज़ कमाने-खाने वाले लोग एक सप्ताह के अन्दर सात हज़ार रूपये कहाँ से लायें? बच्चे आस-पास के स्कूलों में पढ़ रहे हैं, उनकी पढ़ाई का क्या होगा? लोगों के काम-धंधे, रोज़गार का क्या होगा? बरसों के जतन से जो घर बनाया, जो बस्ती बसायी, उसके उजड़ने का घाव

क्या कभी भर पाएगा?

छठपूजा का त्यौहार आया। हर साल यह त्यौहार बस्ती में खुशी और उल्लास के रंग बिखेर देता था। परन्तु इस बार भरे दिल और बुझे मन से त्यौहार मनाया गया। खुशी व उल्लास की जगह ले ली थी अवसाद के काले बादलों ने।

संघर्ष की शुरूआत

अवसाद के इन्हीं घने बादलों के बीच से फूटी आशा की एक छोटी सी किरण। इस बार पहल बच्चों के हाथों में थी। बच्चों ने मिलकर तय किया कि हाथ पर हाथ धरे बैठकर साल बरबाद नहीं होने देंगे। कुछ करना बहुत ज़रूरी है, और जल्दी ही।

अंकुर की कार्यकर्त्ताओं के साथ बच्चों ने 27 अक्टूबर को एक मीटिंग की। मीटिंग में तय हुआ कि तमाम संबंधित अधिकारियों एवं जनप्रतिनिधियों से मिला जाये और उनके सामने यह माँग रखी जाये कि बच्चों की परीक्षायें समाप्त होने तक गौतमपुरी की झुग्गियाँ न तोड़ी जायें। बस फिर क्या था देखते ही देखते बस्ती के सारे बच्चे इस मुहिम में शरीक़ हो गये। बच्चों ने एक माँग-पत्र तैयार किया। स्कूल जाने वाले 258 बच्चों की एक सूची तैयार की।

बच्चों की अपील का सारांश था कि "अंकल/आंटी, हमारे भविष्य की थोड़ी चिन्ता कीजिए। इस समय स्कूल छोड़ने से हमारा साल बरबाद हो जाएगा। मार्च में हमारी परीक्षाएँ हैं। हमारे माँ-बाप ने बड़ी मुश्किलों से हमारा दाखिला कराया है। आगे फिर क्या होगा? हमारे पापा ठेली पर सामान बेचते हैं, ढाबे चलाते हैं। वहाँ जाकर कैसे कमाएँगे खाएंगे? कम से कम इस सत्र के आखिर तक हमें रहने दिया जाए"। हस्ताक्षर किए 9 वर्ष के विकलांग हैदर ने।

इस माँगपत्र और सूची को लेकर 100 बच्चे अंकुर की कार्यकर्त्ताओं के साथ रैली के रूप में एम.सी.डी. (झुग्गी झोपड़ी विभाग) के मुखिया मंजीत सिंह के आई.टी.ओ. स्थित दफ़्तर 'विकास कुटीर' पहुँचे। अब इस दफ़्तर का नाम बदलकर 'पुनर्वास भवन' रख दिया गया है। मंजीत सिंह ने बच्चों से मिलने से इंकार कर दिया। बच्चे उनके दफ़्तर के सामने धरना देकर बैठ गये और नारे-गाने शुरू कर दिये।

जीने रहने का अधिकार ––– मत छीनो–2
हमारी शिक्षा बरबाद ––– मत करो–2
माता-पिता का रोज़गार –– मत छीनो–2

तंग आकर एक घंटे बाद मंजीत सिंह ने उन्हें अपने दफ़्तर में बुलवाया। दो दीदियों (अंकुर की कार्यकर्ताओं) के साथ हैदर और दिलशाद अंदर गये। बारी–बारी से बच्चों ने अपनी बात

मंजीत सिंह के सामने रखी। उनसे आग्रह किया कि मार्च तक उनके घर न तोड़ें। मंजीत सिंह ने इस बात को मानने से साफ़ इंकार कर दिया। मौखिक रूप से बस इतना आश्वासन दिया कि सारे बच्चों के बस पास बनवा देंगे ताकि वे अपने पुराने स्कूल जा सकें और उनकी पढ़ाई को नुकसान न हो। छोटी कक्षाओं के बच्चे कैसे इतनी दूर पढ़ने के लिए आयेंगे, इसका उनके पास कोई जवाब न था। बच्चे समझ गए कि मुखिया साहब उन्हें सिर्फ़ घुमा रहे हैं और कुछ करने-धरने वाले नहीं हैं। तब क्या किया जाये? क्यों न प्रेस के माध्यम से यह बात दिल्ली की व्यापक जनता तक पहुँचाई जाये –– किसी के दिमाग में विचार कौंधा और बाकियों द्वारा तुरंत स्वीकार किया गया। पायनियर, इंडियन एक्सप्रेस, नवभारत टाइम्स, राष्ट्रीय सहारा इत्यादि तमाम अखबारों के दरवाज़े खटखटाने शुरू किये गए। बच्चों ने भरे मन से अपनी दास्तान अख़बार वालों को बतायी। एक बच्ची बात करते-करते फूट-फूट कर रोने लगी। जब से उसकी माँ ने सुना है कि बस्ती टूटने वाली है वह सोयी नहीं है। फ़ैक्टरी में काम करती है। घर का ख़र्चा भी बड़ी मुश्किल से चलता है। सात हजार रूपये कहाँ से आयेंगे? अखबार वालों ने धैर्य के साथ बच्चों की बातें सुनी।


28 अक्टूबर 2000, नवभारत टाइम्स, नई दिल्ली

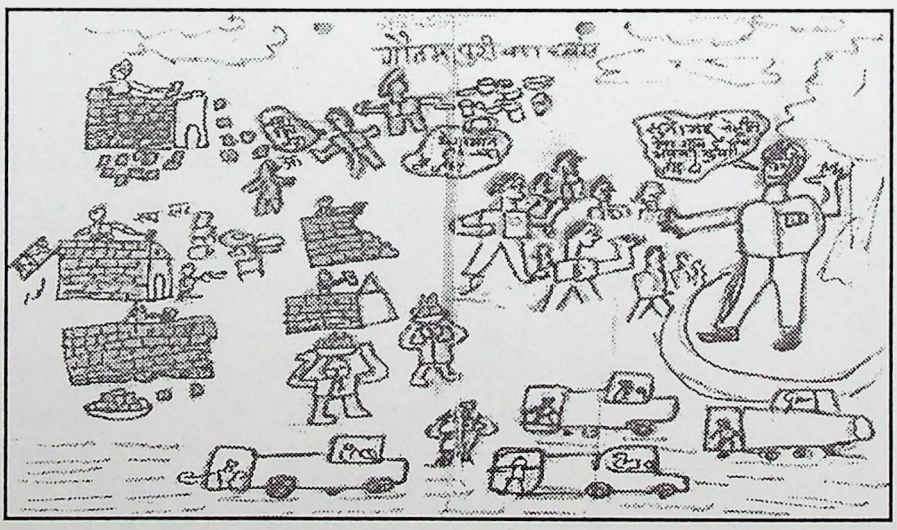
दिल्ली सरकार का सचिवालय आईटीओ पर आने की खबर से गौतमपुरी झुग्गीबस्ती के छात्रों में बेचैनी

नगर संवाददाता

अगले दिन 28 अक्टूबर को जब नवभारत टाईम्स, इंडियन एक्सप्रेस और पायोनियर अखबारों में बच्चों की बातें तथा तस्वीरें छपीं तो उनका हौसला बढ़ा। शायद अब कुछ हो। शायद यह खबर पढ़कर समाज का प्रबुद्ध वर्ग सरकार पर दबाव डाले और हमारी बस्ती टूटने से बच जाये। हमारा साल बरबाद होने से बच जाये। उत्साहित होकर बच्चों ने अपनी शिक्षा और अपनी बस्ती को बचाने के लिए और अधिक प्रयास करने की ठानी। 30 अक्टूबर को पहले से समय लेकर बच्चे दिल्ली के शिक्षामंत्री नरेन्द्रनाथ के यहाँ पहुँचे। अपने तमाम डर, शंकायें और माँगें बच्चों ने मंत्री महोदय के सामने रखी। मंत्रीजी ने कहा "एक तो ज़्यादा शोर मत मचाओ, दूसरे हमसे प्राथमिक कक्षाओं के बच्चों की बातें मत करो क्योंकि वो एम.सी.डी. के तहत आते हैं।" उनके गरम तेवर देखकर भी बच्चे तनिक न घबराये बल्कि ज़्यादा ज़ोर से

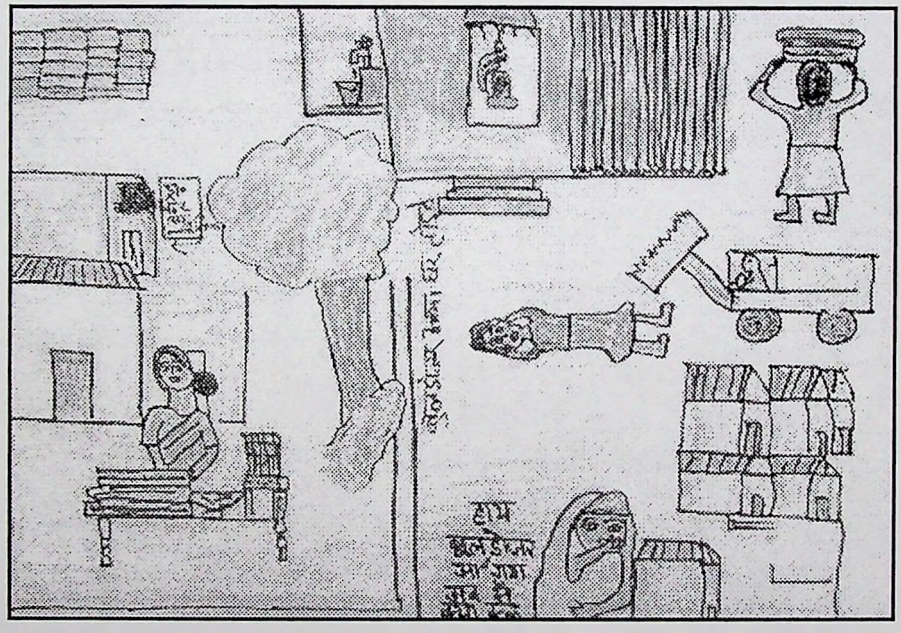
अपनी बातें उनके सामने रखने लगे। एक बच्ची ने मंत्रीजी से कहा "अंकल आप शिक्षामंत्री हैं, आपको किसने मंत्री बना दिया? बच्चों से बातें करनी तो आती नहीं"। बच्चों को मंत्री महोदय "एक आँख नहीं सुहाये"। अंततः कुछ बात बनी नहीं और बच्चों को खाली हाथ वापस लौटना पड़ा। इसके बाद बच्चे मुख्यमंत्री शीला दीक्षित साहिबा से मिलने उनके दफ़्तर पहुँचे। परन्तु वे वहाँ मौजूद नहीं थी। दो-तीन दिन लगातार चक्कर लगाने के बाद मुख्यमंत्री से मुलाकात हो सकी। उन्होंने बच्चों तथा उनकी माताओं की बातों को ध्यान से सुना परन्तु बच्चों की मुख्य माँग कि मार्च तक उनकी बस्ती न तोड़ी जाये इस पर कुछ कार्यवाही करने से उन्होंने भी साफ़ इंकार कर दिया। उन्होंने इस बात का आश्वासन ज़रूर दिया कि बस्ती के टूटने से बच्चों की पढ़ाई का नुकसान नहीं होने दिया जाएगा। उन्होंने कहा कि "हम यह सुनिश्चित करेंगे कि तमाम बच्चों को नयी जगह पर आस-पास के स्कूलों में दाखिला मिलेगा। जो बच्चा अभी जिस कक्षा में है उसे उसी में दाखिला मिलेगा।" मुख्यमंत्री की सचिव रीता कुमार ने शिक्षा निदेशक, दिल्ली सरकार और शिक्षा निदेशक, दिल्ली नगर निगम के नाम एक पत्र बनाकर दिया। इस पत्र में कहा गया कि "झुग्गी बस्ती में पुनर्वास से बच्चों की पढ़ाई में कोई नुकसान न हो, इसके लिए बच्चों को निकटवर्ती स्कूलों में दाखिला मिले। आवश्यक कार्यवाही हो।" यह पत्र हर माँ के हाथ में एक औजार बना। इस पत्र से बच्चों को राहत मिली परन्तु अनिश्चितता बनी रही कि पत्र की कारगरता पर कितना भरोसा किया जा सकता है।

दिल्ली उच्च न्यायालय में एक वकील ने एक केस भी डाला। सुनवाई के दिन 75 बच्चे गए। न्यायालय ने उजाड़ने पर रोक लगाने से इन्कार किया। लेकिन दिल्ली सरकार को आदेश दिए कि किसी भी नए पुनर्वास इलाके में बुनियादी सुविधाओं–बिजली, पानी और यातायात का प्रबन्ध किया जाए। इस छोटी सी जीत के कुछ अच्छे नतीजे निकले। कहीं भी पुनर्वास होने पर प्रशासन को ये बुनियादी सुविधाएँ देनी पड़ेंगी।



बस्ती टूटने का दिन

3 नवम्बर 2000 की सुबह ही झुग्गी-झोपड़ी विभाग के चार अधिकारियों ने बस्ती में आकर घोषणा कर दी "बस्ती खाली कर दो, वरना बुलडोज़र चला देंगे।" बस्ती के बाहर ट्रक लाकर खड़े कर दिये गये। बुलडोज़र के डर से लोगों ने अपने हाथों से अपने घर तोड़ने शुरू कर दिये। इस तरह घर की ईटें, टीन की चद्दरें, सामान वग़ैरह तो बचा पायेंगे। बुलडोज़र चल गया तो सब कुछ तबाह हो जायेगा। जिन हाथों से बनाया था उन्हीं हाथों में हथौड़ा और आँखों में आँसू लिये लोगों ने धीरे-धीरे अपने चमन को अपने ही हाथों ढहा डाला। माँ-बाप व बच्चों ने जिन घरों को कड़ी मशक्कत के बाद बसाया था उसे खुद खंडहर में तब्दील किया।



झुग्गी-झोंपड़ी विभाग के अधिकारी सामुदायिक भवन में जाकर बैठ गये और पर्चियाँ काटनी शुरू कर दीं। यह ज़मीन तो हाथ से गयी कहीं दूसरी ज़मीन भी हाथ से न निकल जाये इसके लिए लोग तुरंत पर्ची लेने में जुट गये। जिनके पास 7000 रूपये थे उन्होंने जमा करा दिये, जिनके पास नहीं थे उन्होंने किसी से उधार लेकर दिये, जिन्हें उधार भी नहीं मिला वे प्लाट के बिना रह गये। इसी धक्कापेली में धीरे-धीरे लोग अपने सामान समेत ट्रकों में बैठकर एक नई उजाड़ जगह के लिए रवाना होते रहे। जहाँ एक समय बच्चों की किलकारियाँ गूंजा करती थी, बूढ़ों की गप्पबाजी चला करती थी और तमाम तरह की गतिविधियों से चहल-पहल बनी रहती थी वहाँ मौत जैसा सन्नाटा छा गया—सन्नाटा और उसे घूरती सचिवालय की इमारत।

92 बच्चों को जहाँगीरपुरी और लिबासपुर के स्कूलों में दाखिला मिला। ये बच्चे दूसरी से नवीं कक्षा तक के हैं। जिन स्कूलों में प्रिन्सिपल थोड़ी संवेदनशील थीं, वहाँ दाखिले की कुछ आसानी रही। अन्यथा अंकुर कार्यकर्ताओं, माताओं और बच्चों को जगह-जगह दरवाजे खटखटाने पड़े। बहुतों की पढ़ाई का बड़ा नुकसान हुआ। इस स्थिति में भी 92 में से 68 बच्चे पास हो गए। उर्मिल जैसी बस्ती की महिला और कल्पना व रोशन जैसी बड़ी लड़कियों के प्रयासों से फरवरी में भी कई लड़कियों के दाखिले हुए। छठी क्लास की छात्रा सुनीता ने पढ़ाई छोड़ दी थी, क्योंकि पिता कमाई के लिए शहर जाते हैं, 3-4 दिन वहीं रह जाते हैं, माँ लिबासपुर के खेतों में मजदूरी करने चली जाती है, घर अकेला कैसे छोड़े। पड़ोसियों और कार्यकर्ताओं के काफ़ी समझाने–बुझाने के बाद सुनीता ने दाखिला लिया। बेहद ग़रीब परिवार की, ग्यारह साल की सत्यवती, अम्बेडकर स्टेडियम के पीछे स्थित मूक-बधिर विद्यालय में जाती थी। आज बीस किलोमीटर की इस दूरी को वह अकेले, डी.टी.सी. बस से तय करती है। सरकार ने भलस्वा में टैन्टों का स्कूल खुलवा दिया है। पहले प्राथमिक था, अब उसे आठवीं तक बना दिया गया है।

जहाँगीरपुरी और लिबासपुर के स्कूलों ने इन बच्चों को ले तो लिया है। पर इनमें पहले से ही एक-एक क्लास में 100-100 बच्चे हैं । बच्चे क्या पढ़ पाएँगे, टीचर क्या पढ़ा पाएँगे। बच्चे कहते हैं "गौतमपुरी के स्कूल में कम से कम बैठने की जगह तो होती थी। यहाँ तो हमें गलियारे में बैठना पड़ता है।" "बिजली नहीं है इसलिए शाम के बाद पढ़ नहीं पाते।"

यह भी याद रखने की ज़रूरत है कि यहाँ हम सिर्फ़ गौतमपुरी के कुछ बच्चों की बातें कर रहे हैं। सैकड़ों अन्य बच्चे रोहिणी, अशोक विहार, ईस्ट ऑफ़ कैलाश, दक्षिणपुरी, सीलम पुर, भोपाल पुर, अशोक विहार, माल रोड़ और जहाँगीरपुरी से उजड़ कर यहाँ आए हैं। उनमें से कितनों को स्कूल मिल पाया पता नहीं। शायद ज़्यादातर स्कूल के बाहर हैं? चाहे जिस स्तर की पढ़ाई थी, कुछ तो मिलता था। शिक्षा की कीमत सब समझते हैं। "सब खत्म कर सकते है। लेकिन हमारी शिक्षा नहीं बन्द कर सकते।" घर टूटने से उनकी शिक्षा पर सीधा असर पड़ा है। नए स्कूलों में बच्चों को अक्सर दुरदुरा दिया गया "यहाँ तुम झुग्गीवालों के लिए जगह नहीं है। मिनिस्टर के हस्ताक्षर लाओ।" 'लेकिन कई बार मिनिस्टर की चिट्ठी के बावजूद दाखिला नहीं मिला।'

आगे लड़ाइयाँ बहुत हैं। जाड़ा आ गया था। ठंडी, पोली ज़मीन पर प्लास्टिक, गत्ते आदि के सहारे लोगों ने किसी तरह रहना शुरू किया। सर्दी, जुकाम, फ़्लू फैला। दो बच्चों की मौतें भी हुई। लोगों को बहुत दूर अपनी रोजी-रोटी के लिए जाना पड़ रहा है। कई व्यक्ति दो-चार दिन वापस नहीं आते, दिन की मजदूरी के बाद वहीं शहर के फुटपाथ पर रात गुज़ार देते हैं। क्योंकि बस में पैसे ज़्यादा लगते हैं। अगर रोज़ 20-30 रुपये किराए के ही दे देंगे तो खाँएगें क्या? बहुत सी महिलाओं की नौकरियाँ छूट गईं। वो घरों में, फ़ैक्ट्रियों में काम करती थीं। बच्चों को, लड़कियों को अकेले नई जगह छोड़कर जाने में भी डर लगता है। कुछेक ने अपनी

अपने घरों के टूटने का दर्द और गुस्सा बच्चों को अभी भी सता रहा है। उनसे हुई बातचीत, उनके बनाए चित्र इसके गवाह हैं :

- दीवाली के एक दिन पहले हमसे कहा गया अपने घर तोड़ लो। हमने दीवाली नहीं मनाई।
- मन किया कि बुलडोज़र वाले का सर फोड़ दूँ। फिर सोचा वो भी तो इन्सान है।
- घर टूटा तो टूटा पर पापा ने मेरे पौधों को क्यों फेंक दिया। बड़ी मेहनत से मैंने इक्टठे किए थे!
- बस्ती टूटने पर हम कुछ कर नहीं पाए, बस देखते रहे।
- वोट सरकार माँगती है हमसे, झुग्गी तोड़ती है झट से।
- जी चाहता है मिनिस्टरों को मार डालूं। हमारे घर तोड़े उन्होंने। चलो उन्हीं के बंगलों में रहें।
- वाजपेयी दिल्ली को पेरिस बनाना चाहते हैं। अच्छा हो पूरे देश को बम से उड़ा दें।
- क्या गन्दगी हमारी ज़िन्दगी है और सफ़ाई जिम्मेदारी? फिर रहने का हक़ क्यों नहीं?

भलस्वा

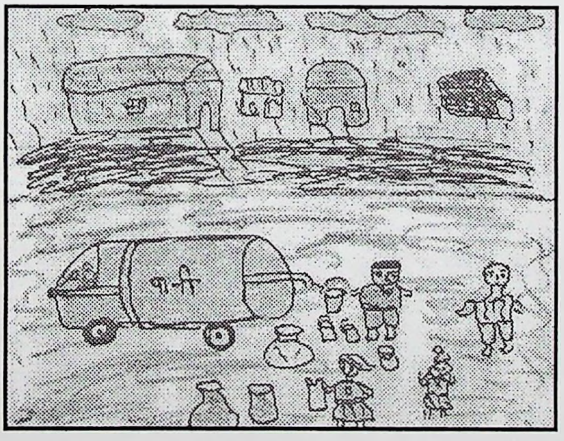
शहर की बाहरी सड़क, जी.टी.रोड से तकरीबन तीन किलोमीटर दूर है भलस्वा। दूर-दूर तक पसरा विशाल बियावान – न पानी, न बिजली, न शौचालय, न सड़कें और न मकान। मौजूद है तो सिर्फ स्लम विभाग का एक बोर्ड और जमीन इतनी पोली की पाँव रखो तो घुटने तक अंदर धंस जाये। प्लाट भी कोई हमेशा के लिए नहीं दिया जा रहा है। लोगों से जो सात-सात हज़ार रूपये लिये गये हैं वे दस साल की लाइसेंस फ़ीस है। यानि दस साल बाद लोगों को फिर उजाड़ा जा सकता है।

यहाँ से शुरू होता है अपनी ज़िन्दगी को फिर से टिकाने के लिए लोगों के संघर्ष का सिलसिला। पानी नहीं मिल रहा था तो मजबूरन पास से होकर जा रही पानी की लाइन को तोड़कर पानी हासिल किया। पेट काटकर, यहाँ–वहाँ से पैसे उधार लेकर मकान बनाने शुरू किये। विधायक, पार्षद सबके यहाँ गये। अपनी बात रखी। धरना, प्रदर्शन किया। सांझा मंच के साथ जुड़कर शहर की एक वैकल्पिक योजना बनाने में सहयोग दिया। एक ऐसी योजना जिसमें शहर को बनाने, चलाने वाले ही शहर के भाग्य-निर्माता भी बनें। तमाम प्रयासों के बाद कुछ न्यूनतम सुविधायें हासिल करने में लोग ज़रूर कामयाब हुए हैं।

बेटियों को गाँव भेज दिया, पढ़ाई छूट गई।
मकानों के नक्शे आँगन–प्रणाली पर आधारित थे। यानि एक खुली जगह के चारों और घर। अजनबी परिवार एक-दूसरे के सामने हो सकते थे। अपनी निजी जगह की बात नहीं थी। महिलाओं ने इसे मंजूर नहीं किया। प्रशासन को डिज़ाइन बदलना पड़ा। और अब ग्रिड यानी सीधी गलियों के मुताबिक प्लॉट काटे गए। "हमसे कहा गया कि घर के आगे-पीछे दो-दो मीटर जगह नालियों के लिए छोड़ दें। यहाँ भी कटौती की है।" शौचालय, पानी और बिजली की कुछ व्यवस्था हो पाई है। कुछ बसें भी चला दी गयी हैं। बीच में बन्द हो गईं, तो महिलाएँ फिर अलग-अलग दफ़्तरों को खटखटाती फिरीं, तब दुबारा बसें चली।

लोग भयंकर दिक्कतों से जूझते हुए जीने की कोशिश कर रहे हैं।

- आँधी आती है तो इन प्लास्टिक टिन के घरों के गिरने का डर लगता है।
- हमने टैन्ट माँगे नहीं मिला। मेरी दो महीने की बहन मर गई।
- गौतमपुरी में हमारी दो दुकानें थीं। खर्चा ठीक-ठाक चल जाता था। यहाँ तो दुकान के लिए जगह ही नहीं है। पापा के पास काम नहीं। भाई को कभी मिल जाता है।
- टैंकर का गंदा पानी पी–पी कर हम बीमार पड़ जाते हैं।
- टैंकर आते हैं। घन्टों लग जाता है पानी भरने में।



बड़े संघर्ष, छोटी लड़ाइयों से थोड़ी सी जीत तो हासिल हो पाई है। लेकिन एक सही ज़िन्दगी बसर करने के लिए लोगों को अभी बहुत जूझना है। महिलाएँ इसमें सबसे आगे हैं। गौतमपुरी के अतिरिक्त रोहिणी, गढ़ी (ईस्ट ऑफ कैलाश), जहाँगीरपुरी, अशोक विहार इत्यादि की अनेक बस्तियों को उजाड़कर लोगों को भलस्वा में जगह दी जा रही है। अलग-अलग संस्कृतियों के हज़ारों लोग यहाँ बसाए जा रहे हैं।

विभिन्न इलाकों की महिलाएँ एक-जुट होने का प्रयास कर रही हैं। मार्च में महिला दिवस उन्होंने अपने तरीके से मनाया। 'जीने रहने का हक़' मुख्य बिन्दु था। तरह-तरह के अनुभव बाँटे गए। नन्द नगरी की महिलाएँ 20-30 साल पहले उजड़ी थीं, उनके अनुभव भी आए। मिलकर क्या कर सकते हैं – इस पर विचार-विमर्श हुए। गीत, नाटक, पोस्टर इत्यादि के ज़रिए ज़ोरदार अभिव्यक्ति हुई। उनके नारे, उनके गीत आगे लम्बे संघर्ष की ओर इशारा करते हैं।

ये दुनियां है हमारी आपकी सबकी
क्यों पूछते हो ज़मीन है किसकी।

आओ बहनों साथ हो जाएं
साथ लड़ें तो हक़ मिल जाएं।

लड़ती नहीं हम सत्ता के लिए
झूठे नाम के लिए, ओहदों के लिए।
लड़ती हैं हम इक छोटी सी लड़ाई
अपने घर के लिए, परिवार के लिए
रोज़गार के लिए, सुविधाओं के लिए।
लड़ती हैं हम इक छोटी सी लड़ाई

बच्चों की शिक्षा के लिए, स्वास्थ्य के लिए,
मान-सम्मान के लिए, अपने हक़ों के लिए।

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अंकुर - संक्षिप्त परिचय

शिक्षा या तालीम को ताक़त का ज़रिया मानते हुए, अंकुर संस्था पिछले १७–१८ वर्षों से दिल्ली की बस्तियों में काम कर रही है। बच्चे, महिलायें, पुरूष अपनी क्षमताओं को उभार सकें, अपना आत्म-विश्वास बढ़ा सकें और अपने हक़ों के लिए एकजुट होकर लड़ सकें – तालीम का सही उद्धेश्य यही है। इन्हीं को लेकर हम गौतमपुरी, नन्द नगरी, भलस्वा, दक्षिणपुरी और लोकनायक जयप्रकाश बस्ती में बच्चों, युवतियों और महिलाओं के लिए कार्यक्रम चलाते हैं। साथ ही समाज के हाशिए पर जीने वालों के हक़ों के संघर्ष में क्षेत्रीय, राष्ट्रीय व अन्तरराष्ट्रीय स्तरों पर लगे अन्य संस्थाओं, अभियानों और गठजोड़ों के साथ कंधे से कंधा मिलाकर आवाज़ें उठाते हैं।

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A campaign
to facilitate people
across the State of Karnataka
to undertake a 6-month process
of awareness, education, consultation and advocacy
leading to the amendment of
the Karnataka Slum Act, 1973,
into a pro-people act

KARNATAKA SLUM ACT 1973

- The Karnataka Slum Act, 1973, is in the process of being amended.
- The Karnataka Slum Clearance Board, which serves as both the regulatory and implementing agency for the Act, has proposed 19 major amendments to this Act.
- The Law Dept has cleared 4 amendments for approval by the Legislative Assembly.
- Consultations with people, which are part of the process of amendment, were not undertaken.
- Activists came to know of these amendments only during the last session when the papers to approve 4 amendments were circulated to MLAs, and the information entered the public domain.
- Jana Sahayog's review of these amendments shows that these will further empower the beaurocracy, while making it even more difficult for people to bring about changes to improve their lives.
- Because of time constraints, the bill to approve these amendments was not taken up at this session – but will now be taken up in the winter session.
- Jana Sahayog believes that this 6-month delay provides a window of opportunity to introduce further amendments in the interests of the people.
- Jana Sahayog has undertaken a brief review of the Act. This is enclosed.

Jana Sahayog believes that a prop-people Act can be advocated if all urban activists, human rights groups, mass organisations and organisations committed to good governance come together under a State-wide campaign forum to

1) undertake an awareness programme amongst people living in slums, elected representatives, media, Bar Associations, and stakeholder organisations
2) formation of campaign units in each of the 27 district centres. These campaign centres will cover all habitations under the town panchayats, town municipalities, city municipal councils and city corporations in their districts.
   a) these campaign centres will facilitate the formation of consultative groups, and will facilitate thee people's groups to study and understand the Act as it stands, and to recommend amendments to protect their rights and interests.
   b) these campaign centres will then coordinate people's groups in their districts to
      i) meet elected representatives of local bodies, and to submit memorandums to these local bodies.
      ii) meet and submit memorandums to their Deputy Commissioners for forwarding to the Chief Minister and the Minister for Housing;
      iii) meet and submit copies of the memorandum to their MLA, MLCs and MPs, with a request to support the amendments on the Floor of the House;
      iv) meet and submit copies of the memorandum to districts of all political parties asking them to formally asking the parties to endorse these amendments and support it in the Assembly.
      v) meet and submit copies of the memorandum to district heads of all progressive and human rights organisations, with a request to act in solidarity with this people's campaign.
   c) These campaign centres will also act as a resource centre for media in the district. The media will be enrolled to report on the campaign, create public awareness, and bring pressure on the government.
   d) These campaign centres will meet with their bar associations and request them to endorse the amendments, act as resource persons to the people's groups, and to influence the legislative ad administrative bodies.
3) form a state campaign forum based at Bangalore to undertake the above actions at a State level.
4) form a campaign secretariat to support and coordinate district and state initiatives of the campaign forums.

INADEQUACIES & LIMITATIONS OF THE KARNATAKA SLUM (Clearance and Improvement) ACT 1973,

The Karnataka Slum (Clearance and Improvement) Act became operational in 1975. A review of the Act highlighted the following:

1. Two third of the sections (provisions) are against slum people; only one third of it is pro-poor. Many of these provisions have not been enforced.
2. One third of unreported High Court judgements are against Article 21 Right to Life and Livelihood.
3. Procedures and formalities for declaration of slums are complicated.
4. The different Acts governing people living in slums - BDA/UDA Act, Regularization of Un-authorised Occupation Act and Prevention of Public Premises (Un-authorised Occupation) Act including Corporation and Municipalities Acts - overlap and are often contradictory, making implementation open to the interpretation of different officials.
5. The Slum Act does not specify the time limit for identification and declaration of slums so as to bring them under the purview of the Act.
6. Discretionary power delegated to the prescribed authority leads to people's opinion and participation being seen as unnecessary by officials in the exercise of their discretionary powers.
7. Misinterpretation and misuse of Sec. 11 dealing with re-location resulting in non-consultation of the affected people has resulted in major human rights violations in the name of slum clearance and redevelopment.
8. Section 58 prohibiting the sale of arrack in slums has not been implemented by the Board despite representation by people living in slums.
9. Procedural delays and inaction has resulted in many slums which come under the purview of the Act not being declared, and thus being vulnerable to continual threats of slum demolition and encroachment
10. There is no Police force within the Board to protect slums declared under the Act, and lands under the jurisdiction of the Slum Board from encroachment/encroachers, and to prevent forcible occupation of Slum Board constructed houses by outsiders.
11. No time limit has been fixed for issue of ID cards after the declaration of slums.
12. There is no scope for representation of slum CBOs, SCs and women in Slum Board. There is no prescribed norm for nomination of members to the Board.
13. There is no scope for people's participation while planning and executing development schemes in their respective slums.
14. Absolute power of the state government to overrule the decisions of the Board in respect of notification and de-notification of slum land and declaration is a major cause of confusion and undermining of Slum board autonomy and democratic functioning.
15. The prescribed rules have lot of in-built confusions, contradictions.

EXISTING CONDITION AND SHAPE OF SLUM BOARD
- as reported by STEM

The following are the observations on the functioning of KSCB by STEM

1. Lack of coordination between ULBs (Urban Local Bodies) & other departments.
2. Absence of in-built monitoring system
3. Restricted allocation of Funds for programmes
4. No provisions for maintenance of amenities provided
5. No effort made to recover the loan from beneficiaries
6. Absence of community participation (Slum people)
7. Inadequate and untrained KSCB staff
8. Inadequate and incompatible data on slums
9. Non existence of community Development wing
10. No scope for participation of NGOs
11. Absence of feedback mechanism
12. Highly centralized decision making system

PROFILE OF SLUMS IN KARNATKA

General Information:

1. 216 cities and towns in Karnataka are governed by the elected Urban Local Bodies (ULBs). Of these: 6 are Municipal Corporations, 40 City Municipal Councils, 82 Town Municipal Councils, 82 Town Municipal Councils, while the remaining 88 are Town Panchayats
2. It is estimated that there are over 4500 slums in Karnataka. However, all slums have not come under the purview of the Slum Act
3. It is important to note that slums in 52 towns have not come under the purview of the Slum Board - even after the completion of 25 years of Board's existence.
4. As per the Slum Board list only 40% of the slums (1977 slums) have been identified & listed by the Slum Board remaining have to be brought to the books but all of them are not declared.
5. Undeclared slums especially on Railway, Defense and Forest and Private land are more vulnerable in Bangalore
6. More than 26 % of the total population of cities and towns in the state live in slums
7. Bangalore city has the highest number of slums in the state with 778 slums with a population of 18.5 lakhs

MAJOR OUTLINES OF ISSUES FACING PEOPLE LIVING IN SLUMS IN KARNATAKA

- Land related
- Basic Amenities
- Education
- Employment
- Violation of Constitutional and legislative provisions
- Misuse and misappropriation of Government schemes

Profile of 21 Class I cities in Karnataka
(proposed to be covered under SUDP programme)

Coverage

❑ Total number of slums in 21 cities	985
❑ Total number of house holds	2,76,769
❑ Total slum population	14,97,366
❑ Percentage to the total population	23.2
❑ Literacy rate	27.8

Highest Percentage of the Population and Number of slums

Cities	-	% to total population	No of slums
❑ Hospet	-	49.20	59
❑ Raichur	-	47.60	56
❑ Bijapur	-	45.40	55
❑ Bellary	-	40.60	77

Land ownership

❑ Public/ Govt. land	761 slums	77.3%
❑ Private land	224 slums	22.7%
❑ Declared so far	389 slums	39.5%
❑ To be declared	596 slums	60.5%

Slums liable for inundation & land ownership

❑ Public land	343	slums	
❑ Private land	70	slums	
Total	413	slums	42%

BASIC AMENITIES

Water supply

❑ Access to water supply	70%	681 Slums
❑ No access to water supply	30%	304 Slums

Toilet facilities

❑ Access to Community toilets	33.7%	332 Slums
❑ No access to Community toilets	66.3%	653 Slums

Underground drainage

❑ Covered by UGD	33%	327 Slums
❑ To be covered by UGD	66.8%	658 Slums

Drainage facilities

❑ Provided	20.8%	205 Slums
❑ Particle provided	41.9%	407 Slums
❑ Not Provided	37.9%	373 Slums

Condition of roads

❑ Bad Condition	54.5%	537 Slums
❑ Fair Condition	40.1%	395 Slums
❑ Good Condition	5.4%	53 Slums

Street lighting facility

❑ Sufficient	36.4%	359 Slums
❑ Inefficient	63.6%	626 Slums

Garbage disposal

❑ Satisfactory	29.5%	291 Slums
❑ Unsatisfactory	705%	794 Slums

SOCIAL AMENITIES

Primary Schools within a kilometer distance

❑ Schools available	65.1%	618 Slums
❑ Schools not available	34.9%	330 Slums

Accessibility to PHC/Health Centre within a kilometer distance

❑ Accessible	24.6%	242 Slums
❑ Inaccessible	75.4%	743 Slums

Ration shops

❑ Available	74.5%	732 Slums
❑ Not Available	25.5%	251 Slums

Community Hall in slums

❑ Existing	21.8%	207 Slums
❑ Not existing	78.2%	741 Slums

Anganawadi/ Balawadi centers in Slums

❑ Available	65.8 %	630 Slums
❑ Not Available	34.2%	328 Slums

Local associations and societies in slums

❑ Existing	52.2%	494 Slums
❑ Not Existing	48.8%	452 Slums

KARNATAKA SLUM AREAS (IMPROVEMENT AND CLEARANCE) ACT, 1973

SALIENT FEATURES, STRENGHTS & LIMITATIONS

I. THE DEFINITION OF SLUM

Any area that is DECLARED by the Government as such under Section 3(1)

1. Area that is likely to be a source of danger to health / safety / convenience
2. building are not fit for human habitation

because the area is

1. Low lying
2. insanitary or over crowded

II. IMPORTANT FEATURES OF THE ACT

1. DECLARATION OF SLUMS
2. PREVET GROWTH OF SLUMS
3. PROHIBIT UNAUTHORISED CONSTRUCTIONS
4. IMPROVEMENT OF SLUMS
5. SLUM CLEARANCE AND DEVELOPMENT
6. ACQISITION OF LAND
7. PROTECTION OF TENANTS
8. SLUM CLEARANCE BOARD

III. PURPOSE OF THE ACT

1. **IMPROVEMENT**
2. **LAND ACQUISITION**
3. **SLUM CLEARANCE**

BECAUSE:

- Slums are increasing and are a source of danger to public health
- To check the increase, eliminate congestion
- Provide basic needs (streets, water, and drainage)
- To clear slums that are not fir for habitation
- To remove unhygienic conditions

TO PROVIDE BETTER ACCOMODATION For slum dwellers

- Acquiring land
- Improving, developing, clearance
- improve public health

IV. PROCEDURES

SECTION	CONTENT	AUTHORITY	TIME
3(1)	Notification, declaring area to to be slum area	Government "prescribed authority"	no time limit
4(1)	Registration. Occupier/owner of building must register it if prescribed	"prescribed authority"	time limit to fixed by the prescribed authority
4(2)	When the prescribed authority is satisfied, he shall issue registration certificate	"prescribed AutoRoute"	no time limit fixed
5(1)	"prescribed authority" may direct that no building can be constructed without prior written permission	"prescribed authority"	expires at the end of 2 years
5(4)	The "prescribed authority can grant or refuse permission but an opportunity must be given to the applicant to show why permission shouldn't be refused	"prescribed authority"	no time FIXED

V. PREVENTION OF UNAUTHORISED CONSTRUCTION

5B(I)(a)	Once slum comes under this chapter, no CONSTRUCTION OR RECONSTRUCTION can be done until permission is received	licensing authority	no time
(b)	no rent etc can be collected from such building		
5B(b)	if done without permission, then Govt. can impose punishment of upto 3 years or fine of Rs.5000/=	Slum clearance board	
5C (1)	Board can order demolition of such building or prevent further construction	Slum Clearance Board	
(2)	Board has to give the owner/occupier/ builder copy of the order of demolition and notice to show cause.	Slum Clearance Board	Reasonable time
(3)	If no cause is shown, then Board shall make order binding and can take any measure for giving effect to the order and recover expanses from the owner		
(4)	If the Board feels that immediate action should be taken it only has to give a minimum of 24 hours notice	Slum Clearance Board	24 hours

VI. IMPROVEMENT OF SLUM AREAS

6	If the prescribed authority feels that at a "reasonable" expense, slum may be improved ; it can serve notice to carry out those works of improvement	Prescribed authority	60 days notice
7	The expenses of the improvement done by the prescribed authority may be recovered from the owner/ person who has interest in that land with interest	Prescribed authority	no time limit
9	prescribed authority can order demolition of building that it deems unfit after show cause notice	Prescribed authority local authority State housing Board	time that prescribed authority specify

VII. SLUM CLEARANCE AND REDEVELOPMENT

11	Government can, on a report of KSCB or other Authority that the most satisfactory way of dealing with conditions in an area is clearance and demolition, it may, by notification declare it to be a slum clearance area	Government	
(2)	Must show cause		
12	If it is declared under S-11, there is an obligation to demolish the buildings within a specified time		Prescribed time
13	If not demolished, the Prescribed Authority can enter the area and demolish the buildings and sell the materials	Prescribed Authority	
15	The prescribed authority also has the power to re-develop a slum clearance area. Must show cause. Specified time to owner to develop & can recover expenses from owner	Prescribed authority	Specific time

VIII. ACQUISITION OF LAND

17	Government has the power to acquire land for improvement/ re development or rehabilitating slum dwellers it can do so after notice in official Gazette , must show cause		

IX. PROTECTION OF TENANT FROM EVICTION

28(1)	No person can evict a tenant from any building or land in a slum area except with prior permission of the prescribed authority	Prescribed authority
(5)	When granting or refusing permission the prescribed authority must consider whether alternative accommodation will be available to the tenant, whether eviction is in the interest of the slum improvement/clearance and other factors	Prescribed authority

X. CONCLUSION AND RECOMMENDATIONS

1. As far as the purpose of the Act is concerned , slum improvement, providing better accommodation for slum dwellers and providing basic needs are all part of the intention of the Act. This is an important part of any act " legislative intention" and can be used to the advantage of people in a litigation. However, it is not sufficient by itself. It needs to be backed up by specific provisions within the Act. Secondly, if the intention of the legislation is divided into its 3 main parts (improvement, clearance and land acquisition), only 1/3 rd is pro people.

2. DECLARATION as a" slum area" is a two edged sword. On the one hand, only if an area is declared to be a " slum area" can slum dwellers even claim any rights to basic needs (water, sanitation, electricity, housing) . Therefore it becomes essential for a notification under 3(1). On the other hand, notification also opens the floodgates for exercise of discretionary power of the Authority for clearance and acquisition of the land. What might be better would be to have two different procedures. Any area that has (a) existed for a certain time (b) a certain specific number of dwellers be automatically declared a slum area which cannot be cleared. What should follow this is the basic procedure for accessing basic needs. Other areas can be open to clearance and acquisition as long as alternative accommodation is provided to the dwellers of those areas.

3. What is evident throughout the Act is that everytime people have to respond to the prescribed authority a time limit is fixed either by the Act itself or by the prescribed Authority. However, when the Government / Prescribed authority has to act, there is no time limit imposed on them.

4. Although the Act has many provisions that can be considered as " pro-people" the long procedure, the non-existence of any time limit, the discretionary power of the Authorities and the power to clear/demolish slums almost defeats the effect of these provisions.

5. It seems that the Act requires many amendments. But for this political will is required and to change that would be a long drawn out (if at all) process.

6. If a public interest litigation is to be filed, there are certain requirements

KARNATAKA SLUM AREAS (IMPROVEMENT AND CLEARANCE) AND CERTAIN OTHER LAW (AMENDMENT) BILL,2001

A Bill further to amend the Karnataka Slum Areas (Improvement and Clearance)Act, 1973 and the Karnataka Public Premises(Eviotion of Unauthorised Occupants)Act, 1974.

Whereas it is expedient further to amend the Karnataka Slum Areas(Improvement and clearance) Act, 1973 (Karnataka Act 33 of 1974) and the Karnataka Public Premises (Eviction of Unauthorised Occupants) Act, 1974 (Karnataka Act 32 of 1974) for the purposes ~~appeared~~ appearing hereinafter.

Be it enacted by the Karnataka State Legislature in the fifty second year of the Republic of India, as follows, namely:-

1. Short title and commencement.- (1) This Act may be called the Karnataka Slum Areas (Improvement and Clearance) and Certain Other Law (Amendment) Act, 2001.

(2) It shall come into force at once.

2. Amendment of Karnataka Act 33 of 1974.-In the Karnataka Slum Areas (Improvement and Clearance) Act, 1973 (Karnataka Act 33 of 1974),-

(1) in section 27,-

(i) in the heading, after the words 'land acquired' the words 'or land transfered by the Government or the local authority' shall be inserted;

(ii) after sub-section(2), the following shall be inserted, namely:-

"(3) Where any slum area is located on the land belonging to the Government or any local authority the Government or the local authority may subject to such restrictions and conditions as it may impose, transfer to and vest in the Board such land free of cost for the purpose of undertaking such measures as may be necessary for improvement, development, clearance or redevelopment of the land or the errection of building or buildings thereon".

~~(2)~~ After section 27, the following sections shall be inserted, namely:-

"27A.**Carryingout the development and allotment of sites etc.,** (1) Subject to section 27, the Board shall form layout on the lands transfered to and vested in it under sub-section(2)~~(3)~~ of section 27 by realigning the internal roads for the easy and convenient movement of the slum dwellers and for improving the hygenic conditions. The Board may undertake all measures necessary for improvement clearance development or redevelopment of such land and errection of building thereon..

(2) The Board may, for the purpose of forming layout under sub-section(1) demolish any structure or building in a slum area in accordance with section 10;

and the persons affected by such demolition shall, as far as, may be accommodated within the same slum area and if it is not possible there, shall be accommodated in the area vailable in the adjacent slum area or any other area meant for rehabilitation of slum dwellers.

(3) Subject to such restrictions and conditions and limitations as may be prescribed, the Board, shall have power to lease, sell or otherwise transfer the sites formed in the layout under sub-section(1) or dwelling unit of any building constructed in such layout.

4. **27B. Recovery of sums due to the Board.**-(1) All cost damages, penalities, charges, rent contribution or any other sum which under this Act or any rule made thereunder, are due by any person to the Board may be recovered by the prescribed authority by issuing a notice of demand to such person and indicating therein the liability incurred in default of payment, and may be recovered in the prescribed manner, within one month from the date of service of the notice such person does not make payment to the Board or;

(2) Any person disputing the demand made in the notice issued under sub-section(1) may prefer an appeal under section 59, within thirty days from the date of service of the notice and the provisions of that section shall mutatis mutandis apply;

5. (2) For sub-sections(1) and (2), the following shall be substituted,namely:

"(1) The Board shall consist of a Chairman and other Officials and non-official members as specified in sub-section(2);

(2) The Board shall consist of,-

(a) A Chairiman, who shall be appointed by the Government;

(b) the Commissioner of the Board shall be the Member-Secretary;

(c) A representative of the Finance Department, Government of Karnataka, not below the rank of a Deputy Secretary to Government;

(d) A representative of the Housing Department, Government of Karnataka, not below the rank of a Deputy Secretary to Government;

(e) The Director of Town Planning Department, Government of Karnataka;

(f) A representative of Health and Family Welfare Services Department, Government of Karnataka, not below the rank of Joint Director;

(g) A representative of the Bangalore Mahanagara Palike not below the rank of a Deputy Commissioner;

(h) A representative of the Directorate of Social Welfare Department, Government of Karnataka, not below the rank of Joint Director;

DEV-3.

Basappanakati slum

Visited by Dr Rajendran (19.5.99)
Ms Roopa & Ms. Shyla (7.6.99)
in Peenya Industrial belt

All of us visited the slum, accompanied by Mrs Jyothi and had the pleasure of interacting with the different ~~4~~ gps members. Some of the information shared with us was

- The slum is under the Bangalore Mahanagara Palike and is an extension of Rajagopalanagara slum.
- There are ~~in~~ 530 families living in huts (popln ~~in~~ 12,000) ~~7000.0~~. 80% of the people belong to the SC/ST gps.
- Approximately 30% of people speak Tamil & 50% Kannada, with a smattering of Telugu & other languag
- ~~The slum is on an old lake bed, rocky; and on the edge of a small lk~~ with the few remaining bits of it
- The slum is on the dried up lake

* Amazingly, fish survive in this water.

† Drinking water is from corporation pipes & tap connections. There is also one bore well bed; with very little water remaining. All the sewage water drains into this sump ~~with~~, and this is used for washing.* During the monsoon, the entire slum is flooded and water enters the houses, we were told.

† The houses are small, approx 5' x 5½' (one or two rooms) and there are no toilet facilities there. There are a row of ~~small~~ large sewage pipes fixed vertically in a row which are supposed to be public toilets, obviously unused as there is no water facility. Waste is everywhere, the people have not thought of a system to dispose of it, nor is there any govt. facility.

The women work as casual labourers on construction sites; roll agarbattis and as helpers in the factories & garment units nearby. Construction work pays Rs 30/- day, 15 days average a month. Girls in

• [Just beyond this lake is the cremation ground]

garment factories earn 300/- to 600 pm. Agarbath rolling pays Rs 3/- for every 1000 sticks perfectly rolled; so they earn between Rs 9-12/ day depending on their skill. This work is adjusted to the housework and managing young children.
The men go to the factories or work as coolies in neighbouring markets, or odd jobs in carpentry / construction.

There is a balwadi school, non-functional. 3% of children attend a private school in Jaggare and most are either playing or helping parents at their work.

There is a good Kannada clinic with a lady doctor & ANM operating daily. The women we spoke to did not know the ANM or anganwadi worker. Most women use the multiple 'clinics' in the nearby busstand area; some have 3-4 beds for "serious" cases. The cost

of a visit to the doctor is Rs 15/- and a drug prescription of medicine worth Rs 40-50, which may or may not be bought. The average cost of an 'admission' is about Rs 600/- The chief problems the women have are complaints of back ache, headaches & white discharge. The presence of the lady doctor does not seem to enable the women to seek help.

The community organised by Ms Jyoti/ Mr. Basavaraju with the Dalit Kranti Dal / and Mr Samuel, and their colleagues in the neighbouring belt of slums was due to have a meeting in a local public hall on Sunday.

After visiting Peenya with Jyothi, we at CHC feel that

1) Considering our ongoing commitment and ~~the~~ physical distance from Peenya we may not be able to get involved at direct grassroot level. Also considering the ongoing work of Jyothi & friends, we (particularly Mr. Rajendran) would be happy to come in as resource people for meetings organised in the slum.

2) On the health front we could involve Jyothi and any other women leaders in ~~the~~ training programmes in which CHC is involved eg - the WAH project. This might help in imparting health information in a spirit of empowerment to the women.

3) CHC could use its network of contacts to put pressure / find out how to help community put pressure on the slum development board

Also 'Sadhana' the group could be put in touch with other groups in town working like them for resources - particularly at Govt programme level they can tap.

(4) Referral links with a few hospitals such as KC General Hospital & Sr. Marthas Hospital (Dr Sr Teresita, Medical Superintendent) could be established with Sadhana / Asta

(5) A priority issue to be addressed is provision of safe water supply & sanitation facilities. This will need to be taken up with the concerned Govt Departments through people's organisations such as Sadhana, supported by Asta. This intervention will result in good health gains.

BASAPPANAKATE SLUM

Visited by Mr Rajendran on - 19.5.1999

This slum comes under Bangalore Mahanagara Palike (city ~~Municipal~~ corporation), specially Dasarahalli MCD CMC. This is attached as an extention to Raja-gopala Nagara Slum, which is a very big slum with 3000. houses. There are 530 families living in huts, in Basappanakate slum. There are 18000 People totally, 7000 of these are women. 80% of the People are Sc and ST. (30% Tamil + 50% kanada, telugu and other languages, but all the People are speaking Tamil and kanada), 20% Gowdas and lingayats.

Municipal Corporation Dispensary

It is situated under a hilly (rocky) terain, old dry lake bed, full of rocks. During every rain, the slum is flooded with water, tempararily they move up and go back to their homes.

There are no major govt-programmes, operational. Now they have laid stone path way. Govt has built six toilets but they are not in use, pits are full and are not cleaned. The drinking water

JN 17/6

NRS 17/6

Roopa 17/6.

connections are in PVC, broken, Sewage mixed with drinking water. There are no garbage collection system. Women roll agarbathis hence majority of them suffering from asthma, T.B and white-discharge problems. There are no clinics ~~in~~ locally but there is one Govt clinic at one k.m. The people are going to that clinic when they get disease. One lady doctor and one ANM daily attending the clinic.

There is one balwadi school. 3% of the children attend a private school in Laggere. Sizable numbers of children are child labourers and majority working with their parents in Agarbathi rolling.

Women here work in building construction, Agarbathi rolling, helpers in small factory units and garment factories. construction work Rs 30/- a day, 15 days average in a month. Girls in garment-factories earn Rs 300 to 600/P.M — Contract work. Men go to dassara-halli market, KR market as coolies. Men also work as helpers in construction and carpentary work.

my observations

I Physical Problems:

① Poor environmental Sanitation

② non availability of Safe drinking water

③ No toilets (women are going far away places, most of the women waiting for evening or dark time and even in dark time michievous young People following women and throwing stones)

④ inadiquate shelter

II Social Problems

① oppression of women

② alcoholism

III Main Health Problems

When People get sick, they go to govt clinic which is one k.m away and Private clinics at Peenya. The main concentration needed to Provide Proper and regular treatment for those who are suffering from Asthma and T.B. Very often they get sickness due to very Poor Sanitation and non availability of Safe drinking water.

IV I was informed that there is a women organisation, when I interacted with local women, I found out that

~~Community Health cell is a NGO organisation working~~ to create

it is not systamatic, and name sake only
The idea may be to prevent other NGOs to enter into it.
Women are much intirested to come together, discuss their problems and find out solutions.

S. D. Reyindran.

Transport - Peenya 2nd Stage Bus stop v. close to Basaveshwara
- from Shivajinagar or Majestic
221

Jyoti - PP Tel. No 8392037
Samuel - ISI 5360960 / 5555189
librarian

17/6/99 - decisions (1) ring Roopa / Jyoti / Samuel
- arrange a visit to the slum
- monthly talks by health - a possibility
- catalyst support
- clarify our position right at the beginning + this AGENDA
(2) choice between Journalists colony
(3) Relate to ongoing commitments.

7/7/99

VISIT TO RAJGOPAL NAGAR SLUM :

A REPORT

Mr. Samuel, founder of 'ASTHA' an organisation working towards upliftement of slums, placed a formal request to CHC; to provide possible assistance for their group on 9th of june 99 CHC team had a formal meeting with Mr. Samuel, Mr. Basava raju and Mrs Jyothi. Mr. Basavaraju is working in Dalit Kranthi Dal and Mrs. Jyothi; is the founder secretary of women's group 'SADHANA', working in peenya slums. The trio explained their concerns and problems of slums and their expectation from CHC. It was decided, that, a CHC team will visit the slums, Rajgopalnagar and Basappanakatte and submit a report to facilitate further plan of action.

On 7th July 99, Dr. Roopa Devadasan and I visited Rajgopalnagar Slum. Mrs. Jyothi also joined us.

Rajgopalnagar slum is surrounded by peenya Industrial area. This slum is on the periphery of the industrial area. Slum is situated next to a tank, which is adjoined to a cremation ground.

Slum has around 700 homes. Huts constitute the major portion. A very few homes are built by brick and cement with tiled roofs. All homes are of 5'x5' dimension.

All the dwellers migrated from other parts of Karnataka, from states Tamilnadu, and Andhrapradesh. They use their respective languages for communication. Almost all of them are Hindus.

A bore well, fitted with a hand pump, is the only source of drinking water. It also provides water for other purposes. A very few houses have electricity and, huts in particular, have no electricity as such.

Many women work in garments, and some are ~~women folk~~ engaged in agarabathi making. Men folk are in masan work, selling agarabatti; and some do fishing in near by Tank. girl Children do participate in agarabathi making.

For every ~~thousand~~ thousand agarabathis made, Rupees three is paid. Hence average income of an experienced women worker in around nine to twelve Rupees. At the same time, work related health problems, like back pain, headache are prevalent.

On health front, a PHC is situated one K.M away from the slum. One doctor, ANM are working there. Through the doctors pays visit every day, particulary in morning hours, women fail to avail the service as they will be either busy is their work, or gone to work.

Tank, situated next to slum, is polluted by a factory near by. During mansoon water rushes into the slum, choking them. It is also a breeding ground for many diseases Few of them expressed, that they are prone to many diseases because of the bore well, which has hard water. Some of them felt that, as they know nothing about prevention measures & personal hygine, it will be of great help, if they can get education in this direction.

Following are my hypothetical observations

1) 'SADHANA' is still in its infancy, as an organisation. It is still weak with no proper implementation of programmes / ideas.

2) Lack of sanitory facilities. Compounded by lack of knowledge of personal hygine; particullarly for women, needs attention.

3) We can collabarate with Sadhana, in conducting health awarness training programs.

DEV-3

Report of
CAMHADD One-Day Workshop on The Tri-Sector Dialogue

For Preventive Healthcare with Special Reference to Bangalore Urban Poor

at **Sri Jayadeva Institute of Cardiology,**
Jayanagar 9th Block, Bannerghatta Road, Bangalore-560 069. INDIA.
held on **11th January 2003**

Sponsored by
The Bangalore Mahanagara Palike (BMP)

In partnership with
Rajiv Gandhi University of Health Sciences, Karnataka
and
Sri Jayadeva Institute of Cardiology (SJIC)

Supported by
The Commonwealth Foundation, London

Prepared by
The Commonwealth Association for Mental Handicap and Developmental Disabilities (CAMHADD)
and
Urban Health Research and Training Institute
Bangalore Mahanagara Palike

A view of the SJIC
- one of the largest Cardiac institutes in Asia

Kempegowda Tower
- a symbolic landmark of the city's municipality - BMP

Inauguration of the Tri-Sector Dialogue Workshop

L to R : Dr. V. R. Pandurangi, CAMHADD
Mr. Sreenivasa Murthy, Commissioner, BMP
Dr. Maalaka Raddy, Hon'ble Minister for Medical Education, Karnataka
Dr. Roberta Ritson, WHO, Geneva
Mr. C. M. Nagaraj, Worshipful Mayor, BMP and
Dr. A. N. Prabhudeva, Director SJIC

Felicitation of Dr. Pandurangi by Mr. C. M. Nagaraj

Dr. Roberta Ritson addressing the Inaugural Session

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V. R. Pandurangi
Consultant to Trisector Dialogue in Health
Bangalore One Day Workshop

21 January 2003

Background to the Workshop

CAMHADD : One of the Commonwealth Professional Associations and A Pan Commonwealth NGO supported by the Commonwealth Foundation, London was established in January 1983. Its main objectives are prevention (primary and secondary) of mental handicap and to strengthen health professional links between and among developed and developing countries.

CAMHADD has organised 27 regional workshops, including 8 Pan Commonwealth workshops from 1985 to 2002 involving 1387 (Male 714 Female 673) invited participants/professionals from 45 Commonwealth countries and 17 Non-Commonwealth countries.

CAMHADD is in Official Relations with WHO since 1990 for collaborative programmes and is a long-standing partner of WHO in a number of technical areas, in particular mental health, disability prevention, maternal and newborn health, reproductive health, prevention of injuries, prevention of childhood blindness and Unity Towards Health to Achieve Social Accountability. WHO has co-sponsored **13 CAMHADD Regional workshops**.

CAMHADD in collaboration with WHO has developed and implemented priority initiatives for the prevention of brain damage due to birth asphyxia (lack of oxygen either before or immediately after birth) a major non-communicable cause of death and disability in newborn to prevent mental, neurological and sensory handicaps as integral component of safe motherhood and child survival.

CAMHADD is granted observer status by the Commonwealth Health Ministers to attend their meetings. **CAMHADD** was accredited as Pan Commonwealth NGO to represent at the Commonwealth Heads of Governments Meetings (CHOGM) at Edinburgh (UK) in October 1997, Durban (South Africa) in November 1999 and Brisbane (Australia) in February 2002.

One of CAMHADD programme activities for the New Millennium is to promote better public understanding of the Commonwealth and the issues that concern its people and also to promote Citizens and Governance Programme that arose directly from out of the Commonwealth Foundation's Civil Society Project in the New Millennium.

The Need for the Tri-Sector Dialogues

Governance as distinct from government is interpreted by most to mean having an inclusive approach to policy and decision-making, and to sharing responsibility for any or all decisions, actions, provisions among the three main social actors –the government, private sector and civil society.

The key question is: ***who does what?*** What roles are appropriate for the state, the business sector (and the market more generally and what roles are most appropriate for civil society (including citizens themselves as individuals as well as their voluntary associations and more institutionalised civil society organisations)?

A second question is: ***What difference does it make?*** What impact is made on a society's ability to meet people's basic needs – such as the need for human security, shelter, health, and livelihood-by new tri-sector distributions of power and responsibilities? What changes to existing relationships are needed in order to increase impact?

A Preliminary discussion of these questions was held at a workshop organised by the Commonwealth Foundation (CF) in Australia in 2001. It highlighted the importance of examining the appropriateness and impact of tri-sector approaches in concrete situations in diverse parts of the Commonwealth. Following this discussion Commonwealth Foundation decided to initiate a series of dialogues in up to 12 different localities in the Commonwealth in collaboration with Ford Foundation.

The Bangalore Trisector Dialogues Workshop on Preventive Health Care for Urban Poor is one of the 12 workshops supported by the Commonwealth Foundation.

The objectives of the workshop

- To promote Commonwealth Foundation's Project: **Citizens and Governance Programme: Trisector Dialogues in Health
- The Role and responsibilities of trisectors: government, private and civil society in social development to achieve social accountability.
- Strategies to develop trisector collaboration for the benefit of citizens.
- Reduction of poverty through health promotion.

Expected Outcome

To develop a strategy to provide preventive health care to the urban poor in Bangalore, in collaboration with trisectors: government, private, and civil society.

The workshop arranged by **CAMHADD** was sponsored by Bangalore Mahanagara Palike in Partnership with Rajiv Gandhi University of Health Sciences Karnataka and Sri Jayadeva Institute of Cardiology Bangalore.

Bangalore " The capital City of Karnataka in South India"

The modern world is experiencing a rapid increase in urbanization leading to more urban poverty in developing countries. Most of the growth is likely to be in Asia and rapid urbanisation will stretch the already scarce resources to the maximum. Urban life offers diverse forms of employment and cannot be contained. Therefore the challenge is to evolve appropriate and sustainable ways to manage the urbanisation process rather than prevent it.

Bangalore with an area spread over 225 sq kms. and a Population of 6.5 million, consisting 30% urban poor and 9% slum dwellers is the capital city of Karnataka in South India. **Bangalore** as the Information Technology (IT) centre is one of the fastest growing cities in Asia and urbanisation is one of the major problems the city will face in the coming decade.

Health Infrastructure of Bangalore : 250 large Hospitals and nursing homes and 5000 family practitioners.

Health facilities run by Bangalore Mahanagara Palike : 68 Urban Family Welfare Centres/Health Centres, 6 referral hospitals, and 24 Maternity Homes.

<u>Tertiary Care Hospitals</u>

- National Institute of Mental Health and Neuro Sciences.
- Jayadeva Institute of Cardiology.
- Kidwai Memorial Institute of Oncology.

Road network: of around 4000 km, catering to about 17 lakh (1.7 million) vehicles, of which nearly 70 percent are two-wheelers. The existing road network has to be upgraded by adding flyovers, grade separators, subways, broad good surfaced roads, development of multi-storeyed car parks.

Naturally, the growing needs of the city and the ever increasing demands of the people, trade and industry, particularly the information technology sector, make it imperative to plan and provide top-class infrastructure facilities like sidewalks and parks besides ensuring all basic civic amenities to the satisfaction of citizens and attract tourism not only from other parts of the country but also from abroad.

The Bangalore Mahanagara Palike a local self Government that is responsible for the civic governance of Bangalore has been making concerted efforts over the years for the development of the city's infrastructure through a series of ambitious projects aimed at improving the existing facilities and providing new ones to meet future requirements.

It plans to unveil a series of new initiatives, to be implemented over the coming months at an estimated cost of 17 Million Rupees(170 crores) funded with financial assistance from State Government, Karnataka Urban Infrastructure Development & Finance Corporation (KUIDFC) and Housing & Urban Development Corporation (HUDCO).

These projects are not only need -based to reduce traffic congestion but also designed to enhance Bangalore's beauty, as a growing metropolis.

Recognising the urgent need to address this problems : **CAMHADD,** the Bangalore Mahanagara Palike, and Sri Jayadeva Institute of Cardiology have come together to identify key areas for intervention in order to develop a city plan for preventive health with special focus on the urban poor. An endeavour of this magnitude will require partnerships to be developed between the Government, Private Sector and Civil Society.

Sri Jayadeva Institute of Cardiology(SJIC) was founded in 1972 by a generous donation by a philanthropist, the late Sri. Ambali Channabasappa to establish a heart care centre. The SJIC has a motto " To provide the very poor and needy with access to expensive cardiac medical care and cardiac surgery" free of cost in deserving cases.

The Institute is to provide excellent service for patients suffering from heart ailments, maintenance of high standards in cardiac medical and cardiac surgical treatment, high achievements in academic and research activities, in the fields of cardiology and cardiac surgery.

Concessional treatment for all patients below poverty level and holders of green ration card is available. The Institute provides for post graduate and super speciality training in cardiology and cardiac surgery.

The pre workshop process

1. The first step in the process was a series of meetings with the Municipal Commissioner of Bangalore in which the representatives of the Health Department of the Bangalore City Corporation, **CAMHADD** representatives, Director of the Manipal Institute of Neurological Sciences, Ramaiah Medical College, Director of Jayadeva *Institute of Cardiology, Representative of* Rajiv Gandhi University of Health Sciences were present. The key decisions at the first two interactions was the willingness of the Bangalore Corporation to be the main nucleus to develop preventive health care for Bangalore urban poor along with the other partners, from slum clearance board, Banks, Institutes and NGOs. These meetings also approved the formation of a Technical Committee consisting off representatives from the Bangalore City Corporation, Sri Jayadeva Institute of Cardiology, Community Medicine Department of MS Ramaiah Medical College, Rajiv Gandhi University of Health Sciences, and **CAMHADD.**

   It was also decided at these meetings to invite the Honourable Minister of Medical Education to preside over the Inaugural Session of the workshop and the Municipal Commissioner to give keynote address. **The minutes of these meetings are enclosed at Appendix 1**

2. The next step was to prioritise the health problems of the urban poor, by organising a series of stakeholder's pre-workshops dialogues to obtain their perspective. Pre-Workshop dialogues were held for key health personnel: health administrators, medical officers, health inspectors, health visitors, and auxiliary nurse midwives, opinion leaders in the slums, community based organisations and link workers,.NGOs working in the slums, and media personnel.

These pre-workshops were conducted as brainstorming sessions and a consensus on the priorities was evolved through a scientific process. One of the pointers in these workshops was that although the set of about 30 issues identified each of the groups were in general similar, the priorities as seen by the opinion leaders were different from those seen by health professionals which in turn varied from the perspective of the NGOs or the media. From these interactions evolved a set of ten priorities.

- Air pollution
- Accidents and trauma
- Violence against senior citizens
- Violence against women
- Cardiovascular diseases
- **Toilets, underground drainage systems, solid waste management
- Substance abuse
- Child labour
- HIV/AIDS
- Primary Health Care

The minutes of the pre-workshops are enclosed at Appendix 2

3. The consultants of the workshop and the organiser of the pre-workshop then decided to examine the seriousness of the problem for each of the issues identified by the information available or from the web sites. Government Departments and NGOs working in the various areas were contacted and available data was gathered. All information gathered was processed and for each of the ten issues the extent of the problem was listed out.

4. The Committee then explored the likely interventions that were necessary. Some interventions were either in place or required strengthening. Some of the interventions need to be looked at differently or required policy changes or re-addressing by the law. It was decided that the problem and the suggested interventions would form a part of the Bangalore Charter Declaration. **The Bangalore Charter Declaration is enclosed at Appendix 3.**

5. **The workshop was structured** broadly as per the suggested format of the Commonwealth Foundation and was modified to suit local circumstances and was planned in two major sessions-The Inaugural and Workshop Sessions. **The programme is enclosed at **Appendix 4.**

The topic of the dialogues *was "Preventive Health Care with special reference to the urban poor in Bangalore. The **workshop was expected to highlight some specific health issues for prevention of diseases and disabilities and also promotion of health after listening to the voices of the poor and other stake holders, so as to achieve the fundamental rights of good health as the greatest asset to the urban poor.*

Preventive Health Care with special reference to Bangalore Urban Poor

Health has long been recognised as one of the human fundamental rights and is reflected in the universal declaration of human rights, yet huge disparities exist in health between rich and poor within developing countries.

Health is not mere absence of disease or infirmity but is a state of well being at the physical, mental, and social (as well as spiritual) levels: WHO

Limited health budget and growing health needs are forcing developing country governments to make strategic decisions on the use of both domestic and foreign funds. Within the health sector, ministries should preferentially allocate resources to primary and secondary care rather than to tertiary care.

When public sector fails to meet the health care needs of the poor out of pocket expenditure rapidly exceeds public expenditure. Payments for private health care can be considerable up to 90% of household expenditure on health in India as in the private sector with the poor paying proportionately more than the rich.

The pattern of disease also varies significantly between rich and poor with disease of category I (communicable disease, maternal, perinatal and nutrition related conditions) dominating amongst the poor and which accounts for 59% of death and 64% Disability against life years lost among them. This does not mean that the poor do not suffer from non-communicable disease because all studies show they do. But they are not the principal cause of excessive morbidity and mortality.

A poor man may not have enough to eat, being underfed, his health may be physically weak, his working capacity is low, which means that he is poor, which in turn means that he will not have enough to eat-he will not be healthy and his family will be a sick family who have inadequate access to basic health care inspite of Bangalore having a good health infrastructure.

The workshop was attended by 51 invited participants from Government and Private Sector and also from Civil Society.

The opening session of the workshop was chaired by Dr. S. Chandrashekar Shetty Former Vice Chancellor of Rajiv Gandhi University of Health Sciences, Karnataka Bangalore and Consultant to Tri-Sector Dialogues

Dr. A. N. Prabhudev - Director of Sri Jayadeva Institute of Cardiology Bangalore welcomed the participants.

Dr. V. R. Pandurangi (CAMHADD) - Consultant Trisector Dialogue Workshop presented background paper and the purpose of the workshop.

Dr. Rajesh Tandon - President PRIA (Participatory Research in Asia) New Delhi (India) delivered the keynote address.

Dr. D. K. Srinivas, Director Curriculum Development Rajiv Gandhi University of Health Sciences Karnataka, Bangalore explained the participants guidelines for group discussion and plenary sessions.

Dr. Roberta Ritson(WHO/HQ/Geneva), Dr. Mala Ramachandran, Ms. Nalini Sampath Dr.Ganesh Supramaniam(CAMHADD) and Dr. S. Pruthvish were Rapportears for the workshop

The Inaugural Session. on 10th January 2003

Included a Keynote address by the Municipal Commissioner, an address by the Mayor of Bangalore City and the Release of the Bangalore Charter Declaration by the Minister for Medical Education. The WHO representative also spoke in this session..

The workshop session was held for a whole day on 11 January 2003.

The Government Sector represented by the Municipal Corporation Health and Education Departments, the Slum Development Department, Police Department, Doctors in Health facilities, Government Dental College, Health University, and All India Radio.

The Private sector was represented by the corporate sector, banking sector, medical colleges, management institutes, and corporate hospitals.

The Civil society was represented by the Bangalore Agenda Task Force, which is a citizen corporate, and Government initiative for improved governance in Bangalore.

Others included NGOs working in different areas like women in distress and community involvement, child labour.

This session began with a brief description of the purpose of the workshop and the presentation of the background. This was followed by a keynote address by Dr Rajesh Tandon, the President-PRIA who represented the civil society.

The participants were then divided into three groups depending on their affiliations.

The groups discussed

Who does what?
What the sector is best placed to do?
How does this compare with the current role of the sector?
What should the future look like?
Who should do what in relation to the need /issue identified?
How does this differ from the present tri sector distributions of power and responsibility?
What expectations are there of the roles best taken on by other sectors?
Where is it appropriate for other sectors to be involved?
Where is it inappropriate for other sectors to be involved?

The groups' common views

Air pollution : The interventions suggested in the background papers were accepted. The groups felt the main player was the Government. In addition some interventions were suggested. The participants felt that the urban poor had poor housing facilities and the lack of ventilation and use of outdated cooking methods caused smoke filled homes.

The slum clearance department said they had a programme of providing housing for the poor and could help in this intervention. The Education Department stated that both teachers and students, should be given awareness in schools, through innovative methods on issues of pollution and hazards as part of a regular curriculum.

Another cause of pollution was by indiscriminate burning of leaves, plastics and other waste material. The intervention discussed was the municipal body should levy heavy fines.

Waste indiscriminately thrown can generate methane and other gases, which cause pollution, and can be avoided by the municipality developing scientific landfills.

Regional transport office and the Food and civil supplies department should initiate action against adulterated fuel sale.

Encourage grass on pavements to prevent dust pollution

Accidents and Trauma : The interventions suggested in the background papers were accepted. The groups felt the main player was the Government. In addition some interventions were suggested :

Training of all the staff of the corporation health facilities in trauma care.

Rationalise the use of the existing ambulances for transporting accident cases and develop referral mapping.

Barricading of dangerous strategic points by the Corporation.

The police department could coordinate school education programmes on traffic and road safety.

Enforcement of law regulating movement of heavy traffic vehicles inside the city.

The police department to standardize speed breakers.

The groups felt that the private sector and the civil society could help in procuring and upgrading ambulances. Also the private sector medical institutions could handle the accident cases. The Indian Medical Association could use its advocacy to ensure that the private medical establishments treat accident cases.

Violence against senior citizens : The interventions suggested in the background papers were accepted. The groups felt the main player was the Government. In addition some interventions were suggested. It was agreed that most of the interventions were by the police department or the local body. The existing help lines needed to be widely publicized.

The intervention of providing security for the senior citizens by a paying guest system for students enlisted with the local police.

The private sector can play a major role in managing old age homes and day care facilities.

The health insurance companies could examine the possibility of providing group insurance schemes for the elderly citizens.

Violence against women : The interventions suggested in the background papers were accepted. The groups felt the main player was the Government. In addition some interventions were suggested. Wide publicity regarding healthy life styles and alternatives like setting up of gyms in slums.

NGOs could play a major role in running counselling centres and provide local immediate assistance to the women in distress.

Cardio vascular diseases : The interventions suggested were accepted and the government was the principal player

Toilets, Underground Drainage System, Solid Waste Management : The interventions suggested in the background papers were accepted. The slum clearance board was in a position to construct toilets through the Sulabh International and maintained by them for 30 years. The group felt that unless awareness was created on importance of use of toilets and the problems of indiscriminate open-air defecation the toilets would not be fully used. Awareness of the community by the health workers and through the school children was advocated. In Bangalore the experience of public participation through the private sector that constructed and managed the toilets in the city needs to be expanded.

Substance Abuse : The interventions suggested in the background papers were accepted. In addition it was felt that disused and abandoned buildings and land needed to be identified by the police and periodic beats daily would be a necessary intervention. The private sector and NGOS could play a role in development of attractive messages against substance abuse, which would be communicated through celebrities.

Child labour : The interventions suggested in the background papers were accepted. In addition, the Chinnara Angala Programme **(?) a bridge course for dropouts needed to be expanded to cover all the urban poor localities. Further the rescue service through a help line of the police department had to widely publicized. The private sector was involved in the practice of engaging child labour. The group felt that the industries, which followed labour laws, could function as advocacy groups to ensure child labour is discouraged The Federation of Chamber of Commerce and Industries could as a professional body take stringent actions against industries, which violated labour laws.

HIV/AIDS : The interventions proposed had to be mainly done with the private and the civil society taking a major role with the Government only playing a minor part. Care and support to HIV positive persons and management of counselling centres was seen as a major point of intervention where the NGO sector plays a leading role.

Primary Health Care : The groups felt that the role of all the three sectors was very important if Primary Health Care was to reach the urban poor. NGOs and the private sector including medical colleges could completely take over running some of the Health facilities. This would enable building in better referral linkages and also provide additional facilities.

Concluding Session

Mr. M. R. Srinivasa Murthy Commissioner Bangalore Mahanagara Palike chaired the closing session along with Dr. D. K. Srinivas as co-chairperson.

Dr. Roberta Ritson representative of WHO/HQ/Geneva presented recommendations of the workshop and Dr. Ganesh Supramaniam Secretary General CAMHADD outline the plan of action. Dr Rajesh Tandon, President PRIA delivered Valedictory Address. Dr. V. R. Pandurangi gave the vote of thanks.

Outcome of the Workshop

To develop a joint pilot project on preventive health care for Bangalore urban poor as a Commonwealth Model in collaboration with various partners in six divisions of Bangalore Mahanagara Palike covering an area of a total population of two hundred thousands. **An agreement among CAMHADD, Sri Jayadeva Institute of Cardiology and Bangalore Mahanagara Palike has been signed on 12 February 2003 to launch the project** by using the existing three Corporation run Health Centre/Urban Family Welfare Centres and one 24 bedded Maternity Home The Urban Health Research and Training Institute to be the nodal centre for the pilot project.

Facilitators Observations.

The local committee had invested a significant amount of effort in the research into local health needs and priorities of the urban poor of Bangalore in preparation for this one-day workshop, as well as a major planning exercise. This advance preparation was very evident during the conduct of the workshop, as was the motivation, professional expertise and commitment of the participants.

The committee consisted of eleven members drawn from both health professional and non-health professional backgrounds, ensuring a mix of government, private sector and civil society backgrounds, in keeping with the emphasis on partnerships and intersectoral action for health. The outcome of the discussions and dialogues between the different partners during these preparatory meetings are incorporated into the Bangalore Charter Declaration.

The Bangalore Charter described the profile of the city of Bangalore, its population and its health infrastructure, before outlining the process by which the ten priority areas for action to improve the health of the urban poor were identified as follows, together with appropriate interventions:

Air pollution in Bangalore City; accidents and trauma care; violence against senior citizens; violence against women; cardiovascular diseases; toilets, underground drainage system and solid waste management; substance abuse; child labour; HIV/AIDS; and access to primary health care. These covered environmental problems, urban health services and social issues, as well as practical and implementable interventions to address these ten areas for action, leading to improvements in the level of health care and access to health care services for the urban poor.

The keynote address at the workshop, which outlined the Trisector Dialogue approach for a healthy community, was delivered by the Commissioner of the Bangalore Mahanagara Palike (Bangalore City Corporation), Sri M.R. Sreenivasa Murthy. The Commissioner emphasized the rapid escalation in urbanization of the city and its resulting increase in the numbers of urban poor living in the city, as well as the burden imposed on the city's community services. He welcomed the initiative of the Commonwealth Foundation and the Commonwealth Association for Mental Handicap and Development Disabilities (CAMHADD), together with the Sri Jayadeva Institute of Cardiology, in launching this initiative for preventive health care in the city. He was also pleased to note the interest of the World Health Organization in the initiative.

A particular feature of the workshop was the involvement of representatives of not only the public sector, but also private enterprise and civil society, all committed to work in partnership towards the common goal of improving the health of the poorest of the city. The vision of a good society was described in his address by Dr Rajesh Tandon, president of a local centre for the promotion of learning and democratic governance. A good society was defined as one where all citizens enjoyed economic, social and physical security: basic human needs which global society recognized as more relevant today than ever before, particularly in the aftermath of 11 September 2001. The Trisector Dialogues launched by the Commonwealth Foundation were aimed at promoting good governance and a good society, as well as the involvement of multiple sectors and partners in the achievement of this vision.

Throughout the workshop, there was lively and controversial discussion on tackling priority issues in preventive health care, and appropriate and practical interventions were identified. Following a review in plenary of the issues raised in all discussion groups, it was decided that priorities for action were cardiovascular disease, oral health, blindness, diabetes, trauma care and environmental issues. The key outcome for the workshop was the identification of a model project in preventive health care for the urban poor of the city, focused on these priority areas. It involved coordinated action by stakeholders from the different sectors who were already committed to the project.

The local committee would follow-up on the recommendations of the workshop and ensure the implementation of the preventive health care initiative. A series of meetings would follow to collect the epidemiological data needed as a basis for a strategy for action. The workshop closed on a positive and optimistic note.

Appendix 1 :

Two Meetings were held with Commissioner Bangalore Mahanagara Palike prior to the workshop and was attended by representatives of Bangalore Mahanagara Palike and CAMHADD

1. **First Meeting** was held on 20 November at 2.30PM at the chamber of the Commissioner, Bangalore Mahanagara Palike and was chaired by Mr M.R. Sreenivasa Murthy, Commissioner Bangalore Mahanagar Palike
2. **Second Meeting** was held on 18 December 2002 at Atria Hotel and was chaired by Mr. M. R. Sreenivasa Murthy Commissioner, Bangalore Mahanagara Palike.

These meetings took the following decisions after detail discussion of various issues.

1. BMP to host the one day workshop on "Trisector dialogue in Health" which is the first of its kind on health for urban poor with some financial support and also to develop collaboration with the CAMHADD/Commonwealth Foundation/Health Division Commonwealth Secretariat/WHO/Sri Jayadeva Institute of Cardiology for on-going programme to make this programme as a Commonwealth Model. Such dialogue in Bangalore is first of its kind in preventive health for Bangalore urban poor.
2. To make use of existing health infrastructure of BMP for preventive,promotive, curative and rehabilitation programme in collaboration with other partners mentioned in appendix 5
3. The Urban Health Research and Training Institute of the Bangalore Mahanagara Palike to be used for training of health workers at all levels.
4. The Yeshwanthpur, Mathikere and Kodandramapura area to be selected for health care project including accident and emergency cases by using existing Health units in the area.
5. A Technical working group to be constituted from amongst the members to design a format for survey for establishing benchmark and to launch health project for urban poor.
6. To arrange a meeting with Commonwealth and relevant programme Divisions WHO in May 2003 during World Health Assembly to initiate discussion to develop collaboration
7. Dr Jayachandra Rao and Dr Mala Ramachandran to be co-ordinator and the Nodal Executive with BMP/ CAMHADD/Commonwealth/WHO.

Third Meeting : Post workshop Meeting was held on 13 January 2003 at the chamber of the Commissioner Bangalore Mahanagara Palike(BMP) and was chaired by Mr M.R. Sreenivasa Murthy, Commissioner BMP. This meeting considered the follow up actions.

Participants: Representatives of BMP, CAMHADD and WHO

This meeting took the following decisions after detail discussion of various issues.

1. To focus on development of a health care project for urban poor in Yeshwanthpur-Mathikere- Kodandarampuram area on the basis of ten priorities identified for improving the health as mentioned in Bangalore Declaration.
2. To develop the project in two stages. First stage as "Pre-Pilot Project" for one year and second stage as "Health Project." The period of the project is to be decided by the Committee.
3. To submit the project proposal on behalf of the Commonwealth Association for Mental Handicap and Developmental Disabilities (CAMHADD) and will later develop collaboration with the Commonwealth Foundation, Commonwealth Secretariat, WHO and Health Related Organisations of United Nations for Bangalore Model project
4. Various Partners and their Commitments(Please see Appendix 5)
5. **Time Schedule**
   - Baseline Survey: 20-31 January 2003
   - Submission of project proposal by CAMHADD : 5 February 2003
   - Meeting of Project Launching Committee with Commissioner BMP : 17 February
   - Launching of the project : Mid March 2003
6. Bangalore Mahanagara Palike to meet the cost to prepare project proposal.
7. To establish a centre for prevention and management of high risk pregnancy integrated with training at all levels

Appendix 2 :

Two Pre Workshop Consultative Meetings held prior to one day trisector dialogue workshop in health : Preventive health care for Bangalore urban poor on 11 January 2003 to get information to prepare background paper and to prioritise health related issues.

First Consultative Meeting was held on 10 November 2003 and was attended by the consultants, facilitators and rapporteurs of the workshop

The objectives of this first meeting

Listing problems related to urban poor
Listing existing health facilities and other services
To prepare guidelines for group discussion for the workshop on 11 January 2003

This initial meeting identified the following important problems of Bangalore urban poor

- Drinking water, sanitation, and communicable diseases
- Non-communicable diseases, malnutrition and disability
- HIV/AIDS and sexually transmitted diseases
- Reproductive, adolescent, perinatal and newborn health- inadequate health facilities
- Lack of facilities to treat accident cases in slum area
- Substance abuse
- Violence and crime
- Community safety and security
- Child labour and street children
- Lack of education and transport facilities
- Housing

Second Consultative Meeting **was held on 28 November at Department of Community Medicine, M.S.Ramaiah Medical College and focused on the urban poor and was attended by 20 invited participants from different disciplines representing health,police,NGOs. The significance of this meeting was bringing together many people from different sectors to share their common concerns regarding health issues in urban impoverished areas.**

Participants presented the experience in their area particularly problems faced by them, intervention strategies, gaps in the programme including lack of unity in health and social accountability

The following issues were discussed

- The basic needs of the people who live in slums.
- To increase the health centres and creating awareness of the facilities provided by the government.
- To work on areas like Waste management, HIV Aids prevention
- Common needs of people, such as access to clean and safe drinking water, sanitation, drainage should be provided.
- Necessary measures to prevent accidents and deaths
- Identification of the hospitals and nursing homes on the highways.

- Coordination with insurance agencies as well as police would ensure that there will be no delay in the treatment of accident victims.
- Creating awareness among the people who are in slums about pregnant women, birth rates, nutrition. Family planning, and health education.

The following Five Workshops were arranged prior to the one day trisector dialogue workshop in health : Preventive Health Care for Bangalore urban poor on 11 January 2003 to get information to prepare background paper and to prioritise health related issues.

1. **Workshop for the Health professionals of the Bangalore Mahanagara Palike on 26th December 2002 at the Urban Health Research and Training Institute to prioritise the Health Needs of the Urban Poor**

2A. **Workshop for the Opinion Leaders at the Nandini Layout Slum of the Bangalore Mahanagara Palike on 27th December 2002 at the Nandini Layout Health Centre, to prioritise the Health needs of the Urban Poor**

The workshop was attended by the local leaders, women's groups, Community Based Organisations, women who worked as link workers in the IPP-VIII and Health Staff of the Health Centre, totalling 35 participants.

2B **Workshop for the Opinion Leaders at the Murphy Town Slum of the Bangalore Mahanagara Palike on 27th December 2002 at the Murphy Town Health Centre, to prioritise the Health needs of the Urban Poor**

The workshop was attended by the local leaders, women's groups, Community Based Organisations, women who worked as link workers in the IPP(India Population Project)-VIII and Health Staff of the Health Centre, totalling 52 participants.

3. **Workshop for the Non governmental Organisations working in the slums of Bangalore on 28th December 2002 at the Urban Health Research and Training Institute, to prioritise the Health needs of the Urban Poor**

The workshop was attended by 25 representatives of NGOs working in the slums of Bangalore.

4. **Workshop for the Health Professionals of the Bangalore Mahanagara Palike on 30th December 2002 at the Urban Health Research and Training Institute, to prioritise the Health needs of the Urban Poor**

The workshop was attended by Deputy Health Officers, Medical Officers i/c of Sanitation in ranges, Doctors of Urban Family Welfare Centres, Health Centres, Health Inspectors, LHVs and ANMs of Health institutions of BMP, totalling 21 participants.

5. **Workshop for the Representatives of the media on 3rd January 2003 at the Urban**

Health Research and Training Institute to prioritise the Health needs of the Urban Poor.

Health, Environment and social Issues Prioritised by the participants at consultative meetings and workshops

Health Issues

- Safe Drinking Water, sanitation and garbage removal
- Toilets, Under Ground Drainage, Gastroenteritis and Cholera.

- Accidents and Trauma Care
- Primary Health Care and Referral
- Handicapped
- Non communicable diseases, Cardio vascular diseases, Cancers,
- HIV/AIDS
- Substance abuse
- Access to cost-effective treatment and investigations relating to Primary Health Care including specialists and referral services

Environmental issues

- Air pollution

Social issues

- Raising awareness of general issues of importance like legal and health issues
- And availability of services
- Violence against women and senior citizen, Crime and Dowry
- Education for all, Enrolment of Dropouts, Adult literacy, Child Labour and street children.
- Housing and Transport

Appendix 3 :

Bangalore Charter Declaration

The consultants of the workshop established a committee to collect information through Pre workshop consultative meetings and workshops. The problems and the suggested interventions form the part of the Bangalore Charter Declaration. The details are available in the publication of " A Tri-sector Dialogue for A Healthy Community : Bangalore Charter Declaration

Appendix 4 :

Workshop Programme

CAMHADD One-Day Workshop on The Tri-Sector Dialogue: Preventive Health Care with Special Reference to Urban Poor (Bangalore)

Venue: Sri Jayadeva Institute of Cardiology, Jayanagar 9th Block

Bannerghatta Road, Bangalore-560 069, Telephone: (080) 6534466

Date: 11th January 2003 Time: 0830-1730

08.30	**Registration**
Session I	**Chairperson** Professor S. Chandrashekar Shetty Former Vice Chancellor Rajiv Gandhi University of Health Sciences Bangalore And Consultant to Tri-sector Dialogue in Health
09.00	**Welcome** Dr. A. N. Prabhudeva - Director Sri Jayadeva Institute of Cardiology
09.10	**Self Introduction of Participants**
09.20	**Purpose of the Workshop and Presentation of Background Paper** **Dr. V. R. Pandurangi (CAMHADD)** Consultant to Trisector Dialogue in Health
09.30	**Keynote Address** Dr. Rajesh Tandon-President PRIA (Participatory Research in Asia) New Delhi
10.15	**Tea/Coffee Break**
Session II	
10.30	**GROUP discussion: Three Groups** Theme: Who does what? **Guidelines for group discussion and plenary session** Dr. D. K. Srinivas-Director, Curriculum Development Rajiv Gandhi University of Health Sciences Bangalore

Government Sector	Private Sector	Civil Society
Facilitator	**Facilitator**	**Facilitator**
Prof. Chandrashekar Shetty	Dr. K. V. Ramani	Ms. Shagun Mehrotra
Rapporteur	**Rapporteur**	**Rapporteur**
Dr. Mala Ramachandran	Dr. Ganesh Supramaniam Ms. Nalini Sampat	Dr. Roberta Ritson Dr. Pruthvish

(Three Sectoral groups: Participants will discuss their sectors current and /future roles and responsibilities)

- What is it that the sector is best placed to do?
- How does this compare with the current role of the sector?
- What expectations are there of the roles that are best taken on by the other sectors (or where it is in appropriate for other sectors to be involved)?

Session III

11.30 **Plenary Session** : Presentation of group reports
Chairperson : Dr Roberta Ritson
Rapporteur : Dr Ganesh Supramaniam
Ms Nalini Sampat

12.45 Lunch

Session IV

13.30 **Group Discussion " What should the Future look like"**

Government Sector	Private Sector	Civil Society
Facilitator	**Facilitator**	**Facilitator**
Prof. Chandrashekar Shetty	Dr K. V. Ramani	Ms Shagun Mehrotra
Rapporteur	**Rapporteur**	**Rapporteur**
Dr Mala Ramachandran	Dr Ganesh Supramaniam Ms Nalini Sampat	Dr Roberta Ritson Dr Pruthvish

Each Sector discusses

- Who should do what in relation to the identified need/issue?
- How does this differ from the present tri-sector distributions of power and responsibility?

Session V

14.30 Plenary Session : Presentation of Group Reports
Chairperson : **Dr A. N. Prabhudeva**
Rapporteur : **Dr Ganesh Supramaniam and Ms Nalini Sampat**

15.30 **Tea/Coffee Break**

Session VI

15.45 **Group Discussion: Three Groups**
Theme: "What we need to play our part"

Government Sector	Private Sector	Civil Society
Facilitator	**Facilitator**	**Facilitator**
Prof. Chandrashekar Shetty	Dr K. V. Ramani	Dr Francis
Rapporteur	**Rapporteur**	**Rapporteur**
Dr Mala Ramchandran	Dr Ganesh Supramaniam Ms Nalini Sampat	Dr Pruthvish

Each Sector discusses

- Their role in the identified issues
- Identifies obstacles and what is needed to overcome them including support, resources, capacity building needs etc.

16.45 **Plenary Presentation of 3 Groups**
Chairperson : Dr Francis(Community Health Cell)
Rapporteur : Dr Roberta Ritson, Ms Nalini Sampat

17.30 **Closing Session**

Chairperson

Mr M. R. Srinivasa Murthy
Commissioner
Bangalore Mahanagara Palike

Co-Chairperson
Dr. D. K. Srinivas
Rajiv Gandhi University of Health Sciences Bangalore

Recommendations
Dr Roberta Ritson
WHO/HQ/Geneva

Plan of Action

Dr Ganesh Supramaniam (CAMHADD)

Valedictory Address
Dr Rajesh Tandon
President PRIA

Chairperson's Remarks

Vote of thanks
Dr V. R. Pandurangi (CAMHADD)

Citizens and Governance Program: The Tri-Sector Dialogue Workshop on Preventive Health Care with Special Reference to Bangalore Urban Poor

Guidelines for Group Discussion and Plenary Session

1. Participants will form three sectoral groups. The three groups will hold discussions simultaneously in separate places.
2. The participants will discuss their sector's current and/or future roles and responsibilities in addressing the identified need/issue focusing on during: the group discussion

I Group Discussion - Theme: ***"Who does what?"***

Discussion Points:

i. What is that the sector is best placed to do.

ii. How does this compare with the current role of the sector?

iii. What expectations are there of the roles that are best taken on by the other sectors (or where it is inappropriate for other sectors to be involved)?

II Group Discussion - Theme: ***"What should the future look like?"***

Discussion Points

i. Who should do what in relation to the identified need/issue?

ii. How does this differ from the present tri-sector distributions of power and responsibility?

III Group Discussion - Theme: ***"What do we need to play our part?"***

Discussion Points

i. What is needed to enable the sector to play its role effectively in the future Identified in the previous session?

ii What obstacles/constraints are anticipated?

iii. What is needed to overcome them including support, resource, capacity building needs etc.

Since the dialogue is only for a day, keeping the time constraint in view, the groups are requested to focus on the issues raised in discussion points

3. Plenary Sessions

During each of the three plenary sessions, the three sector group reports are shared. Overlapping experiences, expectations, points of agreements and areas of disagreement are identified and further discussed. If necessary, plenary could break into 'buzz' groups – small cross- sectoral or sectoral to workout solutions to dispute areas so that a final recommendation on each theme is ready at the end of each plenary session.

In the third and final plenary, the entire group discusses next steps including any related to workshop report and the 2003 international workshop.

4. Group Reports

Each sectoral group report should be brief, precise, specific and action oriented.

The organisers appreciate your cooperation.

Happy Dialogue!

Appendix 5 :
Various Partners and their Commitments

- **Sri Jayadeva Institute of Cardiology : .**
  To provide free diagnostic and treatment facilities for the beneficiaries.
- **The Government Dental College and R. V. Dental College to:**
  Provide free oral health care services through the health facilities in the project area on a regular basis, and develop a referral protocol. They also agreed to take the responsibility to conduct the survey in the project area to know the burden of disease to enable planning of services, through their interns and postgraduates.
- **Lions Clubs International Sight First Programme**
  To provide eye care services through District Blindness Control Society Bangalore (Urban).
- **Comprehensive Trauma Consortium** to provide training to the medical officers and Para medical staff of the corporation facilities in first aid and trauma care, including emergency care management.
- **MS Ramaiah Medical College**
  - Community Medicine Department agreed to conduct the survey in the Project area through their interns and post graduates.
- **Diabetic Club Bangalore Region**
  To provide free screening, treatment and follow up of diabetic patients initially for a period of one year.
- **Samraksha-**An NGO working for counselling,care and support in reproductive and sexual health.
- **Global Trust Bank Bangalore assured support in selected programmes**
- **Slum Clearance Board**
  Assured constructing 100 houses and toilets for free distribution to slum dwellers
- **Karunashraya (NGO)**
  Offer free home care and if needed hospital care to terminal cancer patients.
- **Sumangali Seva Ashram(NGO)**
  Offer to run the day care centre for senior citizens in a building provided by BMP

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Some Snippets...

Participants at Tri-Sector Dialogue

Invitees at the Inaugural Session

Group Discussion in progress

CAMHADD and WHO Representatives with the Commissioner, Bangalore Mahanagara Palike

Drinking water, education are priority areas for urban poor

By Our Special Correspondent

BANGALORE, JAN. 3. Safe drinking water, toilets, underground drainage, trauma care, education, prevention of alcoholism, and empowerment of women to resist violence. These are some of the priority needs spelt out by the urban poor in Bangalore.

The slum dwellers of Nandini Layout were consulted as a prelude to the "Trisector dialogue on preventive healthcare for urban poor of Bangalore", to be held here on January 10 and 11. The Government and NGOs are among participants in the exercise being organised by the Commonwealth Association for Mental Handicap and Development Disabilities (CAMHADD) in association with the Commonwealth Foundation, Bangalore Mahanagara Palike, Rajiv Gandhi University of Health Sciences, and Sri Jayadeva Institute of Cardiology.

Almost similar priorities were spelt out by mediapersons who were consulted on Friday. Emphasis should be given to education, many presspersons felt.

That would mean better jobs, motivation for better living conditions, awareness of preventive healthcare, and income to purchase nutritious food and medicine.

What does the BMP have to say? The bulk of its healthcare budget goes for solid waste management and salaries of the staff at the dispensaries and hospitals.

This is despite the infrastructure of 28 maternity homes, six referral hospitals, 55 health centres, and 19 family welfare clinics.

Barely sufficient for slum dwellers, who form 12 per cent of the five million residents of the City. Those termed "urban poor" comprise 30 per cent of the citizens.

While the civic body has a good track record in population control measures through the India Population Project, it has severe handicaps when it comes to day-to-day health care. There just are not enough essential drugs to be given to the poor. Most of them cannot afford to purchase them on their own. Communicable diseases, which include TB, gastro-enteritis, hepatitis, skin diseases, and even malaria and filaria, continue to prevail. Most of the time, major epidemics are prevented but diseases continue to reduce working days and bring down already meagre incomes.

Thanks to the cooperation of voluntary organisations such as the Rotary, and by educating the urban poor, Bangalore has had remarkable success in polio eradication. next

Whether this can be replicated in the case other diseases, and how far can the sanitat levels of slums be improved will become issu be discussed next week.

THE HINDU, Saturday, January 4, 2003

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ENVISIONING A HEALTHIER TOMORROW

A Trisector Dialogue for a Healthy Community

Keynote Address
delivered by
Sri. M. R. Sreenivasa Murthy, I.A.S.
Commissioner, Bangalore Mahanagara Palike
on 10th January 2003

BANGALORE
MAHANAGARA PALIKE

CAMHADD

SRI JAYADEVA INSTITUTE OF CARDIOLOGY

Keynote address for the Trisector Dialogue
(Government, Private Sector and Civil Society)
for a Healthy Community

The modern world is experiencing a rapid escalation in urbanisation, especially in developing countries, leading to an increase in urban poverty. To meet these challenges different civic agencies need to collaborate and pool their strengths to provide a vehicle by which the vast majority of people living in poverty can improve their quality of life. By 2025 it is estimated that two thirds of the world's population will live in cities and towns. Thus the world's urban population is expected to double within 25 years. Most of the growth is likely in Asia and this rapid urbanisation will stretch the already scarce resources to the maximum. Urban life offers diverse forms of employment and cannot be contained. Therefore the challenge is to evolve appropriate and sustainable ways to manage the urbanisation process rather than prevent it. Bangalore as the IT capital is one of the fastest growing cities in Asia and urbanisation is one of the major problems the city will face in the coming decade. Recognising the urgent need to address this problem the Bangalore Mahanagara Palike, Jayadeva Institute of Cardiology and the Commonwealth Association for Mental Handicap and Development Disabilities have come together to identify key areas for intervention in order to develop a ***city plan for preventive health with special focus on the urban poor.*** An endeavour of this magnitude will require partnerships to be developed between the Government, Private Sector and Civil Society.

General Profile of Bangalore City

- Bangalore Metropolitan area has a population of 65.23 lakhs (Census 2001).
- The Urban poor constitutes 30% of the population
- It is estimated that nearly 10 lakh is the floating population.
- Health infrastructure in Bangalore includes 250 large hospitals and nursing homes, 5000 family practitioners, tertiary care hospitals, like NIMHANS, Jayadeva Institute of Cardiology & KIDWAI and five medical colleges. The Bangalore City Corporation runs 68 UFWCs/Health Centres, 6 Referral Hospitals and 24 Maternity Homes.

Background for prioritising health needs of the urban poor of Bangalore

- A series of workshops were organised to obtain the perspective of all the stakeholders
- A Workshop was held for key health professionals like health administrators, medical officers, health inspectors, lady health visitors, and auxiliary nurse midwives.
- Workshops involving the opinion leaders in the slums, community based organisations and link workers.
- Workshop for NGOs working in the slums of Bangalore was arranged and their perspective of the health needs of the urban poor was also taken.
- Workshop for Media to obtain their perspective
- From these inter actions evolved a set of ten priorities.

Air Pollution in Bangalore City

The problem

- Air pollution is mainly caused by automobiles and industrial emissions.
- Vehicles numbering 12 lakhs in Bangalore account for 60% to 80 % of the total air pollution.
- Vehicles while waiting at traffic signals consume 5000 litres of fuel per day, leading to wastage of fuel and excessive emissions.
- Vehicles emit pollutants like Carbon monoxide, Hydro carbons, Nitrogen oxides, Sulphur dioxide, Lead oxide, Suspended particulate matter, etc.
- Cars and two wheelers in metropolitan cities account for 78% and 11 % of the pollution.
- The KPCB has estimated in 1995-96 that SO_2 produced by petrol vehicles is 1.4 tons per day and Diesel vehicles is 6.4 tons per day.
- SO_2 causes acidification of air.
- Carbon monoxide emitted by automobiles reduces the oxygen carrying capacity of blood to the tissues, and affects the CNS and predisposes one towards heart attacks.

- About 0.25 tons of lead is added to the atmosphere of Bangalore every day. Lead poisoning affects production of Red Blood Cells and causes brain damage. It causes gastro intestinal diseases, liver and kidney disorders, and abnormalities in fertility and pregnancy. It causes impaired mental development in children. More than 40 % of the babies born in Bangalore in the millennium will have poorer cognitive functions and lower IQ due to excessive lead in their blood. In adults headache nausea, loss of appetite, weight loss, muscle cramps and nervous disorders occur
- Oxides of Nitrogen are derived from effluents from industries using nitric acid and also automobile exhausts. Exposure causes eye & nasal irritation and pulmonary discomfort. Nitrogen oxides promote the production of atmospheric ozone and acidification of soil and water. Ozone can harm to huma lungs and other tissues.
- Hot spots which are heavily polluted areas identified in Bangalore City, are Sirsi Circle, SBM Circle and Yeshwanthpur Bus Station

Interventions

- ✓ **Consequently restructuring the public transport mechanism becomes a necessity. An investment of Rs 100 crores has been made to provide 1000 state of the art buses, to encourage use of public transport. There is an urgent need to put in place the mass rapid transport system**
- ✓ **Providing grade separators and flyovers at congestion points to ease the traffic flow**
- ✓ Enhancing the vehicle registration fee is a measure, which will act as a deterrent to purchase of vehicles, as seen from the Singapore experience. This will encourage commuters to use public transport
- ✓ Air pollution from industrial emissions is the second largest contributing factor to air pollution. Widening of the green belt around Bangalore and stopping the issue of licences for factories within a 60 Km belt around the city through a legislation will reduce pollution levels
- ✓ Phasing out old vehicles including two wheelers
- ✓ Synchronise traffic signals to prevent traffic congestion at traffic signals which causes pollution from idling vehicles

Accidents and Trauma Care

The problem

- Road traffic accidents are the leading causes of mortality and morbidity in Karnataka.
- The percentage of head injury due to road traffic accidents in Bangalore is 62 %.
- Head injury from all causes in Bangalore was found to be in the range of 120-160 per lakh with a mortality of 14-20 per lakh population.
- The NIMHANS study has cited 68 % of death due to head injuries in road accidents.
- On an average 60-80 two-wheeler riders including pillion riders meet with head injuries every month, out of which 6-8 succumb to death. It accounts for 48 % of road accidents resulting in head injuries.
- Out of the head injury admissions nearly 10 % die during the hospital stay.
- Death amongst those not wearing helmets is two times more as compared to those wearing helmets.
- Severity of head injuries is higher and skull fracture is 1.2 times more among those without helmets
- Use of helmets by riders of two wheelers would decrease head injuries by 30-50 %

Interventions to reduce the mortality and morbidity include

- ✓ **Establishing an effective golden hour management, through positioning well equipped ambulances at high accident zones, as a critical intervention**
- ✓ **Compulsory use of helmets**
- ✓ **Ensuring pothole free roads**
- ✓ Widening of roads
- ✓ Enforcing lane discipline
- ✓ Restricting the movement of heavy traffic vehicles inside the city
- ✓ Road safety education at school level
- ✓ Examine the rationale of speed breakers
- ✓ Enforcement of laws relating to mandatory treatment and administering first aid for accident victims by all medical establishments.

- ✓ A police force sensitised to non harassment of the help providers and medical establishments
- ✓ Recognition of those persons who help accident victims and publicity of such acts
- ✓ Training police personnel in management and transportation of accident victims

Violence against Senior citizens

The problem

- ➢ Forced suicides of the elderly for economic reasons, sexual, physical and psychological abuse is common amongst the elderly.
- ➢ The number of senior citizens i.e., people over the age of 60 years in India have increased from 12 million in 1901 to 20 million in 1951 and 57 million in 1991.
- ➢ Population projections made by the Registrar General India indicate that the number of senior citizens would be 100 million by 2016 in India.
- ➢ In Karnataka the number of senior citizens, which is currently 6.99 % of the population, is projected to increase to 9.71 % of the population, by 2016.
- ➢ Elderly men have the support of a companion, as they tend to remarry. Hence the proportion of elderly widowed men is lesser than women.
- ➢ Among the elderly men 56.67 % continue to work as against 18.14 % of women in urban areas. In rural areas, 62.43 % of elderly men and 21.43 % of elderly women continue to work.

Interventions

- ✓ **Maintain a directory of senior citizens at the area police stations. Ensuring the security and safety of senior citizens, by periodic contact by the local police.**
- ✓ **Issue of senior citizens cards by the local body**
- ✓ **Local bodies to create old age home facilities to be managed by NGOs in the community halls**
- ✓ **Local bodies to create day care facilities with recreation and catering facilities to be managed by NGOs in the community halls**
- ✓ Old age homes where peer group presence will reduce loneliness is an essential intervention.
- ✓ Encourage formation of local committees of senior citizens, as a self help group
- ✓ Care of the elderly in sickness and chronic ailments with a cost effective package
- ✓ Enrolment of senior citizens as wardens in traffic control and other areas to be explored
- ✓ Health corpus through the network of income tax, sales tax, commercial tax, excise duty to be explored. Examine possibility of tax exemption for contribution to the corpus fund
- ✓ Health insurance package with community or group premiums to be explored.

Violence against women

The problem

- ➢ Violence against women starts at the stage of conception where female foeticide is practiced in favour of begetting a son.
- ➢ Violence against women covers domestic violence, sexual violence, sexual harassment, rape and sexual abuse, marital rape, forced prostitution, dowry related violence, abuse of children and neglect of widows and elderly women.
- ➢ A study by the International centre for Research in Women found that 45 % of women interviewed were victims of domestic violence.
- ➢ According to research conducted by RAHI, a support centre for women survivors of incest, 76 % of 600 women interviewed have been sexually abused in childhood or adolescence
- ➢ 80 % of rapes are perpetuated by relatives or men known to women, 24 % of rapes involve girls below 16 years.
- ➢ Domestic torture constituted 30.4 % of total crimes against women in 1996 and rape formed 12.8 % of total reported crimes against women in India.
- ➢ A study by an NGO SAKSHI in 1996 revealed 72 % of women reported sexual harassment at the work place.

Interventions

- ✓ **Counselling centres with free legal aid facilities for women in distress to be established ward wise by the local body.**
- ✓ **Redressal through women police force, zone wise**
- ✓ Encourage community based womens' groups with both Governmental and non government support.

Cardiovascular Diseases

The problem

- ➢ Among all non-communicable diseases, Cardiovascular Diseases taken together are the leading cause of morbidity and mortality.
- ➢ There is a rising trend, of cardiovascular diseases, which is reaching epidemic proportions, propelled by a shift in the population distribution of risk factors.
- ➢ Cost of diagnostics and therapeutics is high with long term costs being involved. Hence it is prudent to spend resources on preventive and primordial prevention avoiding or reducing modifying risk factors associated with CVD.

Coronary Artery Disease (CAD)

- ➢ Current estimates indicate that at least 50 million people are suffering from CAD in India.
- ➢ A population survey suggests a prevalence rate in India of 10.9% in Urban and 5.5 % in rural males between the age group of 35 to 64 years. The corresponding figures for females are 10.2 % and 6.4 % for urban and rural populations.

Hypertension

- ➢ Hypertension is a major cause of morbidity and mortality in India.
- ➢ The prevalence rate varies from 1.24 to 11.59 % in urban and 0.52 to 7 % in rural areas.
- ➢ Studies conducted by Diabetes Association of Karnataka in rural areas, involving age group of 20 to 85 years, gives a crude prevalence rate of 16.35 % and 18.12% for women and men respectively.

Rheumatic Heart Disease

- ➢ A reliable estimate regarding prevalence of Rheumatic Fever and Rheumatic Heart Disease in school children is 5.4/1000 and 6.4/1000 in urban and rural pupils respectively.

Interventions

- ✓ **Establishment of preventive cardiology centres with cardiovascular diseases made part of the public health package delivered through the health worker.**
- ✓ **Introduction of ECG facility at identified hospitals providing primary health care, and networking with Tertiary care centres through Telemedicine facilities**

Toilets, Underground Drainage System, Solid Waste Management

The problem

- ➢ It is estimated that nearly 50 million people suffer from and 5 million die from enteric related infections in developing countries.
- ➢ WHO (1994-95) estimates only 85 % of people in India have access to safe drinking water and 29 % have access to sanitary facilities
- ➢ A survey by the Bangalore Mahanagara Palike, indicates that there are 675 toilets and 1050 urinals in Bangalore

Intervention

- ✓ **Construction of toilets close to the slums**
- ✓ **Identification and rectification of critical areas of sewage and drinking water mix due to leaks in sewage pipes**
- ✓ Mapping of Sewage lines and water supply lines.
- ✓ Strengthen the Epidemic task force.

- ✓ Maintenance of toilets by generating funds through authorised advertisement hoardings on the toilets
- ✓ Establishment of scientific sewage treatment plants at strategic points
- ✓ Establishment of Mini sewage treatment plants for each extension and reuse of the water for afforestation
- ✓ Periodic repair and maintenance of drains
- ✓ Awareness generation amongst the citizens for waste segregation at source
- ✓ Establishment of transfer stations with segregation
- ✓ Monitoring through GIS mapping of Garbage trucks
- ✓ Transportation logistics through bulk carriers from transfer stations
- ✓ Establishment of sanitary land fills
- ✓ Recyclables to be segregated and reused
- ✓ Strict enforcement of Biomedical Waste Rules
- ✓ Strengthen the Swaccha Bangalore programme

Substance Abuse

The problem - Tobacco consumption

- ➢ There 25 diseases associated with tobacco use.
- ➢ The chronic disabling diseases reduce the life span by as much as 15 years in long term users and result in great suffering and economic loss.
- ➢ Production, availability and role models in the community, lead to perpetuation and reinforcement of the addiction.
- ➢ Every 8 seconds a person dies of tobacco related diseases in the world.
- ➢ With current smoking patterns, about 500 million people alive today world wide, will be killed by tobacco related diseases, and half of these are now children and teenagers.
- ➢ One million Indians die annually from tobacco related disorders.
- ➢ Smokers have a 70 % higher mortality than non-smokers.
- ➢ Tobacco consumption pattern in India is as follows: 50 % beedi, 30 % gutka, or chewed tobacco, and 20 % cigarettes.

Alcohol and Health

- ➢ Karnataka's production capacity of alcohol has increased by 150 % and per capita consumption by 114 %
- ➢ People are beginning to drink at an earlier age,(average age has dropped from 25 to 23 years), drink larger quantities, and develop health problems (Mean age dropped from 35 to 29 years)
- ➢ More than 50 % drinkers have problem drinking patterns and associated morbidity
- ➢ Only 1.4% to 2.3 % of persons were asked by health providers for history of alcohol use and none were advised against it
- ➢ The Karnataka Government's alcohol related health expenditure and alcohol related industrial losses are Rs 975 crores.

Interventions

- ✓ **Perpetrators of Drugs to be severely punished with capital punishment through stricter legislation, as is practised in Singapore**
- ✓ **Awareness through campaign in schools**
- ✓ Public campaign through attractive messages for propaganda
- ✓ Establishment of deaddiction and counselling centres
- ✓ Banning smoking in public places
- ✓ Banning advertisement and sponsorship from tobacco or liquor companies

Child Labour

- Estimates state 11 crore children are involved in labour in India.
- Karnataka has as estimated child work force of 10.5 lakhs.
- In Bangalore about 18000 children have been estimated to be involved in labour.
- Social issues concerned with child labour include sexual abuse, substance abuse, involvement in anti social activities and drug peddling.

Interventions

- ✓ **Stricter enforcement of Labour laws**
- ✓ **Ensuring the safety of these children through establishment of shelters**
- ✓ Organising literacy programmes, motivational programmes for improving the self worth
- ✓ Health care by providing identity cards for free care and sensitising the health care providers to the problem of this target group

HIV/AIDS

- Rate of sero positivity in sentinel surveillance at different antenatal clinics ranged from 0.5% -2 % (1999).
- Similar surveillance in STD clinics shows the sero positivity is 12% –22% (1999).
- In one of the leading Medical College Hospitals in the City, 18/3800 deliveries (0.5%) were identified as HIV positive in Maternity wards, wherein antiretroviral therapy was administered to 13 of these mothers and infants (1999).
- MS Ramaiah Medical College Hospital in the City reports 8 – 12 patients are HIV positive every month.
- According to official reports of Karnataka State AIDS prevention society, Bangalore Urban District, 18033 cases of HIV positive upto December 2001, and 1354 AIDS cases, with reported deaths being 143.

Interventions

- ✓ **Prevention of HIV infection in high risk populations**
  - **Targeted interventions**
  - **STI care and condom programming**
- ✓ **Prevention of HIV infection in low risk populations**
  - **IEC and social mobilisation**
  - **Blood safety and occupational exposure**
  - **Counselling and voluntary testing and counselling centres**
  - **Women and children as a target group**
  - **Youth as a target group**
- ✓ **Programme strengthening**
  - Surveillance
  - Training
  - Monitoring and evaluation
  - Technical resource groups
  - Operations research
  - Programme management

- ✓ **Capacity building for low cost community care**
    - Care and support
- ✓ **Intersectoral**
    - Workplace interventions
    - Inter-ministerial links

In the context of Bangalore, the following are the special groups that the mapping has identified:

- Female Sex workers
- Male Sex workers
- Men who have sex with men
- Street Children
- Trans sexual population
- Truckers
- Migrants
- Intravenous Drug Users
- Prison inmates

The targeted intervention

- Behaviour Change Communication
- Condom Programming
- STI Care and Management
- Peer Education
- Local Level Enabling Environment

Primary Health Care

- Provision of cost effective and easily available primary health care is the right of every citizen.
- This includes Reproductive Health Care, communicable and non communicable disease control.
- Special focus needs to be given on maternal and infant mortality. The weak link that is seen in any primary health care delivery is the weak referral linkage
- Adolescent health care should be given a special thrust.
- Access to health and related information is fast becoming the need of this group, to enable them to make informed responsible decisions and prepare them for responsible parenthood.
- India's adolescent population is 21.8 % of the population i.e. 207 million in number and married adolescent population is 20 /1000 population.
- 6% urban and 21 % rural women aged 15 to 19 years are married before the age of 15 years.
- Adolescent fertility is estimated at 17%.
- Unmarried adolescents constitute a sizeable population of the abortion seekers and their size cannot be estimated.
- STD/HIV and RTIs are problems that are common.
- Other issues include sexual abuse, prostitution, street children, violence, suicides, substance abuse and nutritional problems.

- It has been found that in six major cities of India 15 % of prostitutes are below 15 years and 24 % between 16 to 18 years of age.
- Another area that needs to be critically looked at is the Disabilities.
- It is estimated that there are 5 percent of persons with different disabilities in the developing world.
- Current estimates put the number of disabled persons in India at 4.5 crores.
- Childhood disabilities being more common , locomotor disabilities, communication disabilities , mental retardation, cerebral palsy and visual disabilities form the common disabled conditions .
- 3 percent of estimated 45 million people receive welfare measures of the Government in India.

Interventions in Primary Health Care

- ✓ Cost effective, accessible, and user friendly primary health care services
- ✓ Providing Safe Drinking Water as a primary measure for control of water borne disease
- ✓ Strengthening the existing Reproductive and Child Health Services
- ✓ Life style education at different levels in schools
- ✓ Retention in schools can delay the age at marriage and also empower women
- ✓ Empowering adolescents with information and services
- ✓ Making media responsible to promote values, not contrary to existing norms.
- ✓ Service providers be equipped or trained to handle adolescent development particularly with inter personal skills.
- ✓ Developing of clinical protocols
- ✓ Referral mapping and referral protocols need to be established
- ✓ Energising the Disabilities Act of 1995
- ✓ Creating an environment friendly to the disabled, through improving accessibility measures, vocational training linked with employment measures
- ✓ Sensitising the health care provider to the emotional and psychological needs of the disabled
- ✓ Family support systems need to be established
- ✓ Building a community link concept to increase demand generation through community volunteers

I have in my keynote address attempted to kindle thoughts on the major issues that with intervention can produce a tangible impact on urbanization and its attendant problems. Representatives from the various partners will be deliberating on the issues and possible solutions. In the context of developing a city plan for Bangalore it would be essential to keep the ongoing programmes, which are in place, in mind. This will enable the participants of this workshop to also make recommendations as to which agency can take up a specific component. Bangalore has a wide network of NGOs and Corporate sector who are already involved in various issues of governance. I would be very happy if the roles and responsibilities of the corporate sector in terms of ensuring transparency, accountability and resource mobilization can also be identified. All these aspects put together will help to develop a comprehensive city plan that will be a forerunner to formation of a microplan at implementation stages. I wish the deliberations of the workshop a great success.

BANGALORE MAHANAGARA PALIKE

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Main Identity

From: <civicblore@vsnl.com>
To: <civicvmrmr@vsnl.net>
Sent: Thursday, February 12, 2004 3:02 PM
Attach: Initial three sector dialoguediscussion note.doc; policy matrix.doc; India Urban Strategy June 24,2002.doc
Subject: Invitation for a discussion on Karnataka reforms at CIVIC on the 20thFeb at 10.00 a.m.

Dear Friend,

I invite you for a discussion on Karnataka urban reforms project and governance issues based on the note attached. In addition I am attaching two documents which I request you to download. I hope you can attend this discusion and I Look forward to your active particpation in the dialogue. Please contact us by phone or email for directions to our office, and if possible please confirm your participation by 17th Feb by email.

Vinay Baindur

12/2

pl. print attachment

12/2.

lib - Urban Health Resource, file

Dear Friend.

The state of Karnataka is a client of the World Bank and the ADB for a variety of projects which have been under implementation in Karnataka since 1999. The state has also combined these with a Reforms process both fiscal and administrative and an annual document has been prepared and issued by Govt to inform the officials and the civil society. These are known as the Medium term fiscal plan [*MTFP*] (2001-02, 02-03, 03-04---- url http://www.kar.nic.in/statebudget) and the Governance Strategy and Action Plan [*GSAP*] (2001-02, 02-03, 03-04 ***enclosed)***. In the FY 02-03 and 03-04 22 departmental MTFPs are now prepared annually which replaces the earlier Performance budgets and these are available for reference at CIVIC office. With the passing of a new legislation (Karnataka Local Fund Responsibility Act url http://education.vsnl.com/civic_bangalore/localfiscalresponsibility.html) it is now incumbent on local authorities to formulate their own MTFPs and peoples participation in budget preparation and finalisation has become mandatory.

To understand the nature of these reforms and initiate a three sector dialogue with Govt. civil society and World Bank as key actors CIVIC Bangalore, the DPAR GoK and the NGO Task force on Good Governance held a first workshop, in Oct 2002. The workshop had excellent presentations on the highways project (KSHIP) and primary education (DPEP) projects by researchers and on the health sector by CHC. The inaugural address was on "***Karnataka Reforms process: The way ahead***", by Dr A. Ravindra (then Chief Secretary), and fiscal reforms were presented by Secy FD (Bud and Resources) and Stephen Howse from World Bank.

In collaboration with other NGOs and consumer groups CIVIC is now initiating a dialogue on a series of urban sector projects for which the GoK has approached the WB for loans. The Karnataka Urban Sector Reform project (Bank Approval May16 2004), The Karnataka Urban Water and Sanitation Sector project (Bank Approval 20 Jan 2004), The Karnataka Health Systems project (Dec 2004) are under negotiation and finalisation. The last one has seen a greater involvement from civil society and NGO sector in the formulation of the project. In addition CIVIC proposes discussion on the WB Urban Sector strategy (enclosed) and Urbanisation and Urban Transport Policy would be important topics on the agenda. On governance reforms in an initial discussion last month some concerns were raised a copy of which I will forward to you shortly.

We now invite you to a discussion on some of these issues on 20th Feb 2004 from 10.00 to 12.30 p.m at the office

CIVIC Bangalore
14, IInd Floor,
4th main road,
Vasanthanagar,
Bangalore- 560 052
Phone: 2226 4552, 2238 6864

It will be a pleasure if you could come for the meeting and I hope you will participate and share your valuable suggestions.

Warmest regards

Vinay Baindur

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

Reform Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
I. FISCAL REFORMS & PUBLIC EXPENDITURE MANAGEMENT: *To strengthen the fiscal and financial aspects of government's operations*						
A. Fiscal Sustainability & Transparency **Objective** Fiscal adjustment to avoid a debt trap. Fiscal transparency to promote public debate and awareness.	Develop a Medium-Term Fiscal Plan (MTFP) to guide fiscal adjustment to achieve fiscal targets (zero revenue deficit and 3% consolidated fiscal deficit by 2005/06). Institutionalize the Medium-Term Fiscal Plan into the annual budgetary process Provide legislative backing to the MTFP through a Fiscal Responsibility Act. Move away from reliance on off-budget borrowing.	White Paper on State's Fiscal Position issued and medium-term fiscal targets announced. 2001/02 Medium-Term Fiscal Plan (MTFP) published and disseminated. Monthly monitoring of consolidated fiscal position introduced. In 2001/02, consolidated borrowing as per target (Rs 6786 crore vs. target of Rs 6670 crore)	Publication of 2002/03 and 2003/04 MTFPs Passage of Karnataka Fiscal Responsibility Bill in the State Legislature effective April 1, 2003. First half-yearly progress report as per FRA. Adherence to FRA deficit reduction targets Reduction in off-budget borrowing. In 2002/03, consolidated borrowing below target: Rs 6428 crore vs. Rs 6764 crore (5.4% of GSDP). For 2003/04, target of Rs 5, 610 crore (4.8% of GSDP)	2004/05 MTFP and half-yearly progress report. Adherence to FRA deficit reduction targets Further reduction in off-budget and consolidated borrowing as per MTFP State to obtain credit rating.	2005/06 MTFP and half-yearly progress report. Adherence to Fiscal Responsibility Legislation, incl. elimination of revenue deficit and fiscal deficit to 3% of GSDP. Further Reduction in consolidated borrowing and off-budget borrowing as per MTFP.	*Fiscal performance* Annual deficit reduction targets; monthly monitoring of fiscal position. *Cash/liability management* Number of days of overdraft with RBI (target of zero); *Off-budget borrowing:* reduced over time and eliminated in 2005/06. *Contingent liability management* Compliance with Karnataka Ceiling on Government Guarantees Cap; low devolution of guarantees to GoK.
	Adhere to contingent liability cap and better manage contingent liabilities.	Ceiling on Government Guarantees Act (1999) caps ceiling and makes guarantee fees made mandatory. Adherence to quantitative targets in the Guarantees Act.	Continued adherence to ceiling on guarantees in the Guarantees Act. Issuance of guidelines for sectoral allocations of guarantees.	Continued adherence to ceiling on guarantees, and amendment to Guarantees Act to remove KRIDNL exemption. Improved risk analysis for guarantees, and revised allocation guidelines. Development of strategy to reduce risk exposure to co-operative sector.	Continued adherence to ceiling on guarantees, and guidelines on their allocation. Implementation of strategy for reducing risk exposure to co-operative sector.	*Transparency:* Increased volume of fiscal data in the public domain.
	Make as much fiscal information as possible available to the public	Overview of Budget expanded to include information on off-budget borrowing, tax expenditures and tax arrears. Publication of monthly accounts on the internet commenced.	Introduction of Action Taken Report on last year's budget. Publication of additional material on monthly fiscal accounts on the web. Detailed six-monthly accounts released (CMIE publication.)	Additional fiscal information on the Web (e.g. arrears) Full budget on the Web. Reduced time-lag in tabling annual accounts.	As per 2004/05.	

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

Reform Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
B. Revenues **Objective** Policy and administrative reforms to raise additional revenue, improve efficiency, and reduce compliance costs, based on recommendations of Karnataka Tax Reforms Commission.	*Indirect taxes*: Replace sales tax, entry tax and turnover tax by Value-Added Tax based on self-assessment and a functional organization.	Sales tax concessions for new investments abolished and floor rates for sales tax introduced. VAT preparation initiated.	Rationalization of sales tax regime (reduction of entry tax, turnover tax); abolition of infrastructure cess. Administrative reforms to improve compliance and transparency.	Sales tax computerization complete. Functional organization pilot. Performance based rotation of check-point staff for transparency.	Introduction of VAT. Roll-out of functional reorganization. Computerization of sales tax check-posts.	Rationalized tax structures. Growth in tax revenue and tax/GSDP ratio. Reduction in tax arrears Positive feedback from taxpayers. Increases in user charges and higher collection efficiency.
	Other taxes: Overhaul stamps & registration (S&R), and motor vehicle tax to close loopholes, boost buoyancy, as well as to improve service to customers/tax-payers. Strengthen enforcement and cut rates in excise to reduce evasion.	Implementation of transport tax reforms (shift to ad valorem rates, rationalization of slabs, reduction of exemptions).	Stamp duty reduction from 13.5% to 9%. Abolition of stamps. Establishment of Central Valuation Committee. Formation of Beverage Corporation and reduction in excise rates to reduce evasions. Transport tax reforms to equalize public and private sector rates. Preparation of integrated checkposts (transport, excise, sales tax).	Pilot integrated computerized check-posts with simplification of business processes. Complete Stamps and Registration computerization.	Roll-out of integrated check-posts. Excise computerization.	
	Improve cost-recovery for "non-merit" government services, such as irrigation, transport, higher and technical education, hospital services, and water supply.	Automatic indexation of bus fares introduced. Bus charges increased by 30% since late 1999. Power tariffs increased by 34% since end-2000. Urban water charges for Bangalore increased by 45% in 2001. Irrigation charges doubled. Higher education charges increased by 20%, will increase 10% annually. Retained user charges introduced for hospitals and rural water supply. More systematic monitoring of non-tax revenues. Greater incentives to Departments to collect non-tax revenues.		Adoption of new non-tax revenue strategy.	Implementation of non-tax revenue strategy.	
				Regular revision of user charges, and improved collection.		
C. Composition of Public Spending **Objectives** Reorient spending towards identified priority sectors, control expenditure risk areas; reduce subsidies.	Control wage and pension bill while staffing-up in high-priority areas (education, health, police, forestry).	Recruitment control strategy established including high level control procedure.	Hiring restraint continues. Increased hiring of teachers and medical personnel, especially in rural areas. Continued control of wage bill. Pension forecasting study completed.	Undertake parametric and structural pension reforms.		Wage bill and civil service size. Spending in priority sectors. Power sector financing requirement (monthly monitoring). Spending on subsidies.
				Study of provident fund balances.	Implement recommendations of the study.	
	Reduce subsidies and better target social transfers.	Food subsidy capped at Rs 300 crore.	Reduction in food subsidy.	Surveys/databases of social welfare pensioners, scholarship holders and hostels to improve targeting.		

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

Reform Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
	Shift spending towards high-priority areas: (a) social sectors (school education and health) and basic infrastructure.	Compared to 1999/00 (base year), average spending in 2000/01-2002/03 for priority sectors has increased as follows: o social sectors(school education and health) up by 13% o basic maintenance (irrigation, roads, public buildings) up by 15% o basic capital spending (roads, rural water supply) up by 14%		Additional annual increases in the identified priority sectors.	Additional annual increases in the identified priority sectors.	
D. Public Expenditure Management and Financial Accountability **Objective** Improve spending efficiency, and improve financial performance measurement, reporting, and accountability.	*Improve spending efficiency*: Improve budgetary realism. Improve screening of schemes and capital projects prior to introduction. Improve control of capital projects during implementation. Prioritize payment of arrears, maintenance, and completion of ongoing projects over new investment projects.	Expenditure Review Committee established to review all schemes. Studies on budget estimation and forecasting (fiscal marksmanship) completed. New system of tax monitoring introduced.	Fiscal Responsibility Act introduced requiring fiscal impact of new policies, including supplementary budgets, to be offset by countervailing measures.	Introduce new revenue forecasting methods to improve the realism of budget estimates. Appendix E (civil works) computerization for better budget and implementation control Reduction in supplementary budgets based on provisions of Fiscal Responsibility Act.		Reduced disparities between budget, revised and actual estimates. Smaller volume of supplementary budgets. More timely financial statements Reduction in backlog of accounts and audits of local bodies and PSUs. More timely and complete responses to audit observations prepared and disclosed. Reduction in un-reconciled items, and in magnitude of Public Account deposits
	Reorient budget along departmental lines to give departments greater responsibility and flexibility in the budgeting process.	Departmental budgeting introduced through realignment of demands for grants with Departments (2003/04). Publication of departmental MTFPs (DMTFPs) for 5 Departments in 2002/03 pilot and 22 Departments in 2003/04 roll-out with multi-year budgets, and performance targets. Reduction in the number of schemes from 3,000 (2001/02) to 2, 500 (2003/04). Reduction in the number of object codes from 269 (2001/02) to 70 (2003/04). New budgetary release order replacing spending controls on individual items by controls on aggregate departmental spending (2003/04).		Simplify the budget by introducing departmental programs. Further reduction in the number of schemes and object codes. Continued production of DMTFPs and public reporting of performance against targets.	Reduction in supplementary budgets based on provisions of FRA. Continued production of DMTFPs and public reporting of performance against targets.	
	Computerize and integrate key accounting functions to improve efficiency, controls, and accounting capability. Use Treasury computerization (Khajane) as a platform for MIS, and as a single and central payment stream (e.g. LoC, salaries, PRI grants, employee accounts, pensions, etc).	Computerization of treasuries initiated.	Completion of computerization of Treasuries; Budgetary control introduced. Computerization of capital works control (Appendix E) initiated.	Introduce single payment stream for government transactions (by making LoC payments through Treasury). Complete ZP/TP accounting computerization (linked to treasury). Capital Works Control (Appendix E) computerized (in major capital works departments. Computerize pension payments (civil). Pilot computerized payment of salaries at Secretariat, followed by full payroll computerization. Computerization of DDOs.		

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

form Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
	Strengthen accounting. Develop accounting capability. Improve timeliness and disclosure of financial reporting. Eliminate major distortions (e.g. clean up public accounts) and ensure regular reconciliations. Incentivize compliance with basic accounting requirements.	Office of Controller (Accounts Management) established.	General ban on year-end use of PDAs involving GoK funds. Further measures to clean-up and reconcile items in the Public Account.	Improved timeliness of monthly accounting data. Continue clean up of the Public Accounts. Start reconciling various accounts at all levels. Incentivize compliance with accounting requirements by linking to fund transfers. Induction of professional accountants in KSAD.	Complete clean-up of the Public Account, and ensure regular reconciliation. Revise/ modernize KFC Code and other manuals. Strengthen IFAs role and capability.	
	Improve audit responsiveness.		Data-base created of audit responses, and effective measures taken to reduce the back-log.	Audit response database put on line; further measures to reduce response lag.	Audit responses up to date.	
	Local and para-statal bodies: improve financial accountability and modernize financial management.	Establishment of data base for accounts and audits.	Reduction in backlog of accounts and audits of para-statals (KGID, PSUs, other Boards and Authorities) and local governments.	Eliminate backlog and maintain timely accounts and audits of para-statals (KGID, PSUs, other Boards and Authorities) and local governments. Complete rollout of FBAS at BMP, and accounting computerization at other ULBs. Financial audit of 6 CCs by Chartered Accountants.		
			Karnataka Local Fund Authorities Fiscal Responsibility Bill 2003 passed by State Legislature to improve financial accountability and management of local governments and other authorities	Implementation of Local Fund Authorities Fiscal Responsibility Bill on pilot basis.	Roll out of pilot to other local bodies.	
DMINISTRATIVE REFORMS: *To improve service delivery, increase government efficiency, and reduce corruption*						
vernance gy	Articulate strategy for governance reforms.	First and final Administrative Reforms Commission reports published. 2001-02 Governance Strategy and Action Plan (GSAP) published.	2002-03 GSAP and 2003-04 GSAP published, with action-taken reports.	2004/05 GSAP	2005/06 GSAP.	Monitoring of action taken against proposals in successive GSAPs.

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

Reform Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
B. Service Delivery **Objective** Improved service delivery in services with large public interface	Improve services in a widening number of agencies through agency reforms using business reengineering, citizen charters, and user surveys.	Service delivery reforms in the following agencies: • Transport Regional Offices • BWSSB • BDA • Land records • Government hospitals	Service delivery reforms in the following agencies (in addition to ones already mentioned): • Stamps and Registration • Karnataka State Road Transport Corporation • BCC • PDS	Service delivery reforms in the following agencies (in addition to ones already mentioned): • Rural administrative (taluka) offices • Rural IT kiosks • Primary Health Centres, and other rural health services Increased publicity for charters. External monitoring of the performance of the reformed agencies, including user surveys.		Improved service delivery, as measured by user surveys and reduction in time to deliver services.
	Make service delivery more responsive by bringing government closer to the people through urban and rural decentralization.	Increase untied grant to rural GPs.	Increase untied grants to rural GP. Strengthen PRI Act by amendment. Launch training program for PRI elected representatives. Enforce RTI at local level, incl. through notice boards. Reform property tax regime for rural local governments.	Introduce greater progressivity and flexibility into PRI grants. PRIs increasingly responsible for beneficiary selection. Proper metering, billing and payment arrangements for rural water supply.		Better quality of and cost recovery for local services, e.g. drinking water supply and sanitation.
		Reform property tax in Bangalore	Roll out new tax system to nearly all Karnataka's cities and towns. Increase delegation to urban governments.	Computerize urban local governments services, starting with Bangalore City Council. Develop service benchmarks for urban governments.		
C. Government Efficiency **Objective** Rationalize functions, improve internal efficiency, make greater use of IT, increase transparency	Reduce and rationalize transfers of civil servants through (i) a monitoring system, and (ii) putting in place new institutional mechanisms.	2001/02 ban on general transfers. Monitoring system introduced and placed on the internet. Cadre management authorities established to regulate transfers. Policy of restricting transfers to no more than 5% of staff strength introduced. Transfers kept to 15,000 in 2001-02 (3% of staff strength).	Transfers kept to 35,000 in 2002/03 (5.6% of staff strength). Computerized counseling for transfers of teachers, the largest group of civil servants. Continued low volume of transfers.	Continued low volume of transfers Measures to lengthen tenure of senior (Class A, including IAS and KAS) officers.		Drastic reduction in number of transfers, starting in 2001/02. Increase in tenure for senior civil servants. Functional review implementation. Reduction in file pendency. Successful e-governance initiatives.

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

Reform Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
	Increase transparency in recruitment	Issuance of rules to reduce weight given to interviews vis-à-vis exams. Introduce common exam for candidate primary school teachers to reduce discretion associated with individual college tests.	Common exam for teachers extended to high-school teachers.			
	Improve government effectiveness via a series of functional reviews and implementation of their recommendations.	Completion of functional reviews for 13 major departments to guide the process of rationalizing government functions.	Initial implementation of functional review recommendations by 13 Departments. Comprehensive action plans drawn up for implementation of functional reviews by all 13 Departments.	Further implementation of functional review action plans and recommendations. Extension of functional reviews to new agencies.		Number of positions made redundant. Reduction in arrears of pending files. Number of e-governance projects functioning.
	Speed up Government administrative transactions/decision-making time.	Steps to speed up decision making and reduce the layers through which files move: "desk-officer system" and "single-file system" introduced.	Introduction of computerized file monitoring system for Secretariat. Introduction of level-jumping system.	Introduction of time limits for Departmental file clearances. Introduction of, and adherence to, quantitative targets for file pendency. Revision of Secretarial Manual of Office Procedures to reflect the new system.		
	Improve government efficiency by series of cross-departmental reviews.		Review of departmental rules to rationalize and simplify. Review and increase in delegation of financial and administrative powers across departments.	Develop and implement strategy for outsourcing across Departments.		
	Expand the use of e-governance throughout government.	E-governance initiatives underway in service agencies treasuries.	Secretariat LAN, computerized file-monitoring system, office attendance system, computerized treasuries introduced. Publication of E-governance Strategy Creation of position of Secretary, E-Governance.	Staffing up of e-governance cell. Introduction of paperless office (electronic files). Introduction of Karnataka Portal (?) Installation of Human Resource Database. Wide Area Network for the state, with e-mail ids provided to all heads of offices at State, district and taluka levels. Measures to improve office attendance.		
	Reduce the number of government departments and agencies	Creation of Water Resources Department via merger of major irrigation, minor irrigation and ground water.	Reduction in budgetary demands to 28 from 62 via Departmental grouping. Freeze on creation of quasi-governmental agencies, except in rare cases which are adequately justified, to prevent duplication and waste.	Review departmental divisions and merge departments wherever possible.		

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

Reform Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
D. Anti-corruption **Objective** Reduced corruption through increased freedom of information and more transparent procurement.	*Freedom of Information:* Provide legislative basis to right to information, and implement the same.	Right to Information (RTI) Act passed.	RTI Act made effective. Act publicized and information officers trained. Increased internet placement of Government Acts/Rules and GOs.	Cataloging, indexing, and computerizing of government records. Disclosure of information as per suo moto requirements of RTI Act.	Evaluate functioning and impact of RTI law to improve effectiveness. Public kiosks established at Secretariat for the public to obtain information on the status of their papers in Government departments.	Perception of reduced corruption, as measured by surveys. Increased public access to information. Wider availability of bid documents; use of standard bidding documents.
	Public procurement: Legislate to enforce transparency in procurement. Reform program to strengthen procurement transparency and efficiency.	Transparency in Tenders and Procurement Law passed. Establishment of procurement policy cell. Development of Procurement Reform Action Plan	Continued adherence to the Transparency Act. Rules to Transparency Act amendment to cover consultancy services, and other procurement types previously outside its scope. Launch of centralized web-site for procurement. Appointment of Deputy Secretary (Procurement). Increased use made of Internet for publishing of bid results and for e-procurement. E-procurement made mandatory for tenders above Rs 50 lakh. Greater use of third-party inspections for large contracts.	Adoption of standard bidding documents across government. Steps taken to make bidding documents more accessible. Elimination of PSU exemption from Transparency Act. Greater use of third-party inspections for smaller contracts. Overhaul of drug procurement and drug monitoring.	Review of the Karnataka Transparency in Procurement Act on basis of experience; implementation of survey to gauge effectiveness of procurement reforms, and adoption of revised strategy on this basis.	Survey planned in 2005/06.

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

m Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
IVATE SECTOR DEVELOPMENT: *To improve the business environment and reduce involvement of government in commercial activities*						
gulation *nalization* re d business ment; less rati: nce; more ivestment ner growth	Reforms to make it easier and quicker to start a new business in Karnataka, and to run a business.	Government approval of the Policy Paper on Business Deregulation. Amalgamation of 3 separate single-window agencies. Returns/registers companies are currently required to maintain/submit reduced from 24 to 4.	Strengthening of KUM to make it a more effective one-stop shop for business. Karnataka Industries Facilitation Bill (KIFB) passed by the State Legislature to enable fast-track clearances (through time-bound clearances and self-certification). Introduction of new inspection regime based on random sampling and transparent procedures. Passage of Industrial Township Authorities Act to enable industries to run their own estates. Passage of Special Economic Zone Act by State Legislature. Tenure of trade licenses etc increased (e.g. one year to five year).	Implementation of Karnataka Industries Facilitation Act: introduction of deemed clearances, use of combined application form, launch of new handbook for entrepreneurs; dissemination of new rules. Implementation of Industrial Township Authorities Acts in about 5 industrial estates. Development of special economic zones.	Conduct follow-up survey on industry deregulation. On the basis of feedback from business, further simplify business establishment procedures. Implementation of Industrial Township Authorities Acts in remaining industrial estates. Further development of special economic zones. Outsourcing of inspection functions.	Feedback from industry and farmers via surveys (e.g. on number of inspections, time to set up a business). Investment volumes in Karnataka.
	Agricultural liberalization	Amendment to APMC Act to enable creation of first non-government wholesale market in India. Amendment to APMC Act to replace multi-point by single-point cess collection.	Liberalization of sandalwood sector. Removal of select commodities from purview of APMC Act.	Development of new Agricultural Marketing Policy. Amendment to APMC Act to provide legal basis for contract farming. Consolidation of APMC markets.	Liberalization of silk sector. Privatization of silk farms. Introduction of computerized auctions and tendering at APMCs. Further deregulation of agricultural markets (e.g. entry by private markets).	
	Liberalization of other sectors.	Liberalization of the mining sectors. Revamping of BDA to bring more land on to the market.	Liberalization of public transport sector by allowing private operators to run short-haul urban and long-distance routes. Increased flexibility for conversion of agricultural to non-agricultural land.	Introduction of private sector management into water supply management on pilot basis.	Further utility and land deregulation.	

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

Reform Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
B. Restructure and Privatize Public Enterprises **Objective** Withdraw state from commercial activities to reduce administrative and fiscal burden of PSUs; increase efficiency of PSUs remaining with Government.	Establish and implement policy framework and durable institutional mechanism to support PSU closure/privatization/ restructuring.	Public Sector Restructuring Commission established. Policy paper on PSU Reform and Privatization and related procedures, with 17 PSUs identified at Phase I of program. High-Powered Committee established for implementation of new PSU policy. 4 PSUs closed by 2001/02 New VRS package offered Social Safety Net advisor appointed. Environmental screening completed for Phase I PSUs.	Department of Disinvestment created to accelerate PSU restructuring. 10 Phase I PSUs closed and privatization ongoing for 3. List of Phase II PSUs identified for closure/privatization. Asset valuations underway in closed PSUs through court liquidation. Counselling sessions organized for retrenched workers.	Phase I of PSU restructuring completed. 8 Phase II enterprises to be closed/privatized. Phase III of program for rationalization/ consolidation of remaining PSUs initiated.	Complete Phase II. Progress with Phase III.	Number of PSUs sold/closed/restructured
IV. POVERTY MONITORING AND STATISTICAL STRENGTHENING: *To make better use of data to inform policies and evaluate their poverty impact*						
A. Poverty and Human Development Monitoring System **Objective** A more pro poor development policy making made possible by good poverty-related data being made available on a timely basis	Establish Poverty and Human Development and Poverty Monitoring System (PHDMS). Institutionalize the 1999 Human Development Report with regular tracking of and reporting on poverty and social indicators. Undertake special studies on critical poverty-related issues.	Human Development Division constituted. Advisory Group appointed. Terms of reference of the proposed monitoring system and list of indicators finalized. Production of district level poverty estimates based on latest household survey. Introduction of quarterly economic bulletins for tracking district-level changes in agricultural wages and prices.	Poverty and Human Development Monitoring chapter included in 2002-03 and 2003-04 annual *Economic Survey*. Study of rural drinking water and primary education. Study on impact of drought	Annual monitoring chapter in *Economic Survey*, including assessing progress in reducing regional disparities and improving social indicators in backward regions. Studies on labor markets, gender, and inter-district outcome disparities. Introduction of annual monitoring of absenteeism at public facilities (e.g. schools, primary health centres, Fair Price Shops)	Annual monitoring chapter in *Economic Survey*. Carry out other special-purpose studies as needed. Publication of Karnataka State Development Report	Functioning of the PHDMS. Use of its results by policy makers. Poverty/human development target: to judge success of overall program (including health and education targets).
B. Program Evaluation **Objective** More and more	Make line departments responsible for commissioning independent evaluations of their programs (the "Independent Evaluation Initiative").	Order issued requiring all departments to commission regular program evaluations from external agencies. 10 pilot departments initiate	70 evaluations complete. Regular series of workshops at which evaluations and action-taken reports are presented.	Evaluation of effectiveness of this initiative. Continued roll out of evaluation initiative with focus on action taken as a result of the evaluations.		Number of evaluations undertaken. Quality and relevance of the

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

Reform Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
external evaluations of government programs completed and used to improve program design	Ensure that completed evaluations are used to improve program design	program evaluations. Training provided and guidelines issued. Evaluation Coordination Committee established to review actions taken in response to evaluation reports.	Publication of evaluations and action taken reports on Web. Further training provided.			evaluations. Use of the evaluations to improve program design.
C. Statistical Strengthening **Objective:** To develop statistical capacity of the state, expand dissemination, make estimates of state output and inflation more timely and accurate.	Improve state output estimation by improving data sources and processing, and by increasing the demand for output estimates.	Government Committee report on improving state output estimation.	Production of quarterly industrial production (IIP) series. Computerization of the process of production of 2001/02 quick estimates. Expansion of the annual Economic Survey to include GSDP figures and analysis. Launch of DES website. Training of DES staff in computers.	Publication of IIP data Further computerization. Gaps in GSDP estimation tackled through sub sector studies. Quarterly revision of GSDP estimates.		Timeliness of output and inflation estimates. Reduction in divergence between earlier and later estimates of output growth and inflation. More use and analysis of state output and inflation.
V. SECTORAL REFORMS: *To address sectoral issues critical for achieving Karnataka's strategic development goals.*						
A. Power Sector **Objective:** To reduce the fiscal burden of the power sector, and to improve power sector supply quality and access	Financial recovery	Adoption of Financial Restructuring Plan (FRP). First tariff increase (2002)	Second tariff increase (2003). Reduction in financial losses. Introduction of purchaser-provider model. Balance sheet restructuring to reduce debt overhang.	Reduction in power sector financial losses as per FRP, and in cross-subsidies		Financial losses of the sector. Customer satisfaction with power supply
	Restructuring and private participation.	Corporatization of KEB (establishment of KPTCL)	Unbundling of KPTCL into four distribution companies and one transmission company (June 2002). Publication of privatization strategy.	Privatization of one or more ESCOMs.	Completion of privatization. Develop policy to promote open access	
	Efficiency improvements.	Amendments to Electricity Act to increase the penalties for the theft of electricity (Anti Theft Law or ATL) Launch of universal metering campaign.	Drive to regularize illegal customers resulting in additional 800,000 customers. Provision of police to electricity company to enforce ATL	Improve collection efficiency to 96%. Vigorous enforcement of anti-theft Act.	Completion of universal metering. Maintain high level of collection efficiency and anti-theft activity.	

KARNATAKA ECONOMIC RESTRUCTURING PROGRAMME: 2000/01--2005/06 (September 2003)

Reform Area	Government Strategy	Reform Milestones to Date		Future Reform Milestones		Performance benchmarks
		2000/01 and 2001/02	2002/03 and 2003/04	2004/05	2005/06	
B. Education Sector **Objective:** To ensure quality education for all.	Developing a strategy for education reforms and improve capacity for policy formulation and planning.	Publication of Education Strategy (February 2002)	Creation of Policy and Planning Unit	Strengthening of Policy and Planning Unit by TA and partnership with Azim Premji Foundation.		Number of children enrolled. Number of children completing various levels of education.
	Improve access and enrollment.	Drive to improve enrollment. Launch of school meal program in backward north-east districts	No. of out-of-school children falls from 1 million in 02/01 to 0.4 million in 02/03. Hiring of additional teachers to fill vacancies. Extension of school meal program to the entire state	Program for universalizing elementary education especially in the north-eastern districts (funded through SSA).		Education budget, especially non-salary component.
	Improve quality	Common entrance test introduced for recruitment of teachers.	2003-04 declared as year for improving learning outcomes. Computerized counseling introduced for teacher transfers.	Pilot to decentralize decision-making and funds to the high-school level (high-school development plans). Strengthening of Block and Cluster Resource Centres (funded through SSA). Teacher management reforms to reduce absenteeism	Establishment of School Quality Assurance Organization.	
	Increase and rationalize expenditure on school education.	School education budget increased from Rs 2541 crore in 1999/00 to Rs 3026 crore in 2002/03 (r.e.): increase of 20%. By transfer of teachers' positions from the south to the north, savings of Rs 140 crore generated.		Further increases in school education budget as per MTFP, especially for non-salary component. Rationalization of education spending by transfer of teaching positions towards benchmark teacher/child ratio and rationalization of school size to reduce the number of small higher primary and high schools.		

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INDIA

Urban Sector Strategy

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Energy & Infrastructure Unit
South Asia Regional Office

Currency Equivalents

(as of May 26, 2002)
Currency Unit = Indian Rupee (Rs.)
US$1.00 = Rs.48.00

Abbreviations and Acronyms

ADB	Asian Development Bank
ALM	Advanced Locality Management
AP	Andhra Pradesh
APUSP	Andhra Pradesh Urban Services Project
BOT	Build Operate Transfer
CAA	Constitution Amendment Act
CAS	Country Assistance Strategy
CAE	Country Assistance Evaluation
CBFI	Community Based Financing Institution
CDF	Comprehensive Development Framework
CDFI	Community Development Finance Institution
CDS	City Development Strategy
CIGF	Community Infrastructure Guarantee Facility
CIP	Capital Investment Plans
CSF	Community Support Fund
DFID	Department for International Development
EFC	Eleventh Finance Commission
ESW	Economic Sector Work
FI	Financial Institution
FIRE	Financial Institutions Reform and Expansion Project
GDP	Gross Domestic Product
GIS	Geographic Information System
GOAP	Government of Andhra Pradesh
GOI	Government of India
GOTN	Government of Tamil Nadu
HDFC	Housing Development Finance Corporation Ltd.
HUDCO	Housing and Urban Development Corporation
IBRD	International Bank for Reconstruction and Development
ICIP	India Community Infrastructure Project
IDA	International Development Association
IDFC	Infrastructure Development Finance Company
IFC	International Finance Corporation
IL&FS	Infrastructure Leasing & Financial Services Ltd.
INHAF	India Habitat Forum
JBIC	Japan Bank for International Cooperation
LIL	Learning and Innovation Loan
M&E	Monitoring and Evaluation
MCH	Municipal Corporation of Hyderabad
MDF	Municipal Development Fund
MEIP	Metropolitan Environment Improvement Program
MIGA	Multilateral Investment Guarantee Agency
MPC	Metropolitan Planning Committee
NABARD	National Bank for Agriculture and Rural Development

NGO	Non-Governmental Organization
ODA	Overseas Development Agency (UK)
OECF	Overseas Economic Cooperation Fund (Japan)
OED	Operations Evaluation Department
PHED	Public Health Engineering Department
PPIAF	Public-Private Infrastructure Advisory Facility
PSP	Private Sector Participation
RMK	Rashtriya Mahila Kosh
SAFIR	South Asia Forum for Infrastructure Regulation
SEBI	Securities and Exchange Board of India
SFC	State Finance Commissions
SFI	Specialized Financial Intermediary
SIDBI	Small Industries Development Bank of India
SWM	Solid Waste Management
TA	Technical Assistance
TNUDF	Tamil Nadu Urban Development Fund
UK	United Kingdom
ULB	Urban Local Body
UMP	Urban Management Program
UNICEF	United Nations International Children's Emergency Fund
UNEP	United Nations Environment Programme
UNCHS	United Nations Centre for Human Settlements
UNDP	United Nations Development Programme
UP	Uttar Pradesh
UPRS	Urban Poverty Reduction Strategies
USAID	United States Agency for International Development
UWSS	Urban Water Supply and Sanitation
WBI	World Bank Institute

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INDIA
URBAN SECTOR STRATEGY

I. Objectives of the Urban Sector Strategy

1. The World Bank's Country Assistance Strategy for India proposes to enhance the Bank's support to the urban sector because it is critical to India's overall economic development and particularly its poverty reduction program. This strategy note, and the dialogue held with GOI and stakeholders during its preparation, provides a framework for building a program of urban operations and advisory services during FY02-04. It updates the draft urban operational strategy prepared in 1997.

2. The updated urban sector strategy aims to contribute to India's poverty reduction program by supporting the role of cities in economic development and seeks to improve the living standards of poor urban dwellers. Intermediary objectives are to:

- support the decentralization process initiated under the 74th constitutional amendment;
- strengthen urban governance and management, to make the delivery of urban services more efficient, sustainable, and responsive to users including the poor; and
- improve resource mobilization and financing systems to help address investment backlogs.

II. Sector Background

3. Over the past decade, the context of urban development has changed in India. The country's focus on economic liberalization, financial sector reform and a new emphasis on decentralization will affect urban growth, the economic role of cities, and the service needs of urban dwellers. Until very recently urban infrastructure was not considered a "core" economic issue. National policy discussions focused more on rural development and rural poverty than on the problems of cities. This relative lack of policy attention, combined with flawed incentives and insufficient revenues of most urban service entities explains the dismal performance of the sector. It has led to low quality, reliability and coverage of services, inadequate maintenance and ineffective operation of the existing infrastructure, a mounting backlog of investment requirements and unresponsive treatment of users, especially poor and vulnerable groups.

4. *Urban Growth.* India is still predominantly rural, but its urban population of 290 million (estimate as the 2001 census of India figures of urban population are not available) exceeds the total population of most countries in the world. A third of India's population resides in large cities with more than a million people. The number of such cities is estimated to increase from 23 in 1991 to about 40 by 2001. In 1991, over 65 percent of the population was in the 277 "Class I" towns with a population of more than 0.1 million. Their number is expected to increase to over 425 by 2001.[1] Urban growth is characterized by both rural to urban and a large proportion of urban to urban migration. During the eighties, the rate of urbanization in India declined.[2]

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[1] National Institute of Urban Affairs (1998), *Urban Sector Reforms in India: Issues and Suggestions*, Report prepared for the Asian Development Bank, New Delhi, p.1

[2] As Rakesh Mohan (1996) in his paper on 'Urbanization in India' argues, this is a disturbing signal as it may suggest that industrialization and urban infrastructure have failed to support urban growth. This is also evident from the fact that despite the fall in share of agriculture in total GDP the share of urban centers, where a large proportion of non-agricultural employment is likely to be located, in the total population has not increased significantly.

Despite the deceleration, many analysts have pointed out that the impact of economic liberalization would have led to a renewed growth of urban centers with a greater impact on larger cities.[3]

5. Another feature of urbanization has been a large number of urban agglomerations that include a number of separate municipal entities. Most of the urban centers with more than a million people are 'multi-cities' that include many rural centers on the outskirts. They have complex, ineffective service delivery arrangements and present considerable challenges for intra-urban transport. This pattern could be replicated as urban development is widespread in India and a possible 40 percent of the 500 districts could become predominantly urban by 2001. Even in predominantly urban districts, however the nature of urbanization across India is varied. It is more agriculture led in states such as Punjab to more industry-services led in western states such as Gujarat and Maharashtra.

6. *Contributions to Economic Growth.* Recent studies indicate that the share of GDP emanating from urban centers grew from an estimated 50 percent during the early nineties to over 60 percent by the turn of the century.[4] More than 90 percent of all government revenues come from the cities.[5] India's cities would contribute even more to the country's economic growth and in reducing poverty if they did not suffer from severe infrastructure bottlenecks, service deficiencies, poor local governance and distortions in land and factor markets.

7. *Status of Urban Services.* The information available on the coverage and quality of urban services is limited and its reliability is poor. Available data suggest that there have been improvements in access to water services. However "access" tends to be defined as being connected to a pipe network, regardless of how often water actually flows through it or how safe that water is. Sanitation continues to be inadequate and health statistics show waterborne diarrhea as one of the main causes of morbidity and child mortality in India. The performance of urban transport systems has clearly deteriorated with the rapid growth of the vehicle fleet.

8. *Rising Service Demand and Shortfalls in Investments.* The demand for quality urban services is increasing rapidly with the growth in urban population, incomes and competitive businesses that can be sustained only in an "efficient city" environment with reliable infrastructure and logistics. Even assuming efficient operation and maintenance, investment in the sector falls far short of the amounts needed to cope with this demand. Low investment levels can largely be explained by service charges and local taxes that are set too low coupled with poor collection. Financing has been largely through budgetary allocations and a limited access to government controlled institutional finance. Urban areas would need to make large investments to clear the huge backlog in expanding the provision of services while improving their quality. Different estimates suggest that the quantum of required investment could be 3 to 10 times the likely resource availability through traditional sources. Analysis in the India Infrastructure Report suggests that this level of investment is sustainable from a macro economic perspective [6] though cities would need to tap market-based funds to achieve it. This has already started but wider coverage will require sharp improvement in the creditworthiness of cities and in their

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[3] For example, Dinesh Mehta (1997) in his paper on 'Urban Governance in India – Vision 2021', suggests that by 2021 there will be over 70 cities with more than a million people. It will be possible to assess these differing analyses of trends of urbanization only after the 2001 Population Census data are available.

[4] Based on National Institute of Urban Affairs (1997) "Urbanization in India: Patterns and Perspectives", as quoted in Asian Development Bank "India: Urban Sector Strategy", 1996, p.3.

[5] Based on World Bank (1997) "India: Urban Infrastructure Services Review", as quoted in Asian Development Bank "India: Urban Sector Strategy", 1996, p.3.

[6] Expert Group on Commercialization of Infrastructure Projects (1997). "The India Infrastructure Report", Ministry of Finance, Government of India

capacity to manage their expenditures efficiently. New possibilities of private sector investments in the urban sector have also emerged and will require improved capacities to structure viable transactions together with a more predictable regulatory environment.[7]

9. *Trends in Urban Poverty.* Over the past decade, with an increased share of GDP emanating from urban areas, there was a decline in urban poverty from 38.2 percent in 1987-88 to 32.4 percent in 1993-94. During the same period, rural poverty declined only marginally from 39.1 to 37.3 percent.[8] However, urban poverty in India is less well understood compared to rural poverty. Constraints on formal sector employment have probably affected overall poverty reduction adversely.[9] Besides income related poverty estimates, other man-income dimensions of poverty as reflected in living conditions, poor performance on social indicators, and a lack of opportunity for the disadvantaged are also important[10]. These worsen vulnerability to disease and the impact of labor market fluctuations, domestic violence and natural disasters, such as flood, cyclone or earthquakes. They also result in an increased sense of insecurity.

10. Efforts at poverty reduction are affected by inadequate urban services and worsening urban environmental conditions. The poor are much worse off in terms of access to a range of urban services including housing, access to water, sanitation and transport. They lack security of tenure and the quality of their living environment is poor. Their lack of spatial mobility also affects their participation in the labor market. The participation of the poor in urban governance is minimal because institutions are unresponsive and the poor lack organization. In this regard, special anti-poverty programs in urban areas have been very few. While in recent years programs have improved targeting and their integration with improved local governance, their financial sustainability and greater community control over them remain important concerns.

11. *Emerging Opportunities.* Despite the poor performance of urban services in India, new opportunities have emerged for the sector in the last few years. India's focus on decentralization under the 74th Constitutional Amendment Act together with an emerging emphasis on improved urban governance and management provide the setting for the new strategy in the sector. Other factors include innovations in private sector and community participation in service delivery and new opportunities to mobilize investment resources from the financial markets. These changes coincide with a growing interest of the Government of India and some of the state governments in addressing urban poverty.

III. Review of International Assistance

12. While international assistance supports only a small proportion of investments in the sector in India, it provides an opportunity for innovation and access to successful experiences in other

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[7] For example, see World Bank (1999), 'Country Framework Report for Infrastructure', and DFID (1999), 'Review of Public-Private-Partnerships in Water and Environmental Services for India', mimeo.

[8] Official information is based on consumption information of the National Sample Surveys (NSS) and poverty estimates generated by the Planning Commission using the head-count index based on food-energy method. The poverty line is based on a total household expenditure estimated as sufficient to provide 2100 calories in urban areas and some basic non-food items. (World Bank, 2000, 'India: Policies to Reduce Poverty and Accelerate Development', p.2)

[9] For example, World Bank (2000, op. cit.) argues that "Growth in the urbanized part of the economy was less significant in reducing poverty across states, reflecting the capital intensive, import substituting nature of India's industrial development, its requirements for skilled rather than unskilled labor, and labor market regulations that limited the growth of formal sector employment. These factors limited the impact of urban growth on labor demand and kept the proportion of urban population relatively small, so that its proportionate impact was low." This outlook, however, does not match with the high population growth projections envisaged by many urban analysts during the nineties.

[10] There is very little systematic information and analysis on these aspects available for urban areas.

countries. A number of external support agencies are active in the urban sector, including the Asian Development Bank, UK Department for International Development (DFID), United States Agency for International Development (USAID), the Japan Bank for International Cooperation (JBIC) and the World Bank Group.

13. *The World Bank's Past Assistance.*[11] Bank operations in the urban sector in India started twenty-five years ago. Since then, it has financed thirty projects with total commitments of over US $ 3 billion. In the seventies and eighties, Bank projects focused on 'increasing the public supply of land, shelter and services, and financing packages consisting of sites and services, slum upgrading, water supply and sanitation, and transportation of the poorer groups'. Water supply and sanitation projects 'sought to not only improve the level of urban services and shelter, but to also address the problems of efficiency and effectiveness of resource mobilization, resource utilization and strengthening of institutional frameworks'. During the nineties with growing concern on the quality and sustainability of early projects the Bank's urban sector lending declined.

14. In March-April, 2000 a review of the Bank's assistance in the urban sector was carried out as an input to a Country Assistance Evaluation (CAE) review. It found the performance of most urban and urban water and sanitation projects was less than satisfactory and the project benefits and assets financed lacked long-term sustainability. The study explained this assessment as a result of the complex nature of projects in relation to local client capacities, lack of ownership of reforms needed to make the projects sustainable and chronic difficulties with land acquisition, procurement and corruption. However, the same review pointed to important changes in the Indian urban context and emphasized that the Bank's decreased involvement in the urban sector in India had led to missed opportunities.

15. *International Finance Corporation (IFC).* IFC's strategy for India gives priority to private infrastructure investments, including power and water distribution, telecom and transport facilities. It has supported private investment in urban infrastructure through its investments in IL&FS, which provides long-term financing for private infrastructure investments, and in Sundaram Home, which provides housing finance.

16. IFC is considering investments in Indian companies that will sponsor infrastructure projects. That will depend on the presence of a suitable regulatory framework, transparent processes for selecting project sponsors, a business environment in which investors can take reasonable risks and the availability of a high proportion of long-term local currency financing for projects that have domestic currency revenues. IFC is working with IBRD/IDA to help states improve their regulatory environments. It supports the development of financial markets that will help improve the availability of long-term finance for private infrastructure projects and housing finance. It offers partial credit guarantees to mobilize local currency financing from Indian financial institutions. In addition, IFC has recently entered into swap agreements with Indian counterparts to enable it to offer local currency financing for infrastructure projects.

17. *Other International Assistance.* Most international agencies besides UK-DFID (formerly ODA) and UNICEF have entered the urban scene in India relatively recently. Both DFID and UNICEF have focused mainly on activities aimed at the direct reduction of poverty. DFID's recent projects, especially in Andhra Pradesh, seek to improve sustainability and replicability by integrating poverty reduction efforts with a more comprehensive view of urban governance.

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[11] This section is based largely on Mathur O.P. (2000) 'India: Urban Sector Assistance Review', a study done through support from OED, World Bank, to be used as an input into the County Assistance Evaluation.

18. The focus of external financial assistance has mainly been on urban water supply and sanitation (UWSS) and housing. OECF (now JBIC) has been particularly active in this area. USAID has sought to develop municipal credit and capacity building of local authorities. Over the last five years, the Asian Development Bank (ADB) has developed its urban lending operations by supporting statewide urban development projects and credit lines for housing and urban infrastructure through domestic financial intermediaries.

19. *Lessons Learned.* The experience of earlier operations supported by the Bank and other development partners shows that sustainable development of India's cities will require changes in policies that discourage mobilization of local resources (for instance in certain cases if more local revenues are collected allocations from centrally funded schemes fall). It will also require substantial improvements in the capacity and accountability of local authorities and service providers so that they fulfill their expanding role in the decentralization process. Even experience with poverty-targeted projects, such as on-site slum improvements, show that they cannot be expanded unless they are part of a wider city-level attempt at reform with an emphasis on urban management and revenue improvements. Conversely, city-level reforms cannot be sustained without the involvement of a range of stakeholders, including community based organizations and NGOs. This has been difficult to achieve in practice at any significant scale though several pilot projects have shown potential. An important lesson emerging from these experiences is that elected representatives need to be involved from the outset.

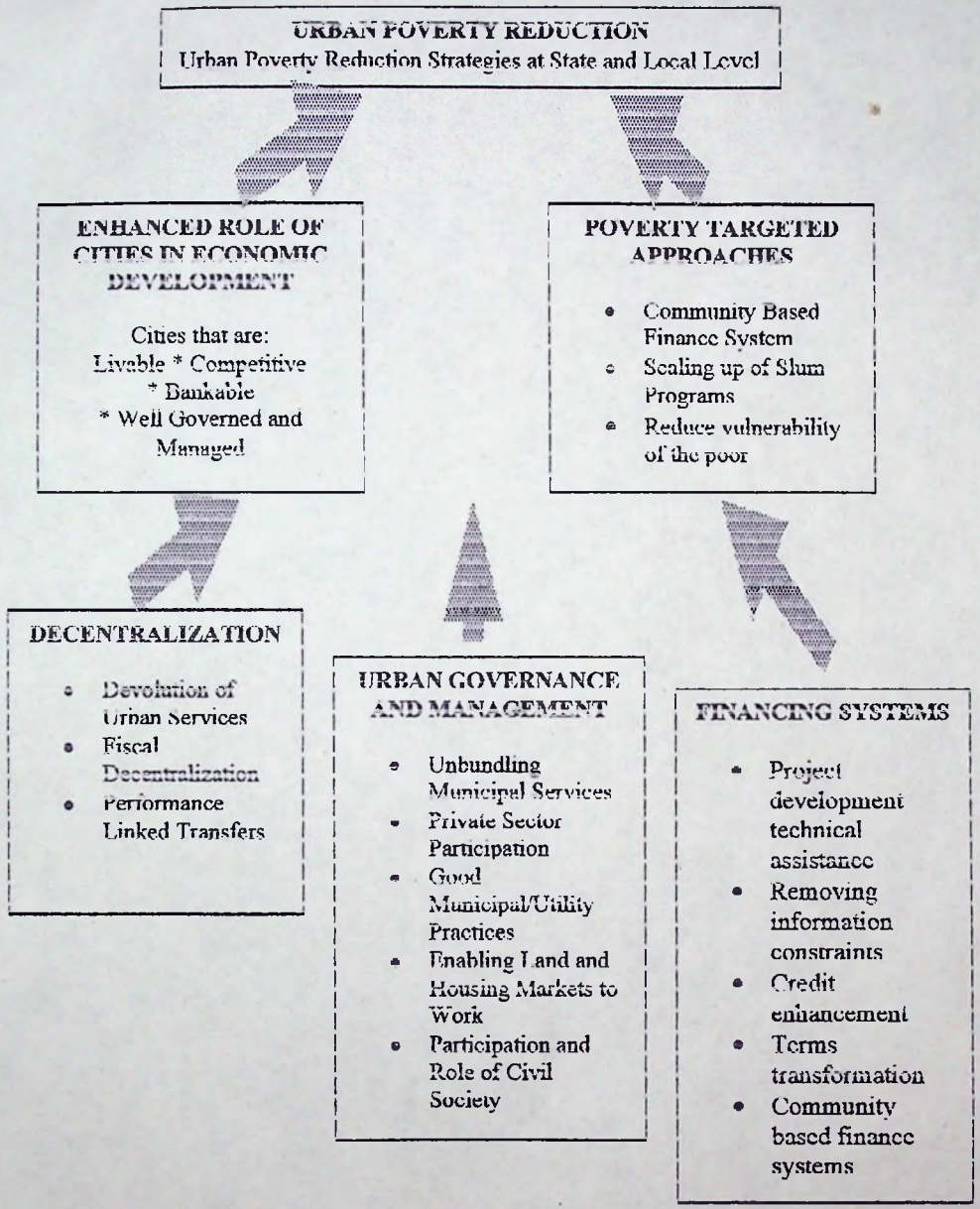
20. State level integrated projects have focused on promoting better urban management and supporting investments in a large number of towns. Experience suggests such investment should be driven by demand and participating towns should "self-select" based on criteria that combine their performance record with commitment to further reforms. Within these projects, an explicit focus on poverty reduction needs to be combined with measures related to improve urban management and city level infrastructure.

21. Third, it has become quite evident that external aid flows and even the much larger flows of transfers that GOI and states channel to local governments cannot meet the huge need to expand service coverage and meet the investment backlog of India's cities. These flows and the reforms they support have to be designed to help cities and service providers mobilize local resources effectively. They must improve access to commercial sources of finance, such as lending by domestic banks, the capital markets and private equity for revenue-earning projects. It was this recognition that lead to a generation of financial intermediary loans funded or advised in particular by the ADB, USAID and the World Bank in partnership with domestic financial institutions. The loans were meant to create a flow of funds with longer tenors, encourage self-selection by local borrowers who were interested in building a credit record and able to borrow at market terms, and improve the urban sector's recognition and credibility among the financial sector community. Early experience with urban credit lines in India suggests that the bottleneck for sector development is a dearth of bankable projects and local entities, even more than the lack of long-dated domestic debt resources.

IV. Focus Areas

22. The overarching goal of the proposed urban strategy is to reduce poverty. This requires a two-pronged approach, combining indirect measures aimed at overall economic development and opportunity through better performing cities, and direct approaches to reduce poverty by improving access to services, contributing to empowerment of the poor and reducing their vulnerability. In turn, these two broad goals can be supported by three focus areas, as shown in Figure 1: support the decentralization process, strengthen urban governance and management, and improve resource mobilization and creditworthiness to help boost the pace of investment in the sector.

Figure 1: Focus Areas for Urban Poverty Reduction



23. *Enhanced Role of Cities in Economic Development.* With economic liberalization and a more open economy, states must compete to attract investments. As a result, it is vital that if cities are to achieve broad based growth of employment, incomes and investment they must possess an enabling framework that permits firms and individuals to become more productive. In competitive cities, output, investment, employment and trade will respond to market opportunities

dynamically. To be competitive, cities need to be supported through appropriate forms of decentralization, improved governance, management and sustainable access to finance for urban infrastructure. Measures in these three strategic focus areas are discussed later. These will help promote higher economic growth in cities together with more job opportunities. The link between economic development and poverty reduction will require a better understanding of the nature of urban economic growth and its likely impact on urban poverty.[12]

24. *Poverty Targeted Approaches.* Along with these indirect measures aimed at poverty reduction across the board through economic development, it will be necessary to target poverty directly to help vulnerable groups participate in the urban economy. First, would be required measures directed at empowerment and inclusiveness. These include more inclusive governance: the development of and strengthening of community based organizations of the poor; enhancing concerns about poverty in government programs and in the design of public-private partnerships; improved planning rules and regulations to incorporate the needs of the poor in housing, land development and delivery of services; and scaling up slum up gradation programs. Second, security for the poor would need to be enhanced through sustainable access to credit and insurance; greater attention to environmental risks that affect the poor disproportionately; and measures to reduce asset poverty especially improvements in the security of land tenure for the poor[13].

25. A critical issue in increasing the effectiveness of direct measures against poverty is appropriate targeting of the urban poor. The practice of using residence in 'slum settlements' as evidence of poverty needs to be reviewed especially as many upgraded slums should now be de-notified. This requires urban local authorities to re-define slum settlements and to develop a good data base on low-income settlements. The experience of urban poverty alleviation programs in Kerala, which utilized more participatory methods involving a number of economic and non-economic criteria, needs to be assessed for its possible relevance.

26. *Urban Poverty Reduction Strategies (UPRS).* At the state and the city levels, urban poverty reduction strategies will be developed to frame urban sector projects and city development strategies. The UPRS will be developed through a consultative process incorporating a diagnostic of urban poverty, an analysis of existing poverty reduction programs, and a review of relevant national and international experience. Poverty reduction requires attention to the broader context of economic development. At the same time attention within the sector should concentrate on ensuring that urban institutions and programs become increasingly pro-poor and that necessary social institutions are supported and strengthened to empower the urban poor. This applies to the local governments and their service organizations, as well as new private service delivery mechanisms.

A. Supporting the Decentralization Process

27. The 74th Constitutional Amendment Act has provided the political, administrative and fiscal basis for decentralization in India. It has given a constitutional status for the third tier of government, and in principle sought functional and fiscal devolution to local governments. In practice, the devolution of administrative powers related to planning, financing and managing municipal functions and services remains partial. Experience across states has been mixed in this respect and needs to be assessed.

28. *Devolution of Urban Services.* In the years following independence, there was erosion in the powers and functional responsibilities of local authorities. State-level and federal agencies

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12 See for example the argument presented in footnote 9 above.

13 Tenure issues are complex and will often require strong local political support, besides good information base.

and programs helped advance development though they often took responsibilities away from local authorities. This has led to fragmented responsibilities for urban management. The strategy envisages, in line with the spirit of the 74th Constitutional Amendment Act, to help interested states reinforce the accountability of agencies involved in local development to elected local representatives. This would require governance reforms and possibly restructuring of agencies such as the state water and sewerage boards and land development authorities, as well as a comprehensive review of the municipal legislation in most states.[14] Devolution to the municipal tier of government should not imply a bureaucratic "municipalization" in which the elected corporation gets involved with the operation of services performed by local civil servants. At the municipal level, a clear separation between the policy and regulatory functions of the municipal body and the responsibility of service providers will need to be evolved.[15] Urban reforms will also need to address how service providers can be kept accountable while preserving their managerial autonomy and reducing political interference in day-to-day operations, staffing and the setting of service tariffs.

29. The devolution of urban services would have to structured within a larger process of decentralization reforms and will include the transfer of functions and staff to appropriate levels of government [16]. Some functions, such as regulation of service monopolies, could be performed more effectively at the state level, while agencies at the central level would be best placed to support comparative (yardstick) competition by collecting and publishing performance benchmarks across cities and states. State governments need to provide leadership to encourage metropolitan development and strengthen Metropolitan Planning Committees (MPCs).[17] During the devolution process, state governments will have to help municipalities and elected representatives develop the capability to discharge their expanded role. It will also have to define and monitor rules and processes that foster transparency and accountability in urban management.

30. *Fiscal Decentralization.* Most states have set up State Finance Commissions (SFCs) by now though their performance has been uneven and their reports show inadequate rigor. Many state governments have given inadequate importance to this important aspect. Issues that require close attention relate to revenue and expenditure (functional) assignment, design and implementation of incentive based intergovernmental transfers and evolving a framework of sub-national borrowing. The link between the allocation of functional responsibilities to local authorities and financial powers they exercise still lacks definition. This lack of clarity needs to be addressed to create a hard budget constraint for local governments. For local governments to plan their financial commitments in a multi-year view and become creditworthy there is also the need to create sufficient predictability in transfer rules. SFCs in the first round of decentralization reforms have decided not to assign any new revenue bases to local authorities though some rationalization of existing taxes was attempted. More importantly, despite lip service to the need for improved local revenue performance in most SFC reports not much attention has been paid to this in practice. As a second round of SFCs are now being set up in most states it is an opportune time to ensure a better match between functional and financial assignments and a to design a more predictable system for inter governmental transfers and a framework of rules for municipal

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14 Only the state government of Tamilnadu has undertaken such an overall review and reform of its municipal legislation. The state government of Punjab has also reviewed the legislation but has not adopted it.

15 Also, refer to paragraphs 32 and 33 for further discussion on this.

16 Some of the states in the country that have set an ambitious decentralization agenda including such reforms are Karnataka, Kerala and Maharashtra. It is likely, however, that these reforms have focused more in rural institutions. An assessment of their experiences, especially with respect to urban sector needs to be made.

17 This is essential as in the coming decade a large proportion of urban population is expected to reside in urban agglomerations with a population of a million plus. Mumbai has taken lead by appointing several independent members in its MPC drawn from NGOs, business and finance sectors.

borrowing. In the case of both transfers and borrowings, it would be important to design incentives for improved performance at the local level. Box1 below illustrates some of the early fiscal decentralization experiences in India.

Box 1: Fiscal Decentralization – Early Experiences in India

The 74th Constitution Amendment Act (CAA) vests responsibility for fiscal aspects of decentralization with the state legislatures, guided by recommendations of State Finance Commissions (SFCs). The first SFCs were appointed in 1994. The recommendations of most SFCs have been accepted by state legislatures though they have not always been implemented. The experience in fiscal decentralization so far suggests:

- *Expenditure responsibilities*: The Twelfth Schedule of the CAA suggests functions for devolution to urban local bodies (ULBs), though these powers are with State governments to be assigned through municipal legislation. The actual assignment of functions has varied in different states and has depended also on past institutional legacies. State agencies continue to play an important role for civic functions such as land development and water. Therefore, changes in responsibilities for expenditure will require significant institutional reform. Even in a state like Kerala, where administrative decentralization has been attempted, management of water remains with a state level authority.
- *Revenue assignment*: Most first SFCs recommended continuation with same taxes and no new taxes were assigned to ULBs. As a result, the ULB's lack an appropriate match between expenditure and revenue assignments and they are also constrained by inadequate information. Recommendations of several SFCs to improve the revenue collection, accounting and financial management of ULBs have not been addressed adequately in most cases.
- *Design of transfer system*: Recommendations regarding the extent and system of transfer to be made by the SFCs have varied from transfers from a general pool as in Karnataka and Tamilnadu, to transfers linked to specific taxes in Kerala. Share of ULBs in total local transfers has been around 15 percent as in Kerala, Karnataka and AP, with exceptions such as UP (70 percent). Tamilnadu introduced performance-linked transfers, though the share of ULBs has been lower at 8 percent and the planned increase to 15 percent has not taken place. Design of transfer systems has also been constrained by a lack of adequate information.
- *Sub-national borrowing*: In the past, most urban infrastructure was financed through budgetary allocations, leading to considerable inefficiency and little regard for financial viability. This was aggravated by debt write off by some of the SFCs as in UP. The increasing potential of commercial borrowing for urban infrastructure, directly through the market or commercial financial intermediaries, requires a rule based state framework that would apply to all municipal authorities who want to borrow on commercial terms to ensure financially viability and minimize the risk of defaults. With considerable market interest in the sector, it is necessary to ensure that ULBs do not 'shop around' for a lender with weaker conditionality.

The national Eleventh Finance Commission (EFC) has placed emphasis on improving finances of local authorities. In most states, the second SFCs are also now in place. Their mandate includes addressing these issues. Special focus, as also highlighted by recommendations of the Eleventh Finance Commission, is required on improving resource base of ULBs, wider use of user charges, strengthened accounting and auditing systems, design of transfer system and a framework for local borrowing. While suggesting transfer designs, second SFCs will need to address issues of autonomy, equity, predictability and simplicity, while ensuring local incentives for improved performance.

B. Improved Urban Governance and Management

31. Good urban governance is the key to providing incentives for improvements in urban service delivery. It focuses on inclusive planning and management, accountability and transparency, and

ensuring security for citizens, especially the urban poor and disadvantaged. A number of different areas vital for good governance are identified below. Their introduction and linked institutional transformation necessitates continued service of professional urban managers. This requires attention at the state and, at times, national level as it may entail changes in recruitment rules and policies. Therefore, it will need to be integrated with macro reforms.

32. *Unbundling Municipal Services.* Evolving appropriate institutional arrangements through suitable unbundling of municipal services is the key starting point for any wider reform process to achieve accountability. Existing arrangements do not distinguish adequately between politically mandated service standards and the need to define the necessity for autonomy and accountability for optimum operational performance. In the case of urban water management, institutional reforms are necessary to permit separation of commercial operations and day-to-day management from inappropriate political interference. While a political mandate will be important in determining the service levels and coverage, responsibility for efficient operational performance would shift to a corporate entity. It will employ necessary professional staff and could serve one large municipality. In the case of smaller municipalities, one corporate entity may provide several services or serve several local areas. This may require smaller municipalities to use pooling arrangements and coordinate with other municipalities. Unbundling to introduce competition and achieve greater service efficiency will also be relevant for many other municipal services. Box 2 below presents some recent and innovative ways of managing solid waste in urban centers. Careful planning at the municipal level to identify such services and to introduce appropriate measures for contracting or outsourcing through private sector, NGOs or community groups would be necessary.

Box 2: Unbundling Municipal Services – Solid Waste Management

Horizontal and vertical unbundling of services to improve service efficiencies and competition is critical for initiating institutional reforms in municipal services. The one municipal service where this has been attempted in several Indian cities is solid waste management. Many forms have been tried, with vertical unbundling across: i) primary collection, often with residents' associations or NGOs, ii) secondary collection and transportation, often contracted out to private sector, through service contracts, and iii) sanitary disposal of garbage, largely through concessions to private firms (with over 50 such deals completed or under preparation across the country).

Municipal Corporation of Hyderabad (MCH) has evolved a system of unit-based service contracts for secondary collection and transportation, which responds innovatively to the statewide, freeze on additional recruitment. Day and night units, in terms of localities, are defined to ensure small and viable contracts. The Corporation has contracted out about 60 percent of the total municipal area through the units, which has improved collection efficiency to over 92 percent. Within this component, horizontal unbundling is done across zones to ensure small but viable contracts. For primary collection, MCH has introduced a scheme to provide incentives for participation by residents' associations and NGOs.

Concession contracts for disposal in several cities have largely focused on compost-based systems, though some recent cases use new technology for electricity generation. These contracts are now being bid competitively with private sector taking full investment responsibilities and appropriate risk allocation. Such unbundling has enabled cities to improve SWM services. Interestingly, some new contracts now explore bundling across secondary collection, transport and disposal, as new private sector capability and interest emerge. In Tamilnadu, horizontal bundling across small towns is being tried to establish a viable regional waste management facility. There is a need to learn from varied experiences across cities in India, identify lessons for further improvements and develop industry benchmarks.

There is a need to learn from varied experiences across cities in India, identify lessons for further improvements and develop industry benchmarks.

33. *Private Sector Participation.* Greater accountability can also be achieved through private sector participation (PSP) in delivery of urban services. If the introduction of PSP is well designed, it can be a means to introduce competition, to clarify contracts and delineate roles by placing regulatory and policy functions at arms length from the provision of services. The primary objective of PSP is to provide incentives for performance and operational autonomy in management. It is likely that the extent and nature of PSP will vary across sub-sectors and even within unbundled components. For example, collection, transportation and disposal for solid waste provide different opportunities for PSP, ranging from multiple service contracts tendered for a limited number of years in solid waste collection and street cleaning, to a long term BOT or private ownership of a landfill. For water, the potential for PSP is high, but as discussed in a companion strategy note for UWSS, each city should define specific arrangements that recognize its initial constraints and best serve its objectives. Given the sector's monopoly features, the development of a regulatory framework that ensures tariff decisions are made with a greater degree of independence from short-term politics is an essential requirement for significant private involvement in water. "Pro-poor" water PSP transactions and regulatory practices will need to be designed, with early consultation of communities, to ensure that the urban poor benefit from the efficiencies gained in operating water utilities commercially. The important role of small-scale independent providers (community-based or small private enterprises) in extending urban services to the poor should be recognized and leveraged as an integral part of pro-poor utility reform designs.

34. *Good Municipal / Utility Practices.* Both for core services managed directly by the municipal authority and for services that are unbundled or contracted out some principles of transparency, fiduciary management and good planning are essential. Box 3 (page 15) illustrates some local initiatives to introduce such practices. The following types of reforms, building upon recent development in a number of Indian cities, should be supported by Bank operations in the sector:

- *Improved Financial Management and Planning*: to build capacity to manage their finances through improved revenue generation and collection performance, financial planning, expenditure management, capital investment planning and budgeting within local financial capacity, predictable processes for setting user charges at cost-covering levels while designing targeted programs for the neediest, effective expenditure controls, and accounting, auditing and procurement reforms;

- *Consumer Orientation and Public Disclosure:* procedures for providing adequate information to customers (related to service levels, new plans, costs and subsidies in service provision), to consult them on new plans through public hearings, a system for effective redressal of consumer grievances and assessment of operational performance and its public reporting with tools such as: development of citizens' charters for local services, publication of annual subsidies and annual environmental status reports and periodic use of report cards;

- *Participatory and Consultative Governance*: approaches to enable participation of different civic groups, women, community based organizations, organizations of the poor and vulnerable and NGOs in planning, budgeting and oversight/monitoring at community and city levels.

Box 3: Good Municipal Practices – Some Local Initiatives

A number of local initiatives demonstrate the nature of improvements in municipal practices undertaken through initiatives by civil society or municipal / state governments:

Report Cards for Urban Services: In cities such as Bangalore, Pune, Ahmedabad and Delhi a number of NGO's like the Public Affairs Centre, Bangalore are using 'report cards' to establish and monitor public opinion regarding the delivery of urban services. The parameters used include: consumer satisfaction, extent and coverage of services, costs faced by consumers, and grievance redressal by service provider. They use various methods including: household surveys, focus group discussions, case studies, information from and interviews with service providers. These efforts suggest dissatisfaction among consumers and high costs linked to accessing services including 'speed money'. Generally, the poor have fared worse and consumers spend very large amounts on coping with service inefficiencies and unreliability. These studies also point to many simple and inexpensive measures for service improvements.

Improved Municipal Accounting: Improved accounting is crucial to support better planning and ensure government accountability to citizens through improved public reporting. Government of Tamilnadu has started a statewide initiative for accrual based accounting for all urban local bodies, supported by a state level accounting code and manual, preparation of software, capacity building support to all ULBs with hardware support and annual awards for good performance. The Bank's Tamilnadu Urban Development Project and USAID FIRE project have supported this state initiative. The Indian Chartered Accountants Institute has provided support for review of the new state Accounting Code. Several other states, including Gujarat, Karnataka and Maharashtra have also initiated similar efforts.

Annual Reports on Status of Environment and Subsidies: Amendments following the 74th CAA in Maharashtra provide for mandatory preparation of annual reports on status of environment and subsidies in services. The report on the status of the environment discloses to citizens the quality of the local environment, the level of services and all improvements achieved during the year. Pune Municipal Corporation prepared the first such report in 1997 and several cities now prepare annual reports. The Report on Subsidies is to assess subsidies in municipal services, identify their sources and the benefits different groups receive. Thane Municipal Corporation has started preparation of such a report with assistance from the USAID's FIRE project. The state government has also initiated work with all municipalities in the state. Such reports will highlight comparative service performance, guide the political representatives in their decisions, including budget allocation, and provide a base for future restructuring of subsidies.

Advanced Locality Management (ALMs) in Mumbai: Citizens' initiatives supported by the Municipal Corporation of Greater Mumbai have introduced community based local self-management in Mumbai through the ALMs. Committees are formed to look after the locality and liaise with concerned municipal officers with an emphasis on solid waste management, local roads and parks. The municipal authority has assigned special officers to attend to the ALM issues, ensure dissemination of information coordination with municipal authority and incorporated clear guidelines with time benchmarks for grievance redressal. Earlier efforts on similar lines have also been made in Pune (Express Group of Citizens) and Bangalore ('Swabhiman Movement'). Over 600 ALMs, with about 50 in slum areas, have been set up in Mumbai over the last 3 years.

35. *Enabling Land and Housing Markets to Work.* An important aspect of urban management is to support well functioning land and housing markets. In India, while there has been considerable debate in this regard action has been woefully lacking. Land use regulations, titling and permitting remain one of the least transparent and ineffective areas of urban management. Red tape is still pervasive and rent-seeking practices adversely impact the poor, as most of them lack land tenure. Urban businesses, housing markets and the development of mortgage finance are also affected. The strategy will help reform-oriented states and cities build the capability and information systems for land registration and titling. It will seek to help them practice integrated planning of land and infrastructure development and review building rules, regulations and codes (with a view to making the regulations less arcane, more transparent and better enforced especially concerning vulnerability to disasters). It would make possible the reduction of procedural delays, the limiting of discretionary authority and the simplification and acceleration of procedures for tenure regularization including de-notification. That would enable them to regularize tenure in upgraded slums. It would also allow improved access to housing finance, especially for the poor. Better land information is also vital to improve the effectiveness of the local property tax and occupancy or property-based service charges.

36. *Participation and Role of Civil Society.* Improved governance includes systems and processes that provide 'space' and a 'voice' for civil society, which includes representation of the poor and disadvantaged. Such participation should take place at different levels from the ground level with the community to consultations on policy so its rationale is widely understood. Informed dialogue will lead to greater ownership of any changes that are being introduced. In this context, it is also necessary to review the provisions and actual experience of ward committees under the 74th Constitutional Amendment Act in different states. The effectiveness of government-promoted community structures under the poverty targeted schemes of Government of India and in several states such as Andhra Pradesh and Kerala will need to be assessed.

C. Improving Resource Mobilization and Financing

37. An important focus area in the operational strategy is to boost investment by developing appropriate financing arrangements for urban infrastructure. Indian cities have so far depended mostly on grants and soft loans from state and central governments and to a much smaller extent on external aid flows. These have financed their investments in service expansion and capital improvements. The India Infrastructure Report shows that these sources can meet only meet a fraction of the needs of cities with their huge service gaps and rapidly increasing demand. Some interesting local projects have and can be advanced with these traditional sources. However, expanding services will require the development of larger and more predictable municipal cash flows. These in turn will need to be used to leverage commercial sources of debt and private equity. A pre-condition to this happening is that local governments, utilities and projects need to become bankable. A key area of support for this is implementation of property tax reform Box 4 hereafter (page 17) refers to some recent experiences and shows rather uneven progress in this key area.

38. India has a high private savings rate and a relatively developed financial sector. It may not need specialized channels such as Municipal Development Funds (MDF) or a Specialized Financial Intermediary (SFI) that have focused only on financing of urban or municipal infrastructure[18] and have been used (with limited success overall) in other developing countries that have weaker financial systems. Rather, the challenge is to improve the creditworthiness of cities and infrastructure projects so that Indian financial markets take a responsible interest in the

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[18] A MDF generally focuses on improving efficiency of resource transfers from higher levels of government, and a SFI helps build a credit culture on commercial terms among local governments.

sector (both in local government debt, and in financing private concessions for local services). Dealing with real world creditors would provide local governments with added incentives for "rating-driven" financial discipline and disclosure.

Box 4: Implementing Property Tax Reforms

Within the context of decentralization there needs to be a correspondence between expenditure assignment and local resources. In this context, property tax is a key local tax source. Despite its potential, property tax in most Indian cities has not been able to mobilize significant resources nor has it been a buoyant tax. Most state statutes have been affected adversely by factors related to definition of their tax base, its linkage to the provisions of Rent Control statutes and a large number of exemptions available to different properties and tax payers. The main issues are a need to: a) de-link the tax base from provisions of the Rent Control statutes to ensure tax buoyancy; b) develop an appropriate definition of tax base (capital or rental value) to avoid ambiguity and create a link with market prices; c) ensure periodic updating of the tax base to ensure buoyancy; d) rationalize and remove unnecessary or inappropriate exemptions; e) standardize the rent/value assessment to ensure simplicity, rationality and transparency; f) ensure effective and efficient collection; and g) identify appropriate state level support for valuation.

In recent years, property tax reforms have been introduced by: a) city authorities like in Patna simplifying the basis of tax assessment and in Mirzapur and Mysore improving tax assessment and collection practices; b) the Government of India through issuing guidelines to states for property tax, and c) several states, including Tamilnadu, Gujarat and Uttar Pradesh through introducing new provisions in their statutes. Tamilnadu and Gujarat governments have passed legislation that has removed the use of annual rateable value as the tax base. Instead, they have linked it directly to key property characteristics leaving the actual tax level to be decided by the local authorities within a range specified by the state government. Limited information available on impact of these measures suggests that in Tamilnadu, property tax collection has increased by over 60 percent. Tamilnadu is also exploring use of information technology such as GIS mapping, which will also enhance performance of tax administration systems. To enhance efficiency and transparency in property tax assessment, several states, such as UP and Karnataka, have introduced initial self-assessment.

The Eleventh Finance Commission has recommended more emphasis on 'property and land based taxes' for local resource mobilization. To achieve this, property tax reforms in India need to be assessed in terms of: legal framework for property tax (tax base and exemptions), development and administration of property tax system (including full coverage and transparency), and organization and management capacity for property tax administration (with local and state authorities).

39. Urban sector projects can be developed within "project finance", "corporate (or utility) finance" or "local government finance" framework. In the two first types of projects, the security of lenders and sponsors is linked to project viability or at least to the viability of the specialized utility or concession by which the project is built and operated. This approach is relevant mainly for revenue-earning sectors like water, even though similarly structured financing arrangements can also be considered in tax-funded services (e.g. a transport investment with a shadow toll, or a landfill BOT with user charges collected by the local government as a component of local taxation). These projects / utilities can also mobilize private equity as part of their financing structure. An important concern in developing these types of projects is to ensure that their underlying viability is sound. It is important that unviable projects are not masked by explicit or implicit contingent liabilities accepted by higher tiers of government. In the second type of local government projects general municipal revenues are pledged for debt service. To be effective such an approach requires a rigorous assessment of future municipal revenues, their

buoyancy and risks, committed or non-discretionary expenditures, a sound approved multi year capital investment plan and adequate security arrangements. They should not depend on a blanket state government guarantee and like those developed on a project finance basis should be based on sound underlying credits.

40. In recent years, a number of financial institutions and commercial banks in India have shown interest in financing urban infrastructure. However, three constraints have inhibited this so far:

- First, on the demand side, there have been few bankable investment opportunities often because the underlying cash flows were too weak or too unpredictable (a result of low tariffs or local revenues, politicized tariff-setting, unclear tax and functional assignment, unreliable financial information including poor financial accounting, auditing and disclosure and a lack of clarity on institutional roles).

- Second, most urban authorities lack commercial credit histories and recognition by the market as viable entities while their experience in using a stream of future revenues (rather than tangible assets) as loan or bond collateral is limited.

- And third, the short tenor of most local debt inhibits its relevance for infrastructure.

41. By focusing on these specific constraints, rather than helping set up or finance ad-hoc instruments such as MDF or SFL the strategy will aim to help "crowding in" the emerging interest of the FIs and commercial / cooperative banks in the sector.

42. Among the above three constraints, the first (lack of bankable projects and borrowers) is clearly the most important. Even the best-developed capital markets would be of little help to a utility or a local government that lacks a relatively secure cash stream against which it can borrow. This is the situation that almost every city and water utility in India faces with the (unfortunate) exception of some cities that still levy octroi. Therefore, the strategy will focus mainly on the credit demand side and help reforming cities improve their revenue streams and financial management. It will not build the capacities of lenders and the Bank will not finance projects with local governments or service agencies, which fail to significantly improve their performance in these critical areas. In addition to this focus on improving the underlying credits, support can be considered for project development technical assistance, improvement of credit information, credit enhancement (used selectively), and parallel financing with commercial lenders.

43. *Project Development Technical Assistance.* The development of bankable projects for urban infrastructure is a complex process. It requires the participation of multiple stakeholders, a sound incentive framework, inputs from experienced advisors, and considerable need for capacity building and learning by doing. Even though considerable adaptation might be required for each city a few successful projects in the early stages of a reform process could serve as good practice benchmarks and have a "public good" value as examples. Several states have created Project Development Facilities that provide grants or small loans to help cities fund the advisory support they need to advance innovative projects. Financing of technical assistance required by participating cities, can be a component of Bank operations in the sector. Box 5 (see page 19) provides brief highlights of such efforts. The Bank can also advise interested states and cities of other resources in the sector, such as PPIAF for private participation in infrastructure, or Cities Alliance.

Box 5: Project Support Facilities for Infrastructure Investments – Emerging Experiences

Many state governments and private sector enterprises in India have recognized the critical importance of project development for attracting private investments in infrastructure. Over a dozen different initiatives have emerged in the last few years. These are either pure project support facilities such as the Andhra Pradesh Infrastructure Investments Facility (APIIF) , or the ones in Uttar Pradesh (UPIIF), Punjab (PIIF), Kerala (I-KIN), West Bengal (I-WIN) and Rajasthan (PDCOR) or integrated agencies providing project development and financing support such as in Tamilnadu (TNUDF), Karnataka (LDECK) and Gujarat (GIIF). In almost all cases, the state governments have worked with private sector entities for private capital and /or management, as direct partners in the facility or through outsourcing.

The initiatives are a response to an understanding that development of bankable investment opportunities require addressing issues related to institutional structures, service tariffs and state level reforms. They are driven by priorities emerging out of efforts to evolve actual project level opportunities. Most facilities emphasize supporting processes of project development and policy reform rather than actual investment support by governments. Their aim at the project level is to leverage limited government resources through market borrowing or direct private sector investments. Most facilities focus on a variety of infrastructure sectors and increasingly the focus is on smaller projects with urban infrastructure emerging as a key sector.

As relatively recent initiatives, they need to be assessed for effectiveness and the nature of support they require. To match institutional responsibility for services related to project development support, capacity building of stakeholders, credit enhancement and actual investment finance appropriate unbundling of existing agencies will be necessary. Key operational issues for urban infrastructure relate to institutional arrangements and its positioning within the wider statewide infrastructure support initiatives.

44. *Removing Information Constraints.* The strategy proposes to address the lack of market recognition for the sector. This could be enhanced by disseminating information and analysis about the urban sector performance and opportunities, providing opportunities for interaction between market and sector participants and by increasing the opportunity for commercial financial institutions to make investments [19]. An important element of the strategy would be knowledge sharing and would help local change leaders network with peers and gain information on good practices elsewhere.

45. *Credit Enhancement.* In the early stages of market development, partial risk guarantees – that should not blur the judgment of commercial lenders and investors in appraising and assuming commercial risk – could be more effective than dedicated lending facilities in leveraging private investment and debt. The guarantees should be designed in the way that reduce lender's exposure to risks created by government itself without creating moral hazard or unmanaged contingent liabilities for the fisc. This could relate, for instance, to the government's failure to implement a tariff indexing formula provided in a concession contract. The Infrastructure Development Finance Company (IDFC) has developed a back-stop facility for take-out finance to enhance tenor of commercial bank loans for infrastructure. Recently MIGA has also been approached by several private investors that are contemplating projects in urban infrastructure in India, for example in the water sector.

[19] Such opportunities for interaction are necessary for awareness regarding concerns and incentives on both sides. Strategic participation of CBFIs in such events will also enhance their market recognition.

46 *Terms Transformation.* Bank lending, in India (under the Tamil Nadu Urban Development Project) and other countries, through financial intermediaries or an "apex" secondtier institution, has been used to enhance the tenor of debt instruments offered by domestic lenders, including for municipal credit. The proposed strategy does not expect IBRD/IDA lending through intermediaries to be a focus. When a sovereign lender such as the Bank funds financial intermediaries, it can raise complex policy issues. It may distort competition in the financial sector. It could also create an exposure for the sovereign that partly denies the purpose of diversifying away from central government funding of local investment. It can create operational difficulties as well. The Bank's safeguard and fiduciary obligations may require it to appraise both the intermediary's financial position and credit processes as well as investments in sizable individual projects. In addition, credit line operations do not address the bottleneck for municipal credit development in India, which as mentioned earlier, is the underlying credit weakness of the final borrowers and projects. However Bank lending in the urban sector will be designed to leave space for commercial co-financing. This could be achieved by capping the percentage of project costs financed by IBRD-IDA or by targeting Bank lending to poverty-related sub-components of projects, with the rest financed from commercial sources. Such co-financing could be effective in providing a "reform umbrella" for commercial lenders and extending the terms of the aggregate debt mix used by participating cities.

47. The above discussion suggests that it may be possible in Indian conditions to move away from the municipal development fund and specialist financial intermediary concepts to enabling existing domestic financial institutions to enter the sector by providing policy and project development support, selective measures for credit enhancement, better market information, and appropriate measures for tenor enhancement. Appropriate financing and institutional arrangements, through unbundling of these functions to different actors[29], will need to be evolved in each state or city in consultation with key stakeholders.

48. A caveat, however, needs to be added to this approach. India comprises states at different levels of development. The level of financial sector development and the risk perception of existing national / regional commercial financial intermediaries are likely to vary significantly across states. A rigorous assessment is necessary in this regard for a given state to identify an appropriate financing arrangement. Domestic credit rating agencies can help in this process. In cases where the existing situation does not permit development of sustainable credit markets, mainly due to a lack of viable borrowers, the focus should be on policy and management reforms. Funding may then be limited to technical assistance and small performance-based grants for local governments that make progress towards improving their finances. Bank experience shows that supporting dedicated financial intermediaries that lend at non-market terms into non-viable credits is neither useful nor sustainable.

49. If the strategy is to succeed in creating replicable financing arrangements for the sector, there must be a level playing field for financing institutions. This may require reforms at the state level, especially for states that operate subsidized credit systems through MDF or SFI. It will also require that states adopt clear rules for municipal borrowing. This could include measures such as borrowing caps and the requirement that any municipal bond issuance should have an independent and published investment grade rating. Thus, a key

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[29] For example, see Peterson (2000), "Building local credit systems", World Bank, for a discussion on "unbundling of all the functions that traditionally have been packaged together in Municipal Development Funds". These functions include: technical assistance in preparation of municipal investment projects and in advice on privatization alternatives; assessment of municipal creditworthiness and capacity to borrow; and making loans to municipalities and construction/project management oversight. State level reforms for urban financing arrangements will need to address this important concern of how to unbundle and to ensure these services can be provided to municipalities in a sustainable manner.

element in the reform agenda for state urban sector assistance will be to review and restructure existing financing arrangements, intermediaries if any and related state policies. Government of India will need to ensure that its sector objectives are being pursued consistently through operations and policies of Housing and Urban Development Corporation (HUDCO), GOI's wholly owned financial intermediary for urban infrastructure and housing.

50. *Supporting Community Based Finance Systems.* Another important element is support for micro-finance systems that provide access to credit for the poor and low-income groups. They may be used to provide credit for income generating activities as well as later for credit for shelter or community infrastructure. Over the last few years, the Government has provided considerable support through NABARD, SIDBI and Rashtriya Mahila Kosh (RMK) to self-help groups, NGOs and micro-finance institutions either directly or through financial institutions such as the commercial banks. This has created a base of institutions providing financial services to the poor and low-income groups though most financing is at subsidized rates. Even the limited funding available through HUDCO and HDFC for financing shelter for the poor and low-income groups is subsidized. These programs are not operating at the scale they are required even though they may be reasonably targeted. In the long run, the element of subsidies could inhibit integration of micro-lenders with the overall financial systems. Box 6 below summarizes the approach adopted for the preparation of the India Community Infrastructure Project.

Box 6: Linking Formal and Community Based Financing Systems

Building on the financial sector development in India, a proposed Bank project, India Community Infrastructure Project (ICIP), focuses on market based approaches for financing community infrastructure for the poor and low-income communities. Housing Development Finance Corporation (HDFC), a premier commercial financial institution, is the main project agency and will route Bank financing to poor and low income communities through a variety of community based financing institutions (CBFIs), to selected local authorities (for external connections to municipal systems) and to private sector firms to provide these services to the poor on a sustainable basis.

The primary objective of ICIP is to improve the living conditions in poor and low income neighborhoods through: a) strategic alliances of the main financial intermediary, HDFC, with CBFIs; b) development of a Community Support Fund (CSF) for sub-project development and capacity building for community driven, participatory approach to neighborhood infrastructure upgrading, and c) a Community Infrastructure Guarantee Facility (CIGF) to provide partial guarantees for lending within the project. Besides the IDA credit for infrastructure investments, bilateral grants from the DFID and Japan Social Development Fund (JSDF) are expected to support the CSF and CIGF.

A number of commercially run domestic financial institutions have shown interest in the infrastructure sector and in smaller community level projects. The successful implementation of this pilot operation will enable market integration and expansion, as all lending under ICIP will be at broadly market terms to be sustainable in the local market.

51. *Supporting Community Based Finance Systems.* Another important element is support for micro-finance systems that provide access to credit for the poor and low income groups. They may be used to provide credit for income generating activities as well as later for credit for shelter or community infrastructure. Over the last few years, the Government has

provided considerable support through NABARD, SIDBI and Rashtriya Mahila Kosh (RMK) to self help groups, NGOs and micro-finance institutions either directly or through financial institutions such as the commercial banks. This has created a base of institutions providing financial services to the poor and low-income groups though most financing is at subsidized rates. Even the limited funding available through HUDCO and HDFC for financing shelter for the poor and low-income groups is subsidized. These programs are not operating at the scale they are required even though they may be reasonably targeted. In the long-run, the element of subsidies could inhibit integration of micro-lenders with the overall financial systems.

52. Other recent trends include the emergence of networks and associations of community based finance institutions (CBFIs) and NGOs/civil society associations that work for the poor in the areas of housing and infrastructure.[21] Further, a special Task Force on Supportive Policy and Regulatory Framework for micro-finance was set up as a result of a policy forum organized in 1998. In 1999, its first Report provided 'an important step in identifying the constraints for micro finance in India and changes required to develop it along sustainable lines'.[22] Despite the efforts made both by the government and by CBFIs themselves, it appears that the overall reach of these institutions is limited. Recent efforts to develop a regulatory framework and provide capacity building assistance could widen their base over time in a more sustainable manner. These measures would also help bring a wide variety of arrangements within a broad regulatory framework. Key issues identified for capacity assessment by the Bank's sector work include: organizational/legal forms, lending methodologies, role of self-help groups, lack of emphasis on financial performance, and the role of apexes in the sector. The main issues in relation to legal and regulatory framework are access to capital markets, institutional transformation and self-regulation.[23] Another key area would be to support measures to enable the community based systems to provide access to finance community infrastructure for the poor and low-income communities. A proposed Bank project being developed with the Government of India and Housing Development Finance Corporation aims to demonstrate the viability of such financing products (refer to Box 6 – page 21).[24]

53. *Focus on Sector Reforms.* Most analysis of urban infrastructure investments highlights the inadequacy of public resources in relation to the requirements. One of the Bank's comparative advantages is its ability to provide sizeable volumes of long-term funds for critical investments at competitive terms. This suggests the possibility of leveraging these resources in a strategic and catalytic manner to provide adequate incentives and support critical urban reforms. This will enable strengthening the demand side for ultimate integration with the markets. Both GOI and state / local governments will have to evolve through consensus a minimum reform program for state and local governments to avail public resources including those of the Bank. When an agreed set of minimum reforms are defined assistance to states and cities will be linked to these and there will be no automatic entitlement. The ownership of reforms by state and city governments will be the key aspect in such an approach. This will require a demonstration of commitment and the initiation of reforms. Box 7 (page 23) provides brief highlights of the statewide sector reforms being taken up under the ongoing Bank funded Tamil Nadu Urban Development Project).

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[21] For example, Sa dhan has been formed as an association of the CDFIs and has taken up work on issues such as self-regulation and capacity building. An association of agencies working in the habitat sector has also been recently formed as India Habitat Forum (INHAF).

[22] World Bank (1999), Technical Note – India: ESW on Micro-Finance (November- December 1999 Mission).

[23] World Bank (1999), Technical Note – India: ESW on Micro-Finance (November- December 1999 Mission).

[24] A proposed Bank project being developed with the Government of India and Housing Development Finance Corporation aims to demonstrate the viability of such financing products.

Box 7: Tamil Nadu State Reforms for Urban Development

The Bank funded Second Tamil Nadu Urban Development Project (TNUDP II) focuses on promoting state wide urban sector reforms along with financing urban infrastructure investments. State Government of Tamil Nadu works closely with the Tamil Nadu Urban Development Fund (TNUDF), which also provides investment finance to ULBs under the project. An asset management company with leading domestic private financial institutions as majority equity partners manages TNUDF professionally. This partnership between the GoTN and TNUDF has also helped to provide incentives for ULBs to undertake reforms. TNUDF also provides strategic advise to local governments in developing and implementing commercially structured infrastructure projects and accessing capital markets.

Government of Tamil Nadu has taken the lead in formulating and implementing statewide sector reforms. It is the first state in India to introduce uniform municipal legislation and reforms in municipal administration. It has shifted from cash to accrual system of accounting in local governments, introduced performance monitoring systems and computerization of municipal functions. It has simplified property tax mechanism with a movement to an area-based system of property taxation. The State has also empowered local governments to raise resources internally as well as from the market. The institutional development component, apart from building capacities of municipal staff and elected officials, supports development and implementation of city development strategies (CDS). The project also finances implementation of reforms, the most important being commercial accounting in municipalities, municipal performance monitoring systems, the use of GIS and a simplified land use planning process.

54. Subject to requests by the states and GOI the design of reform agenda provides the trigger for Bank's involvement in different states. As stated in the CAS, the Bank prefers to concentrate a significant component of its assistance programs in poor, reforming states referred to as "focus states". Financing is also considered for projects of particular merit in other states, as well as for federal programs. Under the urban strategy, states that have a strong overall reform program would be given preference for developing urban sector projects though a commitment to specific reforms in the urban sector will still be necessary. Investment in non-focus states can also be considered if they have particularly strong programs within the urban sector (see Annexes 1 and 2).

V. Strategy Implementation

55. The emphasis in implementing the strategy will be on helping states build a statewide framework and support programs that encourage good urban governance and management. Within these statewide programs, reform-oriented cities would self-select and apply for financial and advisory support to improve services within a City Development Strategy (CDS) framework. These measures will enable the urban investments to be more sustainable.

56. *Partnerships and Coordination.* The urban reform agenda's complexity and its wide coverage mean that coordination among the external agencies for investment and capacity building assistance could maximize the possibility of success. Mechanisms for such inter agency coordination will need to be developed, or existing ones strengthened, to share experiences and plan coordinated actions, where appropriate, on an ongoing basis. Such coordination needs to extend to dialogue with domestic financial institutions to explore co-financing in urban sector

projects. Specific forms of coordinated actions could include: joint development of state urban sector strategies and state level reform agenda, participation in awareness and dissemination measures, joint committees to identify participation in capacity building measures based on comparative advantages of each agency, and sharing of reform templates, toolkits and manuals for key areas of urban reform.

57. *Selectivity and Sector Priorities.* Within the strategic focus areas, prioritization is essential to ensure the selection of activities and operations. It is also necessary to assess the potential match of Bank Group instruments to issues identified earlier. The strategy envisages that selection from among the wide range of key issues will be through demand articulated by GOI, state and local governments. As a result, measures under different strands for strategy implementation will be designed to be demand responsive. Demand will be articulated through consultations, project rules or, wherever possible and appropriate, market linked processes. This is in line with the medium term perspective of the Comprehensive Development Framework (CDF), and the spirit of City Development Strategies (CDS), which are demand driven by clients and stakeholders.

58. To some extent, selection is determined by the terms of Bank's urban sector operations. The strategy envisages the city (small, medium, metro and mega-cities) as the center of the urban strategy with particular focus on civic services. The main assumption is that well functioning cities are essential for economic growth, to provide better living conditions and to reduce poverty. This provides the rationale for the selection of the strategic focus areas primarily improvements in city efficiency, effectiveness and urban governance. It is expected that these key reforms will converge to reduce urban poverty in a significant and sustainable and manner.

59. *Three Strands of Strategy Implementation.* The various members of the Bank Group, such as the World Bank, MIGA and the World Bank Institute (WBI), will jointly implement the strategy. Implementation is envisaged through three main strands of activities. Figure 3 highlights the activities envisaged under each strand and the related potential instruments and partners.

60. *Strand One: Knowledge Sharing.* In developing this strategy and in discussions with various stakeholders it has been evident that the information base and analytical work in the sector are poor. Inadequate availability or access to basic urban data makes rational decisions and systematic prioritization difficult. Under this strand, the Bank, in association with WBI, will work with Government of India and interested state governments to enhance the knowledge base in the sector. Activities under this strand will help to fill this gap. The focus will be to build capacities of key stakeholders in the urban sector through knowledge management.

61. It will involve activities related to i) comparative performance assessment in priority areas leading to setting up one or more benchmarking facilities for service delivery, financial management, citizen orientation, monitoring and evaluation activities; ii) development of templates and toolkits in key areas of governance and management reforms (refer to Annex 1); and iii) knowledge sharing and development through workshops, publications and visits. The World Bank Institute will play an active role in implementing the knowledge sharing programs. Efforts will be made to carry out these activities in close partnership with domestic institutions, network institutions and associations of key stakeholders. This will ensure wider and more cost effective dissemination of information as well as local ownership to achieve

sustainability. Instruments for disseminating the relevant experiences and know-how may include analytical and advisory activities (AAA) of the Bank as well as special technical assistance projects developed with either GOI line ministries, interested state and local governments.[25] It is essential that knowledge management is made participatory. To fill the gap between pronouncements at seminars and ground level policies and actions so common in India it should include more frequent visits and exchange between policy makers and practitioners.

52. A key emphasis in this strand will also be on developing an appropriate framework for *urban poverty reduction strategy (UPRS)* at the state and city level. This will require a diagnostic assessment of urban poverty, review of past urban poverty alleviation programs, constraints to scaling up successful demonstration efforts and identifying key components of UPRS through a consultative process with critical stakeholders. Ongoing preparation for an Andhra Urban sector operation incorporates such an approach. Box 8 below provides brief highlights of the Andhra Pradesh Urban Poverty Reduction Project.

Box 8: State Urban Poverty Reduction Strategy – Andhra Pradesh

Urban poverty in Andhra Pradesh is high with recent estimates that suggest that 24 percent of population is below the official poverty line. The incidence of poverty is likely to be higher in large and medium cities. More importantly, the limited information suggests poor performance on non-income dimensions of urban poverty. For the Government of Andhra Pradesh (GoAP) reduction of urban poverty is central to its long-term vision and strategy. Its approach includes community based direct interventions as well as strengthening finances, governance and management of urban local bodies. It has emphasized the development and strengthening of community based groups, especially those consisting of women, to undertake both economic activities and neighborhood level infrastructure improvements. Special schemes of the Government of India as well as matching funds from the GoAP's Janmabhoomi scheme provide support to these groups.

To support its poverty reduction initiatives, the Bank is developing an urban poverty reduction project with GoAP. This will involve a two pronged approach: i) direct support to multi-sectoral community focused and managed investments to improve quality of life of the poor and low income communities, and ii) strengthening capacity of urban local bodies for poverty reduction through: state wide urban sector management reforms; city level implementation of key management reforms such as property tax reforms and supporting better functioning of land markets; along with investment finance for city level infrastructure systems.

Investment finance will be within the framework of a City Development Strategy (CDS). The needs for financial support will be assessed realistically based on the local capacity of those ULBs that show adequate performance improvements and cover their operation and maintenance costs in a sustainable manner. Financial assistance will be partial to enable participation of other domestic financial institutions and will be progressive.

The project envisages funding support from the Italian Cooperation focusing on capacity building in select small towns to initiate the reform process and facilitate their access to resources from the Bank project. The Bank operation will also follow the performance based approach agreed between the AP Government and DFID for the implementation of the DFID sponsored Andhra Pradesh Urban Services for the Poor Project (APUSP) to be implemented in over 30 class I towns. Close coordination between both project will be institutionalized.

[25] For example, an ongoing Technical Assistance Project for Economic Reforms with the GOI also includes a component for urban sector reforms. Special TA projects at the state level may also be developed, as necessary.

Figure 2: Three Strands of Strategy Implementation

ACTIVITIES	POTENTIAL INSTRUMENTS / PRODUCTS	POTENTIAL PARTNERS / CLIENTS
Strand One: Knowledge Sharing		
• Comparative performance assessment with benchmarking and M&E • Templates and toolkit development • Research and knowledge sharing	• Analytical and Advisory Activities • Technical Assistance	• Government of India • State governments • Domestic research institutions • Private advisory services • Network associations and institutions
Strand Two: Supporting Local Innovations		
• Implementation of governance and management reforms • Development of commercially viable urban infrastructure projects with PSP • Development of CDS / scaling up strategy for poverty targeted interventions	• Lending through Technical Assistance Projects • Learning and Innovation Loan (LIL) • TA for project development • Funding of CDS / UPRS through Cities Alliance	• Government of India • State governments • Local governments • Domestic financial institutions (existing / new) • Domestic project development funds (existing / new)
Strand Three: Implementing Sector Reforms in States		
• State urban sector project linked to commitment of state government to an 'agreed reform agenda' including: preparation of UPRS, decentralization reforms, water sector reforms and review of financing arrangements • Resource mobilization, creditworthiness of local governments and utilities, and improved access to commercial sources of finance	• Lending through a state urban sector project; with cities self-selecting on the basis of performance and reform progress • Co-financing with domestic commercial lenders/ bond markets • Technical Assistance for development of municipal creditworthiness	• State governments • Participating cities and utilities/ concessionaires • Domestic financial institutions (existing / new) • Government of India

63. *Strand Two: Supporting Local Innovations.* The second strand recognizes notable local innovations ranging from private sector participation for solid waste management in Hyderabad, introduction of full commercial accounting system in Chennai Municipal Corporation, property tax system improvements in Patna, consultative community planning processes in Bangalore and Mumbai and the public issuance of municipal bonds without state government guarantees in Ahmedabad. As been highlighted in the country assistance evaluation for urban sector and earlier stakeholder workshops it provides an opportunity to engage more directly with municipal authorities through sustainable intermediation.

64. Three types of activities will be supported under this strand. First, implementation of *governance and management reforms* for which considerable consensus exists in the country. Support for this would be generated under the Strand 1. Under this strand, funding would be

assistance to implement many of these reforms on a wider scale. The three main areas of reform are financial management, service delivery and greater responsiveness of service providers to citizen's concerns. Funding could be through a TA Project or through a line of credit arrangement with commercially oriented financial intermediaries where these can be funded on a commercial basis. Annex 1 provides an illustrative list of the type of governance and management reforms, brief highlights of current status on these and the possibility of funding these on a commercial basis.

65. A second set of activities will support *development of commercially viable urban infrastructure projects* with a focus on private sector participation. The Bank will support technical assistance efforts required to prepare quality projects. Bank will also explore the possibility of support to micro finance linked financing arrangements.[26]

66. The third set of activities under Strand 2 are *development of CDS / scaling up strategy for poverty targeted interventions*. The CDS framework is visualized as one of the key building blocks for the Bank's new global urban strategy. Early CDS may not have focused enough on addressing financial constraints – a new generation of CDS would strengthen the link between a city's vision and its reform needs. Its development will be based on a broadly shared understanding of city's socio-economic structure, constraints and prospects based on an analytical assessment. The consultative processes, supported by analytical assessments of the goals, priorities and requirements will help identify city priorities. The strategic plan of action will be operationalized through the preparation of specific products such as: city level capital investment plans, city financing strategy and a city poverty reduction strategy. The CDS approach will build on experience with participatory strategies and city consultations under the UNEP, UNCHS and UNDP's Metropolitan Environment Improvement Program (MEIP), the Urban Management Program (UMP) as well as the experience in earlier Bank-funded projects[27].

67. While each CDS exercise will be unique, in general a three-phase approach is envisaged. A first 'scoping out' phase will provide a quick assessment of readiness of various stakeholders. A second more in-depth and analytical phase to assess structures and trends in the urban economy, the nature and causes of poverty, as well as potential constraints and strategic option. Finally, a third phase will consist of consultative identification of city priorities and formulation of specific plans for poverty reduction and financing strategies. Support for CDS to interested cities will be provided either through funding from Cities Alliance or under a Learning and Innovation Loan (LIL). The commitment of both the city and state governments to undertake participatory and consultative process will be essential.

68. *Strand Three: Implementing Sector Policy Reforms*. While support to local innovations is essential as a first step and will provide an opportunity to respond to emerging windows of opportunity at local level, important and often difficult policy reforms are also necessary in the sector to achieve sustainable results. This would have to be implemented through both major state level urban sector projects and other operations to support development of commercial financing systems.

69. *State Urban Sector Investment Projects*. Implementation of key sector reforms will require a political and bureaucratic commitment from state governments. In turn the Bank will make a commitment for major investments in states whose governments have implemented most

[26] This will build on the work already being developed with the Housing Development Finance Corporation (HDFC) for financing community infrastructure through community based financing institutions.

[27] Under one of the Bank projects in the state of Tamilnadu, efforts at developing and mainstreaming CDS have been initiated. Examples of scaling up of poverty targeted interventions in the country are very few. One such example is the slum networking program in Ahmedabad. Even here, however, after initial successes and considerable innovation in multi-stakeholder partnerships, the pace of efforts and implementation has been slow.

governance and management reforms listed in Annex 1; show a readiness and commitment to major decentralization and financing related policy reforms, and agree to develop an urban poverty reduction strategy (refer to Annex 2). State urban projects may have different focus. However, for a particular sub-sector focus, particularly for water, commitment on specific minimum reform agenda, as illustrated in Annex 2 under water sector reforms, will be essential.

70. *Resource Mobilization and Financing.* Given India's comparative advantage in terms of development of its capital markets and the existence of several market based institutions for financing infrastructure, the Bank will seek to support access by local government borrowers to the commercial financing systems. A variety of sources can be explored, including direct capital markets borrowing through bonds, use of commercial financial intermediaries as well as pooled borrowing arrangements for smaller entities and projects. However, considerable efforts will be required to promote financial, legal and regulatory reforms aimed at developing these approaches including: development of regulatory framework for urban infrastructure projects, appropriate controls and regulatory mechanisms for municipal borrowing[28], tariff reforms for key urban services, norms for financial disclosures as well as bankruptcy legislation for municipal authorities. With the emerging reforms related to opening up of the insurance sector, pension and provident fund management as well as improving the operating and regulatory framework for debt markets, the emphasis will be on readying the urban sector with bankable investment opportunities and measures to enable access to financial markets through credit enhancement support in the early phases. Box 9 provides brief highlights of a proposed Bank operation within this framework in the western state of Gujarat.

Box 9: Improving Resource Mobilization and Financing

Cities in Gujarat have relatively better management systems, greater autonomy and functional responsibilities than in most other states in India. There are also several financial intermediaries interested in supporting urban investment. Despite these advantages, Gujarat's urban sector suffers from inadequate urban services, poor fiscal health of state and urban authorities and a lack of appropriate financing arrangements for urban infrastructure.

A proposed Gujarat Urban Reform Project will support increased access to domestic capital markets by creditworthy ULBs. At the state level, these efforts will be structured through development of a state-level framework for local borrowing. This will incorporate measures such as a mandatory credit rating, a ceiling on local debt, and the possibility of bankruptcy legislation. The framework will obviate the need for state government guarantees for local borrowing and will reduce the burden of urban lending on already stressed state finances.

To enhance local revenue mobilization and increase credit worthiness, participating cities and towns will adopt property tax reforms, modernize budgeting and accounting systems and improve billing and collections. Performing ULBs will have access to a challenge fund provided under the project to finance priority infrastructure investments. ULBs with the necessary credit worthiness will be assisted to access the local capital market for infrastructure investment.

[28] For example, municipal borrowing needs to be put within a framework of rules such as: an 'approved' capital investment plan, a minimum debt service coverage ratio on total municipal borrowing and an investment grade credit rating for direct market access. Permissions for direct market borrowing may be considered outside of state government jurisdiction and put with an agency such as SEBI to avoid the perception of bail out by state governments. There is also a need to develop bankruptcy legislation for municipal authorities. An important issue would be explicit recognition and assessment of contingent liabilities of local governments. In international examples of problems with sub-national borrowing, often inadequate attention to contingent liabilities has often caused problems (for example see Gomez, 2000, 'Shifting phases of decentralization, bureaucratic reform and the regulation of sub-national policy in Brazil and China', University of Chicago).

71 *Priority Sector Work to Support the Urban Agenda.* Rigorous analytical work will be required in a number of important areas to strengthen the operationalization of this strategy. This is crucial as information base in the sector is weak and it is necessary to draw on international experience for use in areas such as fiscal decentralization, private sector participation and independent regulation. A critical area where an adequate understanding of sector issues and possible policies and programs does not exist is urban poverty. This includes the delivery of more effective social services and a comparative assessment of poverty characteristics across regions. For a better understanding of the enhanced role of cities in economic development a better comprehension of the linkage between nature of urbanization, economic growth and its likely impact on urban poverty is critical.

72. Many of the themes in the proposed three strands approach focus on fiscal capacities of local governments, especially within the emerging decentralization framework. Adequate information and analysis are not available in this important area for meaningful support. Emphasis is needed particularly on a better design for fiscal transfer systems to provide appropriate incentives for improved performance. Lastly, within the area of governance a critical area of sector work would be the incentive structure required to increase city efficiency and competitiveness. Though this is recognized as crucial among policy makers and analysts, little understanding about it exists at present. Thus, three priority areas of sector work for the urban sector are: urban poverty, fiscal aspects of decentralization and economic incentives for enhancing city competitiveness. Carefully targeted work in these areas will also help to mainstream 'Urban' in overall operations of the Bank.

73. *Launching the Strategy.* The strategy has been developed in close consultation with GOI, and with inputs from multiple stakeholders. The next steps include the initiation of knowledge-sharing activities under the first strand in close partnership with GOI, Ministry of Urban Development and Poverty Alleviation. Under the second and third strands, the Bank continue the preparation of the statewide projects already identified in Andhra Pradesh and Gujarat and identify and develop, in close consultation with GOI, new operations in the urban sector. The strategy document is visualized as a living document that will evolve over time based on evaluation of ongoing and new urban sector operations.

Annex 1: Illustrative Urban Governance and Management Reforms

AREA OF REFORM	SUPPORT MEASURES FOR REFORM
A. Financial management	
Property tax	• Development of templates for property tax reforms • TA for implementation of improved systems
Accounting and auditing	• Development of model accounting codes • TA for implementation of accounting and auditing reforms
Budgets and capital investment plans (CIPs)	• Development of model guidelines for performance linked budgets, expenditure management and CIPs • TA for development of CIPs at local level
B. Service Delivery	
Contracting through PSP	• Development of model contracts and agreements for outsourcing services • Review and plan for outsourcing of services • TA for local contracts for collection and transportation of solid waste, billing and collection of charges, etc.
Tariff setting for UWSS	• Development of model guidelines for water tariff • TA for implementation of separate UWSS accounts and tariff setting at local levels
Solid waste management	• Development of guidelines for PSP for secondary collection, transportation and disposal and community / NGO participation for primary collection • TA for assessment of technical choices for solid waste management
C. Citizen Orientation	
Citizens' charters and report cards	• Development of model citizens' charters for municipal services • TA for adoption of citizens' charters and report cards at local level
Citizens' grievance redressal systems	• Development of guidelines for citizens' redressal systems • TA for implementation of redressal systems at the local level
Annual report on status of services and subsidies in services	• Development of guidelines for preparation of services and subsidies report • TA for initial preparation of services / subsidies reports at local level and their institutionalization

Annex 2: Urban Sector Critical Policy Reforms

AREA OF REFORM	REFORM MEASURE
Overall	• Commitment to develop a framework for Urban Poverty Reduction Strategy • All management reforms identified under Strand One initiated
Local/municipal level	• Initiate implementation of property tax reform • Carry out a consultative city development strategy • Prepare and approve a capital investment plan • Review and plan for out-sourcing appropriate services • Initiate accounting reforms with computerization • Introduce a citizens' grievance redressal system
Decentralization	• Commitment to 'municipalization' with rationalization of assignment of functions and revenues to urban local authorities, including autonomy in setting tax rates and user charges • Commitment to introduce transparency and predictability in state-local transfers through rule-formula based systems of transfers and grant allocation to provide incentives for improved performance
Financing arrangements	• Commitment to develop a state level framework for municipal borrowing • Commitment to review existing financing mechanisms, plan allocations and any MDF / state supported FIs and develop a plan to move towards a commercially oriented financing system • Commitment to develop appropriate institutional arrangements for policy and project development support with private sector management
Water sector reforms	• Public announcement regarding a fundamental change in the role of government in UWSS including introduction of PSP • Drafted an adequate tariff policy, targeting full cost recovery in a time-bound manner • Initiated steps to i) separate operating and regulatory functions; ii) define an adequate regulatory framework and iii) establish an independent regulatory body • Commitment to target the poor in water and sanitation strategy • Commitment to submit all UWSS linked financing requests only with PSP • Initiated steps to reform the state level PHEDs or water-sewerage boards and promote commercially oriented companies for local UWSS operations and management • Prepared a comprehensive sanitation plan
Solid waste management	• Plan for contracting out of collection and transportation of solid waste • Plan for disposal of solid waste through PSP • Introduce community based or contracting of primary collection

Annex 3: Illustrative Areas for World Bank Operations in the Urban Sector

A. KNOWLEDGE SHARING	
Description	Activities which support knowledge management such as: comparative performance assessment and benchmarking, development of templates and toolkits for governance and management reforms (refer Annex 1) and to support knowledge sharing and development.
On-going operations	Under the TA Project for Economic Reforms, the Bank provides loans for urban sector management reforms. Operations are being taken up in UP and Karnataka, and developed with the GOI.
	Under the Cities Alliance initiative, funding is possible for selected states and cities.
	Capacity building support to utility regulation through South Asia Forum for Infrastructure Regulation (SAFIR) funded through PPIAF with advisory support from the World Bank.
B. SUPPORTING LOCAL INNOVATIONS	
Description	Activities to support local level innovations within the wider reform agenda through sustainable intermediation using government, private and non-governmental routes as appropriate. Activities may include: implementation of governance and management reforms, development of commercially viable infrastructure projects and development of CDS / scaling up strategy for poverty targeted interventions at the local level.
On-going operations	Under the TA Project for Economic Reforms, the Bank provides loans for implementation of urban sector management reforms. Operations are being taken up in UP and Karnataka.
	Under the Cities Alliance initiative, funding is possible for selected states and cities to develop and implement CDS and scaling up of poverty targeted interventions.
Possible new ideas	Urban Initiatives Fund Project to support demand led local implementation of reforms. GOI, an interested state government or domestic financial institution may set it up. Local governments, private sector or NGOs meeting predefined criteria may access it. A local government may also set up such a fund to promote innovations in different neighborhoods or localities. In case of a FI, the fund would be utilized through local debt on a commercial basis.
	Project Development Support Facility –may be developed with GOI, an interested state government or domestic financial institution, to provide support for development of 'bankable' urban projects in 'urban finance' or 'project finance' frameworks. Such a facility will be run professionally and be commercially viable over a defined time frame. Alternatively, it may be planned as an interim arrangement to support market based project development support within a defined time frame.

C. Implementing Sector Policy Reforms	
Description	Activities to support implementation of sector reforms through: a) state urban sector programs, either through an adaptable loan program or a limited TA project for initial reform implementation to be followed by investment assistance; b) activities to develop urban infrastructure financing systems such as market based access to resources with necessary financial intermediation, credit enhancement and regulatory reforms, measures to enhance local debt tenor, and, strengthening community based financing systems.
On-going operations	Ongoing Bank project with the IL&FS which focuses on development and funding of commercially viable infrastructure projects with private sector participation.
	Ongoing project preparation for India Community Infrastructure project that includes components related to sub-project development, capacity building, support for regulatory reforms and community infrastructure investments.
	State urban sector projects with Tamilnadu (ongoing), and being developed with the Governments of Karnataka and Gujarat.
Possible new ideas	Bank will support a limited number of interested and "committed" state governments to undertake critical urban sector reforms (see Annex 2) and support a program of sector wide investments or for selected sub-sectors as appropriate. A strong indication of commitment to reforms will be essential, with a preference for Bank's focus states. Such operations may be initiated with initial technical assistance support for improving municipal credit worthiness. Bank will also explore co-financing with leading domestic financial institutions.

DEV - 3.

Cover Story

Mr D Sreenivasa Rao of Catholic Hospital Association of India did a study on the health challenges of slums. He was guided by Dr P Venkata Rao and Mr D Rayanna. Health Action talks to Mr Sreenivasa Rao.

Why Slum Health?

On gut level ...

Health Action: What in general are your impressions regarding health action in slums?

Sreenivasa Rao: I shall be quoting some of the reactions of health agents working in slums:

'In my earlier posting, I used to develop muscle cramps, and we were doing a roaring business. Today, here in this bloody posting, I hardly get any clients.'

'How can I visit the villages that you are talking about? Am I supposed to visit them? What for? Besides, there's no jeep'

'These people are illiterate, lack basic hygiene and really are in need of a wash'

'Public defecation is the number one enemy. But how is that my business, I mean what is the sanitation department for?'

'More than 95% of my patients are anaemic women. Many times, I wonder how they are surviving!' This is not the season for good work. Good work means rainy season'.

'I mean, just tell me, what has literacy work to do with my health work?

These statements make us feel sad. They do drive home a point that there is a good bit of work to be done on the attitudes of the health personnel working in the field.

The Crux

HA: What is the crux of the problem with regard to slum health?

S.R: By the year 2000 AD, over 3.2 billion people — more than half of the world's population — will become city dwellers.

Nearly half of this population will live under conditions of extreme deprivation caused by poor sanitation, high density living, industrial pollution, and economically prohibitive and inaccessible health services.

And the question forms: "Can one achieve Health for all without decent shelter, healthy neighbourhoods, adequate water, sanitation and timely garbage collection? "

Problems Galore

HA: What do you think are the other main problems?

S.R: Problems are mainly at the level of urban primary health care. They are of such dimension that if they are not addressed immediately, most expenditure incurred on services will go waste.

These problems are :

- ★ the heterogeneity of the community as compared to rural areas,
- ★ the emergence of individualism and self-centred behaviour of residents, manifesting itself in a relatively low sense of collective responsibility,
- ★ the poorest of the poor are often difficult to reach, although their need for health care is the greatest,
- ★ ironically the main beneficiary of the urban PHC is the relatively well off, who already have some access

Approach Paper 12 5 yr plan

DEV-3.

12

Challenge of Urbanisation

Rising Urban Populations

12.1 In 2001, India's urban population, living in approximately 5,200 urban agglomerations, was about 285 million. It has increased to almost 380 million in 2011. Projections are that by 2030, out of a total population of 1.4 billion, over 600 million people may be living in urban areas. The process of urbanisation is a natural process associated with growth. It is well known that agglomeration and densification of economic activities (and habitations) in urban conglomerations stimulates economic efficiencies and provides more opportunities for earning livelihoods. Possibilities for entrepreneurship and employment increase when urban concentration takes place, in contrast to the dispersed and less diverse economic possibilities in rural areas. This enables faster inclusion of more people in the growth process and is therefore more inclusive. There is no doubt that the condition of the poor in rural India must continue to get major attention but the urban sector development should not be viewed as negating such attention or weakening it in any way. On the contrary, we must acknowledge that there is a synergistic relationship between rural prosperity and the continuum of urban development from small towns through larger cities to metros. A holistic approach to spatial development is needed if the country wishes to achieve more inclusive growth.

12.2 An interesting aspect of the urbanisation trend revealed by the Census is that the number of towns in India increased from 5,161 in 2001 to as many as 7,935 in 2011. It points out that almost all of this increase reflects the growth of 'census' towns (which increased by 2,532) rather than 'statutory' towns (which increased by only 242). 'Statutory' towns are towns with municipalities or corporations whereas 'census' towns are agglomerations that grow in rural and peri-urban areas, with densification of populations, that do not have an urban governance structure or requisite urban infrastructure of sanitation, roads, etc. As more Indians will inevitably live within urbanized conglomerations, with densification of villages, sprouting of peri-urban centres around large towns, and also migration of people into towns, the quality of their lives and livelihoods will be affected by the infrastructure of India's urban conglomerations. The infrastructure of India's present towns is very poor. Sewage, water, sanitation, roads and housing are woefully inadequate for their inhabitants. The worst affected are the poor in the towns. As more urban conglomerations form and grow without adequate infrastructure, the problems will only become worse. Therefore, India's urban agenda must get much more attention.

Urbanization – Challenge and Opportunity

12.3 As stated above, the expansion of urban India is the platform for industrial and modern service sector growth and the creation of greatly improved income opportunities for the youth of this country. In order to realize the opportunities that urbanization offers and to successfully resolve its accompanying challenges, a combination of several initiatives is needed.

- First is to step up investment in new urban infrastructure assets and maintenance of assets. It is estimated that a total of about Rs. 40 lakh crore (2009-10 prices) as capital expenditure and another about Rs. 20 lakh crore for operation and maintenance (O&M) expenditure for the new and old assets will be required over the next 20 years.
- Second, is to strengthen urban governance. A unified and effective administrative framework is necessary in urban areas with clear accountability to citizens. The elective office of mayor supported by the necessary administrative powers and machinery can provide the required framework. This may require significant changes in administrative rules to delineate clear areas of accountability for elected representatives with reasonable tenures in office.
- Third, is to strengthen the 'soft infrastructure' simultaneously with the building of the hard infrastructure. Therefore, along with the strengthening of governance structures, the enormous weakness in the capacity of human and organisational resources to deal with the challenges posed by the sector must be addressed. Efforts must be made to redress this situation in collaboration with State Governments, ULBs as well as private sector.
- Fourth, is to give adequate emphasis to long term strategic urban planning to ensure that India's urban management agenda is not limited to 'renewal' of cities. It must also anticipate and plan for emergence and growth of new cities along with expansion of economic activities. The urban planning exercise, therefore, has to be situated not only in the specific context of municipal limits but also encompass the overall regional planning perspective.
- Fifth, is to address the basic needs of the urban poor who are largely employed in the informal sector and suffer from multiple deprivations and vulnerabilities that include lack of access to basic amenities such as water supply, sanitation, health care, education, social security and decent housing. They are also not sufficiently represented in the urban governance process.
- Sixth, is to ensure the environmental sustainability of urban development. As this is a complex process, which requires co-ordinated action on different facets of urban development; the strategy would require creation of an institutional mechanism for convergent decision-making so that cities become environmentally sustainable. Such an approach would be in line with the objectives of the National Mission on Sustainable Habitats which seeks to make cities sustainable through improvements in energy efficient buildings, management of solid waste and a shift to public transport.

12.4 The urban agenda mentioned above can be described under three headings:

- Desired Inputs
- Expected Outputs/Outcomes
- Instrument of Policy/Funding Intervention

Desired inputs

12.5 Long term urban planning must focus on the development of regions, not merely on the condition of existing cities and towns. Within the region, the aim should be to identify small and medium size towns and expanding villages that have locational or natural resource advantages for future socio-economic growth. Spatial growth around such nodes may be guided by planning and investment of funds for their infrastructure. Such nodes invariably have some in-built advantages, such as lower cost of land, but at

the same time many serious drawbacks too such as poor connectivity and inadequate municipal services. If such issues are addressed by longer term, and spatially wider urban planning, then both the pace and the process of urbanization can be improved.

12.6 Urban infrastructure needs to be strengthened across the board. Primarily:

- Provision of basic amenities like safe drinking water, sewerage, waste management facilities and sanitation facilities in urban conglomerations, while also ensuring that the urban poor have access to these facilities at affordable cost.
- Improved water management, including recycling of waste water in large cities and new townships.
- Transportation in urban centres is a major constraint. Currently, public transport accounts for less than a quarter of urban transport in India. Therefore, urban mass transit including metro, rail, electric buses and trams as well as other forms of public transport must be greatly strengthened especially in under-served urban centres.
- Strengthening preventive healthcare, including 100 per cent vaccination, safe drinking water, management of MSW and ambient air quality and aggressive control of vectors that cause diseases. A National Urban Health Mission may be considered to meet these objectives.
- Strengthening the secondary and tertiary healthcare systems using PPP models wherever possible, and ensuring adequate availability of such services to weaker sections.
- For inclusive urban growth, policy initiatives must result in an enabling environment for productive and dignified self-employment. Permissions, as well as provisions of spaces and other facilities for small enterprises are necessary. Institutions of self-help groups, producer societies, and other forms of cooperatives can be one approach amongst others. The formation and growth of formal enterprises may be facilitated too to enlarge opportunities for good employment within the cities.
- The Skill Development Mission must be geared to creating extensive skilling facilities for a wide range of contemporary occupations.
- The housing business is largely in the private sector. Government should consider using land as leverage for market based strategies and PPP models to greatly improve the scope of affordable housing for weaker sections.
- The condition and needs of the most vulnerable urban citizens must always be kept in the forefront if urbanisation is to be inclusive. Without doubt, the most vulnerable are 'street children' in Indian cities, who have no option than to live and work in miserable conditions on the streets. Safe housing and care of the elderly is also becoming a major concern in Indian cities.

Expected Output/Outcomes

12.7 The emphasis on urban development, keeping in mind both quality as well as geographical spread, should result in improvement of the ability of urban aggregations to gainfully accommodate migrants from rural India.

12.8 The urban centres and their peripheries should become the launch-pads for expansion of manufacturing and modern services. Economies and innovations within them should provide the

country with the desired global competitive edge in larger numbers of products. Such economies of agglomeration would also enable the country to take full advantage of its diverse production base. Thus urban conglomerations can create employment opportunities for a variety of skills and talents.

12.9 Improved urban amenities and infrastructure would not only create acceptable quality of urban life for its large urban population including its vulnerable groups but should also allow India to realise its full potential of emerging as a major tourist destination in the world – which it is not yet in spite of the country's 'incredible' range of potential attractions for tourists.

12.10 Urban centres have also to serve the interest of S&T development and become centres of innovation. However, in order to create the appropriate environment for the pursuit of higher education and scientific and technological research special efforts need to be made to earmark those areas of urban space that are best suited for it.

12.11 Policy interventions like the Rajiv Awas Yojana (RAY), coupled with policy measures for augmenting the supply of affordable housing, and expanded access of subsidized healthcare and education to the urban poor should result in a significant reduction in the proportion of slum dwellers and in geographical spread of slums.

Instruments for Intervention

12.12 Implementation of a comprehensive agenda for managing the urban transition requires action on several fronts.

Governance

12.13 The regulation of urban centres is presently characterized by fragmented authority and responsibility and weak political accountability. The 74th Constitutional Amendment Act (1994) sought to provide clear constitutional status to Urban Local Bodies (ULBs). The range of functions that the ULBs are supposed to discharge is very wide and is in most cases asymmetric with respect to their authority *vis-à-vis* the State Governments and their financial resources. There is a need for adequate devolution of funds under the 3-F principle of Functions, Funds and Functionaries.

12.14 Elections to most ULBs have been held but these bodies must be invigorated and enabled to discharge their responsibilities. At present, ULBs have become are too subordinate to the State Government machinery. It is imperative they have adequate autonomy to function effectively. There is need for constitution of Metropolitan Planning Committees as well as for formation of specialized planning development authorities like Urban Metropolitan Transport Authority (UMTA) to be created under it.

12.15 It is also imperative to demarcate a careful division of responsibilities between State level bodies, Regional planning authorities and Urban Local Bodies (ULBs). Therefore, the 18 functions listed in the Twelfth Schedule of the Constitution must be broken into specific activities and responsibility for each activity assigned to the level which is best suited to perform that function.

Capabilities

12.16 Administration and technical management of urban development must become more professional. Technology must be deployed to improve service delivery and governance. Capacity building must extend

to training of elected representatives in urban governance issues. Since these problems are not unique to any single ULB, the Central Government should catalyze an ongoing process of capacity building and improvement by creating institutions of excellence as well as interactive forums for sharing best practices.

12.17 Changes in power and capabilities of functionaries should result in their capacity to discharge their municipal obligations, as well as capacity to generate financial resources through taxation and fees which will strengthen their autonomy.

Financing

12.18 The Government would need to continue to financially support both building capacity and building urban infrastructure from the public exchequer till capacity is built in the urban local bodies to promote PPP. The investment requirements for delivering necessary infrastructure services in urban areas are huge. The High Power Committee on Indian Urban Infrastructure and Services which was appointed by the Ministry of Urban Development has recently submitted its report and has estimated that water supply, sewage, solid waste management, storm water drains, urban roads, urban transport and urban street lighting would require an amount of Rs. 39.2 lakh crore (at 2009-10 prices) over the next 20 years to meet the requirements of the projected urban population, meeting currently established standards. The Committee recognised that budgetary resources can at best play a catalytic role in channelizing investment to this sector. There has to be a two-pronged strategy to bridge the gap in resources: to create a policy environment for fostering cost-saving innovations; and mobilisation of resources through innovative methods of financing.

12.19 Achieving financial sustainability through own resource mobilization of city level governments through betterment levy, additional FAR charges, conversion of land dues charges, external development charges and infrastructure development charges has been an important objective of JNNURM which must be considerably strengthened in the Twelfth Plan period. Besides attracting private investment, unlocking the value of land for financing infrastructure projects, with intelligent use of Impact Fees and higher FSI, should form a core element of policy initiatives. Better management of property taxes and realization of fair user charges are other sources which need to be tapped by urban local bodies.

12.20 A massive push is needed to attract private investment in all areas of urban infrastructure, both for large infrastructure projects and for drinking water supply, waste water recycling, treatment of MSW and treatment or urban sewerage. This should be done under an extended '4P' framework—People-Private-Public Partnerships as experience across the world indicates that in urban renewal and management, the role of 'People' in design of projects and partnerships is crucial, much more so than in large infrastructure projects such as highways, airports, power, power plants, etc. in which 'People' have a relatively limited role in the ongoing governance of the projects and their outcomes. Therefore, best practices and models for 'PPPP' must be evolved and deployed for India's urban management agenda to succeed. These PPPP projects may become more viable if a subvention from property and other urban taxes is imaginatively used to meet any financial gap in the projects where felt necessary.

Urban Planning

12.21 Urban planning is the crucial element in the whole approach to tackle the challenge of urbanization. The City Master Plan should be a comprehensive plan, containing all details including futuristic development. The Master Plan should form the basis on which further action can be taken by the ULB,

if they are to leverage the value of land, in whatever small extent that is feasible. Much more attention should be given to 'urban forms'. What is the shape and type of city that is desired? The capacity for urban design and planning must be developed to address such systemic issues taking into account all necessary and inter-connected parameters. Urban planning cannot be limited to spatial allocations and engineering solutions: it must encompass and connect various socio-technical considerations too.

12.22 There is an urgent need to shift focus towards an outcome-based approach that is based on service level delivery rather than an approach that focusses only on investments and asset creation.

12.23 International studies confirm that there cannot be a model blueprint of a 'world class' city. 'World class' cities vary considerably in their shapes and flavours. Many large cities in North America and Europe had to undergo substantial renewal and became world class through a process of participative evolution. The spirit of Indian democracy and desire for further devolution makes it imperative that urban planners of Indian cities master participative processes of planning that enable citizens to shape the cities they want. In fact this may be the key to an ongoing process of urban renewal and growth in the country.

Interventions by the Central Government

12.24 The Central Government's thrust on guiding and improving the quality of urbanization in the country must be intensified. The JNNRUM, the flagship program, will have to continue in some improved form. It must be redesigned and improved to incorporate the lessons learned so far and to suit the next stage of India's urban renewal. The Rajiv Awas Yojana (RAY) has been outlined as another major program for urban improvement specifically from the perspective of prevention of slums and improving the condition of the urban poor. As mentioned before, there must be more coordinated management of infrastructure within towns and cities. Therefore, Central Government programs must also converge and the new JNNRUM and RAY should be integrated into a coherent program. Until the new program is introduced in the Twelfth Plan, there must be no hiatus in the implementation of existing projects of JNNRUM that have been partially completed. For this, a suitable transition arrangement will need to be made.

12.25 The key principles for designing the new flagship programme, derived from evaluations of present programs, as well as the analyses done to frame RAY, should include:

- Take a 'whole city' approach to planning and improvement (slums cannot be prevented by focussing on just the slums: the layout and distribution of infrastructure of the whole city must be considered)
- A 'city master plan' must be much more than a zoning plan and an engineering plan for the 'hard infrastructure'. It must address the condition of social services and progressive improvements in the 'soft infrastructure'.
- Focus on the needs of the poorest inhabitants of the city. The richer inhabitants are able to look after their needs through private arrangements, and thus private enclaves will grow side by side with ghettos of the poor if the needs of poorer citizens are not given primacy
- Better management of land use, and leveraging of land values to finance infrastructure
- Innovations in assignment of 'property rights' to enable poorer sections to participate in the orderly development of cities by their ability to access finance

- Strengthen the ability of urban local bodies to finance the maintenance and building of infrastructure
- Avoid 'one size fits all' solutions
- Decentralise decision making and ensure participation of all stakeholders including the local communities so that schemes are suitably calibrated to meet local requirements and aspirations

12.26 The National Development Council, while reviewing the Mid-Term Appraisal of the Eleventh Plan, had noted the importance of the urban sector for inclusive growth, as well as the challenges that need high-level attention by the Centre and the States. A Sub-committee of the National Development Council (NDC) has been set-up to focus on the urban sector. The Sub Committee will consider the recommendation of the High Power Committee on Indian Urban Infrastructure and Services and hopefully also deliberate on the issues raised in the Approach Paper. The findings of the Sub-Committee and its recommendations will be invaluable in formulating the Twelfth Plan.