NGO-8

MCC
Guiding good causes

MURRAY CULSHAW CONSULTING

Helping voluntary organisations **communicate and fundraise**

Certificate programme 2004

515
30/7

MENTORING | TRAINING | RECRUITMENT | RESEARCH | EVALUATION | PUBLICATIONS

Certificate programme in public communication and fundraising

MCC announces its third certificate programme in public communication and fundraising, to be conducted from 4-22 October 2004. The course is aimed at voluntary organisations wanting to build a constituency of support within Indian society. It is also for people who would like to work as communicators and fundraisers in voluntary organisations. Public communication and fundraising implies communicating social causes to, seeking support from and becoming accountable to the public within India.

The MCC programme will train participants over a period of three weeks during which they will learn the basics of communication and fundraising, and apply it to the needs of their organisation. On completion of the programme, they will either be absorbed by the organisation that has sponsored them; or, if they have sponsored themselves, will find placements in the expanding demand for these skills in the voluntary sector.

Fee

The total course fee is Rs 20,000. This will cover faculty, facilities and course materials. The fees can be paid in two instalments: Rs 10,000 at the time of registration and Rs 10,000 on the orientation day.

Faculty

The faculty includes MCC staff, experienced voluntary sector fundraisers, and media and advertising professionals. MCC's core faculty includes:

Murray Culshaw
Former director of Oxfam in India, Murray has 30 years of experience in the voluntary sector, predominantly in India - in managing development initiatives; formulating policy and programme priorities; advising on institutional development; evaluating project plans for financial resource agencies and in developing communications and fundraising strategies.

Bharati Ramachandran
Head of consulting at MCC, Bharati has over nine years of experience in writing and editing, for newspapers, magazines, as well as print and online publications. Bharati trains and provides hands-on assistance to voluntary organisations with their communication materials and strategies to communicate with and raise resources from individuals, institutions, trusts and companies.

Curriculum

Module I - Introduction to philanthropy

- History of the voluntary sector in the region
- International and regional perspectives
- Importance of a diverse income base
- Principles of fundraising
- Psychology of giving
- Tax exemptions
- Resources for fundraising

Module II - Getting started with resource mobilisation

- Ethical policies
- Drafting an organisational ethics policy
- Fundraisers' code of conduct
- Introduction to resource mobilisation
- Importance of public fundraising
- Role of boards and staff in fundraising
- Introduction to databases
- Building your constituency database
- Organising yourself to raise resources
- Fundraising mission and vision statements
- Communication audit
- Characteristics of a good fundraiser
- Accountability and transparency
- Building credibility through regular reporting

Module III - Communication methods

- Why people communicate
- Importance of communication in fundraising
- Methods of communication
- Principles of communication
- Stories of change and statements of achievements
- Use of photographs, aesthetic rules
- Making effective presentations
- Introduction to writing and editing
- Visiting card
- Brochure
- Newsletter
- Annual report - importance, guidelines
- Email and personalised mass mail
- Effective search techniques
- Online briefcases and web calendars

Duration

Intensive course: 4-22 October 2004 Follow-up and evaluation: 17-21 January 2005

The programme contains six intensive modules that will be covered in three weeks at the MCC training centre in Bangalore. Three months after this, a week has been scheduled for follow-up and evaluation. Classes will be interspersed with discussions, seminars, field visits, debates, hands-on exercises and guest lectures. During the three-month period in between, the student will go back to his or her own organisation and implement specific assignments. The faculty will keep in touch with the students during this period. MCC will issue a certificate on successful completion of the programme.

MCC also offers mentoring services to voluntary organisations in communication and fundraising. We would be very happy to provide this to participants and their organisations either during or after the course for an additional fee.

Eligibility

Arts, Mass Communications or Journalism graduates, who wish to work in the voluntary sector in communications and fundraising; or graduates with experience in the media, public relations, marketing and social work can apply. We are looking for individuals with positive personalities and possessing good people skills. Good spoken and written English is essential.

Nisha Purushothaman

Head of training at MCC, Nisha has an MS in communications and over the last three years has developed training curriculum and course content. Nisha trains voluntary organisations in developing strategies for a diverse income base and skills for preparing communication materials like interesting annual reports, brochures, newsletters and direct mail packages.

Ranjini Victor

Coordinator of MCC's training programmes for over a year now, Ranjini has a background in English literature and has conducted research on various aspects of the voluntary sector in India, like patterns of giving in religious institutions. Ranjini organises skill building and custom-built courses and also trains voluntary organisations in the basics of communications and fundraising.

Module IV - Building relationships

- Donor relations
- Interpersonal and presentation skills
- Letters - covering letters, thank you letters, envelopes
- Creating a media database
- Types of coverage
- Press releases, press kits, photo ops
- Planning a media strategy
- Researching corporates and types of support
- Approaching and cultivating relationships with corporates
- Drafting a corporate plan
- Involving all staff in fundraising
- Involving your Board in fundraising

Module V - Fundraising techniques

- Introduction to face to face fundraising
- Types of fundraising events
- Planning an event
- Role of volunteers in special events
- Why direct mail? Cold and warm mail
- Elements of a direct mailer
- Writing effective appeal letters
- Mailing lists
- Types of grants
- Key elements and guidelines
- Writing a proposal idea and a concept note
- Proposal to raise funds for fundraising
- What internet fundraising involves
- Introduction to payroll giving

Module VI - Planning

- Analysing income and setting targets
- Analysing existing experience, capacity, opportunity
- Drafting outline budget
- Preparing an outline communication and fundraising plan for a year
- Basic monthly reporting

'The long-term training course was an enriching experience for me at both the personal and professional levels. I feel that my self confidence and quality of presentation have improved through this training. I liked the way the course was designed and the methodology (participatory, lectures, presentations, individual tasks and work to do at our organisations).'

Sandra D'Souza, Trusts and foundations fundraiser
National Campaign on Dalit Human Rights, Bangalore
Certificate programme in public communication and fundraising 2003-2004

'... Last year my contribution to Khushboo was Rs 77,000 and this year it was Rs 9.5 lakh - this includes a van. The organisations I brought in were Perfetti, Narain Dharmarth Aushdhalya Trust, British Gas and Concern India Foundation. I am really grateful to your training.'

Sudeshna Sengupta, Khushboo Welfare Society, Gurgaon
Certificate programme in public communication and fundraising 2002-2003
(in March 2004, by email)

M|C|C
Guiding good causes

Murray Culshaw Consulting (MCC) is a Bangalore-based organisation working with good causes, primarily in India and South Asia.

Established in 1995 under the name Murray Culshaw Advisory Services, MCC enables organisations to communicate with, seek support from and become accountable to the public. We do this through a combination of hands-on help, training and research.

Send in your application to
Head of Training
MCC - Murray Culshaw Consulting

2nd Floor Vijay Kiran Building
314/1 7th Cross Domlur Layout
Bangalore 560 071 India

Tel: 91-80-2535 2003/ 5115 0582/ 3061 2622
Fax: 91-80-2535 2003
email: training@fundraising-india.org

MENTORING | TRAINING | RECRUITMENT | RESEARCH | EVALUATION | PUBLICATIONS

www.fundraising-india.org

Certificate programme in public communication and fundraising

Application form

INDIVIDUAL DETAILS

Name (in BLOCK Letters) _____
(Ms/ Mr/ Mrs) main name/ surname first name

Home address _____

District/ City _____ Pin _____

State _____ Country _____

Telephone _____ Email ID _____
with area code home

Educational qualification _____

Languages known _____

Date of birth _____

Position/ Designation _____

Describe in 100 words any experience you have in communication and fundraising. ***Use reverse or separate sheet.***

Describe in 100 words why you want to enrol in this programme. ***Use reverse or separate sheet.***

Describe in 100 your career objectives in the next 5-10 years. ***Use reverse or separate sheet.***

ORGANISATION DETAILS (*if applicable*)

Name _____

Organisation address _____

District/ City _____ Pin _____

State _____ Country _____

Telephone number _____ Fax _____
with area code work

Email ID _____ Website _____

PAYMENT DETAILS (please note cheques/DDs to be drawn in the name of **Murray Culshaw Consulting Pvt. Ltd.** , payable at Bangalore)

I/We _____ hereby enclose a cheque/ demand draft number

_____ dated _____ for Rs _____ as the first instalment towards fees.

I agree to pay the balance in full/ _____ instalments as agreed with MCC.

Signature **Date**

Note: MCC reserves the right to conduct an interview before the start of the training (travel expenses to be borne by the sponsoring organisation) to help decide on the suitability of a particular candidate for this programme. If a person is not accepted, any fees paid will be returned.

Applications to: Head of Training, MCC, Vijay Kiran Building, 2nd Floor, 314/1, 7th Cross, Domlur Layout
Bangalore 560 071· Tel: 91-80-2535 2003 / 5115 0582· email: training@fundraising-india·org

Last date for receipt of applications is 20 September 2004. Successful candidates will be informed by 24 September 2004.

culturally cultivated people in this hemisphere".
Besides the embargo, Cuba was more recently devastated by the collapse of the former Soviet Union, its long-time ally and trading partner. Currently, Cuba has few ties with the successor state, the Russian Federation.
Additionally, the global recession has severely affected Cuba's sugar industry, the victim of falling international prices compounded by the industry's domestic ills.
The country now depends primarily on tourism (which brings in about one billion dollars annually) and expatriate remittances (about 600 million to about one billion dollars annually) for its economic survival.
(END)

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DEVELOPMENT-U.S.: Aid Promises Misleading - Report
By Emad Mekay
WASHINGTON (IPS) - The Bush administration's loudly trumpeted recent announcements of development aid hikes coupled with more money to fight HIV/AIDS globally do not match budgetary realities and may translate into far smaller increases than anticipated, say two economic think tanks.
In a report released on Tuesday (May 20), the Center for Global Development (CGD) and the Center on Budget and Policy Priorities, both based in Washington, say the promised aid increases will be far more modest than announced and that U.S. aid remains well below historical standards and far below other donor countries.
"The administration was quick to make large announcements and has been much slower in following through and ensuring that those announcements translate into actual new spending on the ground," said Brian Deese, programme associate at the CGD.
"I think this is more of a reality check ... given adequate pressure and considerable bi-partisan support in Congress, we could still see positive development," he added.
On Wednesday, Bush said he was looking forward to signing a bill next week, passed by Congress on Wednesday, to give 15 billion dollars - including 10 billion dollars in newly-pledged money - over five years to fight HIV/AIDS in Africa and the Caribbean.
He called the plan "the largest, single up-front commitment in history for an international public health initiative involving a specific disease".
The AIDS money comes on top of the president's announcement in

GPPI research file
Jno 22/6/03

March 2002 of the largest increase in development aid since the Kennedy administration (1961-63), through a proposed hike of 10 billion dollars for the Millennium Challenge Account (MCA).
The promised increases were hailed as steps to fundamentally transform U.S. development policy and maximize its impact in the developing world, and received positive reviews from aid agencies, development groups and some civil society organisations.
Yet, the new report reveals that although the administration's original proposal for the MCA called for a whopping 10 billion dollars over three years, to reach and sustain annual funding of five billion dollars a year starting in 2006, Bush's actual request for the MCA in the 2004-2006 budget is only four billion dollars.
"The administration's budget proposes funding the Millennium Challenge Account at levels far less than it has announced," says the report, whose authors say they used data from Office of Management and Budget, the Congressional Budget Office, and the U.S. Agency for International Development (USAID).
"This is only 40 percent of the administration's initial public commitment," it adds. On top of that, some of the four billion dollars would be spent after 2006.
To further undermine the administration's MCA forecast, the report quotes figures from the Congressional Budget Office (CBO), a usually optimistic body, that estimates that actual MCA spending from 2004 through 2006 will be 1..7 billion dollars, or 17 percent of the president's initial public commitment.
When the budget was released in early February, some administration officials suggested that the request was an error, and that the figures for 2005 and 2006 would be corrected to reflect the increase to five billion dollars a year.
But the 11-page report notes that till now, "the numbers have not been corrected".
"If the administration does clarify this issue, it will need to reduce resources proposed for other areas in the budget or build in a higher expected deficit," the report adds.
The disparity between rhetoric and reality also extends to promised funds to battle AIDS. In his State of the Union speech Bush pledged 10 billion dollars in new spending over the next five years, but the report says the president originally requested only 450 million dollars for his new HIV/AIDS initiative for 2004.
The request, says the report, left unclear how that figure would be raised over the coming five years to reach the much-touted 10 billion dollars.

Again here, the CBO dampens the forecast, estimating that only 45 million dollars (of the originally proposed 450 million dollars) is likely to be spent on AIDS in 2004.

With the fine print in place, U.S. aid spending totals a mere 0.12 percent of the economy, or about 12 cents of every 100 dollars, well below the amount devoted to aid from the end of World War II through 1996.

Measuring aid as a share of the economy is the standard approach used in international comparisons.

The report says that after adjusting for inflation, the president's budget, plus a recent wartime supplemental request of 2.5 billion dollars to help reconstruct Iraq, would together result in an increase in development aid spending from 2003 to 2004 of five percent in real terms, continuing a string of recent increases.

"But because this spending has been so low in recent years, and fell so much in the 1990s, the proposed level would still be meagre by historical standards, particularly when viewed as a share of the economy and as a share of all government spending," it adds.

Still, the proposed increases merely reflect expected economic growth, it points out.

Under the budget, development aid spending as a share of the economy would equal an estimated 0.123 percent in 2008, virtually the same as the 0.124 percent level forecast in 2004.

That means that for the next several years, aid as a share of the economy is likely to be lower than it ever was in the 50 years of 1946-1996, and well below one-half the level of Overseas Development Assistance (ODA) now provided by the typical donor country, estimated at around 0.30 percent.

"The United States would still be at the bottom of the barrel among all donors in its spending on development aid (excluding military aid) as a share of the economy," concludes the report.

According to the Organisation for Economic Cooperation and Development (OECD), in 2002 Washington contributed 0.12 percent of its economy to ODA. This was the lowest share of the 22 nations examined, with the second lowest country, Italy, contributing 0.20 percent of its economy.

But Deese, one of the report's authors, warned against interpreting the paper as a call to simply increase foreign aid. He said the Bush administration should continue to pressure developing countries to make aid more effective.

"It's not necessarily that the U.S. should immediately increase its foreign aid budget to some set level but in fact it should continue to

put some real meat behind a commitment (by developing nations) to do more and do it well."

(END)

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ENVIRONMENT-BURKINA FASO: Each Year, Consumers Face Similar Water Crisis

By Brahima Ouedraogo

OUAGADOUGOU (IPS) - For 25-year-old Ablasse Kindo, selling water has been his life. For nearly half his life, it has provided him with all his comforts.

But of late Kindo has been experiencing unusual water scarcity as he plies his trade in Pissy, a poor suburb of Ouagadougou, the capital of Burkina Faso.

"You have to wait until 2 or 3 O'clock in the morning when water begins to trickle from the tap," Kindo says. "In the past, water rationing used to start in April".

Not anymore. The weather pattern seems to have changed. Since February, the City of Ouagadougou has experienced water shortages, and rationing has begun in earnest in parts of the capital.

"The poor can't afford to sleep anymore because if they do, they'll never get water," says Sita Kabore, a housewife in Pissy.

Before February, a 200-litre barrel of water used to cost 60 CFA (about 10 U.S. cents). But the price has now shot up to 1,500 CFA (about 25 U.S. dollars), thanks to the shortage and speculation by vendors.

In January, the National Office of Water and Sanitation, a state-run corporation, banned washing vehicles and filling swimming pools in a bid to conserve water.

"Demands are greater than supplies and our production capacities are limited," says Dieudonne Sawadogo of the National Office of Water and Sanitation. "Rapid urbanisation and population growth require alternative resources of which, unfortunately, there are few".

About 80 percent of Ouagadougou's population, estimated at 1.2 million, is served by the National Office of Water and Sanitation, which has 40,000 subscribers and 600 public water outlets.

During the hot season, which begins in February, temperatures in Burkina Faso, especially in Ouagadougou, frequently hit the 44-degree-centigrade mark.

The water deficit in the capital stands between 15,000 and 20,000 cubic metres per day during peak time. Unfortunately, the National Office of Water and Sanitation can only supply 58,000 cubic metres

NGO - 8.

FRLHT
Foundation for
Revitalisation of
Local Health Traditions

Ref: GG/Hos/03/02

To

Dr.Ravi Narayanan
No. 362, 5th Main,
1st block, Koramangala,
Bangalore-34
Ph: 55315181

24th July 2003

Sub: Interface Meeting with scientists, and medical professionals to discuss the design of an Ayurvedic research hospital, pharmacy and training centre, which is proposed to be established at FRLHT Campus, Bangalore on August 7th 2003. 9.30 pm

Dear Dr. Ravi Narayanan

I am writing to invite you to an Interface Group meeting to advice on a project that FRLHT is developing for establishment of an Ayurvedic research center, pharmacy and International training centre, at Bangalore. This meeting will be held on Thursday, August 7th at the FRLHT Campus in Bangalore (Yelahanka).

Please permit me to briefly introduce FRLHT to you!

FRLHT is committed to the vision of revitalisation of India's medicinal heritage.
During the last ten years, FRLHT has designed and implemented several significant programs involving conservation and sustainable use of medicinal plants. Enclosed, please find a small note on FRLHT describing our activities.

As a part of FRLHT's mission, we are in the process of establishing an Ayurvedic research hospital, pharmacy and an international training center:

- THE RESEARCH HOSPITAL will focus on management of such conditions pertaining to curative, preventive and promotive health care which are relevant today and have successful measures in Ayurveda. We visualize this center to be a center of excellence in clinical medicine which documents the effectiveness of Ayurvedic treatment and therapies, on modern medicine parameters. It will focus especially conditions for which allopathic medicine is either ineffective or too costly.

- THE RESEARCH PHARMACY will be developing standards on modern parameters for Ayurvedic products, to be developed as per *"Bhaishajya kalpana"* principles, which can be applied at home, cottage industry and industrial settings.

- AN INTERNATIONAL TRAINING CENTRE for medical community and health care professionals from India and abroad to receive training in clinical and non-clinical applications of Ayurveda, which they can use in their own institutions.

74/2, Jarakabande Kaval
Post Attur, Via Yelahanka
Bangalore 560 064, India.
Phone +91 080 8568000 / 8568001
8565760 / 8568299
Fax +91 080 8567926
www.frlht.org.in

We are taking on this unprecedented task to link two culturally diverse medical knowledge systems as a stratergy in order to promote understanding of the contemporary relevance of Ayurvedic health-care, to the modern medical world. We are inviting experts from the fields of modern science; I T Tele medicine, pharmacy, pharmacology clinical medicine and biochemistry to appraise our proposal. A detailed program for the day will be sent to you on confirmation of your availability to attend this meeting.

A first draft concept note on our idea of this centre is enclosed for your kind persual. A second draft will be sent to you shortly after we incorporate inputs from a focus group meeting on 12.7.03 and Peer group meeting with Ayurvedic experts, that we are having on 26.7.03. We would like to have this interface with veterans in the fields like you, to help us to design the project to deliver its goals.

To make it convenient for you to attend FRLHT will be pleased to reimburse your travel costs and provide for local hospitality and a per deim.

Kindly confirm your ability to attend the interface meeting on Thursday, August 7th as soon as possible! We look forward to a fruitful interaction and exchange of ideas.

Thanking you in anticipation,

Sincerely yours,

Ph: Direct: 080-8460549
Fax: 080-8567926
Email: vaidya.ganga@frlht.org.in

Ps: Please send your email address, so we have your ID

Dr. G.G Gangadharan
Joint Director, FRLHT

List of Invitees

1. Ms.Urmila thate
2. Dr. M.S Valiyathan
3. Prof. Ranjith Roy Choudari-Delhi
4. Mr. MUR Naidu
5. Dr. Nithishetty
6. Dr. Ravichandar GKU
7. Mr. DBA Narayanan
8. Dr. Anisha, Pargal
9. Dr. Premilla – Chennai
10. ISRO (Telemedicine)
11. Mr. Farooqui IAS
12. Dr. Ramanadhan
13. Prof. Seetharam
14. Dr. Ashok vaidya
15. Dr. Ravi Narayanan
16. Dr. T.K Parthasarathy
17. Dr. Vipul Chawla
18. Dr. C.Suresh Kumar

FRLHT

INTERFACE MEETING

7TH AUGUST 2003

7/8 Introduction
Darshan Shankar

Foundation focus – Indian Medical Tradition

Folk/Prakrit — Codified
Parampara — Ayurveda, Siddha
Medicinal Plant — Unani, Swarikhpa

Yoga
Architecture
Agriculture
Music/Mathematics
(Eco-system diversity)
(Ethnic community specific)

- Folk Medicine
- Conservation – in situ / ex situ
- No earlier programme (codified system
↓
- recognise symbiotic relationship between codified and folk systems
- Vetta/palta/kapha → familiarity in ordinary tradition

↓

Codified stream to contribute to Public Health

↓

Traditional medi policies?
West discovering ASM/CM
UK – Wd use ASM/Pay for it not in NHS

↓

Globalisation

Flow of Technology/funds → Dev countries
↓ NGOs
↓
Opening Markets of Dev. countries to Devd country products

↓

TSM – Chinese/India
Can reverse flow/balance this unilateralism

↓ —

Evidence Generation → Whatis the purpose of evidence base
not only TSM responsibility
↓
Not to validate but help TSM – Communication dialogue
↓
Not only Modern Science – (Western Biomedicine)

↓

India – Mudslinging (Compartmentalisation)

Dialogue ↓
Investment from Consumers
Institutes/Medical Professional system
↓
Not substantial investment →

WELLNESS CENTRE
NOT HOSPITAL

Sri Chitra → Preventive Cardiology

Visit around FRLHT
Gangadharan

Pluralism/complementary medicine

Medical Pluralism
10/90 gap
- Research in Neglected diseases
-

Participants

How to validate
100000 products
Therapeutics/Diagnostics
↙
to help build plural system

Ayurvedic Rx Centre — Coimbatore Arya Vaidyashala / Kottakal Arya Vidyashala

↓

MV generating dialogue information → Document cases on Modern parameter

→ Traditional Pharmaceutical Standardisation/documentation | use of metals/minerals

→ Kajal/Surma (Good user practices) — Balendu Prakash (Standardising Bhasmas)

Standardise for — Home / cottage / Industrial

⟷

Gangadharan

- Wellness Centre
- Pharmacy Centre
- Irh Trg Centre

Need

1. Double burden of Diseases of Poverty & lifestyle (cannot be handled by mainstream health care system
2. Pluralistic Global Health care
3. Ayurvedic tradition (Indian medical heritage)

↓

Marginalised — by ethnocentric policies
— Suboptimal investment - education/clin. research/public health program

Wellness Centre → Research Hospital
- Documenting cases before during and after (modern bio medical parameter
- Diagnosis & Rx on Ayurvedic theory & practice

Need for doctors from both systems

Research Areas

Prioritization.

1. Imp conditions today
2. where Ayurveda is strong
3. where Allopathy does not have enough to offer

Which are the areas in
1. Prevention and Rx where modern medicine seem to have no answer
2. General scheme for rigorous modern documentation of case studies on select condition
3. CASE Studies (based on black box approach) as opposed to single double blind clinical trial.

Physicians Friend

Research Pharmacy

(1) Which tools used in order to standardise traditional pharmac
(2) Standardisation of traditional products/processes/raw mate

Circles of dialogue

(3) What are the other areas where TSM pharmacy should concentrate?
- new dosage forms
- enhance bioavailability
- increase absorption rate
- packaging
- and else ??

Vehicle - alternative to Ghee

Training component

Learn from other CHAI-Imth/GmH comm GK-Seed Dpl/MN

- Scope:
- Area - Clinical Medical
  Non clinical Pre medic.
- Health worker Herb users Common People Students

TSM/ASM as a movement

Limitations

Alternative para digm

Hospital to wellness Centre

Open University for Ayurved,

Rules of Practicing

No ×

AND ✓

Interface

Practices
Ayurveda
Practitioner

Documentation

Obj Quantitative | Subjective Qualitative

Healer doctor | Patient client

(cure) Wellness

Disease/Syndrome Complex

Trend

Surrogate markers Unanimodulate

A note On Establishment of

Ayurvedic health centre, pharmacy and research centre.
At
Bangalore, India

Conceived and promoted by

F R L H T
(Foundation for Revitalisation of Local Health Traditions)

FRLHT
No. 74/2,Jarakabande Kaval,
Attur P.O., Yelahanka Via,
Bangalore – 560 064
India
Ph: +91 080 8565760,8568000,8568001,8568299,Dir.8565895
Fax: +91 080 8567926
Email address: info@frlht.org.in
Web site: www.frlht.org.in

Ayurveda The Ancient Science of Life Establishment of Research health centre, Research pharmacy and training centre at Bangalore.

1. Future of world medicine

The futuristic vision for "world medicine" has to be pluralistic. India with its rich medical heritage has a responsibility & opportunity to contribute to this future.

A centre of excellence as a first step towards this need, an international centre of excellence for Ayurveda is proposed to be created in Bangalore, India to promote learning of the theory and practice of Ayurveda with a focus on:

a) Positive health
b) Therapeutics,
c) Clinical-research
d) Pharmacy
e) Training

Plan for the future

- An Ayurvedic health center will be designed to offer genuine Ayurvedic treatment for prioritized healthconditions and the pharmacy will develop manufacturing protocols for classical Ayurvedic drugs based on Ayurvedic principles of Bhaisajya Kalpana.

- Both these facilities will however use "advanced bio-medical facilities", to evaluate the treatments and standardize the manufacturing protocols, so that the outcomes of the hospital and pharmacy activities can be 'replicated' all over the world.
- Both the health centre and pharmacy will therefore have a strong "training function", in order to promote the development of similar centres and pharmacies, in different Indian states and foreign countries.

Objectives of Health center

1) To establish a centre of excellence in Ayurvedic management in selected thrust areas.
2) To communicate strong aspects of Ayurveda including preventive & promotive health care using tools of modern science for clinical documentation.
3) In due course of time to develop it as a centre of advanced clinical & pharmaceutical training in Ayurveda of international standards.
4) To replicate the Bangalore type centre in different parts of the country and abroad.

2. Objectives of Research Pharmacy

The pharmacy will develop products and processes and dosage forms based on Ayurvedic principles. These will be standardised using modern pharmaceutical tools.It will standardize products at household, cottage & industrial scales

It will also get into the intricacies of bioactivity and bio availability of products which will help modern drug delivery methods.

It will also look into the factors like improving palatability, sensorial and user friendliness.

The research pharmacy will also dwell into the possibilities of the issues of individual drug and formulation standardisation based on Ayurvedic principles of "desa kala vicar"

Objectives of training
The training centre will concentrate on short term and long term, clinical and non-clinical, professional and public, programmes for different kinds of clientele.
The training centre has to become the link between two knowledge systems inorder to promote medical pluralism

Overall goals
Overall objective of this multifaceted programme of clinical, pharmaceutical and training components is to put Ayurveda in the global focus.

3. FRLHT's Track Record (1993 – 2003)

FRLHT has in its 10 years of existence demonstrated that it has the ability to visualize and implement in a focused manner 'pioneering projects' that 'impact' national policies and programs in its chosen area of operations.

The main focus of FRLHT operations during the last 10 years has been on "CONSERVATION of medicinal plant resources".

4. Milestones:

1993	In 1993 the Ministry of Environment & Forests, Govt. of India & the Dept. of Economic Affairs, Govt. of India approved phase I (1993 – 1997) of the country's first "insitu conservation programme for medicinal plants" designed by FRLHT for the Western Ghats region. This programme was supported under a bi-lateral aid agreement with the Govt. of Denmark.
1997	1997 a joint Govt. of India and DANIDA appraisal team declared the project implementation to be outstanding and supported a 7-year phase II (1997 – 2004)
1998	1998 Dorabji Tata Trust (DTT) came forward to support a pilot extension of the conservation project to Maharashtra.
1998	In 1998, FRLHT received the prestigious Norman Borlaug award for its contributions to this field.

1999 In 1999 UNDP extended support under its Country Cooperation Framework (CCF) for extension of the program to Andhra pradesh and Maharashtra.

2000 In 2000 DTT granted FRLHT a corpus of Rs.2 crores to strengthen "Medicinal Plant databases" and its pharmacognsy Lab.

2001 In 2001 the Global Environment Facility and Ministry of Environment and Forests, Govt. of India, commissioned FRLHT to prepare a comprehensive plan for expansion of the conservation program to northeast, northwest and central India.

2002 In 2002 FRLHT's 'Medicinal Plants Program' was one of the 27 programs selected by the United Nations from around the globe for the Equator initiative prize. This prize was awarded in Johannesburg at the World Summit on Sustainable Development.

2002 In 2002 the Ford Foundation, New Delhi granted FRLHT a corpus of Rs.3.6 crores to strengthen its community outreach activities.

2002 In 2002 the Ministry of Environment & Forests, Gov. of India recognized FRLHT as a national Center of Excellence for Medicinal Plants & Traditional Knowledge.

2003 In 2003 the UNDP and MoEF, Govt. of India under their CCF- II (2003 – 2007) have decided to support an FRLHT designed program linking conservation to livelihood and health security in nine states in the country, covering the western and eastern ghats region and including Rajasthan, Madhya pradesh and West Bengal.

5. CRITERIA FOR SELECTION OF "HEALTH CONDITION" FOR FOCUSED WORK, IN THE HEALTH CENTRE.

1. Diseases categorized by Ayurveda as **"krichrasadhya" (**that can be cured with concerted effort) and **"yapya** " (those, which can be managed and kept under control by critical management followed by life long life style adjustments).
2. Diseases of the above category, which are prevalent today and are of national or international concern will be preferred.
3. Diseases that do not have an appropriate and satisfactory treatment in other system of treatment.
4. Diseases, which cause higher mortality and morbidity.
5. Health Practices of a preventive and promotive nature that are unique to Ayurveda

6. UNIQUE FEATURES OF THE HEALTH CENTRE

This will be a centre, which will comprehend and put into practice all aspects of Ayurvedic management.

AHARA VIHARA OUSHADHA	- food, life style and medicine
MANI MANTRA	- use of precious stones and sound
OUSHADHAM (medicine) will include	
YUKTHIVYAPASRAYAM	- based on medical diagnostic skills
SATWAVAJAYAM	- based on psycho analysis
DAIVAVYAPASRAYAM	- based on cultural and spiritual aspects

These features will be consciously adopted in a sophisticated manner so as to evolve a secular and universal nature of health management. Modern diagnostics will be introduced and used to document & communicate the efficacy of Ayurvedic management.

7. RESEARCH PHARMACY

It will be a part of the Research Hospital. The main objectives of the pharmacy will be to set standards based on Bhaishajya kalpana

1. For products at

a) House hold level	- For housewives eg. Kajal: good users practice (GUP), quality, safety & efficacy.
b) Cottage level	- For Vaidyas / Hakims, good users practice.
c) Industrial level	- GMP (Good manufacturing practice)

2.Product development – user-friendly products, new dosage form development, improving the bioavailability, improving palatability, textures etc.

3.Resource management – how to improve extraction and optimum utilization of resources.

4.Technology adoptions-criteria for using technology without compromising basic premises of Ayurveda.

5.Develop methods to improve storage mechanism, increase of shelf life, use of non destructive plant parts instead of parts like root, stem etc.

6.Technology transfer to new units in the area of pharmacy.

8. Physical features

The physical features of this hospital should architecturally so designed to reflect the intrinsic serene & eco-friendly characteristics of Ayurveda.

It will have fourteen components as follows:

Patient's rooms or cottages:

1. a. 60 double rooms bath attached. Common kitchen and treatment rooms for a block of 5 rooms (total 12 blocks of 5 rooms = 60). Rooms should have opening in the front and back. At the backside a small sit out with a small garden open air. Ground floor and first floor. For two people to stay, one patient, one family member, simple and functional.

b. 20 cottages, with treatment rooms / kitchen attached/ two bedrooms.
Opening to a garden in front.

2. Out Patient Department
Consultation rooms – 5 nos. for 5 departments with common waiting room/ drug store/dispensary/reception.

3. Diagnostic Centre.
Clinical lab, blood bank, x-ray analytical instruments, scan etc., all modern gadgets for diagnosis and prognosis – with space for chief pathologist and other technicians. At least 10 technical staff plus waiting place for patients and reception to direct patients to respective areas.

6. Operation Theatres (OT) – 2 nos.
   a. Obstetrics
   b. Minor surgery / ksarasutra / orthopaedics

5. Yoga / meditation hall for 50 people to do yoga and pranayama at a time.

6. Kalaripayattu pit.
   Space requirement, location etc., to be collected from authentic centers (CVN Kalari, Kozhikode or Thiruvananthapuram).

7. A temple of Lord Dhanwanthari with a place for daily Havans.

8. A Goshala for around 20 cows.

9. Staff Quarters for 40 staffs

a.	15 for doctors	2 bedrooms
b.	5 for senior administrative staffs	2 bed rooms
c.	19 for masseurs and other technical staffs	1 bed room
d.	1 for chief physician	3 bed rooms

10. Power house, security house and other common requirements extra.

11. Pharmacy – 4000 sq.ft. For modern lab 1st floor,
4000 sq.ft. For Ayurveda pharmacy ground floor.

12.Canteen for twenty people to dine at a time with patya apatya components.

13.Animal house for animals other than cows.

14.Physiotherapy centre

Special Notes (Zero Energy concept in Design)

1. Solar power for lights & fans
2. Natural cooling system so all rooms are at 20 – 23 ° C temp throughout the year.
3. Rainwater harvesting
4. Sewage water recycling.
5. Herbal gardens interspersed with physical layout.

9. CURRENT STATUS OF THE RESEARCH HEALTH CENTRE AND PHARMACY IDEA.

- Around 100,000 sqft. Of land is available on FRLHT campus at Yelahanka, Bangalore for constructing the Research hospital and Research pharmacy.

- Dr. G G Gangadharan, former Vice-President of Arya Vaidya Pharmacy, Coimbatore has joined FRLHT in April 2003, to serve as the project leader.

- The next steps towards operationalising this project include:

a) Preparing a detailed techno-economic plan for the hospital and pharmacy (by Dec. 2003)

b) Selecting a core team to execute the plan and designing and implementing a training programme for them (by Dec. 2003)

c) Preparing an ecologically sensitive architectural plan for construction of the hospital and pharmacy (by Jan. 2004)

d) Raising the necessary resources for the plan, ball-park figures are: around Rs. 5 crores for infrastructure, Rs. 5 crores for equipment and Rs. 5 crores for working capital (by Dec. 2004).

FOR: REDDEMMA

Robin C. Davis

From: "Robin C. Davis" <rdavis@globalhealthaction.org> RCD
To: <reddemma@rediffmail.com>
Sent: Thursday, March 06, 2003 2:21 PM
Attach: INSA 2-03.doc
Subject: Fw: Future Plans RE: INSA/India

Reddemma,

I could not get your e-mail at nimhans to go through. Will you please send me the full e-mail address for it.

Thank you,
Robin

----- Original Message -----
From: Robin C. Davis
To: reddemma@rediffmail.com
Sent: Thursday, March 06, 2003 2:18 PM
Subject: Future Plans RE: INSA/India

Dear Reddemma,

It was wonderful to speak with you today on the telephone. I have attached the memo that we spoke about for you to share with the officers of the Governing Board before the March GB Meeting. As we discussed, this item can be on the next meeting agenda as "Future Plans" for the GB Mtg. It would be good as we discussed, for the GB officers to meet and discuss this before the next GB Meeting. Please feel free to call me or send an e-mail if you have any questions about this memo. I will post a hard copy to you by express mail as well. Please confirm by e-mail when you receive this e-mail and attachment. Also, I would appreciate having your FAX number for quick communication. In a few days,I will forward you some sample job descriptions that we use at GHA, but these of course would only be for ideas since the responsibilities at GHA and at INSA/India are somewhat different. I look forward to hearing from you.

Warmest regards,
Robin

Robin C. Davis
Executive Director
Global Health Action
404-634-5748
www.globalhealthaction.org

Healthy People, Healthy Communities, Healthy World

3-PAGE MEMO ATTACHED.

INSA India file
JW

Global Health Action

Healthy People, Healthy Communities, A Healthy World

March 5, 2003

To: The Honorable Justice S. Rajendra Babu, President, INSA/India Governing Board
Dr.V. Benjamin, Vice President
Dr. K. Reddemma, Secretary
Mrs. Vatsala Nagarajan, Treasurer

From: Robin C. Davis *Robin C. Davis*
Executive Director
Global Health Action

Subject: Congratulations on 20 years of INSA/India &
Recommendations as we look to the future

It was such an honor to participate in the UTSAV for the 20th-Year Anniversary of INSA/India, to participate in the workshops, and to learn more about the amazing work being done by INSA/India staff and participants. The organization has grown from a little seed into a significant presence for better health in India and neighboring countries. With growth comes the need to further specify and clarify the roles of staff, particularly the staff leaders. When Sujatha retired, the Governing Board decided to give a co-directorship structure a try. Having been part of that discussion before the decision was made, including the pros and cons, I think it is time to reassess this leadership structure in light of the organization's growth and the added pressure to raise more funds and sustain programs for INSA/India. During December, I had the opportunity to work with all staff for a week and a half in the office and at the workshops to see the current structure in action.

I respectfully request of and strongly recommend to the Governing Board that the following be implemented for the new fiscal year, beginning April 1, 2003:

The organization needs one ultimate staff leader/decision maker to guide the organization in its day-to-day operations and with its long-term plans. In my experience of over 25 years in this field, that person must be one with organizational leadership experience, solid management and financial skills, the ability to raise money, and the knowledge of programs and services needed and rendered. Therefore, I recommend that Florence David become the Executive Director of INSA/India and that Edwina Pereira become the Director of Programs, to clarify their roles and the channels of communication within the organization and outside of the organization. It is very difficult for staff to have two equal bosses and it is confusing to those on the outside, particularly when difficult decisions or communications are required. With the current and future demands on the program area, this is a fulltime job in itself and Edwina has shown over the years that this is her strength and her passion. Florence on the other hand is a very good administrator, financial manager, planner, and fundraiser for INSA/India. In the year 2001-2002, the team

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brought in 1 Lakh 4,000 rupees through consultancies. Florence brought in the large majority of these consultancy funds. This year the ICCO consultancy conducted solely by Florence has brought in 82,000 rupees already. Effective this year the relationship between Global Health Action and INSA/India has changed from one of GHA being a financial sponsor to one of GHA and INSA/India being in a collaborative partnership relationship where both work together when appropriate to get outside support for joint efforts. GHA's financial support in 2003 will be US$12,500 and in 2004 it will be US$5,000. By 2005 this type of support from GHA will cease. I believe this also requires a change in the organizational structure where an Executive Director would focus more on building organizational partnerships, building the visibility of INSA/India, and mainly raising funds through consultancies, contributions, grants, and program partnerships to support the organization. These responsibilities will involve focused time and travel, leaving only 10 to 15 percent time for participation in training programs.

Program development and implementation requires a fulltime effort and Edwina is very skilled in this role. Florence on the other hand, has years of experience running an organization and managing its financial and administrative matters. This is why I recommend Edwina for Director of Programs and Florence for Executive Director (the overall decision maker). I recognize that Edwina has more years at INSA/India, but Florence has as many years in the field of health and education in key leadership positions. Given the current staffing situation, I would recommend the salary of the Executive Director be at least equal to that of the Director of Programs. Currently Florence has a lower salary than Edwina and all staff knows about this from the account vouchers that are signed in the office.

In this revised structure, the Executive Director would make the final decisions about the operations of the organization, future organizational plans, and the budget and financial management, including the actual expenditure of funds and the generation of income. Fifty per cent of the Executive Director's time should be allocated to organizational development, fundraising and income generation activities such as consultancies, including the necessary travel required to accomplish these activities. Another ten per cent of the Executive Director's time needs to be allocated for travel related to conducting consultancies and attending networking/fundraising conferences and meetings. The remaining time would be spent on administrative and organizational matters, including working directly with the Governing Board.

All program site visits and follow-ups need to be made by the Director of Programs and the program staff. The Director of Programs and the program staff need to spend their time on planning and conducting programs, courses, and workshops for the organization. This would include the recruitment of course participants and program partners. The program-related travel needs to be conducted by Edwina as Director of Programs and the program team.

In this recommended structure, the Executive Director (ED) is the leader of the staff, with all administrative staff and the Director of Programs reporting to the ED. All program staff would report to the Director of Programs.

I regret that I cannot be there in person to discuss these recommendations with all of you, but please feel free to contact me about them. My office number is 404-634-5748 and my home number is 404-847-0336. My e-mail address is: rdavis@globalhealthaction.org. I would be happy to share examples of job descriptions that would clarify the implementation of these two positions. Even for someone like me who has been closely involved with INSA/India from its inception, the current dual leadership structure often makes communication cumbersome and confusing. Now more than ever, clear lines of authority and responsibility are needed in today's organizations.
I ask that you give the above recommendations your full consideration for implementation on April 1, 2003, the new fiscal year.

Each of you is to be congratulated for your faithful and committed service to INSA/India and its important contributions to health and development. The staff should be acknowledged for their committed and professional work to help INSA/India grow into such a great organization.

HRFDL WORKING AREA

- 20 Taluks from 10 Districts 400 villages,
- Population coverage around 1lakh peoples.

HRFDL-K

- A NESA partner working in 12 districts in the state of Karnataka for Dalit human rights.
- It has a participatory approach to community development and has a rights-based perspective.
- It campaigns for Dalit land rights, promotes Dalit women leadership and provides legal support to victims of atrocities.

HRFDL-K

- **Primary Objectives:**

- ✓ Abolition of caste discrimination and untouchability.
- ✓ Empowerment of Dalits through promoting awareness and capacity building.
- ✓ Working for basic rights to land, education and employment and life with dignity for Dalits.
- ✓ Provision of legal support to victims of atrocities.
- ✓ Facilitation of political participation of Dalits at Panchayat level.
- ✓ Promotion of mutual collaboration with other Dalit movements, activists and NGOs.

HRFDL-K HIV/AIDS Programme

- **Focus:**
- Dalits and other minorities and other communities. Peoples living with HIV/AIDS.
- CSWs

- **Programme Components:**
- Mainstreaming the issue of HIV/AIDS in Dalit communities.
- Capacity building.
- Advocacy Activities.
- Community Participation.

HIV/AIDS Programme Objectives.

- To prevent the spread of HIV/AIDS in Dalit communities.
- To build perspectives on HIV/AIDS as a rights-based development issue.
- TO provide STD treatment facilities.
- To advocate and lobby for rights for people living with HIV/AIDS.
- To sensitise Dalit communities to the issue of HIV/AIDS and remove the stigma attached to the disease.

Capacity building

- Orientation training for 12 HRFDL-K district convenors on HIV/AIDS, STIs and RTIs.
- Counseling skills training given to district convenors and co-convenors. A total of 30 people participated in the programme.
- Sensitization training for Dalit women and their husbands through SHGs
- Sensitization training for youth groups and school and college students,
- Formation traditional cultural teams for street play and public programmes,

Achievements.

- *District level training for Dalit leaders and activists.*

- Training on HIV/AIDS, STI's and RTI's conducted in 8 districts with the participation of 40 local Dalit organisations and 800 Dalit leaders.

- 50 volunteers trained in peer education in 5-day workshop.

Achievements.

- *Self-help groups sensitisation programmes.*

- 162 SHGs receved training in 8 districts.

- 3,240 women sensitised on HIV/AIDS and STIs.

Achievements.

- *TOT (Training for Trainers) for traditional cultural activists.*
- 15 members 2 teams prepared.
- 15 shows performed, reaching out to 30,000 people.
- Public programme conducted in Pavagada and Anaekal taluk.

Activities and Achievements.

- *Mainstreaming issue of HIV/AIDS through creation of taluk level information centres.*

- Provision of condom outlets (50,000 condoms distributed).
- HIV/AIDS and STI referrals for treatment.
- Promotion of community volunteers for care and support.
- 3 information centres opened.
- 5 more to be established shortly.

Activities and Achievements.

- *Advocacy and lobbying for people living with HIV/AIDS.*
- Provision of condoms at local health centres.
- Discussions with local government and private doctors regarding STI treatment.
- Health Action Committee formed in collaboration with other organisations in 3 taluks to carry out advocacy work.

Case Study 1

- Govindamma, an HIV Positive Aganavadi teacher in Pavagada taluk, Tumkur district was discriminated in her village and workplace due to community prejudice.

- HRFDL-K activists discussed the issue with the relevant departments, local doctors and village leaders.

- Since this intervention, village prejudices have been addressed and the issue has been resolved. Govindamma is now happy in her life and work.

Case Study 2

- In Yethanahally, HRFDL-K formed 2 womens SHGs and 1 mens SHG. As a result of this initiative, and the training and sensitisation that they received, the SHGs organised an "Audio Cassette Release Function" for awareness-raising purposes.

- Dr. Venkataramiah, a local doctor, attended the function and was impressed by the initiative taken by HRFDL-K. He offered to provide free or low cost STI treatment to Dalits and other economically poor persons. Women with STIs are now able to receive treatment for the first time.

Case Study 3

- Sukeshini is a young Dalit woman who runs a beauty parlour in Indi Town, Bjapur district. Following a 3-day HIV/AIDS training programme in her area, she became very interested in the issue.

- She now raises awareness through her parlour, educating her customers on STDs and HIV/AIDS prevention, and giving condom demonstrations and distributing them.

- Sukeshini is a very committed person and will soon received further training and support.

Impact.

- This is the first programme in Dalit communities in Karnataka.
- Following HRFDL-K activities, people in Dalit communities are starting to ask about condoms, and they are using condoms.
- Dalit men and women are independently going for STI treatment.

HRFDL-K

HIV/AIDS Workshop

11th-12th December 2003.

HRFDL-K

- A NESA partner working in 12 districts in the state of Karnataka for Dalit human rights.
- It has a participatory approach to community development and has a rights-based perspective.
- It campaigns for Dalit land rights, promotes Dalit women leadership and provides legal support to victims of atrocities.

HRFDL-K

- **Primary Objectives:**

✓ Abolition of casteism and untouchability.
✓ Empowerment of Dalits through awareness raising and capacity building.
✓ Assuring basic rights to land, education and employment and life with dignity for Dalits.
✓ Provision of legal support to victims of atrocities.
✓ Facilitation of political participation of Dalits at Panchayat level.
✓ Promotion of mutual collaboration with other Dalit movements, activists and NGOs.

HRFDL-K HIV/AIDS Programme

- **Focus:**
  Dalits and other minorities living with HIV/AIDS.
- **Core Programme Components:**
- Mainstreaming the issue of HIV/AIDS in Dalit communities.
- Dalit capacity building.
- Advocacy Activities.
- Community Participation.

HIV/AIDS Programme Objectives.

- To prevent the spread of HIV/AIDS in Dalit communities.
- To build perspectives on HIV/AIDS as a rights-based development issue.
- To provide STD treatment facilities.
- To advocate and lobby for rights for people living with HIV/AIDS.
- To sensitise Dalit communities to the issue of HIV/AIDS and remove the stigma attached to the disease.

Activities and Achievements.

- ***Capacity building for HRFDL-K district convenors.***
- Orientation training for 12 HRFDL-K district convenors on HIV/AIDS, STIs and RTIs.
- Counselling skills training given to 30 district convenors and co-convenors.

Activities and Achievements.

- ***District level training for Dalit leaders and activists.***
- Training on HIV/AIDS, STIs and RTIs conducted in 8 districts with the participation of 40 local Dalit organisations and 800 Dalit leaders.
- 50 volunteers trained in peer education in 5-day workshop.

Activities and Achievements.

- ***Self-help groups sensitisation programmes.***
- 162 SHGs received training in 8 districts.
- 3,240 women sensitised on HIV/AIDS and STIs.

Activities and Achievements.

- ***TOT (Training for Trainers) for traditional cultural activists.***
- 15 participants from 3 districts trained and a cultural team formed.
- 10 shows performed, reaching out to 25,000 people.
- Cultural programmes reaching out to 12,200 people in 5 villages undertaken.

Activities and Achievements.

- ***Mainstreaming issue of HIV/AIDS through creation of taluk level information centres.***
- Provision of condom outlets (50,000 condoms distributed).
- HIV/AIDS and STI referrals for treatment.
- Promotion of community volunteers for care and support.
- 3 information centres opened.
- 5 more to be established shortly.

Activities and Achievements.

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- She now raises awareness through her parlour, educating her customers on STDs and HIV/AIDS prevention, and giving condom demonstrations and distributing them.
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Impact

NGO-8.

Social Accountability and Social Audit of NGOs

Some loud thinking for an approach to conduct it.

NGOs (or Voluntary Organisations[VO], as some of them insist on calling themselves - to distinguish themselves from private commercial organisations which, also, in a way, are non-government by status and therefore NGOs) come into existence because (they strongly feel) that something needs to be done to harness "progress" of the society in a meaningful and appropriate manner. "Something critical is wrong! Something critical is lacking! Something critical is side-lined! Some sections of society are wronged or neglected or cheated and something needs to be done to address these issues". These (and other compelling) issues trigger initiation of VOs.

In many ways these VOs are self-appointed and are simultaneously 'independent' (in being self-appointed) and yet answerable to society (which is their *raison-d'etre*). They are also answerable to the society and to themselves to ensure that their practices and endeavour moves appropriately in the direction towards 'ideal' society (they proclaim to cherish) and also the *values* generally attributable to *humane society e.g. secularism, egalitarianism, pluralism, transparency, honesty, and most importantly humane interactions.*

VOs use monitory, human and other resources (of the society) in their *"social" entreprunership.* These resources are *tools)* and tools can be 'used', 'mis-used' and 'abused'. In any enterprise, the function and (with it), the importance of audit is self-evident

1. **Fiscal audit**

   Mandatory (legal) requirements call for fiscal (and monitory) accounting and fiscal (and monitory) audits. Fiscal audit has the longest history and have continuously developed into more and more sophisticated exercises. The important feature of this type of audit is that it is more or less standardised and universally accepted. Because of this reason it is also relatively easy to conduct.

   Unfortunately, with its sophistication, fiscal accounting practice(s) has (have) also carved out ingenious methods for 'hiding' / or camouflaging / or colouring fiscal picture. Auditor's work (in this area) is to 'monitor' 'access' and "point out" variances in the fiscal picture and to ensure that 'legal requirements are complied with before certification or to give 'qualified' certification. Audited report may not be 'transparent' In this case the auditor is not expected

to 'penalise' In fiscal audits, the auditor merely checks, monitors, reports findings and makes qualified certifications.

2. Management audit

The next in line has been the management audit. With important strides in techniques of management (of resources and people), management accounting and management audit has grown in importance and harnessed in practice. The area has been nurtured and developed mainly to usher in 'efficiency' and 'effectiveness' and navigation towards the goals set.

There are many important tools and concepts that have been generated through the development of management science (and art) but the most important for the purpose of the discussion here is the concept of 'optimal'

"Optimal". We use the word 'optimal' to distinguish from the word 'minimal' / 'maximal'/ 'average'. To my mind "optimal" means that which "appropriate with holistic considerations". (What is *optimal* keeps changing from time to time with changes in the situation). It takes into under its wings considerations of (I) economically sustainable, & (ii) harnessing of resource e.g. fiscal, time, effort, personal and personnel etc , on the one hand and creation of space and opportunities for nurture, growth and development of individuals and Organisation.

3. Social Audit

I do not know if the term 'Social Audit' is precisely defined. Which is good for now because it gives one a lee way to define it as one pleases. I would define it as auditing the existence (and performance of Organisation / individual) in terms of meaningful value to the society and its 'idealised' future.

What would that include. I do not know for sure, but for brain storming I am enlisting some 'heads' and elaborating on these wherever I can. (See below)

- **Worthiness Indices**
- Investment worthiness index
  - In an Organisation like CEHAT the funders invest money, the staff its time and effort and the peer Organisations their 'concern and support' (whatever that means). To each of these segments, a repeat of investment would be reason enough to signal *an increment* in 'worthiness.' Again the more investors would mean a signal for greater *perceived worthiness by that investor segment.* A scale would be drawn out based on this 'repeated'

or continued investment. A scale could also be drawn out based on the number of such investors. Larger the base, the larger would be the perceived worthiness to that segment. Based on the score of each of these a "Worthiness Index' (for this segment) could be constructed. This index could be from the investor's angle. Likewise there could be those from the point of view of (1) social action angle (which could be sub-divided into sections as I have tried to list below.

- Social action angle
  - Support to existing social action
  - Research for new avenues for social action
  - Lobbying facilitation
  - Academia facilitation / support
- Debt : Equity ratio (A little diversion for the moment)

  This is a thumb rule popular within the Corporate circles. "If the Share-holders are willing to invest 'x' amount of funds (i.e. investment) then the 'lenders' would brave a risk of '2x' and all this '3x' would be worthwhile, if the product of the enterprise is valued at least '300x' Perhaps if one is able to give 'value' representations to the efforts (and time) put in by the Organisation in terms of 'money' (That is already done because the Organisation pays 'salary 'where the notion is based on converting effort into 'money' - even if this is Hobson's choice. The difficulty would be to set values (in monitory terms) to product of enterprise.
- Honesty index

  It will take some time and effort to develop on this. I have put it here for brain-storming exercise.
- Transparency index

  The term "Transparency" is well known and abundantly used. And yet, I suspect everyone's notion of *transparency* is slightly (and sometimes widely) different. Thankfully across the board there is a common consensus that the greater the transparency between the interacting entities the better it is.

  I shall therefore qualify what I presume transparency means in the context of Organisational behaviour. Used in the context of Organisational behaviour, it entails that entities interacting "with" and "within" the Organisation know (or have access to) information that is (or can be) relevant to the interacting entity. Does this mean everything that goes on within the Organisation is *out on display?* I think not. There are a number of matters that need to be shielded from exposure on ethical grounds (e.g. confidentiality of the personal working

within the Organisation and many such matters) or on grounds of vulnerability to competition (commercial grounds), but transparency demands that these area be demarcated, notified to the entities interacting and be substantiated with appropriate explanation (particularly the ethical merits for such non-disclosures). The commercial (or political) shields against disclosures must also be spelled out with adequate explanations. The *more the disclosure the more* ***Open*** *would be the Organisation. One could workout a scale for* ***Openness of the Organisation*** *based on this concept.*

Likewise, there could be non-disclosures scoring also. Positive scoring for ethically appropriate to null score for commercially / politically appropriate to negative for unacceptable reasons (++++ / +++ / ++ / + / 0 / - / -- / --- /----) Based on the **Openness score (0 % to 100%)** and the **Non-disclosure score** an *index of transparency can be worked out.*

CEHAT is (I am told) planing to have a 'web page' on the internet. On the web page, it is common to have a sub-site titled "about us", In this 'about us' what is the site visitor able to access information (even if that calls for a payment of a fair fee) *about CEHAT* would give a degree of "Openness" and if properly extended transparency of the Organisation.

- Fairness index
  1. Is the Organisation fair to employees
  2. Is the Organisation fair to funders
  3. To the society it uses for its work (e g community in field research)
  4. Is the Organisation fair to the society in which it operates (country)

- Equality index

  To be developed
- Sensibility index

  To be developed.
- Reference index / Reference score (no. of citations of research products)

  CEHAT is a research Organisation It publishes papers and other publications which are to be referred to and quoted. Based on the density(?) of citations a score can be constructed.
- New approach index :
  - Different positions > common goals (Hospital accreditation)

In Hospital accreditation programme - a new approach to zero-in segments from varied "positions" to common acceptable and workable level is - to my mind an innovation - value that could be constructed for 'worthiness index.

- Universal publication (on the internet) access to beat plagiarism? (Web page) (Floppy) (data publication in Journals)

  This is yet another innovation to defeat copy-right madness. This 'value' could be subjected to 'scoring'

- Outreach accessibility

  To be worked out.

- Internal democracy - How much? How effective exercised? How fruitful in nurturing internal 'pluralism' A score could be devised

Interdependence - support index

CEHAT has liased with a number of Organisations (programmes) - complimentary / and supportive functions for a common goal. These inter-responsiveness could be subjected to a value score.

- Optimisation index (?)

  To be developed

- Ripple (meaningfulness) effect index

  - Immediate next group > next immediate group > so on. Each Organisation builds its ethos. The founding members (are presumed to imbibe this ethos *maximally*). The next proximal segment (say, the staff) is expected to be influenced next and so on. For instance practising doctors (who founded the Forum for Medical Ethics FMES) are expected to *fully contribute to the ethos of FMES.* The next proximal groups is expected to be influenced more preferentially in relation to the distal groups. Audits could aim at exploring the reality of this presumption.

- Personnel growth and development index

  (In house poll Entrance poll / Exit poll) The entering staff and the exiting staff of the Organisation have their 'picture' of the worthiness of the Organisation. Some times this is coloured by personal fancies or prejudices. These prejudices or fancies are at their high point immediately (on entering) or (on leaving). Some Organisations (or their representative) try and evaluate the perceptions of these segments *after a cooling period, say of 6-months* This score (it is believed) is useful..

- Intra-Organisation personality gradient. - Space score / involvement score / 'belonging' score

- In house value nurture index - ethics-ethos / social justice index / empathy index / open-mindedness index
- There could be more areas that could be included, with further work in this area

---

One method of scoring

(Many of these indices are *intangible* in character. It is difficult to make measured scoring. The approach adopted in sports like *gymnastics or figure skating* is that there are 6, 8, or10 evaluators. They record their instant score. The highest and the lowest scores are weeded out and an average of the rest is drawn out for arriving at score of that individual).

1. 10 evaluators to cover the range of proximity levels (very close to very distant). Evaluators who *are close* to Organisation and those which are *not close*, form a team of evaluators.
2. On each index organise score gradient (highest to lowest) Leave out the highest and the lowest and add the rest and divide by 10 (or eight) to get score for each. It is expected that scoring of individual evaluators follows a (?) curve. If it happens to be otherwise, the evaluators need to be changed -
3.
4. Organise indexes score wise and divide the range into 3 components The highest segment need to be sustained and middle segment needs to be fortified and the lowest needs to be urgently addressed to for improvement.
5. There are some indices which may need monitoring throughout Some may need to be moderated on the basis of age of the project. Some based on the category of the project Some through correspondence. Some through personal interview
6. Grading of project vis-à-vis meaningfulness
   - to social action
   - to academia
   - to lobbing value
   - to peer Organisations
7. Slippery slopes and Iceberg technique.

   It is important to be aware of areas with slippery slopes and Iceberg technique could be harnessed to investigate these areas. Some such areas that come to my mind are:
   - Asset-building - an exercise for sustenance and necessity or for ego and avarice.

Anusandhan

A note for (potential) Social Accountability Group (SAG) members for CEHAT.

Relevant History

Anusandhan Trust was envisaged and formed in 1991. Though, the thinking then was to engage in rigorous research in the areas of health - {research, particularly from the pro-people (particularly the disadvantaged) perspective} - there was a clear understanding that the outcome of research should make enabling environment for social action. Also, (additionally) (it was conceived) that it was important (where existing social action was not evident) to research and establish data that could lead to initiating social action.

To Anusandhan, it was clear that all pro-people work was important and restricting itself to areas of research would not suffice and hence whilst drawing the Trust Deed a wide spectrum of possible areas to work in were included. It was envisaged that initially there could be a centre for research, but if the need arose, Anusandhan would initiate other centres as well. CEHAT (Centre for Enquiry into Health and Allied Themes) was started some three years later and is engaged in research and action in areas related to health. Over the past six years CEHAT has grown speedily.

Whilst initiating its endeavour, ANUSANDHAN pledged itself to the values of (I) transparency (ii) honesty, (iii) openness, (iv) democratic functioning, (v) collective governance, (vi) constantly improving standards for quality output and (vii) social accountability in all its units. When CEHAT was started, structures for implementing these values were gradually put in place.

The Trust Board of Anusandhan - since the very beginning - realised that merely *constructing* structures was not enough to ensure their effective purposes. Anusandhan believes that just as featuring of financial audit report is mandatory in a company's report to the public, social audit report must also be a responsibility of an organisation in its report to the society in which and for which it exists. Nonetheless, Anusandhan also is alive to the ground realities. While norms for financial audit are tangible and quantifiable and by and large universally accepted, those for social audit are not yet sufficiently well developed. Largely, this is because of three reasons viz. (I) organisations themselves have not laid enough priorities and efforts in developing these aspects (ii) there are no existing paradigms on setting up social audit procedures and (iii) outcomes relevant to social benefits & harms are difficult, if not impossible to quantify and measure.

Rather than wait until such procedures are set up, Anusandhan thought it best to subject its 'efforts' to social accountability. It was envisaged to set up a Social Accountability Group (SAG) of persons with integrity, sensibilities and ability to critically review *all that went into the work of its centre and along*

with it the output of its work. It would be mandatory to include (attach) report of SAG along with the Annual Report of that year. As response to SAG report, Anusandhan would carry (in its next annual report) the action taken report on the recommendations of the SAG report. This way Anusandhan would have the benefit of critically evaluated appraisal for improving its own endeavour on the one hand and would serve to social accountability report before the society it aims to work for, by making it accessible to anyone who requires it and requests for the report. In time, perhaps, parameters (to build up a system) for social audit would (may) also emerge.

In 1994 (check the year / date), the first SAG - comprising of Dr Neera Desai, Dr.S.K.Pandya, Dr.Ashwin Patel, Dr. S L Shetty & Dr Ravindra Soman was constituted and served until now (a tenure of 5 years). A worthy exercise was an outcome of this SAG. But this was the first SAG and Anusandhan requested this SAG to assess the Trust's centre in the way the SAG deemed it fit. For this purpose, CEHAT provided extensive material that was generated in the centre (e.g. all papers / reports published and unpublished, minutes of the Trust Board Meetings, the Staff meetings, rules & regulations & salary structure of CEHAT, etc.).

Reviewing the exercise of SAG now, the Trust now feels that specific & critical evaluation of the Centre (from SAG) in important areas would be helpful to the Trust and the Centre for development and direction in which the Centre moves. This note attempts to list out these areas and also suggest procedures for interactions between the Trust, the Centre and SAG.

CEHAT's working structure

1. At present, CEHAT has offices in Mumbai & Pune and other field offices in Maharashtra and MP.
2. The Centre has as its chief administrator the Co-ordinator. He / She has duties & responsibilities towards (a) the Trust, (b) the administrative wing (accounts / personnel etc.), the research wing, the external contacts. He / she is authorised to depute anyone to this work. In addition, the Co-ordinator has his / her own research responsibilities on the Research Projects he / she is involved in.
3. Wage structure and Rules and Regulations are written down and are available for anyone (even outsider) who asks for a copy. A new employee is furnished with these. These could serve to foster transparency. Whenever, revisions in the wage structure are made, a meeting with staff is organised and the subject is thrown open to debate.
4. In order to nurture collectivism, democratic practices and effective space for communication within personnel and to evolve leadership qualities within the staff, the Centre has instituted a Working Group (WG). WG has elected representatives from both the Mumbai and Pune offices. The WG meets once a month. The Co-ordinator is an ex-officio member of the WG. Expenses (travelling etc.) are borne by the Centre. Elections to the WG are held every

year and any member of the staff is eligible for this. The tenure of the member is 2 years with one-third retiring each year. Care is, however, taken to ensure that both the Mumbai & the Pune offices are represented on WG. Work on the WG entails responsibilities in addition to the work that the individual on the WG has. However, for this additional work the members do not get any allowance. This is made explicit to the individuals on the WG.

5. In addition to the WG meetings Staff Meetings are held twice a year. These are organised as residential meetings at some resort that is both convenient and economical. The agenda for such meetings try and incorporate presentations of the work done by the staff, changes in administrative / accounting as also the hurdles and difficulties in the procedures etc. And any other personnel matter. Often the agenda tries to include a lecture from someone outside the Centre or a workshop. These meetings try to provide space for the staff to have a general awareness of the status (as also the difficulties, challenges etc,) of the work of other members of the staff. It also can (and hopefully does) provide space for harmonising personnel matters.
6. The Centre has put in place the Grievance Redressal Structure (GRS) This is currently under review.
7. The financial accounting and reporting is the responsibility of the accounts wing and Co-ordinator heads this wing. Chartered Accounting Firm is entrusted to oversee and certify the financial accounting. This accounting is done on the half yearly basis but the certification of accounts by the Chartered Accounting Firm is only done after the financial year ends. The Centre has an FCRA account and accounting for this purpose also forms the part of the duties of the accounts wing
8. Research Projects are submitted by the Centre for funding. These projects are drawn out by the Principle Investigator (PI) and discussed within the staff and the WG. For every research project (involving primary data collection) setting up of Ethics Committee (EC) is mandatory. This EC reviews the work at the beginning (planning stage), intermediate stage and final stage. As a procedural requirement all research and action work is subjected to a peer review at various stages and the work discussed threadbare. Copies of publication of these works (and any other publication brought out by the Centre) is sent to SAG members
9. The Trust Board sends the minutes of its meetings to the SAG. CEHAT sends the minutes of the Staff meetings to SAG and the Trust Board Members. CEHAT also sends the minutes of GRS to SAG members and the Trust Board
10. The Trust Board Members and the SAG members are encouraged to meet the staff.

Trust Board and the constitution of new SAG.

Trust Board of Anusandhan has laid great importance to the report of SAG and its (SAG's) report along with the ATR will be a part of Anusandhan's Annual Report this year. Learning from the experience, the

Trust Board recommended some inputs to address the issue. For one, it has to facilitate the co-ordination between SAG and the Trust Board on the one hand and to make Trust's requirement written and itemised for facilitating SAG report. This note is for that purpose.

Anusandhan Trust seeks to have SAG opinion /evaluation / recommendations on the following areas:

- On meeting core objectives of CEHAT
- On transparency of CEHAT's work within the Centre and with the outside environment.
- On Worthiness of the output of CEHAT - preferably with respect to individual projects and administration
- On honouring ethical concerns
- On the aspect of CEHAT's provision of space for nurturing excellence and leadership qualities of individuals on the Staff.
- On CEHAT's interaction with other Organisations
- On the space and nurturing of democracy and collective functioning within the Centre and between Trust Board and Centre
- On CEHAT's growth and development
- the Grievence Redressal mechanism and functioning and effectively of it
- On the quality of research and shortfall in the area
- Other areas that SAG may think pertinent and important.

Anusandhan believes that with a written request to SAG, it may facilitate the SAG to include the items in its report to the Trust on the one hand and to the Public on the other. It will be a binding for Anusandhan Trust to publish (as attachment to its own Report) the SAG report and to state its response to SAG report in form of ATR and what is not taken up for action with explanation to the Public.

Facilitating the functioning of SAG.

For facilitating the functioning of SAG, CEHAT had been furnishing to SAG (on a regular basis) (a) reports of the research work published and unpublished (b) the minutes of Staff Meeting and any request that SAG makes. The minutes of WG are not sent (because these take place every month and are mainly relevant to the staff co-ordination) (**check if this is correct**) but if the SAG makes a request these also can be sent to members of SAG. The Trust Board furnishes (on regular basis) the minutes of the deliberations at Trust Board meetings.

CEHAT helps SAG in organising venues for SAG meeting and re-umburses the expenses incurred for travelling and organises hospitality. Anusandhan Trust has now resolved the ethical hurdle of making allowance payment to members of SAG. Allowance for the SAG members for the days of meeting will be borne by Anusandhan Trust - not from CEHAT's funds. Also to facilitate administrative work of the SAG, - particularly in the 3rd year (when the written report of the SAG is sought) the Trust will provide

funds for a secretariat (of one or two persons) that the SAG may like to set up. The Trust urges SAG to appoint a Chairperson to co-ordinate its activities and to facilitate liaison between Co-ordinator CEHAT and Managing Trustee Anusandhan and SAG.

This note is for preparing a foreground to initiate the new SAG. It is hoped that in the first meeting between SAG members, Trust Board Members and Co-ordinator CEHAT a complete protocol will emerge.

Anil Pilgaokar, cJuly 2000
Ravi Duggal, cAugust 2000, minor modifications

Following section added by Ravi Duggal

Modalities of SAG

It is suggested that the SAG should have five members. These members should be sensitive to social research and action and must have made some significant contribution in it. They will select a Convenor from amongst themselves. The tenure of the SAG would be for three years, at the end of which a social audit report will be produced.

The SAG will get all secretarial assistance needed by them from CEHAT. CEHAT will provide SAG members all documentation, reports, papers, minutes etc., to members once every quarter for review of work. The SAG should meet once a year to take stock of the work of CEHAT and discuss amongst themselves. Also they should meet and hold discussions with all staff members at this meeting. The SAG members may choose to review the work of CEHAT selectively as per their area of interest etc.. This the SAG members must decide at their first meeting. At this meeting they must work out how they would like to structure their working and distribute responsibilities and the process of review to be followed etc..

At the end of each year a brief report after their annual meeting must be sent to the Trustees. The members are also free to send feedback to the Trustees as and when they desire. At the end of three years the SAG should carry out a formal social audit for which Anusandhan Trust will provide resources to set up a Secretariat with an anchor person of the SAG's choice, if such a person is necessary. Once the social audit report is ready it will be presented to the Trustees at a meeting and discussed. Once it is finalised the SAG report will be made public. The Coordinator and Managing Trustee will subsequently prepare an Action Taken Report and both these will be published in the next Annual Report of CEHAT / AT.

Ravi Duggal
24th Oct. 2000

NGO: 8.

ANKUR Utsava

31st March 2003, Shodhagram, Gadchiroli

- One million newborn children die without care every year in India.
- A new method of providing them medical care at home by training a semiliterate woman in villages in Gadchiroli was remarkably successful. (Lancet, 1999)

On 31st March 2003

- 1000 children who were saved by these women will assemble to celebrate the gift of life.
- Poor, illiterate parents of children who were saved by the village workers in 39 villages in Gadchiroli have collected a Gratitude Fund to save children in other places.
- This method is now being introduced in 100 new villages in Maharashtra.
- 100 village women, trained as the 'barefoot neonatologist' will receive their 'degree' in a convocation ceremony in the forests of Gadchiroli.
- They will start working in their villages on 2nd April 2003.

We invite you to join us in celebrating the 'human miracle' by ordinary village women in Gadchiroli. Annually more than a million newborn babies die in the huts and homes in India. No doctor reaches them. Most often, their deaths go unrecorded. These newborn deaths constitute 75% of the Infant Mortality Rate in India

Ten years ago we started looking for a solution. There was no technological miracle or vaccine which would save these babies. So we decided to try the human miracle! We decided to educate pregnant mothers and dais, and trained a literate village woman to become the barefoot village neonatologist in 39 villages in this poorest, semi-tribal district in Maharashtra.

Women in villages of Gadchiroli who are saving newborn babies

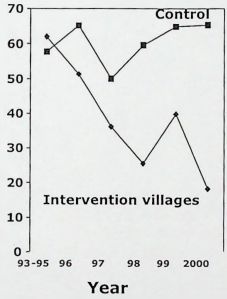
RN

Three years later :

The scientific experiment in 39 villages showed that the newborn deaths reduced by 62%
These ordinary village women could manage seriously sick newborns in villages and save them.
The study was published in the Lancet in 1999 as an original research paper (Bang A T etal. Effect of home-based neonatal care and management of sepsis on neonatal mortality : field trial in rural India, **The Lancet** Vol. 354 : (1999) : 1955-61.
The study has acquired an international recognition in the scientific circle.

As result of such simple 'human' interventions the Infant Mortality Rate (IMR) in these poor 39 villages has reduced from 121 to 30 i.e. equivalent to a semi-developed country!

Newborn Mortality Rate (NMR) in 39 villages in Gadchiroli

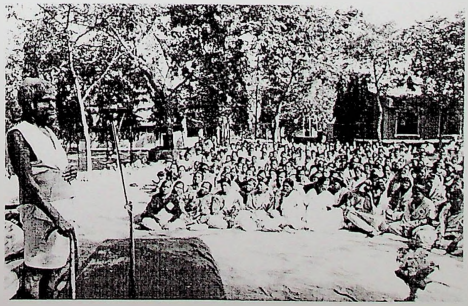


Reduction
(Intervention Vs Control Villages)
from the baseline- 1993-95

to 1998	**62%**
to 2000	**84 %**

Is it a one place wonder?

An initiative called 'Ankur" was launched on the 1st January 2002 with the first rays of the rising sun. New villages came forward from different parts of Maharashtra. Their women, 101 new village health workers took the oath on that day from Baba Amte to save every newborn baby in their village.



Shri Baba Amte gave the oath to new village women

Celebration of human potential to save lives.

- For last 15 months, these 101 village women were learning under guidance and practicing in their villages the art of saving the newborn – Home-based Newborn Care (HBNC). When evaluated by a team, including international experts, these village health workers scored mean 84% marks and 92 have passed the tests.

- We will confer the 'degree' on them in a convocation ceremony and celebrate their beginning of action of saving newborns in 100 villages scattered in different parts of Maharashtra and even in urban slums!

- One thousand children from 39 villages in Gadchiroli who were seriously sick during newborn period but were saved by these village workers, and have now grown up, will also assemble to celebrate life!

- Their parents – poor, illiterate – have collected a 'gratitude fund' for helping to save children in other places. They will dedicate that fund.

Following eminent persons will bless this 'Ankur' and felicitate the new village neonatologists.

- Mr J V R Prasada Rao, Secretary Family Welfare, Govt. of India
- Dr Armida Fernandes, President, National Neonatology Forum of India
- Mr Parvin Verma, Executive Director, Child Relief and You
- Justice C S Dharmadhikari
- Noted film maker Ms Sumitra Bhave

The function will be organised in the deep forest, at 'Shodhagram', in Gadchiroli (175 Kms from Nagpur) on 31st March 2003 from 2.00 to 4.00 PM.

You are invited to participate in this celebration.

Dr Abhay Bang and Dr Rani Bang
Directors, SEARCH, Gadchiroli (Maharashtra)
Members, National Commission on Population

Phone 07138-255407, 255406
Fax 07132-233403, 07138-255411
E-mail: search@satyam.net.in

N°10-8.

Le°6.

Ref.: CHC/Mis/2003/66. September 3, 2003.

Prof. Madhu S.Mishra,
Chairman,
Centre for Management of
Rural Development Programmes,
HM-C Joka DH Road,
P.B. No. 16757,
KOLKATA – 700 027.

Dear Sir,

Sub: Directory of Voluntary and Other Organizations in Rural / Urban Development (Vol. XXXI). Your reference Nil, Dated 21.7.2003.

Thank you for your kind enquiry with regard to the proposed publication of Vol. XXXI of the Directory of Voluntary and Other Organizations. Enclosed please find the filled in format sent by you. We would be happy to receive the copy of the Directory when published.

Enclosed is a copy of our Annual Report.

With regards,

Yours sincerely,

Thelma Narayan

Dr.Thelma Narayan
Coordinator

Encl: as above.

QUESTIONNAIRE FOR INFORMATION ON ORGANIZATIONS INVOLVED

IN

RURAL /URBAN DEVELOPMENT ACTIVITIES

Professor Madhu S. Mishra

Centre for Management of Rural Development Programme
Indian Institute of Management Calcutta
Joka, Diamond Harbour Road
Calcutta 700 104

IDENTIFICATION

1.1 Name and address of the Agency/Organization

Community Health Cell, 367, Srinivasa Nilaya
I Main Jakkasandra, I Block Koramangala
Bangalore -560034

Telephone : 080-553158 Fax : 080-552537 E-mail : Sathara@vsnl.com

1.2 Type of Organization

1. Voluntary; Local/Regional/National/International
2. Semi-Government
3. Government
4. Any other (Specify)

1.3 Name & Address of Collaborating Agencies/Organistions :

1. Several Health related NGO's
2. Govt of Karnataka
3. WHO / WHO-SEARO
4. Rajiv Gandhi University of Health Sciences.
5. Malaria Research Centre - ICMR / GoI

1.4 Year of Establishment : 1984

1.5 Geographic Area of Operation :

Name	Number
State/s	Networking with NGO's, Govt agencies
District/s	involved in Public Health through research,
Block/s	training, policy & advocacy through out
Village/s	India
Town/s	
Any other	People's Health Movement @ National & Global level

1.6 Main objectives of the Organization when established :

→ To create an awareness regarding the principles & practice of Community Health among all people involved & interested in health & related sectors. → To promote & ~~support comity health Action through voluntary &~~ govt agencies.
→ To undertake rsch in comty health policy issues, particularly in → care strategies / training strategies / Integration

1.7 Main objectives at present : → To dialogue & partici pate with health planners, decision makers & implementors of community health ~~oriented activities~~ & → To evolve strategies that will enhance comty health practice, skill & knowledge. → To establish library.
– Same as above –

1.8 Name and Mailing Address of the Head of the of the Organization :

Co-ordinator / Secretary
Community Health Cell.

Contact Telephone 080-5531518 Fax: 080-5525372 E-mail Address: sachara@vsnl.com

1.9 Major activities of the agency/organisation (Please rank in order of importance) :

ACTIVITIES	RANK
1. Agricultural/Animal husbandry	
2. Developing appropriate technology	
✓ 3. Education (Health related)	1
✓ 4. Health/Sanitation/Medical Care	2
5. Housing/Infrastructure Development	
6. Skill formation/Self-employment	
✓ 7. Training	3
✓ 8. Socio-economic development	7
9. Relief/rehabilitation	
✓ 10. Slum improvement	6
11. Extension Service	
✓ 12. Environment Development	5
✓ 13. Women & Child Development	4

14. Any other (specify)

1. Policy/Advocacy of public health issues
2. Research
3. Networking
4. Working with Govt
5. Building community capacity

I.10 Area of concentration :

1. Rural
2. Urban
3. Both
4. Any other : Tribal

I.11 Target Group/Population Covered by the agency/organisation

1. Urban poor
2. Women NGO's / SHGs
3. Poor & marginalised in rural society
4. Service provider - both community & policy making
5. Professional Education institutions level

II. **OPERATIONS*** (Major projects implemented since inception).

Sl. No.	Name of Projects	Year of Starting	Year of completion	Objectives	Location	Beneficiaries No./Type	Remarks
1.	Medico Friend Circle	1984	86	organisation responsibilities	All India		
2.	CHAI	1984	94	Policy & Training support	all India		
3.	Training NGO's	1984	Till date	capacity building			
4.	Library information	1984	open to all				
5.	(Madhya Pradesh Jan Swasthya Rakshak)						
6.	(Malaria Research Centre)						
7.	Womens Health & Empowerment	1999	2001	capacity building throughout	Karnataka		
8.	HIN	2002	2003	ICT use to improve policy & practice	Karnataka		
9.	Orissa strategy policy - state Planning						
10.	HN Project - Govt of Karnataka						

Kindly give details of projects/schemes implemented by your organization during last five years with Government Funding support.

Sl. No.	Name of the Project Scheme	Year of Implementation	Financial/	No. of Beneficiaries	Remarks
1.	WHET	1999–2001		71000	Community women leaders
2.	HNP (Govt of Karnataka)				
3.					
4.					
5.					

- (Please attach additional sheets in case the space is not enough. If reports/details of Project's available kindly attach a copy with the Questionnaire).

III. **RESOURCES :**

1. PERSONNEL

A. No. of Technical Personnel (agronomists, doctors, engineers etc.)

At Inception 02 At Present 10 (03+04+03)

Category - Number	Category - Number
1.	
2.	
3.	

B. No. of Non-Technical (trained) personnel

At Inception 02 At Present 10

Category - Number	Category - Number
1.	
2.	
3.	

C. Total No. of Personnel in your organization 20

At Inception	(04)	At Pesent	20

Category - Number	Category - Number
1.	
2.	
3.	

2. OTHER RESOURCES — No. — Value (in Rs.)

(1) 1. Office Building — Rented
2. Land
3. Equipment
4. Implements
5. Vehicles
6. Food
7. Medicines
8. Any other (Specify)

(2) Funds (Annual)

A. 1. Less than I lakh 2. 1 - 5 lakhs
3. 5 - 10 lakhs 4. 10 - 15 lakhs
5. 15 - 25 lakhs 6. 25 - 50 lakhs ✓
7. 50 - 70 lakhs 8. 75 and adove

B. Source (Percentage of funds)

1. Government — NA — 2. Non-Government — NA —
3. Foreign Govt., — NA — 4. Foreign Non-Government
5. Any other. (Specify) Local contribution & Consultancy

C. What resources could you share with other agencies -

1. Project Funding
2. Tech. Expertise
3. Medicines
4. Food
5. Equipments
6. Vehicles
7. Any other (Specify) Teaching Aids

IV. WHETHER FACILITIES FOR TRAINING AVAILABLE ? (IF YES) SPECIFY THE AREAS AND NUMBER OF PROGRAMMES CONDUCTED DURING THE LAST FIVE YEARS.

Yes, can accomodate 30 Non Resident trainees

The trainings are at field level & in other institution's setup.

V. **PROBLEMS :**

A. Identify three of your major problems (In order of importance)

1. Raising public health awareness for issues through Health Education.
2. Resonate in Govt. Health policies, which affects people's health
3. Difficulty in Building corpus fund

B. Specify the type/nature of help required to solve these problems

1. This is a process, where change occurs gradually further no time frame can be fixed
2. because of the issues
3. would like closer links with Govt

C. Indicate areas in which you would be willing to help other agencies for solving their problems.

1. The organization can be a part of
2. the process in resolving the health related
3. issues vis-a-vis the organization in question specifically in community & Public Health Medical Sociology, Health policy.

VI. **FUTURE PLANS**

A. Kindly give details of plans of action/diversification in the next five years :

→ Reinforcement of the objectives based on social paradigm of CHC will be guiding factor under which health related issues are critically examined/evaluated & alternatives proposed. Further CHC proposes to become alternative research & teaching centre for public health issue

B. What according to you are the present "strengths" and "weaknesses" of your agency/ organisation?

STRENGTHS	WEAKNESSES
→ Multidisciplinary focussed on policy & advocacy	→ 1. Non availability of experts in various fields
2.	2. for further expansion.
→ commitment to people's health movements	→ 3. Documentation needs to be improved
→ Acceptability & credibility of the organization at all levels	4. .....
	→ 5. Work Space.

VII. OTHER AGENCIES/ADDITIONAL REMARKS

1. Please let us have the name and address of other similar agencies/organisations working in your region.

Name and mailing address of the agencies/organisations

1. ....
2. ....
3. ....
4. ....
5. ....

2. Additional Remarks :

(A) Whether the organization is registered under section 35 CCA to undertake rural development activities ?

Yes	No.

(B) Whether the organisation is registered under Foreign Contribution Regulation Act, 1976 with Ministry of Home Affairs, New Delhi.

Yes	No.

(C) Whether the organisation is registered under 12A Section of the Income Tax Act.

Yes	No.

(D) Whether the organisation is a member of any NGO Forum/Association

Yes	No.

(If yes, specify)

Thanks,

Kindly return this to :

Prof. Madhu S. Mishra
Indian Institute of Management Calcutta
Joka, Diamond Harbour Road,
Post Box No. 16757, Alipore P.O.
CALCUTTA 700 027
Telephone (office) : 467 8300 - 04
Fax : 467 8307/8062
E-mail madhu_sm@hotmail.com.

Main Identity

From: "Sanjay Mukherjee" <sanjay@iimcal.ac.in>
To: <Sochara@vsnl.com>
Sent: Wednesday, August 27, 2003 5:02 PM
Subject: August 27, 2003

August 27, 2003

Dear Sir/Madam,

Sub: Management Development Programme on Management of
Non Government Organisations, September 11-13, 2003.

We are happy to inform you that the Management Centre for Human Values, Indian Institute of Management, Calcutta, is offering, in line with its professed ideals, a Management Development Programme on "Management of Non-Government Organisations" during September 11-13, 2003, at the Joka, Kolkata, Campus.

Designed specifically for NGO heads, practising managers and donor organisations, this programme specifically addresses issues confronting NGO's in their operations. Modern management techniques are brought to bear on the issues in the context of the value perspectives or ethos that inspired the inception of the NGO. A South Asian perspective is unique to the programme ever so vital in addressing social, community or simply people concerns in our sub-continent.

We trust this programme will be of benefit to your organisation. To reach out to NGO's with sincerity and commitment, the programme has been very heavily subsidised. We look forward to your participation to enrich this programme. For details, kindly use our web-site www.mchv.org. / aomdp@iimcal.ac.in

Sincerely yours,

(Prof. Ranjan Mitter)
Programme Coordinator

Lib-NGO file
FYI

TH
28/8

NGO -8

Ref : CHC/2003/30 Date : 16th July, 2003

Credibility Alliance,
South Zone,
C/o.Nagariaka Seva Trust,
No. 514, 5th Cross, 7th Main,
HMT Layout, RT Nagar,
Bangalore 560 032.

Dear Mr.Ranjan Rao Yerdoor,

Greetings from CHC!

1. Thank you for sending us the "Draft Norms for enhancing Credibility in the Voluntary sector in India". On behalf of CHC I have given this to Dr. C.M.Francis, our senior consultant for a detailed look. Given below are his comments.

Comments on "Draft norms for enhancing Credibility in the Voluntary Sector, in India (December 2002)

Page 27. Governance :
Principle : "The organisation is committed ..... donations". Delete the words "specially because voluntary organisations draw upon public funds and private donations". Good governance is needed always.

Page 29. "Robust accounting". It is not clear as to what is meant by "Robust". What is needed is "Accounting with integrity and full disclosure"

Page 29. "Consultative decision-making". Change to "Participatory decision-making".

Good Practices :

Page 34. Organisational information
Add a clause : "Positions currently held by the members of the Board in other voluntary organisations".

Page 38. Recruitment
Include a provision for "by invitation"

Page 40. Salary
Delete the words " especially when projects are supported by Government and other donor agencies, either national or international". Minimum wages must always be paid to full-time employees. The attempt should be to pay 'fair' or 'living' wages.

Page 40. Leave
"Ensure that 6 weeks paternity leave is granted". This need not be mandatory but discretionary, depending in the circumstances. The person can avail of other leave such as "earned" leave, if available.

Page 41. Holidays
Holidays other than on the declared list should be based on state laws (National. Festival Holidays Act". It is not clear what is meant by this clause. The three National Holidays are mandatory. Other holidays must be decided by the Organisation in consultation with the staff.

Page 41. Travel Policy
Invitation to National ..... event". The invitation may be personal to a particular person. The clause may be notified. "Invitation to national and international events should be considered an organisational invitation, if permissible. The person most likely to contribute and benefit from the event and able to contribute (as a result of participation in the event) to the development of the organisation should be sent to the event."

Page 42. "Encourage a 360 degree appraisal system.....". It is not clear as to what is meant by "360 degree appraisal system".

Page 43. "Consider appraisals at the time of deciding increments, whenever given, that is, increments should partly be linked to performance". This may be deleted. Increments are not "incentives" or bonus".

2. We feel this initiative is relevant given the changing values and composition of the NGO sector with the present market economy and LPG forces.

With best wishes,

Yours sincerely,
For Community Health Cell,

Dr.Thelma Narayan
Co-Ordinator

Signed & sent

NGO-8

Credibility Alliance

C/o NAGARIKA SEVA TRUST
(Development Support Group)
No 514, 5th Cross, HMT Layout, RT Nagar, Bangalore – 560032. Phone & Fax: 080- 3535532.
Email: nst@sancharnet.in

20.6.2003

Dear friends,

We request you to attend this very important meeting to discuss the "Draft Norms for enhancing the Credibility of the Voluntary Sector" prepared by the Credibility Alliance. The meeting will be held in different districts of the Karnataka State. The details of the meetings, dates and venues are furnished on the other side of this letter. A senior person preferably a member of the board is requested to attend the meeting.

Fevord-K as you are aware has taken this initiative to have this issue discussed as extensively as possible in the State of Karnataka. Other networks have also endorsed the move.

The draft norms book has been already sent to you. If you have not received the book please let us know along with your contact address. The details of the initiative are available in the document. Both English and Kannada copies are available with local convenors and NST Bangalore. For soft copy of the document, send a mail to nst@sancharnet.in. The Kannada version is in Baraha, free software available in the net at www.baraha.com. If requested we can also email the entire software.

HRM pl. get a hard copy of Kannada version.

The schedule of meetings to be held in Karnataka along with the local convenors are listed here below, you may attend any of these meetings at your convenience if you are unable to attend the one organised for your district/region. However let us know in advance as to when and where you will be able to attend the meeting for logistic arrangements. As the entire initiative is being done with a very small budget we request you to cooperate with us by sharing expenses as far as possible. We are also requesting the local convenor to collectively meet the travel expenses of only those participants who have absolutely no other support and are unable to travel and attend otherwise.

Regards,
For Credibility Alliance,

Ranjan Rao Yerdoor.

Ranjan Rao Yerdoor.

NH please ring + find out timing of meeting at Ashirvad on 24/7/03
contact – Muttappa 5361503
SN 11/7

10.30 - 2 pm.
8.30. 1.30

Noted file
SN 14/7

Sl. No.	Districts	Date and Venue of the Meeting and Time	Contact Person, Organisation and Address
1.	Udupi, Dakshina Kannada	7th July 2003 School of social Work (SSW), Roshni Nilaya, Mangalore.Phone:0824-2435791 Mangalore 10 A.M. to 2 P.M.	Ms. Rita Noronha Roshni Nilaya, Mangalore. Phone:0824-2262421
2.	Mandya, Mysore, Chamarajnagar	12th July 2003 ODP-Organisation For Development Of People, 'Pragathi", Bannimantap B Layout, Mysore, Karnataka 570015 10 a.m. to 2 p.m	Mr. Stanley, ODANADI, Mysore, Phone: 0821-22402155 Mob: 9448079155.
3.	Belgaum, Dharawad, Gadag	16th July 2003. institute for Sustainable Agriculture and Rural Development-ISARD, Pune-Bangalore Road, Near Malaprabha Grameena Bank, Dharawad. Phone: 0836-2748397 10 a.m. to 2 p.m.	Ms. Meera Halkatti, Executive Officer, IDS, Dharawad. Phone 0836-2447207
4.	Haveri, Davanagere, Chitradurga.	17th July 2003. Rotary Balabhavana, Opp. Inspection Bung[illegible] near [illegible]vanagere Club, Davanagere 10 a.m. to 2 p.m.	G.N. Simha, REACH, Kumaranahalli, Phone: 08398-820177
5.	Chikmagalur, Hassan, Kodagu.	18th July 2003 Christa Sharana, Birur, Chikmagalur District, Karnataka 577116. Phone: 91-826-755714 Mob: 9448211275 10 a.m. to 2 p.m.	Ms. Tara Serrao, Christa Sharana, Phone: 91-826-755714 Mob: 9448211275
6.	Raichur, Koppala, Bellary.	20th July 2003 D.C.Compound, N.G.O.Club, Bellary. 10 a.m. to 2 p.m.	Sr. Mary Mathew, Arunodaya Poirada Phone: 08394-446045
7.	Bidar, Gulbarga, Bagalkote and Bijapur.	21st July 2003 SEARCH Organisation, Project Office, C/o Gumaste Deshpande, Vijaya Nagar, Road 21st, Vidyagiri, Bagalkot. Phone: 08354-433256. 2 p.m. to 6 p.m.	Mr. Venkatesh SEARCH Kamathgi, Phone: 08351-787801
8.	Tumkur, Kolar and Bangalore Rural.	23rd July 2003 Ashirvad, # 30, St. Marks Road, Bangalore- 560 001. 080-2210154. 080-2279922	Muttappa, DISC, No. 44, New Bamboo Bazaar Road, Cantonment, Bangalore – 560051. Phone:080-5361503
9.	Bangalore Urban	24th July 2003 Ashirvad, # 30, St. Marks Road, Bangalore- 560 001. 080-2210154. 080-2279922	Muttappa, DISC, No. 44, New Bamboo Bazaar Road, Cantonment, Bangalore – 560051. Phone:080-5361503

10/7/03

Enhancing Credibility

These Draft Norms have been evolved through a process of consultation in different regions. This issue has been discussed and debated for years in the NGO sector ever since Bunker Roy (Tilonia) raised the issue of a code of conduct for voluntary agencies when he was Adviser on Rural Development and Voluntary Agencies with the Rajiv Gandhi government at that time it ran into controversy because it was seen as Govt. imposing a code of conduct via the adviser. CHC participated formally and informally in all these debates.

This process described in the book seems more methodical and in the light of the changing values of NGO sector in the light of LPG and Market economy - these initiative seems quite relevant

We in CHC could give feedback to the Alliance by first subjecting ourselves to a review against the norms laid out and then reporting this to them with all enrichments/difficulties if any. In the process some of our own policies may be found wanting in support of the alliance norms. we could become a member or contributor if we wish to do so

CHC to send a feedback form

Feedback form

pTO

11/7/03

Ravi 10/7/03

PK A. go through the book

(1) would you be able to attend
on 24/7 between 10.30 and 2pm

(2) I have another meeting in the morning
that day (Steering Committee of ISEC
research study)

(3) I am sending comments by Dr CMF
to Mr. Rajan Rao. See the letter
(E D.S)

Thanks
TM

PTO for RNs comments

DEENA SEVA SANGHA
22,RISALDAR STREET, SESHADRIPURAM
BANGALORE – 560 020

BACKGROUND INFORMATION

Deena Seva Sangha is a voluntary organisation founded in 1930 by a band of dedicated Gandhian workers to provide education, health care, rehabilitation of orphan and destitute children and for eradication of social evils in the society. The sangha has a number of programmes for assisting very poor people in the slums of Bangalore.

The Deena Seva Sangha is a registered society administered by a Board of Management which is the supreme decision making body assisted by the Standing committee, the Finance Committee and the Life Workers Council.

VISION, AIM AND OBJECTIVES:

VISION: To meet the basic needs of the poor people in the field of education, health care, training, shelter, food, clothing, rehabilitation of disabled, orphans, destitutes and socially handicapped, thus providing them a life of hope, dignity and a better tomorrow.

AIM: To alleviate the suffering of the poor.

OBJECTIVES: Eradication of poverty and illiteracy, by establishing schools, training centres, dispensaries, school for mentally retarded children, community health programme, formation of self help groups, homes for orphans, destitutes and daliths, vocational training programmes for women etc.

The Sangha continues to follow the basic principles of Gandhism namely love, compassion, tolerance, simplicity, self-help, non-violence and truth.

PROGRAMMES:

Educational health care, rehabilitation, computer training, reading room, library, Deena Seva Sangha Community Health project, Deena Seva Sangha School Health Programme, Deena Seva Sangha Free Dispensary, Feeding Programmes, School for special groups, Vocational Training centres for women, Girl's home, Children's home, Deena Seva Sangha Student's home. These are the centres of works of Deena Seva Sangha.

DEENA SEVA SANGHA - COMMUNITY HEALTH PROJECT (DSS-CHP):

The concept of the project was thought of and a Consultant was called into formulate the project for slum development to be submitted to WaterAid, London. The project itself started in November, 1992 And from there onwards upto date the project has been implemented year after year. The details are furnished in appendix....

The Vision, Aim and Objectives were defined in accordance with the philosophy of funding agency. The Consultant in collaboration with the authorities selected the first four slums located right around the office of Community Health Project at No.22, Risaldar Street, Seshadripuram, Bangalore-20. A preliminary survey was organised and a comprehensive project drawn up and submitted to WaterAid, UK for supporting the project.

ABOUT WATERAID, LONDON, UK:

WaterAid, in London, is a company registered under charity, mobilising the resources from water industry, Corporate Sector and General Public to support projects to help the poor in the countries of Africa and Asia. It works in these countries by establishing country offices. Its vision, aim and objectives are ;

Vision: WaterAid's vision is of an enlightened world in which all people have access to safe water and sanitation.

Aim: WaterAid aims to work through partner organisations to help poor people in developing countries achieve sustainable improvements in their quality of life by improved domestic water supply, sanitation and associated hygiene practices.

Objectives:
Support projects that integrate water, sanitation and hygiene education activities;
Help partner organisations develop their capacity to undertake integrated water projects.
Influence other organisations to adopt waterAid's approach.

Obtain the necessary financial resources

Improve continually the management of WaterAid's work

Planning hygiene education interventions, promoting behavioural change and monitoring impact.

Taking into consideration the above vision, aim and objectives of the WATERAID, LONDON, the project drawn up was considered and approved by WaterAid, London. The first phase of the project commenced on November 13, 1992 and thereafter the project has been continued in fresh areas and fresh slums located in and around Seshadripuram and Malleswaram. Altogether a total of 11 slums have been taken for development during the course of 1992 to 2001. The present area taken up from 1st April 2002 consists of three more slums adopted for development under the same project objectives bringing the total slums adopted to 14. It very closely follows Vision, Aim and Objectives of the Wateraid, U.K. The details of these projects with their project numbers and other particulars are furnished separately in appendix.... The present project is in the IX Phase

and is approved for implementation from 1st April, 2002 to 31st March, 2003. (See Appendix.... For Phase chart).

The achievements after implementations of these 9 phases are furnished in Appendix... with full particulars.

Staff has varied from time to time depending upon the needs of the project implementation and till June 2001 the staff was in tact and as much as they were fully geared to the activities taken up. In June 2001 the resources were curtailed by 40% and the staff has to be retrenched according to availability of resources. At present the staff of CHP consists of:
2 hygiene educators,
1Civil Engineer,
1 Stenographer,
1 Multipurpose Worker, in addition to the Consultant. See Organisation Chart at appendix....)

The Community Health Project (CHP) has a high power committee called the Steering Committee which lays down policies, reviews it from time to time at their monthly meetings and gives direction to the Project Implementing officer. The project has a Chairman, a Secretary, a Treasurer and five other members. (See appendix.).

HIGH LIGHTS OF THE PROGRAMME:

The programme may be classified into those concerning improvement of watersupply, concerning improvement of sanitation and those in relation to hygiene education of the resident population of the slums.

In the 11 projects that have gone by, achievements are projected and presented in appendix... as already stated. It has to be emphaised here that the implementation of the project in all its phases is spearheaded by focus on Hygiene education as also gathering of the basic data concerning the population who are involved and who are actively participating in the programmes. The hygiene education programme is a programme undertaken by all members of the staff though two hygiene educators are particularly involved in educating the residents, giving them information, education and communicating with them on all aspects of health and diseases. A detailed programme of health education wherein we have launched a one day's Training programme has its origin in the year 1994 since the other methods of conventional education yielded very poor results and showed that it did not have the impact that was expected from the programme especially education of the individual, the family and the community. This had to be changed over to a lesson of education of one day's training programme and selecting a target population from the women of the residential area. This showed that our education did have a considerable impact, while the conventional methods continued concurrently. The baseline data served as the main source of information involving data on the area, its people, demographic component, social, economic and cultural milieus, food habits, medical aid, etc., etc. The profile of the slums has been published. Profile of Phase-IX is

furnished in appendix. The baseline survey was also helpful in identifying the risk factors, problems that may be faced, the felt needs of the community and various other factors involved for successful implementation of the project. With this information one could easily set forth not only the profile but also the strategies to be adopted with a Work Plan and Plan of Action for guidance. It was also necessary to think about not only the strategies to be adopted but in case of failure, alternatives had to be thought of much before implementation and priorities had to be fixed. This was all possible with the baseline data available and building considerable rapport with the community particularly participatory approach for the community was essential and have yielded very good results.

BUDGET: The Budget, as already stated, has varied from about Rs.10 lakh per annum to a high of Rs.20 lakh and cuts down by 40% in the 2001. It is now hovering at the level of Rs.12.24 lakh. We hope to carry on the work with the available staff as per the Work Plan and Plan of Action.

During the course of implementation, many problems have arisen, many lessons have been learnt and many strategies have been worked out with the experience gained. These experiences are all documented in many of the reports submitted to WaterAid, apart from our routine progress reports, which are submitted every quarter. See list of Special reports at appendix..... Documentation of all activities and procedures has been widely appreciated. The team from London, UK deputed in 1995 arrived in Bangalore and evaluated the projects that had been implemented upto that period. They were satisfied and they stated that the documentation was excellent. The opinion of the Evaluation Committee was of very good help in view of the fact that it paved the way for grants and approval of projects during the future phases of the projects that were sanctioned from year to year.

CONCLUSION:

In conclusion it may be stated that the project implementation has been a challenging experience right from the start and it enriched experience of the staff and it has had its effect on the job satisfaction. WaterAid, London, has been approving and sanctioning grants since 1992. Deena Seva Sangha feels that the continued patronage of an opportunity given to DSS by the supporting agency for the last nearly 10 years is an indication of confidence that it has built and feels privileged and honoured to have been a partner agency of WaterAid, London. On behalf of DSS and beneficiaries we express our grateful thanks to Wateraid, London.

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Child In Need Institute (CINI)

Local Initiatives Program

Building Sustainability Through Better Management

Local Initiatives Program For Reproductive And Child Health

Child In Need Institute has been working relentlessly for the last 28 years to improve the health and nutritional status of women who are disadvantaged by the pressures of poverty and living on the fringe of society. However, CINI's health interventions have primarily served the rural areas adjoining Kolkata. The Local Initiatives Program (CINI LIP) made it possible to extend reproductive and child health services to people living in the slums of Kolkata who were overburdened by poverty, illiteracy and ill-health.

Initiated in 1999, CINI LIP is a pilot program, which works to support and strengthen the efforts of the Government to provide high quality sustainable reproductive and childcare services in the slums of Kolkata. The main focus of this programme is on family planning, safe motherhood, child survival and immunisation, adolescent health and prevention of RTI/STI/HIV/AIDS. It covers a population of 2,38,000 and is being implemented through a network of 725 trained community health volunteers from 34 health posts located in 12 wards of Kolkata Municipal Corporation.

CINI LIP offers a range of services through health posts located in the slums of Kolkata. Services provided encompass family planning, pregnancy care, child survival including immunization, adolescent health, prevention of STD/HIV/AIDS and limited curative care. Besides service delivery, the health posts serve as a nodal point for awareness generation, education and motivation of community members to facilitate effective behaviour change communication.

Community participation is an inherent aspect of the programme. Trained volunteers from the community are directly involved in implementing the programme. Each volunteer has 50-100 families under her charge and is responsible for their health. RCH committees involving local leaders have been formed, to monitor the program at the local level. The community is effectively tapped to mobilize resources and develop infrastructure for service delivery.

The programme establishes linkages with target communities and existing medical facilities through a three-tier referral system, which enables community members to access services from local private medical practitioners and local government hospitals.

Designed in line with the National Population Policy, the programme has resulted in greater family planning acceptance, expanded immunisation coverage and increased number of safe deliveries.
(CINI-LIP receives technical assistance from Management Sciences of Health, Boston and Technical Assistance Incorporated, Bangladesh.)

CINI LIP

fieldnotes@india.lip

Local Initiatives in Reproductive & Child Health

CINI CHILD IN NEED INSTITUTE

LOCAL INITIATIVE PROGRAMME (LIP) IN SLUMS OF CALCUTTA

Radha (28 yrs) lives in a slum of Calcutta. She is a mother of three children. She is pregnant yet again. Her husband is a rickshaw-puller. Radha supplements her family income by working as a maid. Her last child, Champa is a year old. Champa was delivered at home, because the city hospital refused to admit Radha. Champa didn't complete her primary immunisation and has so far received only polio drops. Radha hasn't gone for an antenatal check up for her current pregnancy. She is visibly malnourished and extremely anaemic. She has never used any family planning method. Her husband believes 'children are gift of God'.

Local Initiative Programme (LIP) in the slums of Calcutta caters to the needs of thousands of women like Radha. 60% of the total 12 million population of Calcutta are slum-dwellers, where women are often trapped in the cycle of ill-health made worse by frequent child bearing and hard physical labour.

GEOGRAPHICAL COVERAGE

LIP is being piloted in selected slums, scattered around four municipal wards (36, 56, 58 & 59) of eastern and central Calcutta by Child In Need Institute (CINI). LIP covers a total population of 2,61,000 within a three year period from September 1999 to August 2002.

PROGRAMME COMPONENTS

Encouraging Community Participation And Local Capacity Building - The entire programme is being implemented through a large network of community volunteers. The volunteers receive extensive training under the programme. They are well equipped to handle local reproductive and child health (RCH) issues. Volunteers act as the direct link between the programme and the communities. Local RCH Management Committees, comprising of members from the local communities, will be ultimately responsible for monitoring the programme. Volunteers and committee-members will remain as permanent resources in the communities and thus long-term programme sustainability is ensured.

High Quality Gender Sensitive Service Delivery - LIP introduces the concept of Health Posts and Satellite Clinics in the target communities. Health Posts, located within the communities, offer a range of preventive and promotive services. Curative services are provided by the Satellite Clinics run by the local practicing doctors. Service delivery from the Health Posts and the Satellite Clinics are based on the specific needs of the communities.

Establish Linkage Between The Target Communities And The Existing Facilities & Programmes - LIP acts as a catalyst for the slum-dwellers to access quality health care services from the existing health care facilities and referral hospitals in the city of Calcutta.

SALIENT FEATURES

Built-in Mechanism For Constant Community Needs Assessment - LIP starts with a baseline survey, which provides a clear understanding of the RCH-scenario in the target communities. Volunteers and programme staff jointly review the situation periodically by using community mapping tools and various other participatory methods.

Male Involvement - Active female participation in the programme depends upon the attitudes of their male counterparts. LIP strives to motivate male community members by addressing the male issues as well.

Life Cycle Approach & Adolescents' Involvement - LIP works on a life cycle approach. Along with mothers & children and male community members, the programme also addresses the psycho-social and health needs of the adolescent boys and girls in the target communities.

CINI

Child In Needs Institute (CINI) is working in the field of reproductive and child health in rural and urban West Bengal since last 25 years. CINI has strong commitment towards sustainable health and nutrition development for women and children, living on the fringe of society and disadvantaged by the pressures of the poverty.

TECHNICAL ASSISTANCE

provided by

Management Sciences for Health (MSH), Boston, USA

Technical Assistance Incorporated (TAI), Bangladesh

RCH PACKAGE

Family Planning
Safe Motherhood
Child Survival
Child Immunisation
Nutrition Education
Adolescent Health
Prevention of RTIs / STDs/ HIV / AIDS

March 2000

CINI-LIP
63, Rafi Ahmed Kidwai Road, Kolkata- 700 016
Phone: 033-245-2705, 246-5301. Fax: 033-245-2706. E-mail: ciniasha@giascl01.vsnl.net.in

PROJECT LAUNCHING

THE PROGRAM

The goal of the CINI-LIP project is to support and strengthen the efforts of the Government of India to provide high quality, sustainable reproductive and child care services at the local level. Its guiding principle is that effective, high quality and sustainable service delivery is based on involving local government officials, service providers, community leaders and members in managing and participating in their own Programme. Specifically, the programme will provide gender sensitive, reproductive health services including prevention of STD/HIV/AIDS to the members of the community.

THE PROJECT LAUNCH

The LIP forms a core team of a Project Manager, a Monitoring and Evaluation Officer, a Health Officer, a Communications Officer, three field supervisors with research backgrounds and experience in the field of preventive diseases and public health. Twelve qualified Health Workers have also been appointed. The community groups for motivation and referral services have also identified 600 Community Health Volunteers to work in the slums.

THE COMMUNITY NEEDS ASSESSMENT (CNA)

To establish a baseline, determine the current pattern of service utilization and understand how to organize new interventions to better meet community needs a community based need assessment was conducted. The sample for the CNA consisted of 120 mothers with children under the age of two years and 210 female adolescents. Results of the baseline survey are being used to formulate future plans and intervention strategies. The Management Information System (MIS) is also being revised taking into account new data collection needs to ensure that community needs are served.

THE LOCAL CAPACITY BUILDING

Capacity building has taken place at all levels. TAI, Bangladesh conducted a basic training and orientation program for program and field staff. TAI also conducted a training of trainers (TOT) on quality of care. Overview was provided for a comprehensive MIS and other reporting formats. A training program for the health workers was organized by the CINI-LIP technical team focused on health and related topics, MIS and the utility of behaviour change communication (BCC) materials. Community volunteers were provided with information about the project, resources and ties that can be built along with the basic training on pregnancy care, safe motherhood, child survival and healthy nutritional practices. Each health worker has identified 10 volunteers. Each volunteer is in the process of identifying and contacting 50 households with their respective communities, consulting one Community Extension Unit (CEU).

SERVICE DELIVERY POINTS

To provide comprehensive, quality Reproductive and Child Health (RCH) services, 8 health posts have been identified. Community volunteers will be the first point of contact with the community and will also provide basic promotive and preventive health care. Some private medical practitioners have been identified and contacted in each slum who will also function as 'Satellite Clinics.'

SHARING IMPLEMENTATION LESSONS

The CINI-LIP holds orientation and advocacy meetings with local formal and informal leaders, elected counselors, clubs, NGOs and other organisations to establish contact and ties. Quarterly progress reports are being sent to TAI. CINI also works with two partner NGOs (CRRID and HIHT) in LIP implementation. CRRID works in four states in northwest India and HIHT is located in Uttar Pradesh. Coordination with CRRID and HIHT has begun, to share implementation lessons and other issues.

May 2000

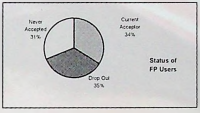
CINI-LIP
63, Rafi Ahmed Kidwai Road, Kolkata- 700 016
Phone: 033-245-2705, 246-5301. Fax: 033-245-2706. E-mail: ciniasha@giascl01.vsnl.net.in

fieldnotes@india.lip
Local Initiatives in Reproductive & Child Health

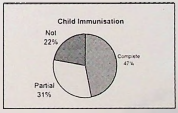
CINI LIP BASELINE SURVEY

CINI LIP aims to provide high-quality gender-sensitive RCH (reproductive and child health) services, including adolescent health and prevention of STD/HIV/AIDS, to the slum population of Calcutta. This project intends to sustain itself through community participation, local capacity building and resource mobilization.

Ameena, a health worker, was initiating an adolescent program amongst her community members. Since she was a new recruit at a newly created health post her interaction with the community was still at a nascent stage. Ameena was conscious of the myths and misconceptions they encountered in their daily lives and the personal turmoil in their lives. Her knowledge came from the findings of the survey conducted in the slums at the beginning of the program. The baseline survey proved to be a blessing as she was aware the struggle they had to face in their daily lives.



The baseline survey was conducted to assess and prioritise the reproductive and child health needs in the slums of Calcutta as well as to formulate tools for monitoring and intervention. The survey presents a dismal picture of the conditions prevalent in the slums.



Lifestyle: A major percentage of the slum population live below or at the brink of poverty. The average per capita income is only Rs 329.50 per month. Large families of 6 or more live in cramped temporary shelters with no sanitation facilities. Women are engaged in an assortment of jobs like working as maids, strap cutters or daily labourers in small manufacturing outfits. Their husbands work as rickshaw/ van pullers, cobblers, masons, carpenters, rag pickers etc.

Maternal Health: Early marriages and pregnancies are common. Most women get married before they are 17 years old and have their first child by the time they are 18. They undergo five pregnancies on an average and one-third of the deliveries take place at home. Antenatal and post-natal follow-up is poor.

Family Planning: The key reasons for not accepting family planning are a lack of knowledge, lack of faith in family planning methods, religious barriers, family pressure and side effects. Around 65% of the populations surveyed were not family planning acceptors and, it was the women who were using family planning methods. Not a single case of male sterilization was recorded.

Child Health: Over 50% of the children were not immunized or were only partially immunized. Immunization against measles was extremely low. Common child morbidities are acute respiratory infection and diarrhoeal diseases. A doctor is consulted only in one-third of the cases.

Female Adolescents: Most of the physical problems of female adolescents are closely associated with menstruation, often blurred with various myths and taboos. Old clothes are predominantly used as sanitary napkins, which could be the reason behind the high prevalence of reproductive tract infections in the slums. Awareness on STDs is very poor and 98% do not know the routes of transmission. Awareness on AIDS is relatively high but only 12% know that it is incurable.

As there was a lack of accurate information on the conditions prevalent in the slums the baseline survey has been a guiding factor for. It has helped us identify the needs of the community and prioritise the interventions.

August 2000

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Local Initiatives in Reproductive & Child Health

COMMUNITY HEALTH VOLUNTEERS

CINI LIP aims to provide high-quality, gender-sensitive RCH (reproductive and child health) services, including adolescent health and prevention of STD/HIV/AIDS, to the slum population of Calcutta. This project intends to sustain itself through community participation, local capacity building and resource mobilization.

Seema, and her fellow community health volunteers are sitting at the Khaldar health post busy completing their specially designed work maps. They are talking amongst themselves about how they managed to convince Fatima's mother-in-law to get Fatima registered at the hospital for her delivery. Their enthusiasm is apparent and they are very proud of their work. They are delighted at their newfound enhanced status in the community and possess a sense of achievement. Seema had to face stiff opposition from her husband initially, as he was totally against her being a health volunteer, but today her husband is extremely proud of Seema and her work.

Role of the Volunteers ~ CINI-LIP's success in the last one year is due to the community health volunteers (CHVs) like Seema. There are around 700 volunteers till date, actively involved, reaching out to 85000 people and continuously monitoring the reproductive and child health status of the community. Each volunteer keeps an account of all eligible couples, pregnant women and children below 2 years in 50 families in her vicinity which she is responsible for. Volunteers motivate couples to practice family planning and counsel them on the right choice of contraceptives besides supplying pills and condoms. They follow up every pregnant woman in the community and ensure that they receive all hospital and domestic care during pregnancy. The volunteers follow up children below two years for primary immunization and booster doses. Volunteers create awareness in the community on specific RCH issues through cluster meetings. They also intervene at the family level to ensure proper RCH care to the women and children.

About them ~Volunteers undergo rigorous training according to our training guidelines, in all aspects of RCH by the health workers. Apart from technical knowledge, they also receive training on community mapping tools and Behaviour Change Communication. A CINI-LIP volunteer is generally a married woman between 20-35 years of age with good verbal communication skills. A major challenge for CINI-LIP was to overcome the obstacle of lack of education among the volunteers. Many illiterate volunteers have achieved a minimum literacy level to be able to report, which is an additional motivation for them. Pictorial registers have been developed as a reporting tool to suit their purpose. The community-RCH-map, which they draw, themselves helps them focus on specific intervention in their areas.

Resource Mobilisation ~ They enjoy their new responsibility as community health volunteers and possess a sense of empowerment. They also play an active role in local resource mobilisation. In some cases volunteers have helped us to secure a place for the health posts and create a new batch of volunteers. Volunteers remain as everlasting resources in the community and work towards the long-term sustainability of LIP.

Oct 2000

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Local Initiatives in Reproductive & Child Health

SERVICE DELIVERY: THE THREE-TIER APPROACH

CINI LIP aims to provide high-quality, gender-sensitive RCH (reproductive and child health) services, including adolescent health and prevention of STD/HIV/AIDS, to the slum population of Calcutta. This project intends to sustain itself through community participation, local capacity building and resource mobilization.

Reena was suffering from excessive discharge and severe abdominal pain. Frequent trips to the local quack provided no relief and were a drain on her already meager income. Left with no money and suffering from acute pain she approached the CINI LIP health worker who referred her to Dr Nandi whose clinic was in the neighborhood. Dr Nandi diagnosed Reena's illness as syphilis. It was discovered that her husband also had similar symptoms. Both of them were treated and counseled for safer sexual practices.

HEALTH POSTS
Primary care
Counseling

▼

PMP
Referral services
Secondary health care

▼

HOSPITAL
Tertiary health care
Pregnancy care

Reena is just one of the many who have availed of the services offered by CINI LIP. CINI LIP offers a three-tier health system, which consists of the health posts at the bottom rung of the ladder.

First tier: Health Posts

The health posts are the focal point around which the whole CINI LIP health care system revolves. They are located in the heart of the community and act as a centre for health promotion. They are also involved in awareness generation and preventive cure. The health posts provide limited curative care and medicines for conditions such as first aid, mild infections like cough, cold, fever, management of diarrhoea, cuts and wounds, worm infestation and mild anaemia. A health worker is in charge of the health post and the community volunteers assist her in her work. When a patient requires more intensive care the health worker refers her to a private medical practitioner.

Second tier: Private Medical Practitioners

The 21 private medical practitioners who are associated with CINI LIP are an essential link in our three-tier set-up. They are qualified professionals who live in the vicinity of the slums and are motivated by CINI LIP to work for the under-privileged section of society. CINI LIP organizes training sessions, discussions and workshops for private medical practitioners to enable them to share their experiences and increase their knowledge base.

The private medical practitioners offer promotive, preventive and curative care. They provide expert consultancy at an extremely low rate, subsidised by CINI LIP. A special referral slip is designed for use by the patients, which ensures follow up care at a nominal cost.

CINI LIP ensures the highest Quality of Care by establishing standard treatment protocol and an essential drug list that the private medical practitioners must follow. A preventive approach, based on emerging health information, is stressed and a follow-up system is ensured

Third tier: Government Hospitals

These private medical practitioners refer the patient to the local hospitals when she requires institutional care. All delivery cases as well as other emergency medical conditions referred by the private medical practitioners are referred to the government hospitals, which have the necessary infrastructure to handle such cases.

This three-tier system has proved to be extremely successful and will go a long way in ensuring program sustainability.

January 2001

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VOLUNTEERS WEEK

The captivating words of a song* dedicated to the community health volunteers of CINI LIP, captures the essence of the 'Volunteer's Week'. The song was specially written by a CINI LIP Health Worker on the occasion of 'Volunteers Week', a week specially created by CINI LIP to commemorate its volunteers. The main objective of celebrating such an occasion was:

- To dedicate one day to the volunteers
- To bring forth the hidden talent of the volunteers and try to utilize their talent for the benefit of the programme
- To improve solidarity between the programme staff and the community health volunteers.

All the health posts of CINI LIP dedicated the last week of May2001 to honour their community health volunteers who play an extremely important role in programme implementation and community development. This was held at every health post involving all the volunteers of the health post. In some cases neighbouring health posts got together to hold a joint event. Councilors and local leaders also attended the function.

The 'Volunteers Week' agenda was more or less uniform at all the health posts. The volunteers were given a free hand in organizing the proceedings and most of them proved to be extremely talented and entertained everyone with a variety of songs, dances, plays and poems. Game shows and discussions on RCH related topics were organized. Volunteers gave emotional speeches during the event. The health posts wore a festive look and the CINI LIP logo occupied a prominent place on the walls.

Particularly noteworthy was a drama on family planning staged by the volunteers of Khanaberia health post and a dance on a song by Rabindranath Tagore, by a volunteer of Lattupara health post. It spoke about the dreams and aspirations of a young unmarried girl but her aspirations remain unrealized once she gets married. This song is based on folklore and taken from the epic, 'Mahabharat'. Another volunteer became nostalgic when she said *"the last time I recited a poem was when I was in class VIII, 25 years back"*. This showcase of talent was an eye opener for every one as in spite of the problems and the poverty that the volunteers have to face they still manage to cultivate their culture.

One got to witness the immense potential of the volunteers, the same people who did not step out of their homes before they joined CINI LIP. The local leaders present at the event also lauded the volunteer's efforts towards community development as well as their motivation and involvement in the program.

* *Always with you O' Dear/We, the 50 LIP volunteers*

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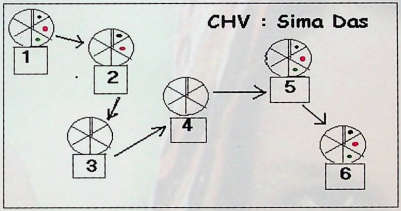
Local Initiatives in Reproductive & Child Health

RTI MANAGEMENT

Reproductive Tract Infection (RTI) is a widespread health problem faced by the adolescent girls and women in slums. Among all RTIs the most common is white discharge, which is often perceived as a normal phenomenon and therefore ignored. The problem is aggravated by the unhygienic menstrual practices and lack of basic awareness about the causes of RTI. CINI LIP has evolved a comprehensive strategy to ensure that every RTI/STD case is identified, treated and followed up till the patient is fully cured. Partner treatment is also stressed upon.

Identification ~ The community health volunteers undertake a rigorous identification of all RTI patients. An innovative RTI map has been specially designed to enable an illiterate or semi literate volunteer to maintain a pictorial record of the families she is responsible for. Once an RTI patient is identified she marks the house with a black color. When the patient is under treatment the black colour changes to red and after the patient is fully cured the map is marked with green. The RTI map gives a snapshot of RTI-status in the community.



Treatment ~ Soon after the patient is identified she is sent to the referral medical practitioner through the Health Post. Whenever required the patient is accompanied by the volunteer. Treatment of RTI is based on the Syndromic Management Guideline recommended by National AIDS Control Organization (NACO). Camps are also organized to create rapid awareness in the community.

Follow up ~ Every single patient is followed up by the referral doctors and the volunteers. While the doctor monitors the prognosis of the disease, the volunteer ensures patient compliance and maintenance of general & menstrual hygiene. This is done through a structured format specially designed for the programme.

Capacity Building ~Everyone concerned including the referral doctors, health workers and the volunteers has been specially trained for the purpose.

Efficacy ~ As a result of awareness created due to this programme, a number of RTI cases have been identified in women and adolescent girls who are now coming forward for treatment.

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Local Initiatives in Reproductive & Child Health

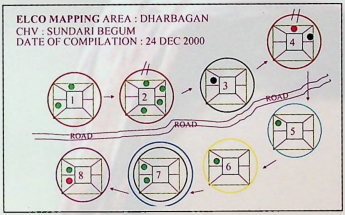
CINI CHILD IN NEED INSTITUTE

User friendly MIS for marginally literate health volunteer

Due to the diverse nature of activities, vast geographical coverage, thrust on quality of care and a huge field force, a comprehensive MIS was necessary in order to effectively monitor the progress of the project. However, the greatest challenge lay in developing a system where illiterate and marginally literate community health volunteer could maintain records. This led to innovations like the pictorial ELCO register and the ELCO map which allowed the volunteer to work unhindered in spite of her illiterate status

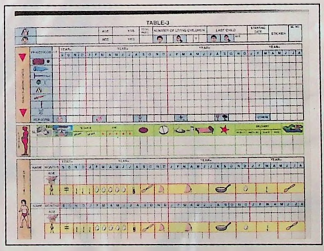
ELCO Map

A powerful management tool, this map provides an overall RCH status of the community at a glance. Each volunteer prepares a map of the 50-100 families she covers that reflects the status of the key RCH components, which need to be monitored. Each family is denoted by a block, which is further divided into several compartments. Each compartment reflects a particular RCH indicator viz. pregnancy, delivery, post natal care and childcare under one and two years of age. An outer circle in various colours represents the family planning method where a particular colour reflects each family planning method. The status of the family represented is denoted by various colours where a green colour reflects an excellent status, a red shows a moderate status and a black indicates a poor status. These ELCO maps serves the purpose of a participatory MIS, where the community health volunteers themselves participate in the analysis and report generating process.



ELCO Register

An innovative pictorial register, which enables an illiterate or semi literate community health volunteer to maintain a record of the families in her charge. It is a pictorial register simplified to such an extent that the community health volunteer just has to put a tick or a cross against each pictorial representation. Each page reflects each family where a detailed record of her family planning status, pregnancy care and childcare is maintained. It truly is a unique example of a simplified record keeping method.



These unique innovations have enabled CINI LIP to overcome shortcomings like illiteracy and have also succeeded in enhancing the motivation level of the community health volunteers who continue work with zeal and enthusiasm.

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Chapter 2

Organisational Reform, Project management, monitoring and research

" God grant me the serenity
To accept the things I cannot change;
The courage to change the things I can;
And the wisdom to know the difference;"

- Reinhold Niebuhr.

2.1 Reforms in Administration

The current structure of health services has evolved over the years, with differing emphasis on the preventive and curative aspects at various points of time. There is a need for the reinstitution of a **strong public health** element in health services. This element, which was the foundation on which these services were instituted, has virtually disappeared due to changing approaches towards the content of these services, mainly from a preventive approach to a curative approach. It is evident that even in current times the absence of the public health element has resulted in skewed services, de-emphasizing fundamental issues such as sanitation and prevention. What would seem essential is to reconstitute the system to have a fair balance between both preventive and curative approaches.

The proposed re-structuring of health services has been indicated by the Task force in its Final Report. The current posts have been redistributed / redesignated. For example, the Maintenance / Engineering Division now included in the Directorate is the transfer, in effect, of the one that is now part of the Karnataka Health Systems Development Project. Also, the posts at all levels have been redistributed..

The posts indicated do not include supporting staff. It would also be necessary to take into consideration the current levels and numbers in the professional cadres while putting in place the proposed structure with the revised positions and designations. The Task Force has kept the following main principles in view while considering the changes to be made in the structure of health services:

1. The emphasis on Public Health should be revived and its essentiality recognized;
2. Separate cadres would be constituted for Public Health and Medical (clinical) responsibilities of the Department;
3. Common functions such as IEC and publicity, supplies and maintenance would be integrated to avoid duplication and lack of internal coordination;
4. The Divisions would be reorganized on the basis of integrated responsibilities and current needs;
5. The cadres should be reorganized so that all health personnel up to the district level form District Cadres, selection being the mode for filling up higher posts. The latter would constitute State Cadres;
6. The State Cadres would constitute the Karnataka Health Service.

7. The availability of services at PHC and taluk levels should be ensured through administrative means, including institution of special pay, a team at taluk level, etc;
8. All national programmes which now function in vertical fashion would be integrated into the system so that local supervision and management of these programmes is at District level;
9. The structures for implementing Externally Aided Projects (EAP) would be more directly integrated into the structure of the Directorate of Health Services;
10. Discipline and control measures would be strengthened while, at the same time building up both expertise and morale through nurturing enhancement of skills and a transparent transfer policy;
11. A Commission on Health would be constituted as a mechanism for interaction with professionals and to assist in policy formulation.

2.2 Strengthening Institutions and Capacity Building

A key element in the process of restructuring the Department is in making various units in the organisation functionally empowered and accountable. In specific terms this will imply the following:

The Directorate of Health and Family Welfare has a large number of very senior officers. However, there is hardly any delegation of powers to them. As a result they are not made accountable and responsible for their sphere of work. Additional Directors need to be given powers of minor heads of department and made fully accountable in their sphere of work. Some autonomy has been given in the functioning of the RCH project to the Project Director, but here too the unit clearly needs to take greater initiative and become more accountable. Two new positions of Additional Directors have been put in place to look after Primary Health Centres and Communicable Diseases and they have been recently given job responsibilities. However, these two vitally important offices are yet to be given clear budgets and responsibility in implementation of programmes.

The role and responsibilities of the Commissioner has now been more clearly spelt out. There is need to delegate greater financial and administrative powers to the Commissioner so that routine programme implementation goes on unimpeded. This matter is currently under examination in the Government.

Over a period of time the Secretariat and its field organisation, the Directorate has become distanced. With the creation of the position of the Commissioner some administrative restructuring is called for to ensure speedy decision-making and avoidance of duplication of work. Apart from delegation, introduction of reforms such as "single file system" and "desk officer system" are under consideration of government. The Administrative Reforms Commission has also recommended these changes.

Clarity of roles, responsibilities and specific accountability upto Joint Director level need to be worked out. Internal decentralization mechanisms for Joint Directors and District level functionaries need to be put in place with adequate powers. Freedom and accountability systems need to be developed.

- Rapid communication systems and mechanisms need to be established. Modern facilities of fax, email, and internet access need to be provided below district level at Taluka and PHC level also.

2.2 Karnataka Health Service

All posts that constitute the State level cadre could be constituted into a service called the "Karnataka Health Service". This would contribute to morale building and create a sense of common identity. The major advantage of constituting such a Service would be that young professionals would, through a process of selection, rise to occupy middle level management positions fairly early. This would ensure that officers with a reasonably long tenure would, in due course, hold senior positions so that stability in management is ensured at higher levels. Often, officers are promoted to senior positions when they have very short periods (a few months) of tenure remaining before they are due to retire. The main features of this Service would be as follows:

1. The Service would consist of all posts above the District Cadres and would include both the Public Health and Medical Cadres;
2. Posts in the Service would be filled through two methods:-
    a. Promotion from the District Cadres on the basis of merit cum seniority; and
    b. Through a process of direct induction from the District Cadres.
3. Appropriate proportions of the posts of the State Cadre, in both Public Health and Medical Cadres, would be reserved for promotion and for induction from the District Cadres. It has been recommended by the Task Force that this proportion be 50 per cent each;
4. All officers in the District Cadres who have the necessary qualifications and satisfy such other criteria as may be specified, including minimum period of experience, would be entitled to apply and compete for the posts reserved in the Health Service for recruitment through this method.
5. All officers appointed to the Karnataka Health Service will, on appointment, be trained in administration and management.
6. In public interest, if officers who satisfy the stipulations of the Cadre and Recruitment Rules are not available for appointment to posts at any level in the Service, and for such time as they are not available, such posts may be filled by induction of suitable persons, with the stipulated qualifications, laterally, on contract basis.

2.3 District Cadre and Zilla Panchayats

The cadres, both Public Health and Medical, up to the District level would be District Cadres coming under the management of the Zilla Panchayat.

With the institution of Constitutional local governments at the village, taluka and district levels, it would be necessary to consider how, in the long run, social services, including health services, appropriate mechanisms could be established to ensure community participation and management of social services, including health services at the district level.

All health services at all area levels are now departmentally organized and managed. The revised structure envisages all health services within a district being managed by the Zilla Panchayat. The health services assigned to the ZP would be those currently offered by PHCs (and Sub Centres), CHCs and Taluka Hospitals. All specialized institutions would continue to be under the Department.

In effect, the ZP, and at the lower area levels, the other panchayat organizations would be responsible for management of the health services in their local areas. The ZP would be the nodal agency and would oversee the working of these services in the talukas and at village level. Such an arrangement is already partly in existence, but what is envisaged in the revised structure is assigning full responsibility to the ZP and including all health services and programmes within the ambit of its responsibilities. It need hardly be mentioned that financial

allocations commensurate with these responsibilities would have to be allocated, to that extent reducing the allocation to the Departmental budget.

The revised structure would imply that all posts of health and medical officers from the village level up to and including the district level, excluding all district level posts such as the DHO / DMO and equivalent, would be part of the establishment of the ZP. The recruitment, control, postings within the district and related matters would be entirely within the competence of the ZP. It must be emphasized that this would not at all mean the absence of Government control, supervision and monitoring. The ZPs would function within guidelines and other stipulations specified by Government with regard to all matters relating to health services. The DHO / DMO, as at present, would continue to represent Government. In effect, a distinct cadre of health personnel would have to be constituted for each district, with common features.

It is recognized that the structure suggested here is a radical departure from the current one. However, it has the merit of ensuring that local persons find employment within their districts, which would reduce the difficulty of filling rural posts. It would also mean that the community, through their elected bodies, takes full responsibility for the adequacy, accessibility and quality of the health services in their district. The Department would then be responsible for overseeing and monitoring of the health services and not have direct administrative responsibility for these services. Its energies would then be better spent in ensuring the efficiency and effectiveness of these services and setting standards through more intensive inspections and reviews.

2.4 Commission on Health

The health services must be responsive to the expectations of the public and must meet current needs. The working of the Department should be transparent and the structure should be able to induct outside expertise as and when necessary for special studies or consultancies. It would be desirable to create a mechanism for general overseeing of the health system which would assist the Government and for providing policy inputs. The facility of lateral advice being tendered at the highest level would assist in ensuring both transparency and public confidence. For this purpose, it is recommended that a Commission on Health be established by Government consisting of both senior officers and non-official professionals.

Commission on Health

Chairperson	Principal Secretary of Health and FW
Members	Secretary (Medical Education), Project Administrator of EAP, Director of Health Services, Director of Medical Services, Director of Medical Education, Director, State Institute of Health and Family Welfare, Director, Indian Systems of Medicine and Homeopathy, Drugs Controller, Vice Chancellor, RGUHS, 8 to 10 eminent persons from professionals, NGOs and prominent persons.
Member Secretary	Commissioner of H & FW

The functions of the Commission would include:

1. Preparation of the Perspective Plan for health services;

2. Monitoring inter-sector issues and recommending corrective appropriate measures;

3. Monitoring implementation of Plan programmes, externally funded projects and Central Schemes and general management of health services;

4. Ensuring that public health is an important component of the health services;

5. Suggesting such studies or consultancies that are found to be necessary from time to time;

6. Reviewing all such aspects of health services as it may consider necessary for ensuring improvement of such services.

The Commission would not be concerned with the administration of the Department, or with disciplinary cases. The Planning and Monitoring Division could serve as the secretariat of the Commission.

2.5 Review and Amendment of Cadre and Recruitment Rules

The structure suggested would need considerable amendments to the existing Cadre and Recruitment Rules.

Recommendations have been made with regard to introducing mandatory tenures of service in rural areas and selection criteria being introduced for certain posts. Also, elsewhere in this Report, there are recommendations that have implications for the C & R Rules. It would, therefore, be necessary to review these rules to take into consideration the recommendations made herein and to bring them up to date. In particular, the rules should identify posts which for which selection criteria should apply such as Joint Directors and above, introduce stipulations regarding tenure in rural postings for entitlement to confirmation / promotion. It is recommended that a Committee for Review of the C & R Rules be set up, with the Commissioner as Chairman, and the Director of Health Services, Joint Secretary, Health Department and a representative of the Law Department as members.

It is recommended that the new structure should be in place within the next one year, with recruitment and cadre choice to new recruits being as suggested above.

2.6 Corruption and enforcement of discipline

The prevalence of corruption in the health services is a serious issue. Corruption in any official agency is deplorable and must be eliminated. However, its presence in an essential social sector such as health is particularly obnoxious because it increases the costs of the services the public is entitled to and quite often determines both availability and quality of the services provided. It is pernicious and pervasive and operates at different levels in different manner. It could range from (a) demanding payment for services which are free or even paid for and for carrying out the legitimate duties of the personnel involved, (b) direct diversion of supplies meant for patients or from hospital supplies, (c) carrying on private practice when this is prohibited, (d) deliberately treating patients outside stipulated hours and charging personal fees for such services, and (e) diverting patients to private clinics with which one is associated and charging fees or obtaining commissions. In particular, corruption in government hospitals has a serious effect on the availability of medical services to the poor.

How to eliminate corruption?

That corruption exists, the various methods adopted in its practice and points at which it is practiced are well known. The issue is the mechanisms for its detection and elimination. The detection of corruption is dependent on the cooperation of the public and the internal

mechanisms for this purpose. In this context, it is admittedly difficult for the public to complain of corruption in a situation where medical services are required because, unlike other official contacts, the need for these services cannot be postponed. However, the system should encourage complaints being received even after the event. Secondly, the consideration of complaints and completion of enquiry proceedings must be quick and thorough. The latter is particularly important to avoid enquiries being deemed as improperly conducted on procedural issues, as is quite often the case.

The current mechanisms inhibit quick enquiry. In particular, the procedures where major punishments are proposed to be imposed are complicated and invariably tend to delay enquiries beyond reasonable periods of time. It would, therefore, be vital for these procedures to be reviewed so that, without taking away constitutional rights to justice, enquiries could be completed within two to three months. It is recommended that the Commissioner of H & FW evaluate the current procedures to determine how they could be modified to ensure quick completion of enquiries.

In the majority of cases, under the current procedures, officers of a senior level are appointed as enquiry officers in individual cases. Such assignments are invariably viewed as an additional burden and given very low priority. There is rarely a sense of urgency and quite often enquiries have dragged on indefinitely. This results in a feeling of complacency in the corrupt that the system is incapable of dealing with them while, at the same time, reducing the morale of the honest and hardworking. The mechanisms for enquiry being within the Department would also seem to inhibit quick enquiry and strong action.

The enquiry into corruption cases, depending on the nature and content of the complaint, are either dealt with by the Vigilance Commissioner or within the Department by the appointment of an enquiry officer. There is, however, no institutional mechanism for detection of corruption. It is recommended that such a mechanism be set up on the lines similar to the Food Cell or Forest Cell. In the latter, a senior police officer on deputation is independently assigned the responsibility of follow up of complaints on corruption, carrying out test checks and the like. This cell should be preferably under the Principal Secretary or under the Commissioner for Health and not an adjunct of the DHS. The specific role and duties of the Cell could be defined. It should be empowered to investigate and take action against corruption and absenteeism. An appeal procedure would have to be provided but time limits must be fixed for disposal of such appeals.

The public should be aware of the services they are entitled to in the Sub Centres, the PHCs, at the Taluka and District levels and in Government Hospitals. Prominent boards should be put up indicating what services are free and the fees for services for which charges are levied. The officer who should be contacted if money is demanded should be indicated and an assurance held out that corruption charges would be investigated. The hospital Visitor system should be strengthened and one of the functions should be to enquire about harassment and demands of money, particularly from the poorer patients. Wide and constant publicity should also be made of measures taken promptly. All complaints of corruption should be acknowledged against corruption.

2.7 Centrally Funded Projects and integration of vertical programmes

A number of Centrally Sponsored Schemes have been implemented, at various points of time, as part of the successive Plans. These include programmes relating to control of blindness, malaria, AIDS, tuberculosis, leprosy and goitre, and enhancement of nutrition. The general principle of funding has been that for the Plan period these are funded either fully or partially by the Central Government, with the financing being taken over by the State at the end of the Plan period. There have, of course, been some exceptions to the latter.

The main issue is not so much the funding or the content of these schemes, since they all deal with important aspects of health services. It is the structural aspects that need consideration since separate hierarchies, with Programme Officers, were established under each such scheme for a specific purpose. This has created vertical hierarchies of a specialized nature within the Department. Also, it has complicated the reporting system by requiring different streams of reporting within the Department and to the Government of India. Such a structure does not lend itself to cost effective use of personnel or coordinated management of services. The difficulty of control and management of such separate vertical hierarchies for some activities is particularly noticeable at the district level. It is at this level that management and coordination need to be clear and effective. The relative seniorities between the DHO and the Programme Officers have added to the problems of coordination.

The vertical programmes must be reviewed to determine the mechanisms of eliminating the concept of independent vertical hierarchies, better utilization of the professionals in the Department, and establishing only one focal point of administration of personnel, management of services and reporting at the district level. It must be emphasized that this can be done without in anyway diminishing attention to these important programmes. As in most activities of the Department, designated officers would be responsible for specific activities. What is desirable is to eliminate vertical hierarchies that are under-utilized and give rise to loose administrative practices. Such integration is possible at all levels, including the senior posts at headquarters. It may, at this point be mentioned that a revised structure for the Department has been suggested later. The review of the vertical programmes would be part of this new structure.

2.8 Externally Aided Projects

There are a number of externally aided projects in operation in the State. In the health sector, the Karnataka Health Systems Development Project and the India Population Project are the major externally funded projects. These projects deal with specific health issues and are not experimental in nature. They operate independent of the DHS though they are very much concerned with health issues in terms of objectives, structure and content. The management structure of these projects is independent of the DHS and so devised as to ensure efficient performance. Special officers are placed in charge of such projects, with officers of various specializations on deputation, and the induction of outside expertise is often assured through a system of appointment of consultants. Decision-making in these projects is expeditious because the high power Project Governing Board and the Standing Committee are delegated with full powers. The conventional system of seeking sanctions, administrative and financial, with many layers of official scrutiny and many departments to be consulted, is absent. There are no financial constraints and performance is intensively monitored by both external and internal agencies. In view of the structure and management independence, these projects are successful and appear as islands of excellence in governance of health services.

These projects are successful because they have well defined objectives, with leadership not generally available in other activities of government, selected competent staff and with operational independence. They provide lessons in management of the health services and innovative structures of delegation of authority and of monitoring and internal control and review systems. However, experience would indicate that once the project is over and the maintenance phase commences, the same performance levels rapidly disappear and the work gets "routinised". While the projects definitely add to both assets and experience, there are fundamental issues that need to be considered if full and, more importantly, permanent advantages have to accrue to the health system from the implementation of such projects. These are (a) how one transplants the work culture of these projects into the larger, parent organization, namely the Health Department, (b) how the tempo and efficiency of the project implementation period could be sustained, (c) how the assets created are maintained for effective use, (d) how the human resources created could continue to be used effectively and

productively and (e) how is adequate funding to be ensured for these purposes. In short, the issue is one of sustainability over time of both the organizational and professional advantages of these projects and building them into the culture of the department itself.

2.9 Sustainability

The issue is essentially one of sustainability of the projects objectives and systems. It would be difficult to integrate the project structure in toto into the departmental structure at the end of the project period, nor would this be necessary. However, the main difficulty would be that the project leadership would no longer be available and the Director of Health Services would have been only generally associated with the project [1]. If integration of project activities in the maintenance phase has to be effective, it would be necessary to ensure that the project is built into and implemented within the departmental structure from the start. While a separate wing or division could be considered desirable because of the special needs of the project and the need to complete it within a fixed period, this wing / division should be a part of the Department; an exclusive project division within the Department should implement such a project. This would ensure that the Director is not merely involved in the project but is also responsible for its efficient implementation. It is recognized that this could limit the choice of officers for being appointed as project administrators but the Project Governing Board and the Steering Committee of the project should be able to enhance their supervision / monitoring to ensure effective implementation. Also, the Commission on Health, suggested as part of the restructuring of the Department, could also be empowered to monitor / review the implementation of the project. The present practice of establishing a separate but temporary project administration structure outside the Department should be given up and the special unit created for implementation of such projects should be placed within the department, even while maintaining its separate identity, with the appropriate structure and operational freedom, for expeditious and efficient completion of the project. The Director should be responsible for not merely fostering the work culture of the project but also for the spread of such a work culture in the other divisions of the Department.

2.10 Transparency / morale building

The Department of Health Services is one of the larger administrative organizations of the State. Its importance both in terms of size and responsibilities dictate that the morale of the officers and staff should always be high. It should be managed in such a manner that administration is not accused either of favouritism or lack of direction. **Morale building** would depend on the personnel having a conviction of fair dealing in matters such as postings, selection for postgraduate courses, promotions and quick redressal of grievances. At present, unfortunately, there would appear to be no internal guidelines or traditions for many of these aspects.

2.11 Transfer Policy

Transfers are admittedly necessary in the department for manning vacant posts, on promotion or for other reasons. However, the system of routine transfers that are made every year has virtually deteriorated into a scramble for "good" postings or for postings in Bangalore, with pressures and pulls of all sorts having free play. In particular, it is most unfortunate that political pressures predominate. This works to the disadvantage of those who adhere to the rules or who have no political backing, and encourages indiscipline and inefficiency. It would be necessary to formulate and adopt a transfer policy under which the transfers would be **transparent** and **unassailable**.

2.12 Delegation of duties and powers

Morale and functional efficiency are also dependent on the ability to exercise powers appropriate to each level in the hierarchy. Currently, there are orders delegating both administrative and financial powers various levels. In particular, the powers of the senior officers are well defined to permit them to function with adequate independence. However, in practice, these powers do not seem to be exercised fully because traditions have been built up that favour centralization of decision-making or excessive caution operates in exercising them. This is reflected in complaints of inability to carry out adequate touring, delays in processing of even simple requisitions, etc. The adequacy of the delegations and, more importantly, the processes through which they are exercised would need review.

There is need to carry out a review of the administrative and financial powers delegations in the Department to –

1. Evaluate their adequacy and determine if any further delegations are necessary;
2. Examine the procedures of exercising of the delegated powers to determine if there are any procedural factors that reduce their effective use.

2.13 Ensuring Overall Responsibility on Health Matters in Urban Areas

The administration of health services in urban areas is largely the responsibility of the local administrations such as the municipalities and Municipal Corporations. The staff in the larger cities are appointed and managed by the Corporations. While the administration of the services in these areas and the management of the staff would be the responsibility of the municipal body, it would be necessary to ensure that the Commissioner, the Director of Public Health and Director of Medical Services have overall responsibility for the technical aspects of these services so as to ensure quality and availability. The Directors should have the right of inspection and monitoring. Such general authority would be specially important in periods of outbreak of diseases and emergency situations. In particular, the public health aspects of urban areas, including water quality and the like, should be reviewed by the Director of Public Health.

2.14 Inter-sectoral Coordination

Health should not be viewed in isolation. While, for pragmatic administrative purposes, the DHS is in charge of health services, the success of the latter depends on the successful implementation of many other programmes. The latter include programmes relating to nutrition, sanitation and water supply, meeting minimum housing needs, literacy, transportation, communication, and the like. It is also dependent, in a larger sense, on social policies, as for example, raising the age of marriage of girls. More specifically, the health services are closely associated with the ICDS and school health programmes.

It is evident that health services would need to be coordinated with activities of the programmes referred to. Such coordination would be necessary both with regard to the relevant elements of these programmes and with the implementing agencies. The establishment of an effective coordination mechanism would also ensure more optimum use of the funds invested in the health services and these programmes. The establishment of a high level mechanism for coordination would develop synergy among these activities. It is recommended that a High Power Coordination Committee be set up with the Development Commissioner as Chairperson, and members being the Commissioner of Health and FW, Director of Health Services, Principal Secretary and Director of Primary / Secondary Education, Principal Secretary, Woman and Child Welfare Department and Director ICDS, Principal Secretary Rural Development and Panchayati Raj, and officers in charge of rural

water supply and sanitation programmes. Other officers could be co-opted if necessary. Representatives of prominent NGOs could also be inducted as members. Similar coordination mechanisms must be established at the district and taluka levels.

2.15 Coordination with other institutions

There are autonomous specialty institutions, which include the Kidwai Memorial Institute of Oncology, Sri Jayadeva Institute of Cardiology, Sanjay Gandhi Accident Hospital and Research Institute, and others. Government is represented on the management of these institutions and, therefore, mechanisms are present for ensuring coordination. The links permit review of performance, monitoring of activities and also provide for an active role of intervention if necessary.

2.16 Contracting out non-clinical services

The KHSDP has identified 28 non-clinical services, which could be performed by private sector agencies on contract. The advantages are obvious. Large number of staff need not be on the permanent payroll of government. Services are likely to be performed better because penalty clauses could be enforced, which would not be easy in the case of government employees. It would allow more time and effort to be invested in health and medical issues. It is recommended that this system of contracting out non-clinical services could be extended to as many hospitals as possible.

In the context, the view that general services cannot be contracted out under the laws relating to abolition of contract labour would seem to be of doubtful validity. In the arrangement contemplated, the contract would be with service firms and not individuals.

2.17 Improving Registration of Births and Deaths

The importance of improving the system of registration of births and deaths cannot be overemphasized. The data provided by the system, if complete in coverage and valid in recorded information, would provide information at regional, sub regional and micro level on health parameters.

The placement of the system of reporting would seem to need consideration. Currently, it is monitored by the Director of the Bureau of Economic and Statistics, with a network of notifiers and registrars at the field level. The latter are revenue officials. The system merits a review for its reorganization and vitalization. It is recommended that this be examined in consultation of the Departments involved. The Government of India would also have to be consulted at the final stages.

2.18 Planning and monitoring

Health services must meet current needs and the management must have the capacity to adapt them to such needs. Any modifications or expansion of services have implications in terms of staff, training, and financial outlay. It is therefore necessary to have an in-built ability for carrying out such reviews and in the preparation of perspective plans. Tthe Department should also have a strong, unified system of reporting as part of the Health Management Information System. This would necessarily have to form part of the planning and monitoring structure of the Department. These activities would call for the establishment of a **Planning and Monitoring Division**.

Present structure

There is, at present, a Joint Director in the office of the DHS in charge of planning. The post is currently designated as Joint Director (Health and Planning). The JD (H & P) is assisted by a Deputy Director (Planning) with supporting staff. The functions of this post include preparation of the annual plans, five -year plans, and preparation of the monthly monitoring reports (MMR) which deals with financial and physical progress and the Karnataka Development Plan which deals with staff and organizational issues, that are submitted to Government. An important function is the preparation of the Annual Report of the Department. The Preparation of these reports involves obtaining information from all units in the Directorate, including the Programme Officers on a monthly basis. Coordination and constant interaction with the other Divisions and sections in the office of the DHS are essential elements of the post. The JD (H & P) is concerned with the preparation of only schemes relating to the Plan. Non-Plan elements are prepared by the Chief Accounts Officer cum Financial Adviser. This is because the latter are more concerned with staff and maintenance issues. However, information on the latter is incorporated in the reports mentioned above. The JD (H & P) is also in charge of the Bureau of Health Intelligence.

Role of the Planning and Monitoring Division

The planning process in the office of the DHS is restricted in scope and serves the immediate administrative needs of routine reporting. The process of preparation of Plan schemes is also fairly well established, as well as statistical reporting in specified formats. These are essential activities in themselves but the constant internal monitoring of performance, particularly the sensitive appraisal of available information, is near absent. The Planning Unit, which should be designated as the Planning and Monitoring Division in view of its importance, should play a more central role in the management of information systems within the Directorate. It should be responsible for all information flows, appraisal of such information and feed back of such appraisal to the functional divisions concerned. Currently, the appraisal of performance is within the functional divisions concerned, which would render it routine. Also, a total appreciation of the functioning of the Directorate would not be available to the Director.

The reporting system is envisaged as common to the Department and not in sectional components, more related to individual programmes, as at present. With this change in the structure and focus of the HMIS, it would be logical to place its management under the Planning and Monitoring Division.

Functions of the Planning and Monitoring Division

1. Coordination of all reporting activity as part of the unified system of the HMIS and providing the information that other Divisions would require on the basis of the unified HMIS;

2. Coordination of all statistical activity in the Department, at various levels, including ensuring of quality of data, and processing and analysis of such data in the prescribed manner as may be required for various purposes;

3. Production of the Annual Report, periodic reports such as the Monthly Monitoring Reports, Karnataka Development Plan, and such other prescribed reports. The reports of the projects such as IPP and KHSDP should be incorporated so that there is one report for the entire health department;

4. Monitoring progress in implementation of Plan programmes and schemes each month to enable mid-course corrections to be made;

5. Preparation of Annual Plans and Five year Plans of the Department, coordinating with the other wings such as Medical Education, State Institute of Health and Family Welfare and the like;

6. Preparation of a perspective plan for the Health Sector and its updating at appropriate intervals.

7. Organization and management of the Geographical Information System that is recommended for establishment;

8. Organization and management of the Computer System that is recommended for establishment;

Structural changes in the Statistical System

The statistical system within the Department has developed in a rather ad-hoc manner. The statistical and reporting system at headquarters could be said to consist of three distinct wings as follows:

a) The Bureau of Health Intelligence (BHI)

b) The Demography and Evaluation Cell (D & E Cell)

c) The statistical units / personnel attached to some Divisions on an independent basis.

The BHI is the unit that generates the Annual Administration Report and all statistical reports, excluding those relating to the RCH programme. It is also responsible for collection and collation of information on health indicators, including the macro indicators from the RCH programme. One important responsibility of the BHI is collection and processing of data relating to morbidity and mortality.

It would be evident that if the planning process in the health sector has to be unified, as indeed it should, it would be necessary to recognize the need for basic structural changes. Such changes would include (a) unifying the statistical functions at all levels and of the various units, (b) the inclusion of the reports of distinct projects such as the IPP and KHSDP within the unified reporting system, and (c) coordination within the Department with the Chief Accounts Officer / Financial Advisers of the Department itself and of the special projects.

The distribution of the posts in the various statistical / reporting units, as would be seen from the table above, is very uneven. There is no uniformity in the work load and the levels of posts seem to have been determined more by what was acceptable to the sanctioning authorities than any rational considerations of work load, position in the hierarchy, etc.

The efficiency of the HMIS and GIS, the ensuring of quality of data, the management of the computerized system of maintenance and analysis of data and production of monitoring reports for better management would depend on the structure of the reporting and statistical system. If the system has to perform at peak efficiency and be able to serve its purpose, it would be necessary to consider certain structural changes.

In principle, it would be desirable to have a unified statistical and reporting system so that the planning and monitoring requirements are adequately met. The Planning unit in the office of

the DHS may be designated as the Planning and Monitoring Division, as suggested earlier, and assigned a central role of information management and appraisal, with the functions indicated.

Structural changes at Headquarters

The Planning and Monitoring Division should be constituted with the following sections:

- The Reporting and Monitoring Section for production of reports based on the analytical statements generated by the Computer Section, and for preparation of all monitoring reports required by Government or needed for internal management;
- The Computer Section for information processing
- The GIS Section for assisting in monitoring and planning
- A Perspective Planning Section which would formulate the Five Year Plans and the annual plans, monitor plan implementation, prepare and continuously update the perspective plan of the Department and monitor implementation of the Health and Population Policy of the State.

This Division should be responsible for the following:

- Strategic Planning of activities of the entire health system, including long term planning;
- Coordination with the Zilla Panchayats to ensure that the health plans of the districts are formulated, including taluka and Gram Panchayat plans, and integrate them into the State Health Plan;
- Assess budget resources for current and future needs, taking into consideration population, level of services, norms for services and other relevant parameters;
- Assess human resources and all material resources on a continuing basis.

All statistical and reporting functions in the headquarters should be unified. The various wings and units referred to earlier would form part of the Planning and Monitoring Division. These would include the BHI and the D & E Cell. There is a senior officer of the rank of Joint Director on deputation from the Directorate of Economics and Statistics, who heads the D & E Cell. This officer could be the Joint Director in charge of HIMS, the GIS and all statistical reporting within the Directorate. This Joint Director could be designated as **Joint Director, Health Information System**. This officer would be the Chief Statistical Officer and Head of the HIMS / Monitoring Section.

Structural changes at District level

Strong statistical units would have to be established in the offices of the DHO / DMO and all reporting and statistical functions in the district should be placed under them so far as their jurisdictions are concerned. A computer cell in their offices would also have to be set up. These cells would generate reports in standardized formats, which would be sent to Headquarters for consolidation and analysis. However, analysis at the district level would also be carried out so that monitoring by the DHO / DMO is possible at the district level. The Programme Officers of the district would get the reports in the formats they need from this cell

The central role of the Planning and Monitoring Division

The role of the Planning and Monitoring Division, as envisaged herein, is much wider than what it is at present and its responsibilities are much heavier. It is the Division that **plans for and monitors the performance of the Department.** In view of this expanded role, the Planning and Monitoring Division may be headed by an Additional Director. This Division would function as the secretariat for the Commission on Health that has been recommended to be established. The division will use an evidence-based approach & hence have close links with the HMIS & Surveillance system. It will need to establish good inter-sectoral linkages with departments dealing with nutrition, water supply and sanitation, education, Panchayati Raj, etc. The unit needs to develop multidisciplinary capacities in Epidemiology, Health Planning and Management, Health Economics, Bio-statistics, Anthropology, Social Sciences etc.

Strengthening the capacity for Strategic Planning had been identified as a key objective under KHSDP. However, mechanisms to ensure that Strategic Planning begins to take place are yet to get institutionalized. There is an immediate need to fill up the newly created positions in the Strategic Planning Cell (SPC) so that studies, research, and planning functions can start taking place. These initiatives planned under KHSDP need to be carried forward in to the present project as well.

2.19 Project implementation and integration

Earlier experience with national health programmes, and more recently with externally aided projects, teach us that;

a) Basic objectives and strategies, even if explicitly outlined in policy documents/ project proposals, are often re-interpreted or forgotten, in such major ways that expected outcomes are not achieved.

b) The focus of attention and activity tends to be on construction, purchase of equipment/consumables and appointments. 'Softer' service issues such as quality of care, access to care, establishment of referral services, surveillance and health management information system etc. have not yet become functional. Training of health personnel has been undertaken but outcomes of this activity have been variable.

c) The Department of Health, as a whole, does not manifest a sense of ownership of important health programmes. Responsibilities and systems have become fragmented with vertical programmes and specific projects.

Hence, during the next five years, the PRIMARY FOCUS of this project will be to ensure, IMPLEMENTATION and INTEGRATION, particularly at the critical point of interface between the public and service provider at sub-centres, PHCs, CHCs, schools, anganwadi centres, Mahila sanghas and hospitals at different levels.

Special planned efforts will be made to internalise and embed processes and factors that ensure implementation, into the institutional functioning of the system.

2.20 Safeguards to ensure implementation

a. Involvement of credible and knowledgeable NGOs, people's movements, academic institutions, i.e. representatives of civic society in the steering committees. The choice of representatives is critical, as the objective is to bring in openness, transparency, accountability, knowledge of field realities and alternative expertise. It will also enhance collaboration, cooperation and a joining together of forces if appropriately facilitated.

b. Make public the annual statements of income and expenditure of the project. Explanatory notes to be given for non-utilization of funds.

c. The Annual Report of the DHFW, under which achievements of the different programmes and projects are given, need to be more widely disseminated. The DHFW could also have a Website on which reports are made available. With increasing computerization of the Department these reports will be easily available to peripheral/ all health institutions and their staff.

d. The supervisory and senior management staff to take responsibility and be accountable for implementation at all levels. For this there needs to be adequate delegation of authority and financial powers – i.e. a decentralization within the department. This is separate from decentralization under Panchayati Raj.

e. Supervisory staff to provide technical guidance, problem solving advice and encouragement, rather than focusing on fault finding and inspection. Maintaining motivation, morale and job satisfaction of field staff is an important responsibility of senior staff.

f. DHFW staff needs to be given strong feedback on the wide gap between the people's expectations and the health services. At the same time, the good committed and competent work by several government personnel needs to be recognised and appreciated. Recognizing that this factor is critical to implementation, the department will introduce a series of measures to facilitate behaviour change, e.g. sessions on group dynamics, personal growth, interpersonal relations, and management techniques. The Task Force on Health has also recommended steps to be taken to reduce corruption and political interference in appointments, transfers, and promotions.

g. While taking steps to provide a good working atmosphere, the DHFW will also tighten its administrative functioning by taking disciplinary action, as per the rules; clarifying job responsibilities and ensuring that they are carried out; keeping to time frames.

2.21 Project management structure

The KHSDP has built up a fairly extensive management structure, headed by a super-time IAS officer. Another super-time officer is heading the project team dealing with IPP VIII and IX. The government has recently also put in place the post of Commissioner, who is also a very senior, Secretary-rank IAS officer. A team of senior Doctors and Engineering staff supports both the KHSDP as well as IPP projects. Given the nature of the project which is very ambitious both in size and scope, and the limited capacity, at the present moment, within the Directorate, there is need to have a strong management team to lead the project. Multi-disciplinarity, and management capacity will need to be part of the long-term leadership structure in the health sector. The experience of KHSDP has been that the presence of a dynamic leadership is able to give the necessary momentum to the project. At the same time, in view of the large size and scope of the civil works and equipment procurement requirements, the project team is unable to give the required attention to service delivery and some other "software components'. The KHSDP staffing structure will be continued at the end of the project and integrated into the health system as a dedicated, specialised, professional management support agency of the department for all civil works construction and maintenance, equipment procurement and maintenance, and other specified "hardware components". This wing will continue, as at present, to be headed by a senior IAS officer. This wing will also manage all the civil works and procurement components of the new project. This will free the project director, who is proposed to be a full time super-time IAS officer to concentrate on actual service delivery. He will lead a project team that will work

closely with the Commissioner and the Director and directly with the state programme officers so that there is full integration from the commencement of the project.

A dedicated management structure will also be put in place for the special project initiatives proposed for the backward category C districts of the state.

2.22 Project Governing Board, Project Steering Committee and Project Implementation Committee

The Project Governing Board constituted under the KHSDP with the Chief Secretary as Chairperson has worked well and it is proposed to retain the same structure for the proposed Project. Similarly, the Project Steering Committee has also provided a structure that has facilitated quick decision-making. In addition to these two structures there is need to ensure that decisions taken at the Project Steering Committee are implemented and there is constant monitoring in respect of all components of the Project. There is also need to integrate the Project management structure with the DHS. It is therefore proposed to have a Project Implementation Committee under the Chairmanship of the Commissioner Health and Family Welfare.

2.23 Local project consultancies

The project has several new uncharted thrust areas, such as in the area of women's health, health promotion, and community participation, HMIS etc. where the services of experienced NGOs and other professionals will be required from the commencement of the Project. They will support not only the project team but more critically be asked to directly work with the State Programme Officers to ensure that the department has a feeling of "oneness' with this external team and vice versa. Their main role will be in providing both expertise as well as elements of "capacity building" into the department.

2.24 Capacity building for programme implementation

Cadre of professional managers

Over time the DHFWS has created at Taluka, District and State level an adequate number of positions to supervise and implement various National Health and Family Welfare programmes. In recent years, it has been noticed that at all levels the Taluka Health Officers, DHOs, as well as Deputy Directors/Joint Directors have very short tenures and are unable to spend time on management of national health programmes.

In many States and in several countries around the world health programme managers and hospital managers are non-medical professionals in public health, and hospital administration. The Project therefore seeks to develop a cadre of professional managers to help in programme management at the district level, state level and to help in hospital management. It is proposed to recruit young graduates, preferably with post-graduates/diploma in management, Hospital administration, Masters in Social Work (MSW), Masters in Economics, Masters in Nutrition/ Communication and related disciplines to function as Assistant Programme Managers at the District level, in major Hospitals, and at the State level. These officers will be recruited at the Group B level and will have opportunities for career advancement based on their performance and merit. They will be recruited through a very transparent system based on their qualifying marks and a Common Entrance Test and will undergo specialized training for six months before being assigned any responsibilities. About 150 posts will be created for this purpose. To ensure management teams including this new cadre become effective, there will also be a need to develop manuals on integrated health care responsibilities for different institutional levels and various programmes.

Introducing merit and competence in respect of some crucial posts

Currently all senior positions are filled by seniority, except the post of Director. There is therefore no incentive for good performance or any system to reward good work. Private sector structures need to be brought in at least to man crucial positions at the district and State levels. Meritocracy and transparency would be introduced and seen in the overall context of good governance. A study has been commissioned by the Task Force to review the organisational structure and design job responsibilities. The DHFWS is a very large organisation in terms of manpower and responsibilities, with about 60,000 personnel of which more than 4700 are grade A officers. There are several levels of technical expertise. The study makes a systematic effort to identify requirements at various levels & to develop job responsibilities. The Task Force final recommendations and study findings will be incorporated to the project proposal.

Engineering wing

Under the KHSDP an Engineering Wing has been established which is exclusively dedicated to designing, constructing and maintaining all the facilities taken up under the Project. A Chief Engineer heads the Engineering wing while a Deputy Chief Architect heads the Design wing. These positions are supported by the necessary complement of supporting staff. All these positions will require to be continued to support the Civil Works in the present Project. The present proposal envisages the renovation of a large number of primary health institutions scattered throughout the rural parts of the State. There is a need to prepare detailed estimates, design renovation, for each of the over 1000 buildings proposed for renovation/expansion in the project.

There is also need to ensure that the major civil works component is taken up and completed quickly so that more substantive programme components get full attention during the project. IPP VIII has successfully demonstrated capacity to take up construction of a large number of small institutions in quick time by employing the services of a consultancy agency on a "turn key" basis. There is need to identify an appropriate Civil Works consultancy Agency to survey all the institutions, make detailed estimates for renovation and expansion well in advance of the Project start, as a pre-project activity. The Agency can be selected through a bidding process.

Routine maintenance of sub-centres, PHCs and Taluka hospitals will have to continue to be looked after by the Zilla Panchayat engineering divisions and the engineering divisions.

Enabling work environment

One reason for poor work culture at the state and district levels is due to the shabby physical environment in which the offices are maintained which is also an expression of work culture. It is expected that an integrated office complex for all health programmes, including for the Project staff will be constructed under KHSDP. The building will require maintenance expenditure etc. Similarly provisions will require to be made for the DHOs office buildings, including the seven new districts.

2.25 Implementation challenges and strategies of the integrated health project

Karnataka has had mixed experience in implementation of health programmes and services. Health programmes so far have largely used a top-down problem centred approach, that is largely rational (focusing on major decisions), linear and prescriptive. Implementation has been on the whole hierarchical and techno managerial, attempting measurable outputs and compliance, with people often seen as target groups or objects. Evaluations of several

programmes report big implementation gaps even in programmes and projects with well thought out health goals, objectives and strategies. In Karnataka this is seen in the National Tuberculosis Programme (NTP and RNTCP), the Reproductive and Child Health (RCH) programme, the National Programme for Control of Blindness (NPCB), the National AIDS Control Programme etc. The Karnataka Task Force on Health has raised poor implementation capacity as an issue of serious concern by senior government officials and. The public have expressed a lack of confidence and trust in the services through elected representatives, through peoples health dialogues conducted as a part of the peoples health assembly process, and through increasing protest as recorded by the media. It is imperative that implementation processes are given importance and viewed as being as critical as decision-making, resource allocation and proposal writing. It is what happens between front line implementators and the public that really determines policy.

Current opportunities and strengths

It is therefore suggested that using the same policy and programme / project management approach may not improve functioning of the system adequately. Achieving good quality performance or implementation should be the key strategic objective or mantra of the entire Department of Health during the next five-year phase. There is a window of opportunity presently open with government showing signs of greater political commitment to health; with the participatory processes already initiated by the Karnataka Task Force on Health; with a small but critical mass of good leadership at the top; and with the possibility of augmenting financial and technical resources through a healthy process of dialogue with partner donor agencies. Therefore a slightly different approach will be utilized in this implementation plan. It will build incrementally on the several good initiatives of the past decade including the mechanisms and management systems that are functioning well. It will use the learning points and evidence gathered from studies already undertaken and then planned.

Broad approach

It will use the bottom up integrative approach that is process orientated, recognizing the political, iterative, interactive and evolutionary dimensions of policy process. This will require a major change in mindset, through regular workshops and training programmes. It will consciously build motivation, capacity, work strategies, work culture and ethics of implementors, especially at front line and different levels. It will increase inter-organizational and inter-departmental interaction. People and communities will be given opportunities to become active participants in decision-making and in becoming change agents of health services and of their own health status.

The social construction and complexity of disease, ill health, poorly functioning health services and programmes are accepted, including underlying iniquitous social relations and issues of power and conflict. Hence, no magic or perfect solutions are offered, nor miraculous changes expected. However, planned, systematic efforts that are responsive to ground realities will be made, to use public health policy to move towards some leveling of social inequity.

Specifics

Some of the factors important for implementation are:

Health policy so far has not been explicit but has developed in an ad hoc, add on manner, often driven by national health programmes or by externally aided projects. A Comprehensive Integrated Draft Health Policy has been recently written by the Karnataka Task Force on

Health and published for wide discussion within the government health sector by the Government of Karnataka (KHSDP) and with others. After modification and adoption this will provide a cohesive framework for the next five-year period.

Developing leadership at state district, taluka and local levels. State leadership for all components should have the ability and acumen to mobilise power, political, financial and other resources for health and to positively influence implementation. Leadership that nurtures encourages and supports its teams to perform better. Leadership that is open to questioning, demands and pressures from the public and civil society organizations, seeing these as a positive sign of interest and support and not as a threat. Leadership that looks ahead, beyond and is inspirational. Leadership that is sometimes willing to follow. Selection of leadership will necessarily need to depend on competence and capacity and will have to be free of political interference. Leadership for district and state level will depend on track record of past performance, with seniority coming as the lower criteria.

This is a complex project and **selection of the Project Director (PD)** is critical. The PD will require having good management skills, good interpersonal skills, a firm administrative hand, and an understanding of the project goals and objectives, especially the technical, health aspects. It is advisable that the PD is available to steer the project for a period of 5 years.

Develop a core implementation team working with the Commissioner and Director of Health and the Project Director; with a mandate to see that implementation of all key aspects outlined above occurs on time, maintaining quality. Members of the Project Preparation Committee who have been active will continue in the Implementation Team.

Taking forward the Task Force recommendations - The recommendations of the Task Force, especially Health Systems Management and on Implementation will influence all programmes. Mechanism for implementation of recommendations will be initiated in 2001 and will carry over into the integrated health project being proposed. The preliminary steps in brief suggested by the Task Force are:

a) Formation of a **small core group** to process, prioritize and set time frames for implementation of recommendations;
b) Formation of an **Implementation Committee** (for health system reform and reorganization);
c) Formation of **Subject Matter Sub-Committee** reporting to the above;
d) Formation of a **small secretariat or cell** to support the Implementation Committee and follow up on action points; this function to be taken over by the Planning and Monitoring division or unit;
e) Formation of a **Commission for Health.**

The Task Force recommendation broadly fall into four categories:

a) **Structural changes** to re-institutionalise public health and primary health care, with district and state cadres and increased professional capacities in public health, management and administration, primary health care and curative care;
b) **Governance issues** – transparent appointment and transfer policies; mechanisms for motivation and morale building; personal appraisal systems; supervisory systems; monitoring finances and performance; relationship with elected Panchayat bodies; access of the public to information; feedback systems from the public and patients; improving ethical and legal aspects of work;

c) **Building of institutional capacity** – through training and continuing education: good intra and inter-organizational communication systems: partnerships with NGOs and private sector: developing administrative and management skills at PHC's, CHC's, tahika and district hospitals: assessment of need and impact through studies and research:

d) **Those relating to equity, quality, integrating access** and to technical aspects.

The department will be taking action on the recommendations that are accepted by the government. Mechanisms evolved will link with the project.

The KHSDP and IPP IX **systems for construction and procurement** will be integrated into the department and will be utilized for this project. Maintenance functions will be allocated to the same unit. Minor repair and maintenance work will be undertaken locally upto a specified financial level. Annual maintenance contracts for equipment may be made with companies concerned after studying the cost effectiveness of such arrangements.

Good communication systems will be evolved to keep all functionaries or team members of the Dept. of Health (DOH) informed on a monthly (or two monthly basis to start with) of the process and activities in the project and the department. The public should also be kept informed through information boards in each institution and through the mass media, especially the radio and press. Specific communication systems for specific aspect, such as surveillance and referrals, make use of faxes, telephone, and emails. These systems will have to be introduced. Rapid and free flow of information is important for optimal functioning.

NGO-8

Social Accountability and Social Audit of NGOs

Some loud thinking for an approach to conduct it.

NGOs (or Voluntary Organisations[VO], as some of them insist on calling themselves - to distinguish themselves from private commercial organisations which, also, in a way, are non-government by status and therefore NGOs) come into existence because (they strongly feel) that something needs to be done to harness "progress" of the society in a meaningful and appropriate manner. "Something critical is wrong! Something critical is lacking! Something critical is side-lined! Some sections of society are wronged or neglected or cheated and something needs to be done to address these issues". These (and other compelling) issues trigger initiation of VOs.

In many ways these VOs are self-appointed and are simultaneously 'independent' (in being self-appointed) and yet answerable to society (which is their *raison-d'etre*). They are also answerable to the society and to themselves to ensure that their practices and endeavour moves appropriately in the direction towards 'ideal' society (they proclaim to cherish) and also the *values* generally attributable to *humane society e.g. secularism, egalitarianism, pluralism, transparency, honesty, and most importantly humane interactions.*

VOs use monitory, human and other resources (of the society) in their "*social" entrepreunership.* These resources are *tools)* and tools can be 'used', 'mis-used' and 'abused'. In any enterprise, the function and (with it), the importance of audit is self-evident

1. **Fiscal audit**

   Mandatory (legal) requirements call for fiscal (and monitory) accounting and fiscal (and monitory) audits. Fiscal audit has the longest history and have continuously developed into more and more sophisticated exercises. The important feature of this type of audit is that it is more or less standardised and universally accepted. Because of this reason it is also relatively easy to conduct.

   Unfortunately, with its sophistication, fiscal accounting practice(s) has (have) also carved out ingenious methods for 'hiding' / or camouflaging / or colouring fiscal picture. Auditor's work (in this area) is to 'monitor' 'access' and "point out" variances in the fiscal picture and to ensure that 'legal requirements are complied with before certification or to give 'qualified' certification. Audited report may not be 'transparent' In this case the auditor is not expected

to 'penalise' In fiscal audits, the auditor merely checks, monitors, reports findings and makes qualified certifications.

2. **Management audit**

The next in line has been the management audit. With important strides in techniques of management (of resources and people), management accounting and management audit has grown in importance and harnessed in practice. The area has been nurtured and developed mainly to usher in 'efficiency' and 'effectiveness' and navigation towards the goals set.

There are many important tools and concepts that have been generated through the development of management science (and art) but the most important for the purpose of the discussion here is the concept of 'optimal'

"Optimal". We use the word 'optimal' to distinguish from the word 'minimal' / 'maximal'/ 'average'. To my mind "optimal" means that which "appropriate with holistic considerations". (What is *optimal* keeps changing from time to time with changes in the situation). It takes into under its wings considerations of (I) economically sustainable, & (ii) harnessing of resource e.g. fiscal, time, effort, personal and personnel etc., on the one hand and creation of space and opportunities for nurture, growth and development of individuals and Organisation.

3. **Social Audit**

I do not know if the term 'Social Audit' is precisely defined Which is good for now because it gives one a lee way to define it as one pleases. I would define it as auditing the existence (and performance of Organisation / individual) in terms of meaningful value to the society and its 'idealised' future.

What would that include I do not know for sure, but for brain storming I am enlisting some 'heads' and elaborating on these wherever I can. (See below)

- **Worthiness Indices**
- Investment worthiness index
  - In an Organisation like CEHAT the funders invest money, the staff its time and effort and the peer Organisations their 'concern and support' (whatever that means). To each of these segments, a repeat of investment would be reason enough to signal *an increment* in 'worthiness.' Again the more investors would mean a signal for greater *perceived worthiness by that investor segment.* A scale would be drawn out based on this 'repeated'

or continued investment. A scale could also be drawn out based on the number of such investors. Larger the base, the larger would be the perceived worthiness to that segment. Based on the score of each of these a "Worthiness Index' (for this segment) could be constructed. This index could be from the investor's angle Likewise there could be those from the point of view of (1) social action angle (which could be sub-divided into sections as I have tried to list below.

- Social action angle
  - Support to existing social action
  - Research for new avenues for social action
  - Lobbying facilitation
  - Academia facilitation / support
- Debt : Equity ratio (A little diversion for the moment)

  This is a thumb rule popular within the Corporate circles. "If the Share-holders are willing to invest 'x' amount of funds (i.e. investment) then the 'lenders' would brave a risk of '2x' and all this '3x' would be worthwhile, if the product of the enterprise is valued at least '300x' Perhaps if one is able to give 'value' representations to the efforts (and time) put in by the Organisation in terms of 'money' (That is already done because the Organisation pays 'salary 'where the notion is based on converting effort into 'money' - even if this is Hobson's choice. The difficulty would be to set values (in monitory terms) to product of enterprise.
- Honesty index

  It will take some time and effort to develop on this I have put it here for brain-storming exercise.
- Transparency index

  The term "Transparency" is well known and abundantly used. And yet, I suspect everyone's notion of *transparency* is slightly (and sometimes widely) different. Thankfully across the board there is a common consensus that the greater the transparency between the interacting entities the better it is.

  I shall therefore qualify what I presume transparency means in the context of Organisational behaviour. Used in the context of Organisational behaviour, it entails that entities interacting "with" and "within" the Organisation know (or have access to) information that is (or can be) relevant to the interacting entity. Does this mean everything that goes on within the Organisation is *out on display?* I think not. There are a number of matters that need to be shielded from exposure on ethical grounds (e.g. confidentiality of the personal working

within the Organisation and many such matters) or on grounds of vulnerability to competition (commercial grounds), but transparency demands that these area be demarcated, notified to the entities interacting and be substantiated with appropriate explanation (particularly the ethical merits for such non-disclosures). The commercial (or political) shields against disclosures must also be spelled out with adequate explanations. The *more the disclosure the more Open would be the Organisation. One could workout a scale for Openness of the Organisation based on this concept.*

Likewise, there could be non-disclosures scoring also. Positive scoring for ethically appropriate to null score for commercially / politically appropriate to negative for unacceptable reasons. (+++ / ++ / + / 0 / - / -- / --- /----) Based on the Openness score (0 % to 100%) and the Non-disclosure score an *index of transparency can be worked out.*

CEHAT is (I am told) planing to have a 'web page' on the internet. On the web page, it is common to have a sub-site titled "about us", In this 'about us' what is the site visitor able to access information (even if that calls for a payment of a fair fee) *about CEHAT* would give a degree of "Openness" and if properly extended transparency of the Organisation.

- Fairness index
  1. Is the Organisation fair to employees
  2. Is the Organisation fair to funders
  3. To the society it uses for its work (e g community in field research)
  4. Is the Organisation fair to the society in which it operates (country)

- Equality index

  To be developed
- Sensibility index

  To be developed.
- Reference index / Reference score (no. of citations of research products)

  CEHAT is a research Organisation It publishes papers and other publications which are to be referred to and quoted. Based on the density(?) of citations a score can be constructed.
- New approach index :
  - Different positions > common goals (Hospital accreditation)

In Hospital accreditation programme - a new approach to zero-in segments from varied "positions" to common acceptable and workable level is - to my mind an innovation - value that could be constructed for 'worthiness index.

- Universal publication (on the internet) access to beat plagiarism? (Web page) (Floppy) (data publication in Journals)

  This is yet another innovation to defeat copy-right madness. This 'value' could be subjected to 'scoring'

- Outreach accessibility

  To be worked out.

- Internal democracy - How much? How effective exercised? How fruitful in nurturing internal 'pluralism' A score could be devised

- Interdependence - support index

  CEHAT has liased with a number of Organisations (programmes) - complimentary / and supportive functions for a common goal. These inter-responsiveness could be subjected to a value score.

- Optimisation index (?)

  To be developed.

- Ripple (meaningfulness) effect index

  - Immediate next group > next immediate group > so on. Each Organisation builds its ethos. The founding members (are presumed to imbibe this ethos *maximally*). The next proximal segment (say, the staff) is expected to be influenced next and so on. For instance practising doctors (who founded the Forum for Medical Ethics FMES) are expected to *fully contribute to the ethos of FMES.* The next proximal groups is expected to be influenced more preferentially in relation to the distal groups. Audits could aim at exploring the reality of this presumption.

- Personnel growth and development index

  (In house poll Entrance poll / Exit poll) The entering staff and the exiting staff of the Organisation have their 'picture' of the worthiness of the Organisation. Some times this is coloured by personal fancies or prejudices. These prejudices or fancies are at their high point immediately (on entering) or (on leaving). Some Organisations (or their representative) try and evaluate the perceptions of these segments *after a cooling period, say of 6-months.* This score (it is believed) is useful..

- Intra-Organisation personality gradient. - Space score / involvement score / 'belonging' score

- In house value nurture index - ethics-ethos / social justice index / empathy index / open-mindedness index
- There could be more areas that could be included, with further work in this area.

One method of scoring

(Many of these indices are *intangible* in character. It is difficult to make measured scoring. The approach adopted in sports like *gymnastics or figure skating* is that there are 6, 8, or10 evaluators. They record their instant score. The highest and the lowest scores are weeded out and an average of the rest is drawn out for arriving at score of that individual)

1. 10 evaluators to cover the range of proximity levels (very close to very distant). Evaluators who *are close* to Organisation and those which are *not close*, form a team of evaluators.
2. On each index organise score gradient (highest to lowest) Leave out the highest and the lowest and add the rest and divide by 10 (or eight) to get score for each. It is expected that scoring of individual evaluators follows a (?) curve If it happens to be otherwise the evaluators need to be changed -
3.
4. Organise indexes score wise and divide the range into 3 components The highest segment need to be sustained and middle segment needs to be fortified and the lowest needs to be urgently addressed to for improvement.
5. There are some indices which may need monitoring throughout Some may need to be moderated on the basis of age of the project. Some based on the category of the project. Some through correspondence. Some through personal interview
6. Grading of project vis-à-vis meaningfulness
   - to social action
   - to academia
   - to lobbing value
   - to peer Organisations
7. Slippery slopes and Iceberg technique.

   It is important to be aware of areas with slippery slopes and Iceberg technique could be harnessed to investigate these areas. Some such areas that come to my mind are:
   - Asset-building - an exercise for sustenance and necessity or for ego and avarice.

Anusandhan

A note for (potential) Social Accountability Group (SAG) members for CEHAT.

Relevant History

Anusandhan Trust was envisaged and formed in 1991. Though, the thinking then was to engage in rigorous research in the areas of health - {research, particularly from the pro-people (particularly the disadvantaged) perspective} - there was a clear understanding that the outcome of research should make enabling environment for social action. Also, (additionally) (it was conceived) that it was important (where existing social action was not evident) to research and establish data that could lead to initiating social action.

To Anusandhan, it was clear that all pro-people work was important and restricting itself to areas of research would not suffice and hence whilst drawing the Trust Deed a wide spectrum of possible areas to work in were included. It was envisaged that initially there could be a centre for research, but if the need arose, Anusandhan would initiate other centres as well. CEHAT (Centre for Enquiry into Health and Allied Themes) was started some three years later and is engaged in research and action in areas related to health. Over the past six years CEHAT has grown speedily.

Whilst initiating its endeavour, ANUSANDHAN pledged itself to the values of (I) transparency (ii) honesty, (iii) openness, (iv) democratic functioning, (v) collective governance, (vi) constantly improving standards for quality output and (vii) social accountability in all its units. When CEHAT was started, structures for implementing these values were gradually put in place.

The Trust Board of Anusandhan - since the very beginning - realised that merely *constructing* structures was not enough to ensure their effective purposes. Anusandhan believes that just as featuring of financial audit report is mandatory in a company's report to the public, social audit report must also be a responsibility of an organisation in its report to the society in which and for which it exists. Nonetheless, Anusandhan also is alive to the ground realities. While norms for financial audit are tangible and quantifiable and by and large universally accepted, those for social audit are not yet sufficiently well developed. Largely, this is because of three reasons viz. (I) organisations themselves have not laid enough priorities and efforts in developing these aspects (ii) there are no existing paradigms on setting up social audit procedures and (iii) outcomes relevant to social benefits & harms are difficult, if not impossible to quantify and measure.

Rather than wait until such procedures are set up, Anusandhan thought it best to subject its 'efforts' to social accountability. It was envisaged to set up a Social Accountability Group (SAG) of persons with integrity, sensibilities and ability to critically review *all that went into the work of its centre and along*

with it the output of its work. It would be mandatory to include (attach) report of SAG along with the Annual Report of that year. As response to SAG report, Anusandhan would carry (in its next annual report) the action taken report on the recommendations of the SAG report. This way Anusandhan would have the benefit of critically evaluated appraisal for improving its own endeavour on the one hand and would serve to social accountability report before the society it aims to work for, by making it accessible to anyone who requires it and requests for the report. In time, perhaps, parameters (to build up a system) for social audit would (may) also emerge.

In 1994 (check the year / date), the first SAG - comprising of Dr Neera Desai, Dr.S.K.Pandya, Dr.Ashwin Patel, Dr. S L Shetty & Dr Ravindra Soman was constituted and served until now (a tenure of 5 years). A worthy exercise was an outcome of this SAG. But this was the first SAG and Anusandhan requested this SAG to assess the Trust's centre in the way the SAG deemed it fit. For this purpose, CEHAT provided extensive material that was generated in the centre (e.g. all papers / reports published and unpublished, minutes of the Trust Board Meetings, the Staff meetings, rules & regulations & salary structure of CEHAT, etc.).

Reviewing the exercise of SAG now, the Trust now feels that specific & critical evaluation of the Centre (from SAG) in important areas would be helpful to the Trust and the Centre for development and direction in which the Centre moves. This note attempts to list out these areas and also suggest procedures for interactions between the Trust, the Centre and SAG.

CEHAT's working structure

1. At present, CEHAT has offices in Mumbai & Pune and other field offices in Maharashtra and MP.
2. The Centre has as its chief administrator the Co-ordinator. He / She has duties & responsibilities towards (a) the Trust, (b) the administrative wing (accounts / personnel etc.), the research wing, the external contacts. He / she is authorised to depute anyone to this work. In addition, the Co-ordinator has his / her own research responsibilities on the Research Projects he / she is involved in.
3. Wage structure and Rules and Regulations are written down and are available for anyone (even outsider) who asks for a copy. A new employee is furnished with these. These could serve to foster transparency. Whenever, revisions in the wage structure are made, a meeting with staff is organised and the subject is thrown open to debate.
4. In order to nurture collectivism, democratic practices and effective space for communication within personnel and to evolve leadership qualities within the staff, the Centre has instituted a Working Group (WG). WG has elected representatives from both the Mumbai and Pune offices. The WG meets once a month. The Co-ordinator is an ex-officio member of the WG. Expenses (travelling etc.) are borne by the Centre. Elections to the WG are held every

year and any member of the staff is eligible for this. The tenure of the member is 2 years with one-third retiring each year. Care is, however, taken to ensure that both the Mumbai & the Pune offices are represented on WG. Work on the WG entails responsibilities in addition to the work that the individual on the WG has. However, for this additional work the members do not get any allowance. This is made explicit to the individuals on the WG.

5. In addition to the WG meetings Staff Meetings are held twice a year. These are organised as residential meetings at some resort that is both convenient and economical. The agenda for such meetings try and incorporate presentations of the work done by the staff, changes in administrative / accounting as also the hurdles and difficulties in the procedures etc. And any other personnel matter. Often the agenda tries to include a lecture from someone outside the Centre or a workshop. These meetings try to provide space for the staff to have a general awareness of the status (as also the difficulties, challenges etc,) of the work of other members of the staff. It also can (and hopefully does) provide space for harmonising personnel matters.
6. The Centre has put in place the Grievance Redressal Structure (GRS). This is currently under review.
7. The financial accounting and reporting is the responsibility of the accounts wing and Co-ordinator heads this wing. Chartered Accounting Firm is entrusted to oversee and certify the financial accounting. This accounting is done on the half yearly basis but the certification of accounts by the Chartered Accounting Firm is only done after the financial year ends. The Centre has an FCRA account and accounting for this purpose also forms the part of the duties of the accounts wing.
8. Research Projects are submitted by the Centre for funding. These projects are drawn out by the Principle Investigator (PI) and discussed within the staff and the WG. For every research project (involving primary data collection) setting up of Ethics Committee (EC) is mandatory. This EC reviews the work at the beginning (planning stage), intermediate stage and final stage. As a procedural requirement all research and action work is subjected to a peer review at various stages and the work discussed threadbare. Copies of publication of these works (and any other publication brought out by the Centre) is sent to SAG members
9. The Trust Board sends the minutes of its meetings to the SAG. CEHAT sends the minutes of the Staff meetings to SAG and the Trust Board Members. CEHAT also sends the minutes of GRS to SAG members and the Trust Board.
10. The Trust Board Members and the SAG members are encouraged to meet the staff.

Trust Board and the constitution of new SAG.

Trust Board of Anusandhan has laid great importance to the report of SAG and its (SAG's) report along with the ATR will be a part of Anusandhan's Annual Report this year. Learning from the experience, the

Trust Board recommended some inputs to address the issue. For one, it has to facilitate the co-ordination between SAG and the Trust Board on the one hand and to make Trust's requirement written and itemised for facilitating SAG report. This note is for that purpose.

Anusandhan Trust seeks to have SAG opinion /evaluation / recommendations on the following areas:

- On meeting core objectives of CEHAT
- On transparency of CEHAT's work within the Centre and with the outside environment.
- On Worthiness of the output of CEHAT - preferably with respect to individual projects and administration
- On honouring ethical concerns
- On the aspect of CEHAT's provision of space for nurturing excellence and leadership qualities of individuals on the Staff.
- On CEHAT's interaction with other Organisations
- On the space and nurturing of democracy and collective functioning within the Centre and between Trust Board and Centre.
- On CEHAT's growth and development
- the Grievence Redressal mechanism and functioning; and effectively of it
- On the quality of research and shortfall in the area
- Other areas that SAG may think pertinent and important.

Anusandhan believes that with a written request to SAG, it may facilitate the SAG to include the items in its report to the Trust on the one hand and to the Public on the other. It will be a binding for Anusandhan Trust to publish (as attachment to its own Report) the SAG report and to state its response to SAG report in form of ATR and what is not taken up for action with explanation to the Public.

Facilitating the functioning of SAG.

For facilitating the functioning of SAG CEHAT had been furnishing to SAG (on a regular basis) (a) reports of the research work published and unpublished (b) the minutes of Staff Meeting and any request that SAG makes. The minutes of WG are not sent (because these take place every month and are mainly relevant to the staff co-ordination) (**check if this is correct**) but if the SAG makes a request these also can be sent to members of SAG. The Trust Board furnishes (on regular basis) the minutes of the deliberations at Trust Board meetings.

CEHAT helps SAG in organising venues for SAG meeting and re-imburses the expenses incurred for travelling and organises hospitality. Anusandhan Trust has now resolved the ethical hurdle of making allowance payment to members of SAG. Allowance for the SAG members for the days of meeting will be borne by Anusandhan Trust - not from CEHAT's funds. Also to facilitate administrative work of the SAG, - particularly in the 3rd year (when the written report of the SAG is sought) the Trust will provide

funds for a secretariat (of one or two persons) that the SAG may like to set up. The Trust urges SAG to appoint a Chairperson to co-ordinate its activities and to facilitate liaison between Co-ordinator CEHAT and Managing Trustee Anusandhan and SAG.

This note is for preparing a foreground to initiate the new SAG. It is hoped that in the first meeting between SAG members, Trust Board Members and Co-ordinator CEHAT a complete protocol will emerge.

Anil Pilgaokar, cJuly 2000
Ravi Duggal, cAugust 2000, minor modifications

Following section added by Ravi Duggal

Modalities of SAG

It is suggested that the SAG should have five members. These members should be sensitive to social research and action and must have made some significant contribution in it. They will select a Convenor from amongst themselves. The tenure of the SAG would be for three years, at the end of which a social audit report will be produced.

The SAG will get all secretarial assistance needed by them from CEHAT. CEHAT will provide SAG members all documentation, reports, papers, minutes etc., to members once every quarter for review of work. The SAG should meet once a year to take stock of the work of CEHAT and discuss amongst themselves. Also they should meet and hold discussions with all staff members at this meeting. The SAG members may choose to review the work of CEHAT selectively as per their area of interest etc.. This the SAG members must decide at their first meeting. At this meeting they must work out how they would like to structure their working and distribute responsibilities and the process of review to be followed etc..

At the end of each year a brief report after their annual meeting must be sent to the Trustees. The members are also free to send feedback to the Trustees as and when they desire. At the end of three years the SAG should carry out a formal social audit for which Anusandhan Trust will provide resources to set up a Secretariat with an anchor person of the SAG's choice, if such a person is necessary. Once the social audit report is ready it will be presented to the Trustees at a meeting and discussed. Once it is finalised the SAG report will be made public. The Coordinator and Managing Trustee will subsequently prepare an Action Taken Report and both these will be published in the next Annual Report of CEHAT / AT.

Ravi Duggal
24th Oct. 2000

mahlade.ut
12/1/2001

NAGARPALIKA (74TH AMENDMENT) ACT, 1992

THE ROLE OF VOLUNTARY ORGANISATIONS

REPORT OF THE NATIONAL WORKSHOP
HELD IN BOMBAY
MAY 14-15, 1994

ORGANISED BY

YOUTH FOR UNITY AND VOLUNTARY ACTION, BOMBAY
AND
VOLUNTARY ACTION NETWORK INDIA, NEW DELHI

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In particular, VANI deeply acknowledges the support and solidarity of the Youth Unity and Voluntary Action, (YUVA) the local host, who not only made all arrangements for the workshop but also mobilised participants and resource persons and prepared design of the workshop. Our special thanks goes to all participants and resources persons, especially Dr. Nawas Mody, Shri Dinesh Mehta, Dr. (Mrs.) Marina Pinto, Ms Sneha Palnitkar, Ms. Sheela Patel, Shri B.M. Suktankar and Shri Amitabh Kundu for their participation, preparing paper and its presentations during the workshop.

The first draft of this report has been prepared by YUVA team and final text by Seema Gaikwad, Vimi Khanna and Anil K Singh.

New Delhi, August 1994.

ANIL K SINGH
EXECUTIVE SECRETARY

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SUMMARY OF THE NATIONAL WORKSHOP

A National Workshop on the Nagarpalika (74th Amendment) Act, 1992 was jointly organised by Voluntary Action Network India (VANI) and Youth for Unity and Voluntary Action (YUVA) on May 14-15, 1994 in Bombay.

The aim of the workshop was to enhance the understanding of the legislation among different actors of civil society, academicians, social activists, voluntary organisations, media persons, bearing in mind that civil society has an important role to play in strengthening grassroots democracy.

The presentations, recommendations and discussions of the workshop may be summarised as follows :

Implications of the Act :

- The discussion on the historical context of the Act stressed the fact that the Act is a belated but welcome constitutional acceptance of the principle of urban local self - governance. The Nagarpalika Act is expected to refurbish the whole system of urban local self-governance.
- The Amendment had become essential due to the systematic erosion of autonomy in the municipal functional domain. Inadequate financial resources, the inadequacy of personnel staffing, outdated management systems, stifling control of the State Government, invasion of factional politics in local self-government, the development of a nexus between the underworld and the political set-up and increasing corruption were seen as some of the factors ailing the current system.
- The implications of the Act on urban affairs was outlined and its scope was detailed especially that, issues of social justice including aspects of urban poverty alleviation, slum upgradation etc. would greatly enlarge the scope of the municipal government. The idea of democratic decentralisation, transferring power to the people, reservation for women and scheduled castes and scheduled tribes, establishment of a State Finance Commission and a District Planning Committee were stressed. Another important issue for consideration was that of accountability of the governing mechanism to the people at large.
- The discussion on municipal finance and the 74th Amendment underlined two important aspects:

  i) the setting up of a State Finance Commission which can make recommendations to the Governor to suggest measures needed to improve the financial position of the Municipalities and Nagarpalikas.

  ii) empowering municipal corporations to impose taxes directly as well as obtain taxes

imposed by State Governments; however, the powers of the Municipal body to borrow, have not been specified.

It was noted that a disparity in distribution of and access to resources exists between different types of towns and cities. An analysis of patterns of urbanisation show that class I cities show greater financial stability because of their sounder economic footing whereas small and medium towns with a weak economy are unstable. The need to stabilise the infrastructure of small and medium towns was expressed.

- A need to review the participation of women who have been elected was expressed as women are increasingly being seen as a third force in politics. It was felt that since poor women are caught-up in a daily struggle for survival, they are unable to play the role envisaged for them since democracy is more than just representative governance. It becomes meaningful only if those who represent the group are able to articulate the issues of that particular group.

- The findings of a study undertaken by Sneha Patnitkar on the elected women corporators of Bombay Municipal Corporation (BMC) were presented. It was found that reservation had resulted in an increased number of women in politics, most of who women were found to be from the upper castes. It was felt that though there is a one-third reservation, this could be increased to 50% as they would be able to win from open wards also. Sneha Palnitkar saw an increasing confidence among 9 women about their ability of women to perform their roles. This perception was however not shared by the BMC officials who felt that there was inadequate intervention and participation by women during meetings. The study also revealed that women corporators were comparatively less corrupt.

Role of Voluntary Organisations:

Outlining the role of voluntary organisations in urban local self - governance, it was stressed that the voluntary organisations need to play an intermediary role between "government", "the system" and "the people".

The roles envisaged for voluntary organisations therein are:

- to ensure space in the ward committee for voluntary organisations - to include people's organisations, and local coalitions as representatives of the people.
- to initiate political processes at the people's level - in the context of elections, ensuring voter education, voter association by preparation of 'people's manifestos; 'people's observers' during election and 'people's audit' of elected candidates.
- to train women, scheduled caste and scheduled tribe elected representatives on Municipal Bodies and District Planning Committees, as well as evolve mechanisms where by the functioning of the committees are monitored. .

THE FOLLOWING ARE SOME ISSUES WHICH WERE HIGHLIGHTED :

- Political will is necessary to implement the provisions of the Act.
- The provision for the involvement of non-elected members in Ward Committees is vague and unclear.
- The role of the State Finance Commission (SFC) and the mechanism through which the SFC would review the financial position of Municipal bodies, their capacity to raise resources, resource-gap etc. and then make recommendations for supplementation of resources.
- The uncertainty of the State Legislature accepting the recommendations of the SFC ?
- The first exercise to be carried out at the State level would be that of enacting obligatory State Legislation in congruence with the Central Act. Overall reforms of Municipal functions such that the local bodies can be made most responsive, and the need for instrumentalities, such as ward committees to become a reality.
- Financial decisions which uptil now are not debated and are shrouded in secrecy should be presented in a simple, transparent manner.
- Overall context of centre-state relations, decentralisation and dissolution of power from the centre to the states.
- The necessity for laying down broad guidelines detailing how such transfers would take place.
- The basic principle of public finance is that taxes should be collected at points where it is most efficient to collect. At local levels, certain functions have been usurped by the State Government. Local self-governments need to be restored the power of accessability to resources.

Recommendations of the Workshop

It was agreed by the participants that the voluntary organisations should:

- hold regional level workshops on similar themes;
- extensively disseminate information related to Nagarpalika Act and other related issues;
- to develop a list of learning material and list of resource persons;
- to organise awareness campaigns to educate the people politically and to make them aware of their voting right, to enable them to actively participate in the election process;
- to develop training modules and training strategies for elected representatives and train them, so that they can play their due role in municipal bodies;
- Emphasise the role of women and other weaker sections of society in this process.

CONTEXT

The question of Governance has acquired a significant and critical status at this juncture. Questions have often been raised about the accountability of governing mechanisms to the public at large. Issues of transparency and responsibility in Governance have also become vital.

In our country the process of governance has moved from local control to a supra-national centralised activity in the last 46 years. It is shrouded in secrecy and smacks of an 'anti-public interest' posture. Anonymous decision making and the absence of accountability are the hallmarks of the system of governance in India. Movements, institutions and associations within the civil society are demanding a direct and active role in governance. The demands to set up and build institutions of local self-governance have thus acquired an urgency in India today.

While the urban local self-government institutions have operated in some form or the other in post-independent India, it is only now that the political leadership of the country is trying to provide it with an autonomous, independent constitutional identity. The 74th Constitutional Amendment Act provides such possibilities. The Nagarpalika Act provides for regular and time -bound elections, gives the responsibility of an extensive role in socio-economic development of urban centres and makes provisions for transfer of resources from central to state governments for various sectors of development. Most important, the Act provides for 1/3rd reservation for women and a proportionate reservation for scheduled caste and scheduled tribe members. It is true that party politics may vitiate the process of elections, still the potential for strengthening institutions of local self-governance and creating a system of accountable development exists within the realm of this Constitutional Amendment. The question, therefore, is whether concerned citizens and voluntary organisations will take this opportunity to contribute positively to the possible of formation of strong, vibrant and accountable institutions of urban local self-governance. Two roles need attention: The **first**, and most critical role is to provide orientation and necessary inputs to the newly elected members. This orientation will be critical for women and members of the scheduled caste and tribes. The focus of such orientation should include the rightful and responsible role in making such institutions a viable reality; **Second**, Voluntary Organisations, with their vast experience in micro level planning and implementation, could be effectively utilised and made available to the institutions of urban local self-governance. It is in this context that a National Workshop was held in Bombay during May 14-15, 1994. Nearly 80 participants (the majority from Bombay) and respresentatives of voluntary organisations from 8 states (Maharashtra, Uttar Pradesh, Bihar, Rajasthan, Kerala, Tamil Nadu, Gujarat and Delhi and eminent persons in the field of civil society participated in this workshop. It helped to understand the implications of the 74th Amendment Act and the potential role of voluntary organisations in strengthening institutions of Urban Local-Self Governance.

This report summarises the extensive discussions which took place during the workshop.

Lord Ripon, the founding father of the municipal authorities in British India, implanted the concept of municipal authorities as the basic units of "self-government". Their role as such has substantially declined over the years. The debate concerning the relevance and utility of the Urban Local Self-Governance system has been going on since Independence.

The initiative to accord a constitutional status and reactivate the urban local-self government bodies began relatively recently. The initial debates and activities, led to the consultations and conferences of State Chief Secretaries and State Ministers of Local Self-Government in 1988-89, which was followed by a conference of State Chief Ministers in New Delhi on July 7, 1989. The present amendment was introduced after review in the Lok Sabha in September, 1990. Later, the Constitution Bill, 1991 relating to municipalities which was essentially based on the Constitution (65th Amendment) Bill, 1989 was introduced.

The Constitution (74th Amendment), Act 1992, also known as the Nagarpalika Act was passed by the Parliament and the Central Legislation came into force on June 1, 1993. As the urban local self-governance comes under the list of State subjects, all the States and the Union Territories were asked to ratify the Act and bring the existing State legislation in congruence with that of the Central Act.

The objective of the legislation is primarily to strengthen local democracy in India by transferring 'power' to the 'people' and encouraging their participation and involvement in the decision- making processes concerning the overall concept of 'Governance'.

WHAT AILS THE EXISTING SYSTEM

The existing scenario has a number of anomalies which has led to a substantial decline in the System. Some of these are :

1. The undefined role of municipal authorities has resulted in considerable erosion in the municipal functional domain. This is manifested in state encroachments into municipal functions on the plea that the traditional municipal authorities do not have requisite resources to effectuate the challenging tasks.

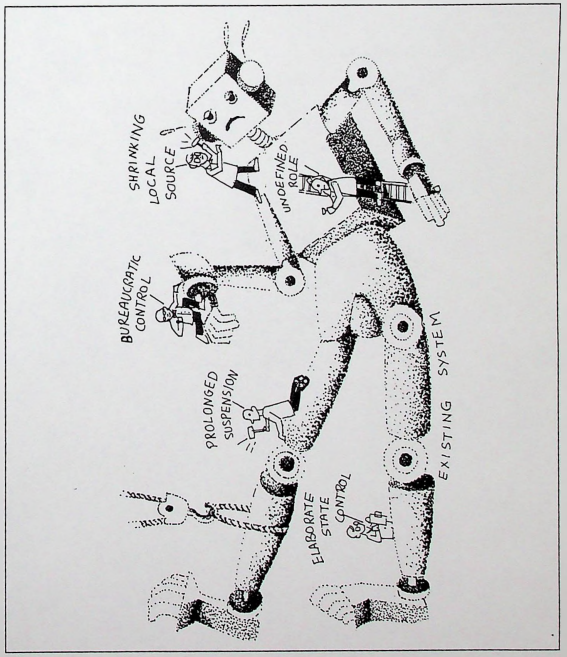
2. On the resources front, the local resource base has been shrinking. The share of municipal authorities in the total public sector expenditure has declined from about eight per cent in 1960-61 to about 4.5 per cent in 1977-78.

3. The executive powers in the municipal corporations are vested in the Council and its executive committees, while the executive functions are performed by the appointed Commissioner. Substantial executive powers enjoyed by an appointed executive, rather than by the elected representatives has led to bureaucratic control and hence erosion in local democracy and self-rule.

4. An elaborate state control on the day-to-day functioning of the municipal authorities has a crippling effect on them. These powers are frequently exercised through inspection, calling of records, giving directions for performing civic functions and framing of bye-laws and rules. Despite being the units of self-government, it is incredible that the municipal authorities do not have the powers to approve their own budgets and decide the tax rates. Even the Municipal Corporations are required to obtain state approval of expenditures beyond certain limits which in Kerala is Rs. one lakh, in Andhra Pradesh, Rs.50,000 and in Himachal Pradesh, Rs.20,000.

5. The most drastic mechanism of control is applied by the Act of supersession whereby the Council need not be reconstituted through a fresh election for years together. Due to this, a large number of municipal councils are under prolonged suspension.

All these have gone a long way in weakening the institutional capability of municipal authorities.



74TH AMENDMENT (THE NAGARPALIKA) ACT AND ITS SALIENT FEATURES

To comprehend the efficacy of the 74th Amendment it is important to look at the important provisions of the Constitution Amendment in terms of (i) structure, (ii) composition, (iii) powers and functions, (iv) finances, (v) Urban planning, and (vi) Empowerment of women and weaker sections of society.

(i) Structure :

Through the Amendment, the Constitution provides for constituting three new types of institutions for urban self-government. These are: (a) Nagar Panchayats for an area in transition from a rural to an urban area; (b) Municipal Councils for smaller urban areas, and (c) Municipal Corporations for a larger urban area. The right to decide which areas are to be called "transitional", "smaller" and "larger" urban areas have been left to the discretion of the State Governments. It also provides for decentralisation of municipal administration by constituting Ward Committees in territorial areas of such municipalities which have populations of over three lakh which would help bring the citizens and units of local self-government closer.

The Amendment is completly silent about the future fate of Cantonment Boards which are important variants of municipal authority performing similar functions constituted under a Central Act. If this silence implies the demise of Cantonment Boards, is implied, it will be injurious to the civic administration of cantonments.

A very important provision in the Amendment pertains to the right of the Municipal authorities' to exist (Article 243-U). It allows a five year term to the Municipalities, and stipulates that if at all they have to be dissolved, they must be given an opportunity to be heard, and then fresh elections must be held within a period of six months. This will hence forth prevent their prolonged supersession for years together. In fact, this provision remedies one of the major problems facing Municipal authorities in the recent past the continuous interference in their functioning by the State Governments.

(ii) Composition:

The Composition of Municipalities has been designed in such a manner that all the seats are to be "filled by persons chosen by direct election" (Article 243-R (1)) to make it more responsive to the people. For elections the territorial constituencies in municipal areas have been divided into wards and each seat shall represent a ward in the Municipality. The nature and method of the election of the Chairperson has been left to be specified by the concerned State Legislatures.

The second tier, that is, the Ward Committees, are to be composed of the Members of the Municipal Council representing the wards within their jurisdiction and one of the elected representatives from within the wards is to be appointed as its Chairperson. In addition to the elected representatives, the Ward Committee is to consist of nominated members. It will be the prerogative of the State Governments to decide the composition and the manner in which the seats in the Ward Committee are to be filled (Article 243-S(2)). This provision to nominate the members does not go well with the ethos of self-government.

(iii) Powers & Functions:

The Amendment envisages that functions relating to preparation of plans for economic development and social justice as well as for implementation of various development schemes shall devolve to the municipal authorities. It has appended a new Twelfth Schedule (see enclosure - I) to the Constitution of India which lists out 18 functions to be performed by them.

Some of the unconventional and ambitious functions include urban planning, regulation of land use, construction of buildings, roads and bridges, urban forestry, slum improvement and urban poverty alleviation programmes (Article 243-W). This would indicate that hence forth the gradual encroachment by the State on Municipal functions will stop as these have been so clearly specified in the new Schedule.

But this hope is belied primarily because of the discretionary powers the Amendment allows to the State Governments. Left to the State Governments, the devolution of functions would not be as complete as is envisaged in the Twelfth Schedule.

It has, therefore, been suggested that the Twelfth Schedule should be made mandatory, not discretionary and should provide for a Local List of functions in the Constitution of India in unambiguous terms.

Another area of doubt relating to the devolution of functions pertains to the nature of some of the functions which seem to be quite ambitious and even redundant and irrelevant for the municipal authorities. Planning for economic and social development, protection of the environment and promotion of ecological aspects, and urban poverty alleviation are functions which belong to this category. It is not that these are not important functions. Performance of such functions requires a much stronger financial capability and human resources than which the municipal bodies command. With the existing funds they are not in a position to discharge even the basic functions. Even the provisions relating to the strengthening of their financial base are not likely to achieve this objective in the near future, as is discussed here subsequently. To expect

them to discharge these functions efficiently, therefore, seems to be a tall order indeed.

Yet another grey area of the Amendment pertains to the functions to be performed by the Ward Committees. It simply talks of devolving to them such functions by the State Governments which may be necessary to enable them to carry out responsibilities conferred upon them. Thus the second tier of local government has been created without specifying the functions to be performed by it.

(iv) Finance :

Devolving of functions without devolution of sources of revenue does not carry any meaning. As discussed earlier, the decline in the institutional capability of municipal authorities is largely due to weak fiscal capabilities. However, the Amendment has very conveniently ignored this critical area of municipal governance. The taxes, duties, tolls and fees to be levied by them and assigned to them as also the grants-in-aid to be given to them have been left to the discretion of the State Governments. We have seen in the past that a large number of states, the State Governments have not only been indifferent to the need for revamping of municipal finance but have even encroached upon the legitimate sources of local revenue. Profession Tax, for example, has been taken over by the State Governments in Karnataka, Haryana, Madhya Pradesh, Meghalaya, Nagaland, Tripura and West Bengal. In Andhra Pradesh, the Entry Tax is being used by the State Government. In Madhya Pradesh, even Property Tax had been taken over in the past by the State Government. Left to the discretion of State Governments, the prospects for refurbishing of the municipal finance system do not seem to be very bright. It was, therefore, required to specify the sources of local revenue in the Constitution of India itself so that these could be constitutionaly protected and guaranteed.

Features of the Finance Commission:

The only redeeming feature of the Seventy-Fourth Amendment in the financial sphere is the mandatory constitution of Finance Commission by the State Governments once in every five years.

* The State Finance Commission (SFC) is to make recommendations regarding principles to govern the sharing of the state taxes, duties, tolls and fees between the State Government and the municipalities and also its distribution between the municipalities.

* The SFC is also to suggest the principles for the determination of taxes, duties, tolls and fees to be assigned to them and the grants-in-aid to be given to the municipal

authorities out of the Consolidated Fund of the State.

* It also has the mandate to suggest ways and means of improving the financial position of the municipal authorities.

* The Governor is required to lay before the State Legislature the recommendations made by the FC along with an explanatory memorandum containing the action to be taken on it. Thus the suggestions and observations of the SFC shall have to be taken note of by the State Governments. This is one of the most important aspects of the Seventy-Fourth Constitution Amendment.

The mechanism of the SFC seems to be the only hope for the refurbishing of municipal finances, as the decision on sources of revenue has been left to the states discretion. The recommendations to be given by the SFC will fill this void as it has the mandate also to suggest the taxes, duties, tolls and the fees to be devolved upon the municipal authorities. This Amendment will go a long way in integrating the non-plan municipal financial needs with the state and federal finances through the mechanism of the committed expenditure of the State Governments. It is worth stressing, even at the cost of repetition, that the exercise of the SFC is based on the functions performed by the municipal bodies. If the functions of the Twelfth Schedule are not devolved upon them, the transfer scheme suggested by the SFC will be shortsighted, limited and meaningless. Moreover, as it is to be a composite State Finance Commission for the Panchayati Raj institutions as well as for the municipal authorities, one has to wait and watch if it gets dominated by the rural local bodies' interests.

Another provision of the Constitution Amendment Act having important ramifications for strengthening the financial capabilities of the municipal authorities is the amendment of Article 280 of the Constitution pertaining to the Terms of Reference of the Central Finance Commission (CFC). The new provision requires the CFC to suggest measures needed to augment the Consolidated Fund of a State to supplement the resources of the Municipalities in the State on the basis of the recommendations made by the SFC. Thus, the need for non-plan funds of the Municipalities is now to be looked into by the CFC as well.

Federal transfers will now be available also for the municipal authorities from the Eleventh Finance Commission onwards. This is an amendment of far-reaching importance.

The Amendment however does not say anything about the borrowing powers of municipalities, on mechanisms of determining user charges on services rendered by municipal bodies, on disposal of municipal properties, etc. . There are also restrictions imposed on investment of funds by local bodies.

It is sometimes felt that decision to be taken at the municipal and panchayat level could not be taken up at the higher level due to larger size of community, exposure to media etc. .

It is, therefore, important that the issues are analyzed not within a framework of competition between state and local administration, since mere transfer of power to raise resources to the elected representatives at local level, may not necessarily result in larger earnings.

A study conducted by Prof. Amitabh Kundu of Jawaharlal Nehru University, New Delhi shows that the pattern of urban growth in India shows a significant distortion across States, districts and size classes. The small and medium sized towns with populations below 50,000 in the backward states have experienced rapid growth during the seventies and eighties similar to that of the class I towns. In the developed states, however, the larger towns grew at a relatively faster rate. Detailed statistical analysis reveals that the growth of small and medium sized towns was not backed up by the growth of manufacturing or other economic activities and infrastructural facilities. Interestingly, a large majority of these towns are located in the backward districts. Rural poverty, stagnant agriculture, absence of sectoral diversification etc. would, therefore, emerge as possible factors in explanation. With the decline in central assistance to States, most of the towns have already gone dry in raising resources and are unable to make investments for improving infrastructure and basic services. This has compounded the problem of inadequacy of basic amenities in these towns, experiencing high population growth. It is thus evident that the small towns have come to depend increasingly on grants-in-aid, primarily due to their poor economic base and incapacity to mobilise tax and non-tax revenues.

The same study brings out that a disparity exists in per capita ordinary income and its various components across size class of urban centres at the All India level. It may be noted that taxes make up, as a proportion of the per capita ordinary income for Classes IV, V and VI, one-third in the metropolises and about half in Class-I cities. The tax and non-tax revenue together constitute 70 per cent of the ordinary income in the case of the former while in the case of metro cities, the figure is 85 per cent. While the grants for the smaller towns have grown by about 200 per cent at current prices during the period between 1974-75 and 1979-80, the corresponding increase in the case of metro and Class I cities is 100 per cent only. The low economic strength of the small and medium sized towns may be also inferred from the fact that while the Class I cities, on an average, have over 30 per cent of the male work force engaged in manufacturing, the figure is less than 8 per cent for the towns with less than 50,000 population. As high as twenty per cent of the male workers in the latter are engaged in the agricultural sector

which can hardly yield any revenue to the civic authority. The tertiary activities in these towns are also poorly productive. As a result of these, the level and quality of basic services are extremely low. What is worse is that the situation is deteriorating over time. **It would, therefore, be reasonable to argue that the Act, by making the civic bodies in small and medium sized towns increasingly dependent on their own tax and non-tax resources, would increase the disparity in the level of services and economic infrastructure across different size classes of urban centres. This would affect the capacity of small and medium sized towns to absorb the future growth of population and attract new economic activities.**

The segmentation of the cities into rich and poor colonies, with an increasing gap in the level and quality of urban amenities has been very sharp in recent years. The process is backed up by market forces as well as governmental programmes, pushing the poor out of the high income localities. Poor migrants have generally sought refuge in slum colonies in city peripheries or on marginal lands within the cities.

(v) Urban Planning :

The Amendment provides for setting up of District-Planning Committees to consolidate the plans prepared by the Municipalities and the Panchayats within the district and to prepare an Integrated Development Plan for the district as a whole. The municipalities are to be represented on it. The integrated development plan has to be prepared with respect to the matters of common interest between the Panchayats and Municipalities, including spatial planning, sharing of water and other physical and natural resources, integrated development of infrastructure and environmental conservation. Plans so prepared are to be forwarded by the Chairperson of the District Planning Committee to the State-Government. Similarly, Metropolitan Planning Committees are to be set up in the metropolitan areas with representatives from the municipal authorities. The Committee will be doing a similar planning exercise for the metropolitan areas as is to be done by the District Planning Committee in a district.

However, one wonders as to how the plans prepared by the Panchayati Raj Institutions are to be consolidated to form the draft District Plan. As this is not provided for in the Seventy-Third Amendment, from where will these institutions derive the powers to formulate the plan? And if the plans are not prepared by the Panchayat Raj Institutions, how are they to be consolidated along with the municipal plans to form a District Plan?

The setting up of a Metropolitan Planning Committee is going to create further confusion about the role and relationship of the Urban Development Authorities (UDAs) vis-a-vis the proposed Metropolitan Planning Committees (MPCs). Does it mean the demise of the UDAs? Or are the UDAs to be merged with the municipal authorities as their planning and development agencies? These questions are not

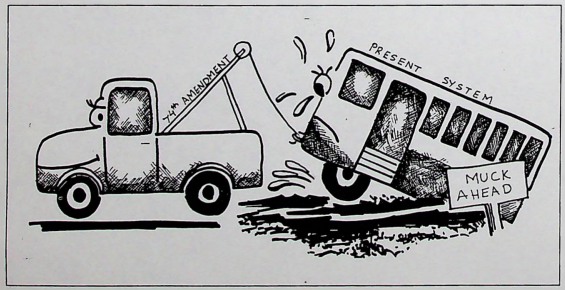
settled in the Amendment. If, however, the MPCs and the UDAs are to exist side by side, it will make the planning function fragmented and chaotic, adding further to already compounded problems of coordination.

(vi) Empowerment of Women and other Weaker Sections of the Society:

Empowerment of the weaker sections of society and of women is one of the most substantive provisions of the Amendment (Article 243-T). With a view to empower the scheduled castes and tribes as well as women, it provides for reservation of seats in the Council according to the proportion of these groups in the total population of the municipal council. The most important provision is the empowerment of women for whom one-third of the total seats are to be reserved. It also provides that the chairpersons in the municipal authorities have necessarily to belong to the scheduled castes and tribes and women.

Another important feature of the Amendment is the appointment of a statutory authority that will conduct elections to the Municipalities. All the powers of election superintendence, and control will be with the State Election Commission. This will reduce the control of the State Government and introduce impartiality and independence into the election system.

The Amendment is hence the first serious attempt to ensure adequate constitutional obligation so that stabilisation of democracy in Municipal Government is established.



ROLE OF VOLUNTARY ORGANISATIONS

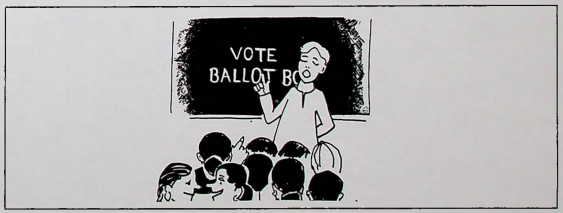
The active political role of voluntary organisations was debated. While some feel that voluntary organisations should primarily function as intermediaries between people and governments, others feel that voluntary organisations should express themselves at all levels of civil society and especially at the level of local self-governance, since local self - governance is supposed to be part of citizenry and non-party. Voluntary Organisations need to critically analyse their role in development and in political processes. It is also felt that voluntary organisations need not necessarily participate in political area but should attempt to make systems and service delivery more efficient. Voluntary organisations could form a federation to act with a consensus on matters of local self - governance, and create city resource centres to provide information to municipalities and its elected members etc.

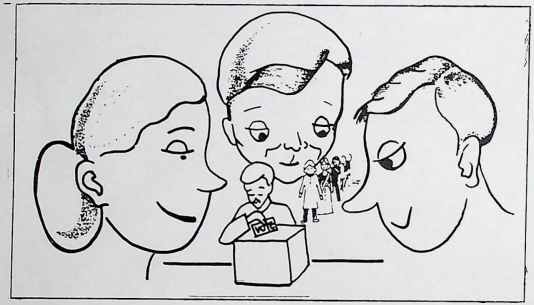
Sometimes it is also debated whether voluntary organisations are true representatives of the people. We should also see how community - based organisations and local groups can be helped to participate in the process. It is, therefore, stressed that the role of voluntary organisation would be to act as support organisations to community groups, to be intermediaries between local organisations and the system. Voluntary Organisations need to have a strategic vision and have external linkages with the system.

Voluntary organisations can thus play important roles **before the election, during the election, and after the election.**

a. Before the elections:

- The role of voluntary organisations is not merely to interface between governments and the people but between multilateral agencies and the people and even between people and people.





- Voluntary Organisations should educate and organise voters to assert their rights. Voters' fora can be formed which would help the education of voters, analyse manifestos of political formations, prepare alternate Peoples' Manifestos and have candidates declare their support etc. The academic community can help people analyse political manifestos, and experts on urban issues can help evolve alternate plans or policies.

b. During elections

- Voluntary Organisations can play a major role in identifying peoples' observers who could move around communities and polling booths ensuring no election were malpractices are taking place. Seeing peoples' observers trying to ensure free and fair elections would also increase the confidence of people. Human rights activists, literacy figures, jurists, and cultural groups can also be enlisted as peoples' observers.
- The criteria for nomination to Ward Committes should be objectively defined and voluntary agencies can play a role in this through lobbying and advocacy.
- To curb election malpractices, voluntary organisations must insist that all citizens are provided identity cards.
- Alliance between (Ward Committees, Voluntary Organisations, Community based organisations, academicians needs to be built.

c. Post-election

- Voluntary Organisations can form a Committee of 3-4 people in each municipal area to audit' or review the performance of the elected representative so as to ensure accountability. Corporators should also be prevailed upon to tell people of their agenda, to listen to the people's views on them, etc. .

d. Long-term

Voluntary organisations have a long term role to play. This would be that of preparing both the leadership as well as the community to enable effective participation.

(i) Training

Women and members belonging to the scheduled castes and the tribes among the elected representatives, who have been left out of the political processes for centuries need to be trained to enable them to perform their role effectively. As assigned in Twelfth Schedule of the 74th Amendment Act, Nagarpalikas are supposed to plan and implement 18 types of developmental activities. Newly elected members of the Nagarpalika may not have experience or knowledge about these developmental activities. Voluntary Agencies have a vast experience in handling such of developmental activities. All those voluntary agencies working in urban areas or on urban issues can help the Nagarpalika and its elected members in these endeavours.

(ii) Ensure proper representation

Voluntary Organisations should ensure that Ward Committees and District planning committees are represented by people's organisations and voluntary organisations. Mechanisms by which the functioning of these committees can be monitored need to be developed. Alternate plans for development can also be drawn up by a process which would require a broad alliance between researchers, people's organisations, community-based organisations and voluntary organisations. Many voluntary organisations have vast experience in micro-level planning and they can assist the Nagarpalikas.

(iii)Public Interest Litigation

Communities can be organised to file public interest litigation if institutions of local self-governance are not functioning properly or working against the people's interest. However, this should be as a last resort. The attempt must be to mobilise people to pressurise local bodies.

(iv)Social accountability

Voluntary Organisations can insist on the social accountability of the Municipal system, for example urging the local corporator to share information about his role, responsibility, performance etc. through mechanisms such as monthly bulletins, pamphlets etc. . They should also mobilise people in support of public hearings, discuss the agenda of their meetings and seek people's views on the matters to be discussed.

(v) Form networks

Voluntary Organisations should form a network of people having different kinds of experiences and expertise and build linkages with the Municipal structure. Networks between Ward Committees also needs to be built.

(vi)Dissemination of information

Voluntary Organisations have an important role to play in the dissemination of information about the Act as well as on other developmental issues, programmes, structures, socio-economic political system etc.

(vii) Function as pressure groups

Voluntary Organisations must explore areas where there is no danger of getting coopted, and function as pressure groups, enable people's audit, and in the

preparation of people's manifestos etc. . However, some participants felt that one-third reservation for women and Scheduled Castes and Scheduled Tribes can be a form of cooption.

(viii) Dealing with Political Parties and formations

Voluntary Organisations cannot escape having to deal with political parties. During election and after Political Parties will try to influence the Nagarpalika and its decisions. Voluntary Agencies are working on a neutral basis and therefore they can resist being influenced by political parties. For such functioning a strong ideological basis is a must for voluntary organisations.

(ix) Sharing dual relationship

Elected representatives share a dual relationship with voluntary organisations. It is only when voluntary organisations are cooperative and don't raise too many questions that elected representatives are open to discussion with them. Voluntary Organisations are also used by elected representatives to gain mileage. Therefore, it should be ensured that a amicable relationship is established between the two, to maintain a flow of information.

(x) Capacity building of voluntary organisations

Voluntary Organisations need to build their capacity to equip themselves to play these above mentioned roles, because all voluntary agencies do not have the capacity or skill to play these roles.

ROLE OF WOMEN

The role of women in political processes cannot be understood without looking at the ongoing processes in the entire society. Women in poor communities are caught in a struggle for survival and face the contradiction between inclusion in the political processes and the tremendous stress on the economic front, if they do give up their jobs and take part in the political process.

(i) Training of elected representatives

An analysis of the participation of elected representatives, from poor income groups shows that they have not really been successful in representing their issues. Women need to be trained so that they understand how systems actually work. **Support structures** to enable women from poor income groups to stand for elections, if they wish to do so, need to be generated.

In the **post-election** phase, elected women representatives, would need to be trained so as to increase their confidence. Areas of training would include gender sensitisation, personality and leadership development, etc. . Training manuals in regional languages should be developed.

(ii) Political Education to be emphasised

Mere representative participation is not democracy. Representation of a group is meaningful only if the representatiives are able to push forward the agenda of the group they represent. Women's participation is generally around very practical issues like water, food prices, etc. . They have been unable to demand changes in the system itself; they do not know how to interact with the administration etc. Thus, political education and mobilisation of women should be ensured if they are to effectively participate.

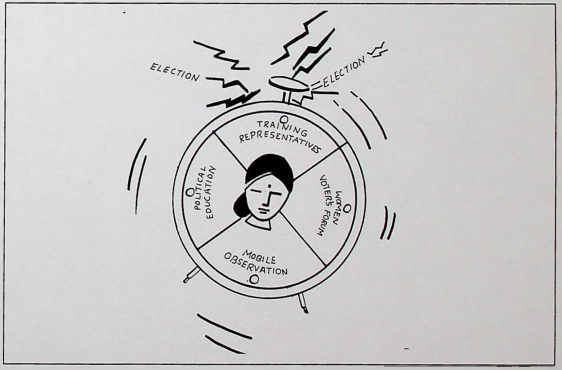
(iii)Women voters' forum

In the pre-election phase, encourage activities such as formation of women's voters' fora which would monitor the manifestos of different political formations to see whether they are gender sensitive, secular, democratic or not; prepare alternate women's manifestos and have candidates express their commitment.

(iv)Mobile observation teams should be formed

To prevent malpractices during election, mobile observation teams should be constituted. This would ensure unbiased elections. If women came out in large numbers, they can check malpractices and ensure peaceful elections.

Women should not be satisfied with one-third reservation but demand reservation equivalent to their proportion in the population. However, though the reality is that women constitute 50 percent of the population, they have no power or no control over resources. They have no base, no mechanism by which they can utilise these legislations.



RECOMMENDATIONS OF THE WORKSHOP

- It was decided that regional level workshops on similar themes would be organised. Participants from different states agreed to organise such meetings within the next few months. These meetings/workshops would be organised to encourage as well as equip the members of the voluntary sector to educate the masses in their own areas of operation.

- It was also decided that a comprehensive list of learning materials and list of resource persons available in different states would be prepared and widely circulated. VANI was assigned this responsibility.

- Participants were of the view that more stress should be given on women and other weaker section of the society.

- Representatives agreed to do lobbying and advocacy at the state level for formulation of progressive state legislations.

- All representatives were of the view that a massive awareness campaign is needed to educate the people politically and to make them aware of their voting rights and the importance of these, and thus prepare them for active participation in the election process.

- Participating organisations agreed to develop training modules and training strategies for elected representatives of Nagarpalika. It was also agreed upon that special efforts would be made to train elected women, and those belonging to the scheduled castes and tribes and other backward classes so that they can effectively participate in the Nagarpalika.

- It was suggested that learning materials, should be prepared in popular forms, for the grass-root level activists. Films could be one such effective learning tool.

- VANI and YUVA agreed to prepare and publish a detailed report of the workshop in Hindi and English for wider dissemination.

THE CONSTITUTION (SEVENTY-FOURTH AMENDMENT) ACT, 1992

[20th April, 1993]

An Act further to amend the Constitution of India

Be it enacted by Parliament in the Forty-third Year of the Republic of India as follows:

NOTES

The only distinction between a law amending the Constitution and an ordinary law in a rigid constitution is that an amendment of the Constitution has always to be made in the manner and form specially prescribed by the Constitution. *Kesavananda Bharati v. State of Kerala*, (1973) 4 SCC 225, paras 1345 and 1579.

1. **Short title and commencement.**—(1) This Act may be called the **Constitution (Seventy-fourth Amendment) Act, 1992.**

(2) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. Insertion of new Part IX-A.—After Part IX of the Constitution, the following Part shall be inserted, namely:—

PART IX-A

The Municipalities

243-P. Definitions.—In this Part, unless the context otherwise requires,—

(a) "Committee" means a Committee constituted under Article 243-S;

(b) "district" means a district in a State;

(c) "Metropolitan area" means an area having a population of ten lakhs or more, comprised in one or more districts and consisting of two or more Municipalities or Panchayats or other contiguous areas, specified by the Governor by public notification to be a Metropolitan area for the purposes of this Part;

(d) "Municipal area" means the territorial area of a Municipality as is notified by the Governor;

(e) "Municipality" means an institution of self-government constituted under Article 243-Q;

(f) "Panchayati" means a Panchayat constituted under Article 243-B;

(g) "population" means the population as ascertained at the last preceding census of which the relevant figures have been published.

243-Q. Constitution of Municipalities.—(1) There shall be constituted in every State,—

1 Received the assent of the President on April 20, 1993 and published in the Gazette of India, Extra., Part II, Section 1, dated 20th April, 1993 pp. 1-10, S1. No.70

(a) a Nagar Panchayat (by whatever name called) for a transitional area, that is to say, an area in transition from a rural area to an urban area;

(b) a Municipal Council for a smaller urban area; and

(c) a Municipal Corporation for a larger urban area, in accordance with the provisions of this Part:

Provided that a Municipality under this clause may not be constituted in such urban area or part thereof as the Governor may, having regard to the size of the area and the municipal services being provided or proposed to be provided by an industrial establishment in that area and such other factors as he may deem fit, by public notification, specify to be an industrial township.

(2) In this article, "a transitional area", "a smaller urban area" or "a larger urban area" means such area as the Governor may, having regard to the population of the area, the density of the population therein, the revenue generated for local administration, the percentage of employment in non-agricultural activities, the economic importance or such other factors as he may deem fit, specify by public notification for the purposes of this Part.

243-R. Composition of Municipalities.—(1) Save as provided in clause (2), all the seats in a Municipality shall be filled by persons chosen by direct election from the territorial constituencies in the Municipal area and for this purpose each Municipal area shall be divided into territorial constituencies to be known as wards.

(2) The Legislature of a State may, by law, provide—

(a) for the representation in a Municipality of—

(i) Persons having special knowledge or experience in Municipal administration;

(ii) the members of the House of the People and the members of the Legislative Assembly of the State representing constituencies which comprise wholly or partly the Municipal area;

(iii) the members of the Council of States and the members of the Legislative Council of the State registered as electors within the Municipal area;

(iv) the Chairpersons of the Committees constituted under clause

(5) of Article 243-S:

Provided that the persons referred to in paragraph (i) shall not have the right to vote in the meetings of the Municipality;

(b) The manner of election of the Chairperson of a Municipality.

243-S. Constitution and composition of Wards Committees, etc.—(1) There shall be constituted Wards Committees, consisting of one or more wards, within the territorial area of a Municipality having a population of three lakhs or more.

(2) The Legislature of a State may, by law, make provision with respect to—

(a) the composition and the territorial area of a Wards Committee;

(b) the manner in which the seats in a Wards Committee shall be filled.

(3) A member of a Municipality representing a ward within the territorial area of the Wards Committee shall be a member of that Committee.

(4) Where a Wards Committee consists of—

(a) one ward, the member representing that ward in the Municipality; or

(b) two or more wards, one of the members representing such wards in the Municipality elected by the members of the Wards Committee, shall be the Chairperson of that Committee.

(5) Nothing in this article shall be deemed to prevent the Legislature of a State from making any provision for the constitution of Committees in addition to the Wards Committees.

243 T. Reservation of seats.— (1) Seats shall be reserved for the Scheduled Castes and the Scheduled Tribes in every Municipality and the number of seats so reserved shall bear, as nearly as may be, the same proportion to the total number of seats to be filled by direct election in that Municipality as the population of the Scheduled Castes in the Municipal area or of the Scheduled Tribes in the Municipal area bears to the total population of that area and such seats may be allotted by rotation to different constituencies in a Municipality.

(2) Not less than one-third of the total number of seats reserved under clause (1) shall be reserved for women belonging to the Scheduled Castes or as the case may be, the Scheduled Tribes.

(3) Not less than one-third (including the number of seats reserved for women belonging to the Scheduled Castes and the Scheduled Tribes) of the total number of seats to be filled by direct election in every Municipality shall be reserved for women and such seats may be allotted by rotation to different constituencies in a Municipality.

(4) The officers of Chairpersons in the Municipalities shall be reserved for the Scheduled Castes, the Scheduled Tribes and women in such manner as the Legislature of a State may, by law, provide.

(5) The reservation of seats under clauses (1) and (2) and the reservation of offices of Chairpersons (other than the reservation for women) under clause (4) shall cease to have effect on the expiration of the period specified in Article 334.

(6) Nothing in this Part shall prevent the Legislature of a State from making any provision for reservation of seats in any Municipality or offices of Chairpersons in the Municipalities in favour of backward class of citizens.

243-U. Duration of Municipalities, etc.—(1) Every Municipality, unless sooner dissolved under any law for the time being in force, shall continue for five years from the date appointed for its first meeting and no longer:

Provided that a Municipality shall be given a reasonable opportunity of being heard before its dissolution.

(2) No amendment of any law for the time being in force shall have the effect of causing dissolution of a Municipality at any level, which is functioning immediately before such amendment, till the expiration of its duration specified in clause (1).

(3) An election to constitute a Municipality shall be completed,—

(a) before the expiry of its duration specified in clause (1);

(b) before the expiration of a period of six months from the date of its dissolution:

Provided that where the remainder of the period for which the dissolved Municipality would have continued is less than six months, it shall not be necessary to hold any election under this clause for constituting the Municipality for such period.

(4) A Municipality constituted upon the dissolution of a Municipality before the expiration of its duration shall continue only for the remainder of the peirod for which the dissolved Municipality would have continued under clause (1) had it not been so dissolved.

243-V. Disqualifications for membership.—(1) A person shall be disqualified for being chosen as, and for being a member of a Municipality—

(a) if he is so disqualified by or under any law for the time being in force for the purposes of elections to the Legislature of the State concerned:

Provided that no person shall be disqualified on the ground that he is less than twenty-five years of age, if he has attained the age of twenty-one years;

(b) if he is so disqualified by or under any law made by the Legislature of the State.

(2) If any question arises as to whether a member of a Municipality has become subject to any of the disqualifications mentioned in clause (i), the question shall be referred for the decision of such authority and in such manner as the Legislature of a State may, be law, provide.

243-W. Power authority and responsibilities of Municipalities, etc.—Subject to the provisions of this Constitution, the legislature of a State may by law, endow—

(a) the Municipalities with such powers and authority as may be necessary to enable them to function as institutions of self-government and such law may contain provisions for the devolution of powers and responsibilities upon Municipalities, subject to such conditions as may be specified therein, with respect to—

(i) the preparation of plans for economic development and social justice;

(ii) the performance of functions and the implementation of schemes as may be entrusted to them including those in relation to the matters listed in the Twelfth Schedule;

(b) the Committees with such powers and authority as may be necessary to enable them to carry out the responsibilities conferred upon them including those in relation to the matters listed in the Twelth Schedule.

243-X. Power to impose taxes by, and Funds of, the Municipalities.—The Legislature of a State may, by law,—

(a) authorise a Municipality to levy, collect and appropriate such taxes, duties, tolls and fees in accordance with such procedure and subject to such limits;

(b) assign to a Municipality such taxes, duties, tolls and fees levied and collected by the State Government for such purposes and subject to such conditions and limits;

(c) provide for making such grants-in-aid to the Municipalities from the Consolidated Fund of the State; and

(d) provide for constitution of such Funds for crediting all moneys received, respectively, by or on behalf of the Municipalities and also for the withdrawal of such moneys therefrom, as may be specified in the law.

243Y. Finance Commission.—(1) The Finance Commission constituted under Article 243-I shall also review the financial position of the Municipalities and make recommendations to the Governor as to—

(a) the principles which should govern—

(i) the distribution between the State and the Municipalities of the net proceeds of the taxes, duties, tolls and fees leviable by the State, which may be divided between them under this part and the allocation between the Municipalities at all levels of their respective shares of such proceeds;

(ii) the determination of the taxes, duties, tolls and fees which may be assigned to, or appropriated by, the Municipalities;

(iii) the grants-in-aid to the Municipalities from the Consolidated Fund of the State;

(b) the measures needed to improve the financial position of the Municipalities;

(c) any other matter referred to the Finance Commission by the Governor in the interests of sound finance of the Municipalities.

(2) The Governor shall cause every recommendation made by the Commission under this article together with an explanatory memorandum as to the action taken thereon to be laid before the legislature of the State.

243-Z. Audit of accounts of Municipalities.—The Legislature of a State may, by law, make provisions with respect to the maintenance of accounts by the Municipalities and the auditing of such accounts.

243-ZA. Elections to the Municipalities.—(1) The superintendence, direction and control of the preparation of electoral rolls for, and the conduct of, all elections to the Municipalities shall be vested in the State Election Commission referred to in Article 243-K.

(2) Subject to the provisions of this Constitution, the Legislature of a State may, by law, make provision with respect to all matters relating to, or in connection with, elections to the Municipalities.

243-ZB. Application to Union territories.—The provisions of this Part shall apply to the Union territories and shall, in their application to a Union territory, have effect as if the references to the Governor of a State were references to the Administrator of the Union territory appointed under Article 239 and references to the legislature or the Legislative Assembly of a State were references in relation to a union territory having a Legislative Assembly, to that Legislative Assembly:

Provided that the President may, by public notification, direct that the provisions of this Part shall apply to any Union territory or part thereof subject to such exceptions and modifications as he may specify in the notification.

243-ZC. Part not to apply to certain areas.—(1) Nothing in this Part shall apply to the Scheduled Areas referred to in clause (1), and the tribal areas referred to in clause (2), of Article 244.

(2) Nothing in this Part shall be construed to affect the functions and powers of the Darjeeling Gorkha Hill Council constituted under any law for the time being in force for the hill areas of the district of Darjeeling in the State of West Bengal.

(3) Notwithstanding anything in this Constitution, Parliament may, by law, extend the provisions of this Part to the Scheduled Areas and the tribal areas referred to in clause (1)subject to such exceptions and modifications as may be specified in such law, and no such laws shall be deemed to be an amendement of this Constitution for the purposes of Article 368.

243-ZD. Committee for district planning.—(1) There shall be constituted in every State at the district level a District Planning Committee to consolidate the plans prepared by the Panchayats and the Municipalities in the district and to prepare a draft development plan for the district as a whole.

(2) The legislature of a State may, by law, make provision with respect to—

(a) the composition of the District Planning Committees;

(b) the manner in which the seats in such Committees shall be filled:

Provided that not less than four-fifths of the total number of members of such Committee shall be elected by, and from amongst, the elected members of the Panchayat at the district level and of the Municipalities in the district in proportion to the rato between the population of the rural areas and of the urban areas in the district;

(c) the functions relating to district planning which may be assigned to such Committees;

(d) the manner in which the Chairpersons of such Committees shall be chosen.

(3) Every District Planning Committee shall, in preparing the draft development plan,—

(a) have regard to—

(i) matters of common interest between the Panchayats and the Municipalities including spatial planning, sharing of water and other physical and natural resources, the integrated development of infrastucture and environmental conservation;

(ii) the extent and type of available resources whether financial or otherwise;

(b) consult such institutions and organisations as the Governor may, by order, specify.

(4) The Chairperson of every District Planning Committee shall forward the development plan, as recommended by such Committee, to the Government of the State.

243-ZE. Committee for Metropolitan planning.—(1) There shall be constituted in every Metropolitan area a Metropolitan Planning Committee to prepare a draft development plan for the Metropolitan area as a whole.

(2) The Legislature of a State may, by law, make provision with respect to—

(a) the composition of the Metropolitan Planning Committees;

(b) the manner in which the seats in such Committees shall be filled:

Provided that not less than two-thirds of the members of such Committee shall be elected by, and from amongst, the elected members of the Municipalities and Chairpersons of the Panchayats in the Metropolitan area in proportion to the ratio between the population of the Muncipalities and of the Panchayats in that area;

(a) the composition of the Metropolitan Planning Committees;

(b) the manner in which the seats in such Committees shall be filled:

Provided that not less than two-thirds of the members of such Committee shall be elected by, and from amongst, the elected members of the Municipalities and Chairpersons of the Panchayats in the Metropolitan area in proportion to the ratio between the population of the Municipalities and of the Panchayats in that area;

(c) the representation in such Committees of the Government of India and the Government of the State and of such organisations and institutions as may be assigned to such Committees;

(d) the functions relating to planning and coordination for the Metropolitan area which may be assigned to such Committees;

(e) the manner in which the Chairpersons of such Committees shall be chosen.

(3) Every Metropolitan Planning Committee shall, in preparing the draft development plan,—

(a) have regard to—

(i) the plans prepared by the Municipalities and the Panchayats in the Metropolitan area;

(ii) matters of common interest between the Municipalities and the Panchayats, including co-ordinated spatial planning of the area, sharing of water and other physical and natural resources, the integrated development of infrastructure and environmental conservations;

(iii) the overall objectives and priorities set by the Government of India and the Government of the State;

(iv) the extent and nature of investments likely to be made in the Metropolitan area by agencies of the Government of India and of the Government of the State and other available resources whether financial or otherwise;

(b) consult such institutions and organisations as the Governor may, by order, specify.

(4) The Chairperson of every Metropolitan Planning Committee shall forward the development plan, as recommended by such Committee, to the Government of the State.

243-ZF Continuance of existing laws and Municipalities.— Notwithstanding anything in this Part, any provision of any law relating to Municipalities in force in a State immediately before the commencement of the Constitution (Seventy-fourth Amendment) Act, 1992, which is inconsistent with the provisions of this Part, shall continue to be in force until amended or repealed by a competent Legislature or other competent authority or until the expiration of one year from such commencement, whichever is earlier:

Provided that all the Municipalities existing immediately before such commencement shall continue till the expiration of their duration, unless sooner dissolved by a resolution passed to that effect by the Legislative Assembly of that State or, in the case of a State having a Legislative Council, by each House of the Legislature of that State.

243-ZG. Bar to interference by courts in electoral matters.— Notwithstanding anything in this Constitution,—

(a) the validity of any law relating to the delimitation of constituencies or the allotment of seats to such constituencies, made or purporting to be made under Article 243-ZA shall not be called in question in any court;

(b) no election to any Municipality shall be called in question except by an election petition presented to such authority and in such manner as is provided for by or under any law made by the Legislature of a State".

3. Amendment of Article 280.— In clause (3) of Article 280 of the Constitution, sub-clause (c) shall be relettered as sub-clause (d) and before sub-clause (d) as so relettered, the following sub-clause shall be inserted, namely:—

"(c) the measures needed to augment the Consolidated Fund of a State to supplement the resources of the Municipalities in the State on the basis of the recommendations made by the Finance Commission of the State;"

4. Addition of Twelfth Schedule.— Schedule to the Constitution, the following schedule shall be added, namely:—

TWELFTH SCHEDULE OF 74TH AMENDMENT ACT

1. Urban planning including town planning.
2. Regulation of land-use and construction of buildings.
3. Planning for economic and social development.
4. Roads and bridges.
5. Water supply for domestic, industrial and commercial purposes.
6. Public health, sanitation conservancy and solid waste management.
7. Fire services.
8. Urban forestry, protection of the environment and promotion of ecological aspects.
9. Safeguarding the interests of weaker sections of society, including the handicapped and mentally retarded.
10. Slum improvement and upgradation.
11. Urban poverty alleviation.
12. Provision of urban amenities and facilities such as parks, gardens, playgrounds.
13. Promotion of cultural, educational and aesthetic aspects.
14. Burials and burial grounds, cremations, cremation grounds and electric crematoriums.
15. Cattle ponds, prevention of cruelty to animals.
16. Vital statistics including registration of births and deaths.
17. Public amenities including street lighting, parking lots, bus stops and public conveniences.
18. Regulation of slaughter houses and tanneries.

ANNEXURE II

DESIGN OF THE WORKSHOP

May 14, 1994

SESSION I	SUBJECTS	SPEAKERS
10.00 am - 10.05 am	Welcome	Shri Minar Pimple Hon. Director, YUVA
10.05 am - 10.15 am	Inaguration	Ms. Nirmala Samat Mayor of Bombay (Invited)
10.15 am - 10.30 am	Introductry Talk and Context	Shri M.Z. Shahid Co-ordinator, YUVA
10.30 am - 11.00 am	Evolutionary Description of the Nagarpalika (74th Amendment) Act, 1992.	Dr. Nawaz Mody, Professor, Dept. of Civics & Politics, University of Bombay.
11.00 am - 11.15 am	**Tea Break**	
11.15 am - 12.00 pm	Implications of the Nagarpalika (74th Amendment) Act, 1992, on the Urban Affairs.	Shri Dinesh Mehta, Director National Institute of Urban Affairs (NIUA) Delhi.
12.00 pm 0 01.00 pm	Discussion & Conclusion by Moderator.	
01.00 pm - 02.00 pm	**Lunch**	
Session II **Moderator**		Dr. (Mrs.) Marina Pinto Reader, Dept. of Civics & Politics, University of Bombay. (Invited)
02.00 pm - 02.30 pm	Experiences in the Local Self-Governnace	Ms. Sneha Palnitkar Director, AIILSG, Bombay
02.30 pm - 03.00 pm	Role of NGOs in Urban Local Self-Governance	Shri Minar Pimple Hon. Director, YUVA
03.00 pm - 03.30 pm	Role of Women in the Urban Local Self-Governance	Ms. Sheela Patel Director, SPARC

03.00 pm - 03.45 pm	**Tea - Break**	
03.45 pm - 05.00 pm	Discussion & Conclusion by Moderator	

May 15, 1994

Session III **Moderator**	Additional Municipal	Shri B.M. Ambhaiker Commissioner, MCGB
10.00 am - 10.30 am	Urban Local Self-Governace in India & the Nagarpalika (74th Amendment) Act, 1992 — A Critical Analysis	Dr. Gangadhar Jha Research Professor NIUA, Delhi
10.30 am - 11.00 am	Urban Local Self-Governance in India — what Ails the Existing System?	Shri S.M.Y. Sastri, All India Institute of Local Self-Government, Bombay.
11.00 am - 11.15 am	**Tea-Break**	
11.15 am - 11.45 pm	Municipal Finance and the Constitution (74th Amendment) Act, 1992 — Implications	Shri D.M. Suktankar, Ex Chief Secretary, Government of Maharashtra
11.45 am - 12.15 pm	Urban Planning & the Constitution (74th Amendment) Act, 1992 - Implications	Prof. Amitabh Kundu Centre for the Study of Regional Develop ment,JNU, New Delhi.
12.15 pm - 01.00 pm	Discussion & Conclusion by Moderator	
01.00 pm - 02.00 pm	**Lunch**	
Sesson IV **Moderator**		Shri Minar Pimple Hon. Director, YUVA
02.00 pm - 03.00 pm	Future Planning	Workshops in Groups on Agenda for Action. Area: Women's Participation NGO's Role Municipal Finance Governance
03.30 pm - 03.45 pm	**Tea-Break**	
03.45 pm - 04.45 pm	Plenary & Conclcusion by Moderator	
04.45 pm - 05.00 pm	Vote of Thanks	Shri Anil K Singh Executive Secretary, VANI & Closing.

ANNEXURE III

LIST OF PAPERS CIRCULATED AT WORKSHOP

Papers specially prepared for Workshop

Gangadhar Jha	-	The Seventy-Fourth Constitution Amendment and the Empowerment of Municipal Government PP-20
Nawaz B. Modi	-	The Seventy-Fourth Amendment Act, - Its Implications for Urban Local Self-Governance India PP-20
M.Z. Shahid		Perspective Note : National Workshop on the Nagarpalika (74th Amendment) Act, 1992, PP-3.
Amitabh Kundu		The Seventy-Fourth Constitution Amendment Act: Search for a New Federalism PP-5
Shri S.M.Y Sastri		Urban Local Self-Governance in India-What Ails the Existing System?

141 CM 19/5

Government — Non-government ~~part~~ organisations partnership

NGO-8.

Introduction

There is a growing realisation of the need to develop a healthy partnership between the government and non-governmental organisations (NGOs). It calls for better understanding and appreciation of the roles of each other and how best they can collaborate for better health of the people. There is need to create an atmosphere of trust.

Non-governmental organisations focus on a range of issues in health and development. We do not have the exact number and type of non-governmental agencies participating in the field of health nor the scope of their activities. Collaboration between government and non-government organisations can ~~produce~~ produce

- a synergistic effect;
- avoid unnecessary duplication;
- augment resources (human, material and financial);
- reach people, especially those in remote, peripheral areas

The partnership can make the efforts more flexible, and less formal and give a qualitative boost to the efforts to improve health.

NGO activities - field

6/6/03

Government – Non-Governmental Organisations Partnership

~~Who?~~

Government :

The governmental health care services may be provided through the National, State or local (Municipalities and Panchayats) services. The National Health Policy – 2002 lays down what will be done by the Central Government and who will be responsible. The draft Karnataka State Health Policy (to be finalised and approved) lays down what the State Government ~~the~~ proposes to do. With decentralisation, a large part of health care services are to be provided by the local bodies.

PTO

Non-governmental Organisations (NGOs)

The term NGO is rather vague. By strict definition, it would include all private (other than the Government) organisations. It would include private for-profit organisations and private not-for-profit (voluntary) organisations. It is in the latter sense that the term NGO is commonly used. It is also in that sense the term NGO is used here — not-for-profit, voluntary organisations.

NGOs play a substantial role in health and development. They address the human needs, especially those of the underprivileged persons. NGOs are

- agents of change;
- catalysts for peoples and governments action (advocacy);
- promote public awareness of problems and opportunities;
- testing alternate approaches;
- trying innovative strategies
- tackling sensitive social issues
- cost-effective

They may be linked to international organisations

NGOs may be national, state or local. They may be involved in a variety programmes or be focussed on particular issues. The activities may be tried out in small communities, which could serve as models for wider replication.

What do we understand by partnership?

Though the term 'partnership' is used, it is often misunderstood. The relationship between Government and NGOs is often one of subcontracting. The Government develops the policies and programmes and expects the NGO to implement the programmes without any change. The NGO accepts and implements the programme as stipulated by government, on a 'take it or leave it basis'. Often the NGO 'leaves it' as found in the study conducted by P.P. Talwar JF: "In spite of several schemes which have been floated and for which funds could be secured, the takers have been few — only about 300 NGOs out of an estimated number of 70,000 voluntary organisations are taking some form of assistance from the government to work for health and family welfare activities. Even the money allocated for NGOs remains unutilised." (Greater involvement of non-governmental organisations in Family Welfare Programmes in India: issues and recommendations, P. P. Talwar, 1991).

Partnership calls for mutual respect and trust. It respects autonomy and independence. It values differences in opinions and approaches. It allows for the NGO challenging the policies and styles of functioning of the government.

There is need for a healthy, collaborative relationship.

- Create a ~~climate~~ climate conducive for collaboration through dialogue and mutual appreciation, understanding each other.
- Provide access to information; better communication.

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- Formulate policies, strategies and plans of action after full discussion between government and NGOs. The proposal may be initiated by government or NGO.
- Have the roles defined for action; eliminate areas of conflict.
- Provide flexibility
- Share expertise and know how.
- Implement the programme in the best interests of the people.
- Participate in monitoring and evaluation.

Constraints to effective partnership

A major factor against genuine partnership is lack of mutual trust and understanding. If there is trust many of the problems will vanish. There is also need for

1. understanding by the government and NGO executives about programmes and their roles and responsibilities;
2. flow of information to the NGOs, especially the smaller ones and those working in the district and subdistrict levels;
3. involvement of the NGOs in the formulation and planning of programmes in health and development.

Other problems include

- unfamiliarity with government procedures for providing support to NGOs;
- rigidity in Government schemes;
- lengthy and cumbersome application processes;
- access difficulty for the isolated NGOs;
- unsupportive attitude of some government officers;
- too much interference of government;
- innovation not possible;
- delays in release of funds.

An important factor is the frequent changes in government officials. By the time the officials become familiar with the NGOs and their problems, the officials are changed and the whole process of building support has to be repeated. A resource person at ~~the~~ an International Workshop said that he was happy over the development of an important programme " but it was unfortunate the Secretary

PTO

of Health and Family Welfare who had shown all commitment to implement recommendations got transfered."

Opportunities

How to improve partnership?

Many steps can and should be taken up to improve partnership for better health of the people. Administrative and structural requirements must be met for greater collaboration between NGOs and government, at all levels. There must be continued dialogue on policy issues. Ensure greater co-ordination of Government and NGO efforts. They must work together in harmony.

When NGOs are involved in government programmes, there must be

- greater autonomy to NGOs
- less government interference

There must be data sharing and avoidance of duplication of services

The initiatives and pioneering efforts of NGOs must be appreciated. These are likely to be community based, flexible

Training of government officials to collaborate with NGOs and ②

Joint monitoring of programmes

② better understanding of NGOs, their objectives and mode of operation

Define the roles of Government and NGOs

Establish the nature and method of Government financial and technical support to NGOs (programme management, monitoring and evaluation).

Prompt release of funds.

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Government — NGO co-ordinating Council

The Council should have operational and financial autonomy. There should be equal number of members from Government and representatives of NGOs; the suggested number will be 14. The chairmanship of the Council should rotate between Government and NGOs.

The Council may be re-constituted once in 3 years.

The Council will have executive powers and professional skills to promote collaboration between Government and NGOs and will have sufficient funds at its disposal.

The Council will be responsible for

- promoting voluntary activity
- identification of credible NGOs
- calling for and processing of applications for support
- approval of programmes and projects
- facilitating technical support
- sanction and release of funds
- monitoring and ~~release of~~ evaluation.

The Council may establish decentralised fora for more effective and widespread function.

The Council may constitute, from among themselves, a 5 member board for more effective functioning:

- ~~One~~ two ~~member~~ representative of government
- ~~two~~ representatives of NGOs
- Chief Executive Officer (full-time) nominated by the Council.

Measures to promote Government—NGO Partnership

- Make an inventory of NGOs in health and related areas in the State, classified according to
  - location,
  - special interests, and
  - capabilities.
- Promote voluntary accreditation of NGOs.
- Conduct workshops ~~between~~ involving Government and NGOs to
  - facilitate partnership;
  - sort out common issues of concern;
  - understand NGOs better (for Government officers) and understand Government requirements (for NGOs);
  - understand the National and State Health Policies
- Have a High Level Co-ordination Committee to
  - have regular dialogues between Government and NGOs;
  - identify the important obstacles to effective Government–NGO collaboration and take necessary action to remove them;
  - identify the opportunities to improve Government–NGO relationships and take action to use these opportunities;
  - determine the criteria for partnership;
  - select NGOs for partnership.

* The Co-ordination Committee will have district/local level co-ordination committees.

- Develop programmes for support of NGOs to strengthen their management capabilities and improve performance in absorbing funds and implementation of programmes.

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- Ensure wide dissemination of all relevant information.

~~Why of Partnerships?~~

Selection of NGOs

Partnership requires trust in each other. Government, at times, faces problems in choosing NGOs for collaborative efforts. So also, problems arise when NGOs apply for support in carrying out health related programmes.

Criteria for selection of NGO

- Objectives and pursuit of objectives
- Credibility — people in the area; other NGOs
- Maintenance of records.
- Transparency.
- Accountability to stakeholders
- Organisational set-up; governance.
- Staff: professional, technical, management, supportive
- Efficiency and effectiveness in solving problems and making use of opportunities (annual reports)
- Evaluation of programmes; achievements (physical and financial).
- Salary structure
- Financial management; resources; accounts; auditing.
- Ethics of the organisation and its members and adherence to the laws of the country and the State.

N90-8.

fr - anshu-goonj

6-15 Lib

Dear All,

Hope you are well. I have been writing regularly to some of you, to keep you in the loop around the kind of activities GOONJ.. does from time to time. We have just finished organising a VASTRA-DAAN collection camp, last weekend, in Noida with the support of Prudential ICICI and then in a company- Intersolutions. Both went well. From today we've a camp at Alcatel, Gurgaon and then on Sunday at Mayur Vihar, Delhi.

The successful collection camps, as some of you who have participated will bear witness to, are about volunteers and their enthusiasm against all odds. My heart felt thanks to all GOONJ.. Volunteers and a fervent call to all who read this mail **that we desperately need people who believe in what we are doing, to come and volunteer your time for GOONJ.. Collection camps and other activities.**

I do hope to hear from you soon.

Till then take care and keep in touch.

With warm regards,

Anshu K Gupta

FOR PEOPLE WHO ARE GETTING MY MAIL FOR THE FIRST TIME:

A brief introduction : GOONJ.. a strong force of over 300 volunteers is working on a very basic concept that out of the three basic needs of mankind i.e. Roti, Kapra & Makan (Food, Clothes and Shelter), we can solve the problem of clothing to a very large extent just by the simple concept of recycling and re-using.

In the last five years of its existence, GOONJ.. has achieved this target to some extent. In the last few months itself we have been able to send thousands of clothes, utensils, woolens, footwear etc to various parts of Orissa, Bihar and west Bengal.

Apart from thousands of people, among the contributors to this movement are Maruti Udyog Ltd., American Express, Delta securities, Gillette, HSS, Xansa & Intersolutions, who organised camps in their premises involving employees to come forward and donate. Our regular collection camps in residential areas are also doing very well with the continuing support of volunteers.

In our nationwide movement VASTRA-DAAN, we are not asking for much – just your old woolens/ general clothes/shoes/blankets/ bed sheets, basically anything you don't use anymore, and if possible just 97 paisa with each cloth. This money takes care of expense on collection, sorting, packing and transportation to the remotest part of the country.

Believe us, in less than a rupee, GOONJ.. can reach a cloth, anywhere in the country, solving atleast one basic need of someone and giving him an opportunity to reallocate his meager resources to more important things like food and health.

Please continue with all your good work. Our aim is to involve more and more people, Corporate houses, offices, residential areas, school and colleges in this campaign. Anyone who can support in any of these areas please contact us.

Motivate as many people as you can, circulate this mail to as many people as you can.We want to organise a number of camps in various corporate houses, residential areas, schools, colleges and institutes.

With this note is enclosed, a list of collection centers in Delhi and NCR, Mumbai and Kolkata, where you can donate material. This wide spread network has been made possible with the help of volunteers. We are now trying to workout collection centers in, Pune, Bangalore, Chennai and in few other places from where we keep getting reguiar inquiries.

Please feel free to write or call and ask as many questions as you want on how, where and whom etc. But do take out time, we have seen in the last five years that even an old cloth has a potential to save someone's life on the roads, in the far-flung areas..

With warm regards

Anshu K. Gupta

Director

GOONJ..

Tel.- 011-26972351, 98681-46978 (M)

E-mail- anshu_goonj@indiatimes.com, anshu@goonj.org,

Website- www.goonj.org

You can also contact- Rahul at- rahul_goonj@indiatimes.com, ruchika_goonj@indiatimes.com or Mini Dwivedi at minid@indiatimes.com

Our sincere thanks to Actionaid India, Sir Dorabji Trust and NFI

for believing in our efforts and supporting us ..

VASTRA-DAAN

WHAT ALL CAN YOU DONATE...

CLOTHES- woolens/ Sarees/ Salwar Suits/ Kurta/ Pyjamas/Trousers/Shirts/ children clothes/ Bedsheets/ Blankets, Old / New but in wearable condition.

FOOTWEAR - in pairs, left and right tied together.

UTENSILS - Old/ New- Pans, Plates, Bowls, Glasses, Tawa, Spoons & Ladles, Cooker, Cups,Tongs etc

STATIONARY- Pen, pencil, sharpner, eraser, scale, Old/new school bags, lunch boxes, water bottles

PAPER- News paper, magazines, one side used paper

CASH DONATIONS

For Communication/ Collection camps/ storage/ sorting/ packing / travel /Transportation, local distribution expenses. Cash donations can be made at the collection centers or you can send an account payee Cheque/ Draft in the name of GOONJ at J-93, Sarita Vihar, New Delhi-44
(All donations to GOONJ.. are tax exempted u/s 80 G of IT act)

TIME DONATIONS

WE ALSO NEED VOLUNTEERS, who can spare a few hours to be with us for door to door campaigns, and who can help us in sorting, packing etc.

SPACE DONATIONS

We need many more collection centers to ensure easy accessibility for everyone who wishes to make a donation. So if you can spare a corner in your house/office please inform us, also check with your friends/relatives if they would allow the use of a small place in their premises as collection center.

VASTRADAAN

COLLECTION CENTRES

- **Please make sure to call up to check the availability of the volunteer and for directions to avoid any inconvenience..**

DELHI

- **Alaknanda**

A-005, Yamuna Appartment, Tel.- 26212546, Cont- Rajeshwari

- **C.R.Park**

J- 1868,C.R. Park , Tel.- 26407747 Cont.- Ms. Suneepa

- **Dwarka**

B-702, Pragjyotishpur appt., Sector-10, Plot-7, Dwarka, Tel.- 98111-74024

Cont.- Ms. Rhinushmita

- **Janakpuri:**

A-2-A/244,Tel: 25529244,25535435, Cont.- Ms.Lynda

- **Karol Bagh:**

6A/67,WEA, Tel: 25723892, 25746993,Cont.- Mrs.Sushma Kumar

- **Khan Market:**

Narula Stationary Store, 6,Prithviraj Mkt., Khan market

- **Mayur Vihar-**

103, Samachar appartment, Tel.- 22713460 Cont. Keshav Chaturvedi

- **Patparganj:**

C-501,UNESCO Appt.,I.P. extn. Tel: 22431308, Cont.- Mr.-Rajeev Sachdeva

- **Paschim Vihar:**

Flat No.-262, GH-9, behind Sunder vihar, Tel.- 25282682, 98112-95790

Cont.- Mini Dwivedi

- **Rohini:**

22-B,Dhruv Appt., Sec-13, Tel: 27552754, Cont.-Mrs/Mr. Pankaj Mehta

- **Saket**

G 70, Saket Cont. S.S. Venkat On- 9818402186 / Gautam Shanbagh on - 9818402187

- **Shekh Sarai-**

250 RPS Flats, Shekh Sarai phase- I Tel.- 26012477, Cont - Reena Mohan

- **South Extn.:**

Standard Chartered Bank, M-1, South Extn. Part-II, N.D.Tel: 26252671/ 26252674

- **Safdarjung Enclave:**

B-6/34/2,DDA Flats, New Delhi, Tel.- 26107260, Cont.- Mr.Sunil Rao,

- **Sarita Vihar:**

GOONJ...J-93,Sarita Vihar,N.D. Tel: 269/2351, 98681-46978 Cont. -Anshu K. Gupta / Ruchika / Amresh

- **Vasant Kunj:**

4494, Sector-B, Pocket- 5 & 6 cont.- 26895021, 98100-36003, Cont.- Ms. Pooja Chopra

- **Vikas Puri:**

Promise Appt. F-114, Near Oxford School, N.D. Tel: 20067174,

Cont.- Pooja/ Ruchika

FARIDABAD

1. H.No.939, Sec-21-C, Tel: 95129-5425261, Cont. -Dr.P.L.Trakroo
2. C-156, Ashoka enclave-II, sector –37, Tel.- 98681-46978

Cont.- Anshu K.Gupta / Meenakshi,

SURAJKUND:

12/5,Basement No-I, Opp. Charmwood Plaza, Tel.- 95129-2253268

Cont.- Mr. Manoj Kohli

GURGAON :

(1)- Flat No.-201, block-B, Rail vihar, Sector-15/2 Tel.- 95124-2307850

cont.- Mr. S.D. Gupta

(2) House no. 315, Housing Board colony, Saraswati vihar, chakkarpur, Gurgaon Tel.- 98182-41421, cont.- Rahul Vashishtha

NOIDA:

C-1, Sec-15, Tel: 95120-2511552, Cont.-Ms. Upasna Pandey

MUMBAI-(Call up Mr. Gyaneshwar Kadge on 26324912, only on every 1st & 3rd Saturday between 11am & 3 pm)

Add- c/o Mr. Priyavrat Goenka, brighton units B # 9, Lokhandwala complex, Andheri (west), Mumbai- 53

KOLKATA-

S /8 , Alipore Park road, Kolkata-27, Contact- Mr. Rajeev Goenka

Tel.- 24791887 (R), 2449753 (O)

Part I
Introduction

1
Scaling-up the developmental impact of NGOs: concepts and experiences

Michael Edwards and David Hulme

Introduction

There are now some 4,000 development non-governmental organisations (NGOs) in OECD member countries alone (OECD 1989), dispersing almost three billion US dollars' worth of assistance every year (Clark 1991, p.47). They work with around 10,000 to 20,000 'Southern' NGOs who assist up to 100 million people (ibid p.51). Yet despite the increasing scale of this sector, and the growing reputation that NGOs have won for themselves and for their work over the last ten years, their contribution to development on a global level remains limited. Many small-scale successes have been secured, but the systems and structures which determine the distribution of power and resources within and between societies remain largely unchanged. As a result, the impact of NGOs on the lives of poor people is highly localised, and often transitory. In contrast to NGO programmes, which tend to be good but limited in scope, governmental development efforts are often large in scale but limited in their impact. Effective development work on a sustainable and significant scale is a goal which has eluded both governments and NGOs.

One of the most important factors underlying this situation is the failure of NGOs to make the right linkages between their work at micro-level and the wider systems and structures of which they form a small part. For example, village co-operatives are undermined by deficiencies in national agricultural extension and marketing systems; 'social-action groups' can be overwhelmed by more powerful political interests within the state or local economic elites; successful experiments in primary health care cannot be replicated because government structures lack the ability or willingness to adopt new ideas; effective NGO projects (and not all are) remain 'islands of success' in an all-too-hostile ocean. 'If you see a baby drowning you jump in to save it; and if you see a second and a third, you do the same. Soon you are so busy saving drowning babies that you never look up to see that there is someone there throwing these babies in the river' (Ellwood, quoted in Korten 1990a). Or, as an Indian development worker once asked us in Rajasthan, 'Why help trees to grow if the forest is going to be consumed by fire?' In other words,

small-scale NGO projects *by themselves* will never be enough to secure lasting improvements in the lives of poor people. Yet what else can NGOs do, and how can they increase their developmental impact without losing their traditional flexibility, value-base and effectiveness at the local level? Resolving this dilemma is the central question facing NGOs of all kinds as they move towards a new millennium.

Of course, an emphasis on *quality* in NGO work is never misplaced. Good development work is not insignificant just because it is limited in scale, and some might disagree with Clark's statement (in this volume) that 'maximising impact is the paramount objective of NGOs.' As Alan Fowler (1990, p.11) rightly points out, the roots of NGO comparative advantage lie in the quality of relationships they can create, not in the size of resources they can command. Some NGOs appear to have lost sight of this fact in a headlong rush for growth, influence and status, forgetting that 'voluntarism and values are their most precious asset' (Brown and Korten 1989). Simple, human concern for other people as individuals and in very practical ways is one of the hallmarks of NGO work. There is a danger that these qualities will go 'out of fashion' because of mounting concerns for strategy and impact, but in so doing the voluntary sector will lose its most important defining characteristic.

Nevertheless, all serious NGOs want to increase their impact and effectiveness, ensure that they spend their limited resources in the best way possible, and thereby maximise their own particular contribution to the development of people around the world. The question is, how are these goals to be achieved? We believe that there are many possible answers, but none which ignore the importance of macro-level influences in determining the success of people's development efforts at grassroots level. We find it inconceivable that NGOs will achieve their objectives in isolation from the national and international political process and its constituent parts. It is this interaction, this search for greater impact, that forms the central theme of this book. Although many contributors use the term 'scaling-up' to describe the goal of 'increasing impact', it should be noted at the outset that this does *not* imply expanding the size of NGO operations. There are many different ways in which impact can be achieved, and the contributions to this book have been chosen deliberately to reflect the wide diversity of approaches chosen by different NGOs at different stages in their development. There is no attempt to identify the 'best' strategy for achieving greater impact, still less to impose a consensus where none exists.

The term 'NGO' also embraces a huge diversity of institutions, though the chapters in this volume are consistent in differentiating between: international NGOs such as Save the Children and Christian Aid (commonly referred to as Northern NGOs or NNGOs); 'intermediary' NGOs in the South (SNGOs) who support grassroots work through funding, technical advice and advocacy; grassroots movements of various kinds (grassroots organisations or GROs, and community-based organisations or CBOs) which are controlled by their own members; and networks and federations composed of any or all of the above. Clearly, each of these 'NGOs' plays a distinctive role in development and faces a different range of choices and strategies when considering the question of impact. Added to this is the obvious importance of *context* in determining which strategies are chosen and how effective they are in practice, and the observation (made with particular force in Ireland and Klinmahorm's paper in this volume) that 'scaling-up' is often a spontaneous process rather than the result of a pre-planned strategy. These complications make generalisation difficult and dangerous.

Nonetheless, a conceptual framework is needed if any sense is to be made of such a wide range of case studies. There are at least five models of scaling-up we have considered in writing this introduction. The first comes from Clark (1991), who differentiates between 'project replication', 'building grassroots movements', and 'influencing policy reform'. These distinctions are echoed by Howes and Sattar (in this volume), who separate organisational or programme growth (the 'additive' strategy) from achieving impact via transfers to, or catalysing other organisations (the 'muliplicative' strategy). Mitlin and Satterthwaite (also in this volume) comment that successful NGOs concentrate on 'pulling in' resources rather than expanding the scale of their own service provision, while Robert Myers (1992:379) makes the opposing case, defining scaling-up as 'reaching as many people as possible with services or programmes.' This is a limiting definition, but Myers goes on to make a useful distinction between 'expansion, explosion and association'. 'Explosive' strategies begin with NGO operations on a large scale and adapt programmes to local circumstances afterwards. In contrast, 'associational' strategies 'achieve scale by piecing together coverage obtained in several district (and not necessarily coordinated) projects and programmes, each responding to the needs of a distinct part of the total population served' (Myers 1992, p.380). In Myers's model the most obvious form of scaling-up is direct programme expansion. Robert Chambers (this volume) adds a further important dimension to the debate by highlighting what he calls 'self-spreading and self-improving strategies' – 'to develop, spread and improve new approaches and methods', gradually extending good practice through NGO and government bureacuracies until their entire approach is transformed, and rejuvenating the NGO sector by stimulating the formation of new, independent NGOs.

From all this, and on the basis of the experience recounted in the chapters that follow, it seems to us that the most important distinction to be made lies between *additive* strategies, which imply an increase in the size of the programme or organisation; *multiplicative* strategies, which do not imply growth but achieve impact through deliberate influence, networking, policy and legal reform, or training; and *diffusive* strategies, where spread is informal and spontaneous. These distinctions are important because each group of strategies has different costs and benefits, strengths and weaknesses, and implications for the NGO concerned. Different strategies may be more, or less, effective according to circumstance, and it may not be possible to combine elements of each one in the same organisation. We make some preliminary observations about these trade-offs in the conclusion to this volume. The value of a strong conceptual framework is that it can clarify the strategic choices available to different NGOs and help them to make the decisions appropriate for the specific realities they face.

For the sake of clarity, we have divided this introduction and the rest of the book into four sections, each representing a particular approach to scaling-up. Three of these approaches fall into the 'multiplicative' and 'diffusive' categories: working with government, linking the grassroots with lobbying and advocacy, and advocacy in the North. The fourth strategy – increasing impact by organisational growth – falls under the 'additive' approach. These categories are not intended to be wholly self-contained, and indeed as the chapters illustrate there is a good deal of overlap between them. In particular, when this volume was edited, we found that several examples combined support for local-level initiative with lobbying at the national level (see the chapters by Constantino-David, Dawson, Hall, and Mitlin and

Satterthwaite) so that Section IV covers both of these approaches and looks at their linkages. Nonetheless, a structure is needed to order the debate and to ensure a degree of clarity in the discussion.

Working with government

Traditionally, most NGOs have been suspicious of governments, their relationships varying between benign neglect and outright hostility. Governments often share a similarly suspicious view of NGOs, national and international, and their relationship, at least in Africa, has been likened to cat and mouse (Bratton 1990). It is not hard to see why this should be the case. Government structures are often rigid, hierarchical and autocratic. Power and control rest at the topmost level where programmes are designed and resources allocated. All governments are encumbered with authoritarian relationships with their citizens, for they are collectors of taxes, enforcers of the peace, and protectors of the social order (Copestake 1990). They have a natural tendency to centralisation, bureaucracy and control. NGOs, on the other hand, are (or should be?) distinguished by their flexibility, willingness to innovate, and emphasis on the non-hierarchical values and relationships required to promote true partnership and participation.

Nonetheless, there are sound reasons for NGOs to enter into a positive and creative relationship with the institutions of both state and government. Governments remain largely responsible for providing the health, education, agricultural and other services on which people rely, though this is changing under the impact of the 'new conditionality' and its attempts to expand the role of the private sector at governments' expense. The state remains the ultimate arbiter and determinant of the wider political changes on which sustainable development depends. Some would argue that *only* governments can do these things effectively and equitably – that any attempt, for example, to privatise services is bound to result in declining access to quality care for the poor. Whether or not this is true, it remains a fact that (in most countries) government controls the wider frameworks within which people and their organisations have to operate. While this remains true, NGOs ignore government structures at their peril. An increasing number of NGOs have acknowledged this and are working actively to foster change at various levels. International NGOs tend to restrict themselves to the institutions of government, working within ministries to promote changes in policy and practice. National NGOs, on the other hand, can take a more active role in the political process and the wider institutions of the state. Usually, this takes the form of subjecting these institutions to various forms of external pressure and protest, as in the case of social action groups in India lobbying the local Forest Department or Block Development Officer (a strategy covered under 'linking the grassroots with lobbying and advocacy' below).

A more direct approach is to work *within* the structures of government in an explicit attempt to foster more appropriate and effective policies and practices, which will eventually be of benefit to poorer and less powerful people as they filter through into action by civil servants 'lower down' the system. The aim here is to ensure that governments adopt policies which are genuinely developmental at national level – policies which will ultimately enable poor people to achieve greater control over their lives in health, education, production and so on. NGOs have attempted to do this via direct funding, high-level policy advice, 'technical

assistance', the provision of 'volunteer' workers, or (usually) a mixture of these things. Many NGOs provide government with a 'package' of inputs which includes material support as well as people and ideas. It is important to remember that these strategies are *not* an attempt to 'replace' the state, but rather to *influence* the direction of government policy or support existing policies. 'NGOs cannot seek to replace the state, for they have no legitimacy, authority or sovereignty, and, crucially, are self-selected and thus not accountable' (Palmer and Rossiter 1990).

Although the case studies in this section of the book cover a wide range of approaches and contexts, their conclusions are strikingly similar. First, when the decision is taken to work within government, the constraints and difficulties of the government system have to be accepted as a starting point. Unlike in NGO programmes, good staff cannot be handpicked and supported with high salaries or generous benefits; systems and structures cannot be changed at will and resources are always in short supply. Motivation is often lacking because salaries are low and conditions poor. Public services are suspicious of change and often officers at lower levels in the hierarchy have been actively discouraged to experiment, innovate or take initiative. Inevitably, progress, if it is achieved, will be slow, and agencies must commit themselves to partnership for long periods of time. The chances of succeeding in this approach are increased if NGOs agree to work within the government system, right from the start. This increases the likelihood of sustainable reforms and enables the NGO to understand and deal with the constraints faced by the official system.

Second, personalities and relationships between individuals are a vital element in successful government–NGO partnerships. If these relationships do not exist, no amount of money or advice will make a difference. In addition, conflicting interests and agendas within government ministries may make dialogue and consensus impossible, undermining the efficacy of even the strongest NGO inputs. The whole notion of 'counterpart training' needs to be closely examined to ensure that NGO expatriate inputs really do have a lasting impact when faced with such a range of constraints. Even when good relationships do exist, this is no guarantee of success. This is partly because individuals are moved around the government system with alarming regularity (making influence through individual training and advice difficult to achieve), and partly because there is often a barrier between the 'pilot project' stage of co-operation (which is heavily dependent on a small number of likeminded officials) and the acceptance and diffusion of new approaches throughout the government hierarchy. The case of special education in Bangkok related in this volume by Ireland and Klinmahorm provides a graphic illustration of this problem. VSO has also had some success in making this transition by using what Mackie (in this volume) calls 'the planned multiplication of micro-level inputs' – the slow and careful evolution of different forms of support which are small in themselves but significant in the aggregate. Such approaches appear most likely to make an impact in smaller countries where NGOs have better access to key decision-makers. John Parry-Williams's account (in this volume) of legal reform in Uganda provides just such a case.

Third, NGOs are generally 'small players' when it comes to influencing governments, as compared to bilateral and multilateral donors such as the World Bank. It is these much larger agencies that tend to determine the ideological context in which policies are formed, a classic case in point being the 'new conditionality' of good governance and free markets which NGOs have thus far largely failed to

influence (Edwards 1991). In addition, in a situation where donor funds abound and government needs are acute, NGOs which insist on detailed assessment of programmes and on long-term, low-input strategies may be labelled as 'unhelpful' and 'obstructive', a case in point being SCF's work at provincial level in Mozambique (Thomas 1992). There are many official donors (and NGOs?) who are willing to commit large-scale resources for immediate consumption or ill-thought-out interventions, with little acknowledgement of the longer-term implications of their actions. The impossible recurrent cost burdens imposed by vertical programmes in basic services are a good example of this problem.[1]

Certainly, greater success may be achieved if NGOs allow governments to take credit for progress in programme and policy development, regardless of their own influence in these areas (for an example of reforms in Primary Health Care in Indonesia see Morley et al 1983, p.13). Something similar may be happening in the much-vaunted District Development Programme supported by Britain's Overseas Development Administration (ODA) in Zambia (Goldman et al 1988). There is also evidence that concentration at central ministry level, and coalitions of NGOs reinforcing each-other's influence, can help to combat the impact of the larger donors (Edwards, 1989).

The relative influence of NGOs and official agencies on Southern governments is a useful reminder that this strategy needs to be approached with care. The decision to work with (but not for) government must be based on an assessment of the 'reformability' of the structures under consideration, the relationship between government and its citizens, the level at which influence can be exerted most effectively, and (for international NGOs), the strength of the local voluntary sector. NGOs must also calculate the costs and benefits of this strategy in relation to others. For example, it may be difficult to operate simultaneously as a conduit for government and an agent of social mobilisation, or to work both within government and as an advocate for fundamental change in social and political structures. There are also dangers in identifying too closely with governments, which may be overthrown or voted out (as in the case of well-known health activists in Bangladesh). Nonetheless, even under the most authoritarian governments there are often opportunities for progressive change. For example, the Ministry of Health in Pinochet's Chile developed a strong policy on breastmilk substitutes with help from NGOs. The example quoted by Clark (in this volume) of an OXFAM programme which worked alongside rigid government structures in Malawi is also instructive. There are certainly enough examples of NGO impact on government policy and practice to give hope for the future, so long as the conditions for influence are right.

The direct approach: increasing impact by organisational growth

For many NGOs the obvious strategy for increasing impact is to expand projects or programmes that are judged to be successful. Over the 1980s this approach has been pursued in the South, where it has led to the evolution of a set of big NGOs in Asia (see the chapters by Howes and Sattar and by Kiriwandeniya in this volume for discussions of two such cases), and in the North where many NGOs have dramatically expanded their operational budgets and staffing. Expansion can take

[1] SCF is currently carrying out a major research programme on the 'Sustainability of Health-Sector Development' to address these issues. Contact Anne LaFond at SCF for details.

several forms. It may be *geographical* (moving into new areas or countries); by *horizontal function* (adding additional sectoral activities to existing programmes, eg adding a housing component to an income-generating programme); by *vertical function* (adding 'upstream' or 'downstream' activities to existing programmes, eg adding an agricultural processing project to an agricultural production scheme); or, by a combination of these forms.

Apart from the strong common-sense appeal there is a logic in supporting direct operational expansion. At its foundation is the argument that any agency capable of alleviating poverty has a moral obligation to help as many poor people as it can. Added to this are the claims that, in a resource-scarce situation, NGOs can use existing resources more efficiently than other agencies (but, Robinson, in this volume, disputes this claim) and can mobilise additional resources. Successful past experience means that NGOs have already 'learned' what to do, so that they can tackle development problems with comparatively short 'start-up' times. For the NGO itself large-scale operational successes enhance credibility for other scaling-up strategies (eg lobbying domestic governments or international agencies is more effective for organisations that demonstrate a considerable operational capacity in the field). Finally, one can draw upon institutional theories arguing that organisational pluralism in service delivery creates choice and efficiency that makes poverty-alleviation more probable (Leonard 1982).

Those who espouse the direct expansion approach recognise that difficulties will be encountered, particularly in terms of how to manage organisational change (see the chapters by Hodson and by Billis and MacKeith for a detailed discussion of issues). The characteristics that are presumed to explain NGOs' comparative advantage in local-level poverty-alleviation – the quality of relationships with beneficiaries, their flexible and experimental stance and their small size (Fowler 1988; Tendler 1987) – all require modification or compromise as expansion occurs. If we conceptualise the internal features of an organisation in terms of its systems or procedures, its structure and its culture (values and norms), then we can identify the nature of these problems. Commonly, expanding NGOs assume that the systems or procedures developed in a locally 'successful' project or programme can be used on a wider scale, providing that internal structures are suitably modified. These modifications usually require: *i* the extension of the hierarchy that separates those who manage the organisation from those who manage field operations; *ii* increased functional specialisation between parts of the organisation, and; *iii* increased capacity to raise resources, both material and human. The need to raise significant additional finance almost invariably requires 'Southern' (and often 'Northern') NGOs to take grants from official aid agencies. This fosters upward accountability and may lead to NGOs being increasingly '... driven by the procedures ...' (Fowler 1991).

The impact of these changes on organisational culture can be dramatic, as Billis and MacKeith (in this volume) demonstrate. There is a shift from a task-orientation to a role-orientation; control from 'higher up' the hierarchy grows in significance; and professionalism subordinates commitment and 'mission'-related values. As Dichter (1989:2) warns, many NGOs encounter severe problems as they expand because they retain '... cultural predispositions to non-hierarchical structures and are often anti-management'. The NGOs that seem best able to avoid partial paralysis during such transitions are those directed by charismatic, and often autocratic, founder-leaders.

As expansion occurs, these changes in culture, structure and accountability may accumulate to change the organisation from a voluntary organisation (based upon the pursuit of a developmental mission) trying to shape events, to a public service contractor oriented towards servicing needs as defined by donors and national governments. Korten (1990) has provided examples of NGOs foundering with expansion and, in particular, has charted the evolution of the International Planned Parenthood Foundation (IPPF) from a path-breaking crusader on a forbidden topic to '... an expensive and lethargic international bureaucracy ...' (ibid:126).

For observers who adopt a more explicitly political form of analysis then the co-optation of expansionist NGOs by the status quo (both domestic and international) is not simply the result of changes in organisational characteristics. Rather, it is an outcome that is consciously sought by those who hold power as they respond to the growing popularity of NGOs. At the level of local and national power structures it can be argued that a strategy of service delivery expansion permits the alleviation of the symptoms of poverty without challenging the causes. From this radical perspective, NGOs are seen as eroding the power of progressive political formations by preaching change without a clear analysis of how that change is to be achieved; by encouraging income-generating projects that favour the advancement of a few poor individuals but not 'the poor' as a class; and by competing with political groups for personal and popular action.

A focus on international relations yields a different but equally distressing scenario. NGO expansion is seen as complementing the counter-revolution in development theory (Toye 1987) that underpins the policies of liberalisation, state withdrawal and structural adjustment favoured by official donors. NGOs are viewed as the 'private non-profit' sector, the performance of which advances the 'public-bad, private-good' ideology of the new orthodoxy.

It is no surprise to such radical commentators that strategies of operational expansion emasculate NGO attempts to serve as catalysts and advocates for the poor and lead to a focus on delivering health care, credit, family planning and housing while issues such as land reform, access to public services, civic and human rights, the judicial system and economic exploitation lose significance.

Given the strength of these counter-arguments in some contexts, the strategic decision to scale-up by additive mechanisms should never be seen as incontestable 'common sense'. At the very least, NGOs that are considering operational expansion need to plan for the stresses of organisational restructuring and cultural change; examine how dependent they will become financially on official donors and consider the consequences of this for accountability; study the trade-offs and complementarities with other strategies for enhancing impact; and analyse the implications of such a choice for the poor majority who are not beneficiaries of their projects or programmes.

Advocacy in the North

Rather than working directly *within* the structures they intend to influence, NGOs may choose to increase their impact by lobbying government and other structures from the outside. This is a time-honoured activity for NGOs around the world, particularly for Northern NGOs, some of whom focus exclusively on advocacy and have no 'practice base' overseas. The rationale for this approach is simple: many of the causes of under-development lie in the political and economic structures of an

unequal world – in trade, commodity prices, debt and macro-economic policy; in the distribution of land and other productive assets among different social groups; and in the misguided policies of governments and the multilateral institutions (such as the World Bank and IMF) which they control. It is extremely difficult, if not impossible, to address these issues in the context of the traditional NGO project. Other forms of action are necessary, particularly on the international level where the biggest decisions are made.

However, success at this level has proved elusive. There are, for sure, some signs of impact, and Clark (in this volume) provides examples such as the international baby milk campaign, increasing environmental awareness, and better systems for food aid, to illustrate how effective and sophisticated NGO advocacy has become. One commentator goes so far as to claim that 'non-governmental groups managed by half a dozen professionals have shown that they can change the course of decision-making about a country they may never have seen' (Jha 1989). Northern NGOs have made some progress on the debt issue (playing a major part in lobbying for successive improvements in the terms on offer for debt-relief); on 'structural adjustment' (though here the influence of another multilateral agency – UNICEF – was more important than that of the NGOs); on international refugee issues (with NGO consortia persuading international agencies to adopt improved food regimes for refugees); and in primary health care (Save the Children Fund-UK in particular being a constant thorn in the flesh of UNICEF and WHO on the issue of sustainability in health-sector development).

NGO strategies in this field range from direct lobbying of key individuals within bilateral and multilateral agencies, through staff exchanges and working together in the field, to publications, conferences and participation in joint committees (such as the World Bank–NGO Committee). One of the most controversial issues here is the choice all NGOs must make between 'constructive dialogue' (the incrementalist or reformist approach) and 'shouting from the sidelines' (the abolitionist approach). Opinion differs widely among NGOs as to the usefulness of these opposing approaches, the choice resting on the degree to which the NGO concerned feels its 'target agency' is reformable over time. This debate has been fuelled by the increasing profile given to NGOs by neo-liberal thinking on 'governance and democratisation'. Most NGOs see their relationship with bilateral and multilateral agencies as a dialogue on policy, but the donors themselves are increasingly enthusiastic about NGOs as *implementers* of projects. This is true of both Northern and Southern NGOs, and indeed, some NGOs are perfectly happy with this trend. It gives them vastly-increased resources and enables them to 'scale-up' their work directly as never before (see Part III of this volume, on organisational growth). The international NGO community is deeply divided over this issue. 'NGOs have generally been used for the ends of the borrowing governments or the [World] Bank, and not as partner institutions with their own unique development purposes' (Salmen and Eaves 1989). The same internal World Bank report states that only 11 per cent of NGOs with whom the Bank co-operated in 1988-89 were used in the design phase of projects (Salmen and Eaves 1989). If this remains the case it is difficult to see how NGOs will be able to take advantage of the wider windows for international advocacy which Clark claims are opening up to them in the wake of the 'new conditionality', environmentalism, the end of the Cold War, and the increasing scale of NGO operations (Clark, this volume).

It is probably true to say that, while NGOs have succeeded in influencing official

donor agencies on individual projects (such as the Narmada Dam in India and the Polnoreste Project in Brazil), and even on some programme themes (such as participation and the environment), they have failed to bring about more fundamental changes in attitudes and ideology, on which all else depends. Nagle and Ghose (1990) make the telling comment that, while operational guidelines on participation in project design will be useful to World Bank staff, many do not actually see the connection between 'participation' and 'development' that NGOs take as axiomatic. They do not, in other words, see *why* people should be placed at the centre of the planning process. Clark's optimistic assessment of the future of NGO advocacy in this volume needs to be tempered by an acknowledgement of the limited gains made thus far. Lobbying, alongside the other strategies examined in this book, has to be carefully planned and evaluated to establish what really works, and why. The importance of advocacy cannot simply be taken for granted. It is worth reminding ourselves that decades of NGO lobbying have not dented the structure of the world economy and the ideology of its ruling institutions, nor has it brought about the alternative vision of development that most NGOs ascribe to, albeit poorly articulated in practical terms. Indeed, one of the criticisms often made to NGOs by official donor agencies is that insufficient work has gone into developing workable alternatives to the policies NGOs oppose: alternatives which will guarantee rising living standards without the social and environmental costs imposed by current systems.

NGO contact with the wider structures they seek to influence is often too limited to effect any real change. By definition, NGOs are peripheral to the systems they are trying to change, and lack the leverage necessary to maintain their influence when there are other, more powerful interests at work (World Bank 1991). Although NGO lobbying networks do exist (organised, for example, around debt and environmental issues), they have yet to make a concerted effort to work together on a common agenda, a weakness highlighted by Chris Dolan in his contribution to this volume. In contrast to Clark, Dolan is sceptical of the future of NGO lobbying, arguing that, at least in the United Kingdom, development NGOs lack the shared vision and commitment to working together on a joint agenda which might make success more likely. They also have to deal with a more restrictive legal framework which makes 'political activities' a sensitive area.

In addition, the sheer size and complexity of international institutions is often overwhelming, even to large NGOs such as OXFAM and Save the Children Fund. Many NGOs do not understand the way in which multilateral agencies operate, though the specialist advocacy groups have developed a good knowledge of their targets. Even if the agency's structure and procedures are known, these organisations remain hierarchical, technocratic and often unwilling to listen. Multilateral and bilateral donors have been keen to set up internal 'NGO liaison units' in recent years, but it remains to be seen whether these are to facilitate communication or merely keep NGOs away from the departments that take significant decisions. The fundamental requirement for successful influencing is a degree of openness on the part of the organisation that is being lobbied; if this is not present, no amount of information or experience-sharing will induce changes in the system.

Many NGOs maintain that a practice base overseas is essential for successful influencing. There are organisations (such as the World Development Movement) in the UK which have no involvement in development practice, but they are not

registered as charities: there are also charities outside the UK (such as Bread for the World in the USA) which are purely advocacy-based. For the majority of British development charities, however, there is no escaping the linkage between practical experience and influencing, for it is their practice base which generates the themes and the evidence (and therefore the legitimacy) for their related, but subsidiary, information and educational work. In his presentation to the Manchester workshop on scaling-up, Ahmed Sa'di of the Galilee Society for Health Research and Services made a powerful plea that NGOs put much more effort into research and information work based on grassroots views and experiences, in order to counter the 'knowledge produced by the official institutions which reflects the interests of the powerful' (Sa'di 1992). John Clark (in this volume) takes this one step further by admonishing NGOs for their failure to capitalise on their knowledge of grassroots realities in their dialogue with governments and donor agencies. As the role of Northern NGOs changes in response to the growing strength and range of Southern development institutions, they will have to develop new attitudes, skills and partnerships as they move from 'operational' work overseas to international advocacy in support of local NGO efforts – from 'projects' to 'information', as Clark puts it. How many NGOs recognise the need for such a transition, let alone being equipped to manage it successfully?

A consistent theme in the chapters that follow is the need for much stronger links between development efforts at micro-level, and NGO advocacy at meso- and macro-levels. Only when these activities are mutually supportive can lasting change occur. For example, the success of the Voluntary Health Association of India in influencing government policy comes only partly from its sophisticated use of the Indian media and parliamentary process, but also because it maintains very strong links with thousands of voluntary health workers and organisations around the country. In this way, advocacy is anchored in real experience and the messages transmitted to government have a power and legitimacy which is difficult to ignore. NGO agendas for advocacy must grow out of grassroots experience if they are to claim to 'speak for the poor.' Similar themes are raised in this volume by Dawson and Hall, who show how progress in particular cases was achieved in Peru and Brazil respectively through a combination of pressure 'from above' (national and international advocacy) and 'from below' (strengthening grassroots organisation and concrete initiatives), acting towards the same goal. In this analysis, development at local level and advocacy at other levels form complementary components of the same overall strategy. The key question (to which we return in our Conclusion) then becomes how to strengthen these complementarities so that action at each level informs and supports the other. Few agencies have achieved this, either in their own work or in the partnerships they have formed with other organisations working for the same objectives.

If it is true that advocacy will become a more important strategy for NGOs in the future, then legitimising this activity in the eyes of governments, official donor agencies and the general public (whose financial and moral support is vital) is going to be a vital task in the years ahead. Development education among the countries of the rich North will play a key role in generating widespread support for changing NGO roles, just as official donors will have to see NGOs as valuable, independent actors with something different and positive to offer. Unless this happens it is difficult to see how the NGO voice will be heard, let alone acted on, fatally undermining the credibility of this approach to achieving greater impact.

Linking the grassroots with lobbying and advocacy

Grassroots organisations (GROs) or community-based organisations (CBOs) that are managed by members on behalf of members, have been central to the activities of many NGOs. Such organisations can originate spontaneously from local initiative but '... while isolated instances of local institutional development can be impressive their cumulative effect is negligible ... what counts are systems of networks of organisations, both vertically and horizontally' (Uphoff 1986:213). As a consequence of this many Southern and Northern NGOs have recognised and adopted an intermediary role to accelerate the creation of local organisations (sometimes referred to as catalysis), to provide assistance in strengthening and expanding such organisations, and fostering linkages between them. This, it is believed, will lead to the proliferation of grassroots organisations that can, as a 'people's movement', have a beneficial impact on development policies and wider political processes.

The main emphasis for NGOs involved in such efforts is usually held to be the 'process' involved in supporting local initiative – awareness raising, conscientisation, group formation, leadership, training in management skills – rather than the 'content' of the programmes and activities which local organisations pursue. This is because such a strategy seeks the 'empowerment' of people – a much used and abused term that we take to mean the process of assisting disadvantaged individuals and groups to gain greater control than they presently have over local and national decision-making and resources, and of their ability and right to define collective goals, make decisions and learn from experience. While in its pure form such an approach would mean that NGOs should not influence GRO activities, many intermediaries mix catalysis with their other programmes and provide members with loans and services. Mitlin and Satterthwaite (in this volume) present a number of examples of such mixes. The relative weightings in such mixes – ie whether catalysis or service delivery is paramount – are usually very difficult to determine.

Many different ideas underpin strategies of grassroots organisation but all have in common the notions that disadvantaged individuals need to be stimulated into taking group action, that groups of the disadvantaged can have a discernible impact on the local situation, and that the combined efforts of grassroots organisations can coalesce into movements that have the potential to influence policies and politics at the national level. The conceptual bases for these ideas range from liberal-democratic notions of pluralism (for example Esman and Uphoff 1984) to radical formulations that see grassroots organisations as confronting (sometimes violently) oppressive social forces. Paulo Freire's ideas have been particularly influential on those agencies adopting the radical perspective, arguing the need to 'conscientise' the poor as an initial step in the process of identifying and ultimately challenging the social and political structures that oppress them.

Differences in the conceptual roots which intermediary NGOs recognise, along with local contextual factors, mean that approaches to supporting local level initiative vary considerably. Amongst agencies that seek to serve as catalysts for group formation there is a vast analytical gulf between those who believe that membership should be open to all in a 'community' (ie inclusive) and those who opt for exclusive organisational forms in which membership is open only to the disadvantaged. Depending on the ideas that guide an approach, the work of the promoter (facilitator, change agent, catalyst) may initially focus on the advantages

of group action and the management of group activities or alternatively, concentrate upon an analysis of the social and political causes of poverty in a locality and the need for groups to see themselves as political actors. Group formation is usually recognised as a slow process (at least in public statements if not in practice) and one in which non-governmental intermediaries have a significant comparative advantage over state intermediaries, because of the quality of their non-directive, 'participatory' interaction with intended beneficiaries.

While a vast number of GROs can be seen as having the potential to achieve locally beneficial results, intermediary organisations are usually keen to create linkages between GROs (see Chris Roche's chapter on ACORD). In part this is to promote more effective local action (through exchanges of knowledge and access to pooled and external resources). Even more significantly, however, such linkages are seen as making it possible to take actions that are beyond the capacity of local associations. Karina Constantino-David (in this volume) examines the highly sophisticated networking and federating of NGOs that has occurred in the Philippines in an attempt to challenge national policies and establish new institutions. Linkages may be horizontal (ie networking between GROs so that they can exchange information and negotiate collective action) or vertical (ie federating GROs into a regional or national level organisational structure, in the direction of which all member organisations have a say and a vote).

From the foregoing arguments a strong case can be made for supporting and linking grassroots organisations: they 'empower', relate knowledge with action, are sensitive to local contexts, flexible and, when collectivities take collective action, can tackle regional and national level issues. In addition, and in contrast to other NGO activities, this approach may permit a degree of downward accountability so that NGOs which claim to represent the 'voice of the poor' may add some legitimacy to the image they seek to portray.

There is, however, a potential 'downside'. From a programme management perspective, there are difficulties in maintaining the interests of poor people in conscientisation, mobilisation and empowerment when they have pressing short-term needs. Hence, many intermediary NGOs incorporate a 'service' element, such as savings and credit schemes, in their approaches. The case study of BRAC (Howes and Sattar in this volume) provides an illustration. This helps to maintain member interest, but it can also be seen as contradicting the logic of empowerment and group autonomy. In some cases it leads to the beneficiaries of NGO mobilisation strategies reporting to independent researchers that they are recipients of service delivery programmes (Hashemi, forthcoming). There is also the practical problem of 'who' does the catalysis. Few NGOs have been able to tap into volunteers on a significant scale, and so they rely on paid staff. This places them in a position, not dissimilar to government mobilisation efforts, of having to maintain the commitment of change agents for whom mobilisation is a means to a livelihood.

From a political perspective a number of objections can be raised. For some, the assumptions of pluralism that underpin liberal configurations of mobilisation are misplaced. Genuine empowerment will generate responses from local and national elites, and the state, that range from intimidation to violence (as in the case of Thailand in the mid-1970s when more than 20 organisers of agricultural labourers' associations were murdered). There is thus an ethical dilemma for NGOs, about exposing staff and intended beneficiaries to violence, and a practical dilemma as to whether entrenched local and national elites need to be confronted more radically.

For those who adopt a radical view (for Bangladesh this position is examined in Wood and Palmer-Jones 1991:220–4) then NGO mobilisations are seen as supporting the status quo. They are 'diversionary' in that they take resources (finance, leadership, popular action) away from political parties and underground movements dedicated to fundamental political change, and they create false impressions of pluralism and change.

Have the results of mobilising strategies been as negative as the radical critics suggest? Much depends on the cases and regions one examines. In terms of the 'narrow' goal of providing tangible benefits to members, then Uphoff (1986:208) provides considerable evidence of success in South and South-East Asia. In terms of broader political change, claims have been made that networks of local organisations significantly helped the push for democracy in the Philippines (the fall of Marcos) and Bangladesh (the fall of Ershad). However, these have only been weakly substantiated. In Latin America, the evidence of local organisations working together to promote political change is clearer (Hirschmann 1984) in no small part because such organisations saw the local and national political arena as a major focus for their actions. Tony Hall's study of Itaparica (in this volume) provides a clear example of the way in which well-supported local initiative has influenced national and multilateral development policies in Latin America. Elsa Dawson's chapter illustrates the complementarities that can be found between strengthening local level organisations and advocating policy reform. The involvement of groupings of grassroots organisations in African development would appear, from the literature available, to be much more limited than in Asia or Latin America. The reasons for this are complex (Fowler 1991) but clearly a major factor in many countries has been the desire and ability of the state to control or eliminate any non-official mobilisation of the populace. Clearly contextual factors are of great significance in determining the feasibility and results of such approaches.

Commentators on the future role that NGOs should play in development are presently highlighting strategies for catalysing and federating local-level organisations. Clark (1991:102–19) sees such movements as reshaping national politics, redefining and ultimately 'democratising development'. Hirschmann (1984) sees 'collective action' as the means by which the economic and political well-being of the masses is most likely to be attained in Latin America. For Korten (1990:127) the key to future effectiveness is '... to coalesce and energise self-managing networks over which it [the NGO] has no control whatever' and '... involve themselves in the broader movement of which they are a part as social and political activist'. Developmental NGOs will not only forge linkages between grassroots organisations, but they will also forge linkages with other movements that have related missions – peace, environment, women, human rights and consumer affairs. In this grand vision NGOs become a force for dramatic social change that restructures class relationships and reforms global economic processes by non-violent, non-revolutionary means.

Organisation of the book

This introductory chapter is followed by two further background chapters. Mark Robinson's chapter presents a summary of the Overseas Development Institute's research on NGO effectiveness and reviews the implications for scaling-up. It finds

that NGOs are effective in reaching the poor, but not the poorest, and that their unit costs are broadly comparable with those of the public sector. The chapter by Robert Chambers makes the case for diffusive strategies to enhance NGO impact.

The book is then divided into four sections, following the framework outlined in this chapter. The section on 'working with government' includes three case studies of specific projects (Klinmahorm and Ireland, Jones and Parry-Williams), a study of Voluntary Service Overseas (Mackie) and a summary of a large-scale research project into NGO-government interaction in agricultural technology development, drawing on cases from Africa, Asia and Latin America (Bebbington and Farrington).

Part III examines the strategy of scaling-up by organisational growth or operational expansion. Two of these chapters describe and analyse the growth of individual South Asian NGOs (Kiriwandeniya and Howes and Sattar). Although the Sri Lanka case study is based on a multiplicative strategy it is included in this section because it illustrates problems that arise when growth is achieved by using official finance. The two other chapters examine the management problems encountered by expanding NGOs with particular reference to northern agencies (Hodson, and Billis and MacKeith).

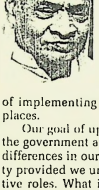
The next section focuses on 'strengthening the grassroots' and linking grassroots action with lobbying and advocacy, with case studies from Peru (Dawson) and Brazil (Hall), a review of initiatives in the urban sector (Mitlin and Satterthwaite), a description and analysis of NGO networking in the Philippines (Constantino-David) and a detailed examination of ACORD's experiences in supporting local level initiative in Africa (Roche). Several of these papers illustrate the advantages of linking local-level institutional strengthening with national-level policy advocacy.

Part V is comprised of two papers that focus on lobbying and advocacy in the North. Clark reflects on the lessons of experience gained from many years of advocacy work targeted at bilateral and multilateral development agencies by OXFAM, while Dolan draws pessimistic conclusions about the likelihood of British NGOs achieving the 'shared vision' and resource commitment that would permit them to make their lobbying more effective.

In the concluding chapter we summarise the lessons that can be generated from the materials that have been presented and identify the key issues that form a basis for future action and research on enhancing the developmental impact of NGOs.

Calling the Third Sector

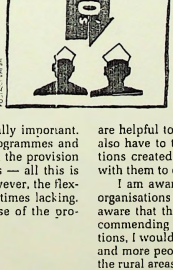
Non-governmental organisations have a vital role to play in motivating people to manage their own resources better



P V NARASIMHA RAO

I AM happy that a large number of leading non-governmental organisations (NGOs) are meeting for a consultation with key development ministries. I had addressed a gathering of NGOs in December, 1991, where I had offered to withdraw the government from certain areas altogether, provided the NGOs take over the responsibility of implementing all development programmes in those places.

Our goal of uplifting the poor can be achieved only if the government and the NGOs work together, despite the differences in our work and style. I don't see any difficulty provided we understand how to harmonise our respective roles. What is clear to me is that the early eradication of poverty is not possible unless all the resources available to us — human, material and organisational — are mobilised and efficiently directed to areas and programmes which need them most.



RITCO VARMA

We have to remember that the people must occupy the centrestage. They should be the focus of all that we aim to do. Therefore, when I talk of a participatory approach to development, what I have in mind is an approach where the people would be helped to help themselves. If a particular area is taken up by a NGO, a time should come when the people are fully mobilised and empowered to deal with their own problems. In other words, the NGO should withdraw after the task is done.

As far as the government is concerned, the concept of withdrawal is equally important. The formulation of policies, initiating programmes and schemes consistent with such policies and the provision of adequate resources for the programmes — all this is the legitimate duty of the government. However, the flexibility required to take initiatives is sometimes lacking. This quite often defeats the very purpose of the programmes designed for the people.

Agents of delivery

We are changing all this but we need the assistance of the NGOs in some areas. NGOs, being the agents of delivery, need not make things better for the people. What is important is to prepare the people, which is what the NGOs can do most effectively. It is this preparation which is going to be the most important aspect of the NGOs' programme. They are also better equipped to give the government feedback. So, a meaningful dialogue between the NGOs and the government is necessary before the state launches any programme. The central issue in all development is social mobilisation — enabling and empowering the people to fully receive what is intended for them. The NGOs have a crucial part to play in this task.

We now have the Constitution (73rd Amendment) Act, 1992, under which we would have self-governing *panchayats* elected by the people. As many as 29 areas of development, including agriculture, watershed development, small-scale industries, rural housing, drinking water, primary health care, fuel and fodder, public distribution system and education would be in the hands of the *panchayats*. This is a revolutionary step that we have taken. Here, the NGOs have a crucial role to play as external catalysts.

Don't ask me what the NGOs have to do when the *panchayats* come. Motivating the people, working among them, not getting into a clash with anyone — that is the crux of the whole thing. The *sarpanch*, who has some power at the village level, should be able to appreciate the work of the NGO. Otherwise, he will say, "This is another parallel *sarpanch* coming and interfering with my work." I am warning all the NGOs that this is going to happen more often in the villages. Please be clear as to where the *panchayat*'s power ends and the persuasive power of the NGOs begins so that the *panchayat* does not misunderstand the NGOs as meddlers. Already, the *panchayati raj* institutions are likely to clash with the legislature. Seen in the local perspective, the *sarpanch* is more powerful in his own field than the Prime Minister of India.

The challenge before the NGOs, therefore, is clear. The question is how to take full advantage of the environment that the government has created through formulation of policies and schemes that are helpful to the poor, particularly the rural poor. They also have to take advantage of the decentralised institutions created at grassroot levels and work in harmony with them to empower the poor.

I am aware that we have a few thousand voluntary organisations in our country. At the same time, I am also aware that the spread of these is indeed limited. While commending the work being done by all these organisations, I would like to take this opportunity to invite more and more people of goodwill to come forward to work in the rural areas.

Tomorrow, the *nyaya panchayats* are coming. Let me tell you that the *panchayat* is a very powerful body because it is a combination of the legislature and the executive and also the judiciary in the *nyaya panchayats*. Now, how are the NGOs going to interact with this very, very powerful body? ■

This is abridged from the Prime Minister's speech to the Conference on Collaborative Relationship between Voluntary Organisations and the Government, held in the Capital in March this year.

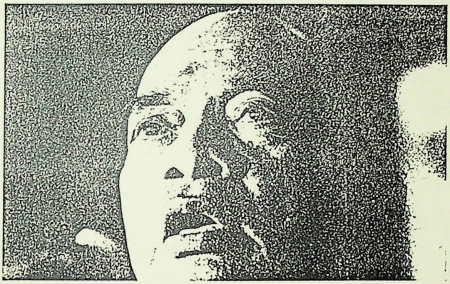
Poverty alleviation

One goal, two roads

Non-governmental organisations are taking the government's proposal for cooperation in poverty alleviation with a healthy pinch of salt

AT THEIR most convivial, Indian NGOs tend to keep a wide no-person's-land between themselves and the government. So when Prime Minister P V Narasimha Rao called for voluntary organisations to cooperate with the government in order to eradicate poverty, they considered the possibility with lips pursed in doubt. They made their trepidation clear at the two-day NGO-government meeting, organised by the Planning Commission on March 7 and 8 at the PM's behest.

The meeting was also attended by Union minister for human resources Arjun Singh, Union minister for health and family welfare Sitaram Kesari, and minister of state for health B Shankaranand. Rao stressed the need for the government and NGOs "to understand one another so as to arrive at workable methods of cooperating closely at the grassroots level and perhaps all other levels". The Deputy Chairperson of the Planning Commission, Pranab Mukherjee, emphasised the need to prepare a network of NGOs to supplement the work of the government.



P V Narasimha Rao: calling all NGOs

Where the twain shall meet

The meeting between the NGOs and the government identified the following key areas for NGO participation:

- Watershed development
- Sanitation and drinking water
- Integrated Rural Development Programme
- Family welfare
- Education
- Health
- Women and child development
- Welfare
- Labour
- Forests and environment
- Science and technology
- Non-conventional energy sources
- Urban development (dealing with problems of urban slum dwellers, street children)
- Development of women and children in rural areas

But NGO representatives, hackles raised, iterated as they have often done before that the government should keep its hands off the Third Sector.

Rao replied that in 1991 he had offered NGOs free rein to develop any administrative system of their choice, but had received no response. He requested them to keep the people informed of government programmes and stressed the need for a meaningful dialogue between the government and the NGOs to ensure feedback. "The role of NGOs is both as agents of delivery and agents of change," Rao said.

He, nevertheless, warned that with the 73rd amendment and the empowerment of panchayats, conflicts could arise between them and NGOs. He advised NGOs to develop an appropriate interface with the panchayats and not appear as "meddlers".

It was agreed upon that every ministry would set aside a part of its annual budget for NGOs and involve them in the planning process. Mukherjee added that a single-window clearance for all NGO projects was being set up.

Participants at the meeting observed that many NGOs were being formed to avail of grants from ministries. "This trend is going to increase," says Anil Singh of the Voluntary Action Network of India. Participants also decided that NGOs will mobilise the poor by educating them and implementing rural development programmes, with the assistance of the government or government-approved external agencies.

But the meeting, says Singh, was unsatisfactory. Lalit Pande of the Uttarakhand Seva Nidhi of Almora, Uttar Pradesh, says that by asking NGOs to help in poverty alleviation the government has admitted its failure in delivering its promises to the poor.

He flayed the concept of the government, the panchayat and NGOs working together. "Already, politicians are unhappy with the autonomy of the panchayats. If NGOs are to work in the scenario proposed, it will get worse," he said. Pande was also critical of the role of "contractors" that the government visualises for NGOs. "What does the government mean by NGOs 'preparing the people for its programmes'? We don't want to be the government's spokespersons," he said.

P R Mishra of the Chakriya Vikas Pranali of Palamau, Bihar, who has undertaken pioneering environmental regeneration work, felt that the meeting did not achieve much. "It ended in a farce," he said. "There are lots of seminars like this which make no impact." ■

from RGS - Paid magazine

NGO-8-

NATIONAL POLICY ON THE VOLUNTARY SECTOR 2004

To the Hon for information and Comments if any.

Preamble

Recognising the high status and respect accorded to voluntary action by Indian traditions and cultures, and the wide prevalence of the spirit of voluntarism among people of this country;

Acknowledging the significant contribution voluntary action has made to the country by fostering participatory development through local initiatives, local resources and social action;

Realising the limitations of governmental systems and institutions in raising the level of awareness among people about social and environmental issues and problems, in effectively delivering economic and social services to all segments of society, and in policy advocacy;

Taking note of the potential of the voluntary sector to supplement the efforts made by government and to provide alternative channels for economic, social and environmental development, and to improve the levels of governance in terms of accountability and transparency of public institutions;

Having due regard for the necessity of harmonizing the actions of public, private and voluntary sectors for realizing potential synergies and obtaining optimal effects in terms of economic and social development of all sections of the people especially for the poor;

Deciding that there is a need to provide an appropriate policy and institutional framework to consolidate and expand the voluntary sector and to empower it to act as an instrument of social mobilization, community action, societal and national integration.

The National Policy on Voluntary Sector 2004 is enunciated as follows:

1. Vision

To create conditions in India whereby the innate urge of human beings to selflessly contribute to the betterment of their society can find full expression through a variety of roles and alternative institutional channels, and their contribution to the nation be given all due respect and recognition and regard.

For CHC Ltd NGO/Vol. sector file
Jo
27/9/04

2. Objectives

In pursuance of the above vision, the objectives of this policy are to:

2.1 Create an enabling legal environment to promote voluntary action, in general, and voluntary organizations, in particular.

2.2 Promote the involvement of the voluntary sector in the design and delivery of economic and social services to the people, especially the poor, the excluded and the disadvantaged.

2.3 Enhance the role of the voluntary sector in advocacy, awareness generation and social mobilization.

2.4 Consolidate and expand the capacity of the voluntary sector to act as a partner of the State in disaster management and preparedness and in building societal capacity at grass roots level.

2.5 Enable the voluntary sector to effectively discharge the role of watchdog of the operation of public institutions and to function as conscience-keepers of public functionaries.

2.6 Provide a framework for adequate flow of financial resources to the voluntary sector for it to carry out its functions without undue hindrance or compromises.

2.7 Improve the capacity of the voluntary sector to act as a medium for the transfer of entrepreneurship, technologies and skills.

2.8 Indicate measures through which the reputation and image of the voluntary sector can continuously be enhanced in the public eye.

3. Definitions and concepts

3.1 Voluntary action is strictly defined as an activity or function undertaken by a person or persons for the benefit of others without any personal financial or material returns. The livelihoods of persons so engaged are expected to be generated from elsewhere or from other activities. The main sources of livelihood of persons who have formed the VOs are expected to be generated from elsewhere or other activities. The VOs engaged in providing services in specialized areas such as health and education, etc. are however, not precluded from paying suitable compensation to professionals to maintain the quality of service.

3.2 A voluntary organization (VO), therefore, can be defined as an association of persons: (a) established to organize and facilitate the exercise of voluntary action; or (b) assuming such functions in addition to its regular activities.

3.3 In the main, non-partisan and non-profit or non-profit-distributing organizations established for the purpose of attaining social objectives or general public good *and* where the office bearers/members do not receive remuneration from the organization are recognized as VOs.

3.4 In recognition of the fact that social entrepreneurship has emerged as a valuable vehicle for transfer of technological and management skills to rural and backward areas, such organizations too will be treated as VOs provided that the remunerations and/or returns are significantly lower than those in comparable public sector or commercial organizations as the case may be.

3.5 In cases where voluntary action is carried out by individuals in their personal capacity, such individuals will be treated as a VO *in persona*.

3.6 Any other form of organization which undertakes social and community work or assumes social responsibilities *and* where the owners/members do not get additional remuneration from such activities will also be classified as a VO for the purpose of carrying out such specific activities.

3.7 Networks, associations and federations of VOs shall be recognized as VOs as well.

4. Legal and operating environment

4.1 Formal or statutory recognition of VOs is presently governed by the Societies Registration Act (1860), the Indian Trusts Act (1882), the Charitable and Religious Trust Act (1920), Section 25 of the Indian Companies Act (1950), and by similar legislations of the States. Recognizing that many of the provisions of these laws including the laws relating to receipt of financial support from foreign sources and requirements under the Tax Laws have become obsolete or redundant and that today there is greater need for promotion of voluntarism than for its regulation, all such laws shall be reassessed and suitably amended after due consultation with the stakeholders of the voluntary sector and representatives of VOs.

4.2 For non-corporate private commercial organizations, such as proprietorships, partnerships, cooperatives, etc., appropriate provisions will be made in the laws governing their operations for facilitating them to undertake voluntary activities.

4.3 Informal groups or associations undertaking voluntary work, whether as their principal activity, such as community associations, youth clubs, *mahila mandals*, etc., or as a subsidiary activity, such as self-help groups, may be listed, if they so desire, at the level of local governments with appropriate linkages with higher tiers of government. Care will be taken to ensure that such registration is user-friendly and non-regulatory if public funds are not accessed.

4.4 To promote the involvement of individuals in voluntary action, rosters of interested persons will be established at the level of local governments, which will be freely available to all government and non-government institutions engaged in economic and social development activities.

4.5 Networks, associations and federations of VOs shall be encouraged and supported to strengthen the voluntary movement in the country and to give it a larger voice. Such organizations are expected to be formally registered.

4.6 For ensuring that all volunteers receive due respect and cooperation, a model Charter of Volunteer Rights, Duties and Privileges shall be drawn up for adoption by all arms of government and by public institutions.

4.7 Rules and procedures for engaging VOs in publicly funded action shall be streamlined by adopting simplified formats and tools of e-governance.

4.8 Joint Machinery or Consultative Forums for collaboration with the voluntary sector shall be set up in all States/UTs as well as in the Planning Commission at the Central Government level.

4.9 Coordination mechanisms shall be set up at the Ministry/State department and the District levels to redress the grievances of VOs and to resolve all issues pertaining to their work, particularly implementation of projects.

4.10 The registration/rostering process of VOs shall be computerized and the Planning Commission shall make provision for a nation-wide meta-data base on the voluntary sector.

4.11 The Government, both Centre and State, shall institute mechanisms for recognition and reward of outstanding work by the voluntary sector, and for publicizing success stories and working models for generating policy debate and promoting replication and improvement of such efforts.

5. Partnerships in development

5.1 Partnership entails the notion of jointly agreed goals shared among the participants, and that the participants have an obligation to actively work together in the spirit of common interest and common ownership.

5.2 In order to improve the quality of public services both through the availability of additional manpower and through greater commitment and sensitivity, the government shall encourage involvement of volunteers in public service delivery institutions such as schools, vocational training centers, family welfare centers, PHCs, hospitals, etc. Particular attention will be paid to utilizing the knowledge and experience of retired persons and elders. Guidelines for such involvement of volunteers shall be drawn up by the States and local bodies for mandatory implementation in relevant public facilities.

5.3 In order to improve the utilization of public and community assets, the government shall draw up guidelines for permitting, and indeed encouraging, use of government facilities by VOs for undertaking voluntary works as a supplement to the normal functioning of these institutions.

5.4 In view of the familiarity of the voluntary sector with local concerns and common needs, the involvement of VOs shall be encouraged in planning at the district, block and village levels.

5.5 VOs shall be encouraged and supported in developing and maintaining local databases for the purposes of advocacy and planning.

5.6 The Ministries/Departments of Centre and State governments shall draw up representative lists of VOs and network organizations of proven capacity for regular consultations on matters relating to economic and social policy, planning and design of development interventions.

5.7 State and local governments shall be encouraged to involve VOs in the management and operation of various public service facilities and welfare schemes with suitable delegation of power and authority.

5.8 VOs shall be encouraged to mobilize and organize people for preparation, implementation and maintenance of projects at the local level.

5.9 VOs shall be the preferred vehicle for undertaking suitable local public and/or community projects in a spirit of public-private partnership. Guidelines for this purpose will be framed and notified.

5.10 Involvement of VOs in monitoring the operation of public facilities and implementation of government projects and schemes in social sectors shall be institutionalized in a phased manner on the actual performance and capacity of VOs unless there are compelling reasons to do otherwise. Care will be taken to ensure that there is no conflict of interest between the monitoring function of VOs and their direct participation in implementation.

5.11 All government schemes and programmes, especially those which are beneficiary-oriented, shall necessarily involve VOs in providing the widest possible publicity about their objectives, targets and nature of the benefits. All relevant information shall be made available for VOs to carry out this function effectively.

5.12 The government shall actively engage with the voluntary sector, including provision of financial support, to generate mass awareness about pressing social and economic issues, and shall institute mechanisms for receiving and processing the feed-back.

5.13 In order to enhance mutual understanding and empathy between the government and the voluntary sector, the government shall encourage government/public sector employees to participate in voluntary action and make appropriate provisions in the service rules.

6. Financing Issues

6.1 In the main, VOs are expected to generate resources from the community and from donations from charitable or commercial organizations. Extent and continuity of community support would be a key indicator of the reputation, acceptability and dedication of the VO.

6.2 In situations where the voluntary sector complements and/or supplements the on-going activities of public institutions (such as those mentioned in paras 5.2, 5.3, 5.4, 5.6 and 5.7 above), suitable provision shall be made in the budgets of the concerned institutions for defraying the *costs* incurred by or incidental to the VO.

6.3 Where public funds need to be transferred to the VOs for carrying out the specified activities, accreditation procedures are inescapable. Recognizing the diversity of VOs, the government shall evolve a graded system of accreditation for different tiers of government with different financial limits in consultation with representatives of the voluntary sector.

6.4 In order to leverage the flow of funds to the voluntary sector, the government shall evolve a modality for providing access by VOs to bank/financial institution funds on the basis of either accreditation or group guarantees. Servicing of such loans could be made from recurring revenues of VOs or from releases from the government in the case of government sponsored programmes.

6.5 The scope of various existing schemes operated by the government and its autonomous agencies for providing support to the voluntary sector, such as

those under CAPART, shall be strengthened and extended after suitable amendments to reflect the intentions of this Policy.

6.6 In view of the decision taken by Government of India to encourage channelisation of external bilateral aid funds towards non-governmental entities, modalities shall be established by the government to facilitate this process, including, if necessary, the provision of adequate comfort through a formal government interface. VOs shall be given preferential consideration for such flow of funds.

6.7 FCRA rules shall be suitably amended to require only first point clearance.

6.8 Stability and predictability in the flow of funds are essential to ensure that the pace of implementation is not adversely affected and the viability of VOs is not compromised. Central and State Vigilance Commissions shall set up fast-track procedures for addressing cases of extortionary behaviour or deliberate dilatoriness by concerned public functionaries.

6.9 There should be no change in either the terms or structure of funding without prior consultation with the concerned VO and other stake-holders.

7. Capacity Building and Training

7.1 The government will endeavour to promote institutions, especially those sponsored by VOs and network organizations, for providing professional training to aspirants who would like to engage in voluntary action or social entrepreneurship as a career and for assisting them in forming VOs.

7.2 The government shall encourage and support VOs in organizing training workshops for imparting organizational, managerial and technical skills and for disseminating best practices to other VOs.

7.3 The government shall encourage and support VOs in organizing training to build local capabilities and for upgrading the capacity of PRIs.

7.4 The government shall provide all assistance in forging linkages between the voluntary sector and public S&T institutions for wide dissemination of appropriate technologies.

7.5 The government shall provide appropriate training to volunteers working in public institutions in order to enhance their capabilities.

7.6 Arrangements shall be made to familiarize the voluntary sector with the major current and emerging economic and social issues on a regular basis to raise their capacity for participation in policy discussion. All important government Ministries/Departments will be encouraged to make familiarisation workshops a regular part of their activity calendar.

8. Governance

8.1 Accountability and transparency are key issues in governance, and the voluntary sector is expected to set benchmarks in this regard. Accountability to funding sources, though important, is not enough, and greater emphasis should be placed on social accountability to the stakeholders.

8.2 Recognising the diversity of entities comprising the voluntary sector and the undesirability of specifying uniform standards for all, VOs shall be encouraged to evolve their own codes of conduct and governance standards. These should be appropriately notified and given publicity by the federating or network organisations along with disclosure and reporting procedures.

8.3 All VOs will be expected to formally subscribe to one or more of such accepted codes and standards.

8.4 A key element in transparency is the accounting standards that are followed by VOs. Two essential characteristics which need to be reflected in the accounts of VOs are:

- Extent of voluntarism, say as measured by the 'cost to the organization' of members, office bearers and key employees
- Extent and continuity of community support.

8.5 Formal voluntary organizations, i.e. those which are registered under the various acts mentioned in para 4.1 and possibly para 4.2, are expected to comply with the accounting norms laid down in the statutes. In most cases, these norms are inadequate from the point of view of transparency and shall be reassessed and suitably amended in consultation with representatives of the voluntary sector.

8.6 In the case of all other forms of VOs, suitable accounting standards will have to be developed, which would have to be at once adequate and non-demanding. Care would also need to be taken to ensure that such accounts are acceptable to government and other public organizations. The government shall endeavour to develop model accounting standards in consultation with the Institute of Chartered Accountants, the Comptroller and Auditor General of India and representatives of the voluntary sector.

8.7 Provision shall be made to assist small, resource-poor VOs in adopting governance and accounting standards.

8.8 Network or federating organizations of VOs will be expected to develop their own systems to validate and accredit VOs for membership. They will also be expected to monitor and discipline VOs not functioning properly or bringing disrepute to the voluntary sector.

8.9 Notwithstanding anything contained in the formulation of the Policy, nothing shall be done to compromise the autonomy of the Voluntary Sector.

This National Policy on the Voluntary Sector 2004 is the beginning of a process to evolve a new partnership between Government and the voluntary sector in the economic and social development of the nation. The Policy will be periodically reviewed by the Government and the voluntary sector jointly in light of the experiences gained and problems encountered.

CRT
N 60-8

राष्ट्रीय जनसहयोग एवं बाल विकास संस्थान
NATIONAL INSTITUTE OF PUBLIC COOPERATION AND CHILD DEVELOPMENT

Dr. Usha Abrol
Regional Director

NI/SRC/CS/3/2002-2003/831

1.5.2003

85 The Co-ordinator
Community Health Cell
#367, Srinivas Nilaya, 1st Main,
Jakkasandra 1st Blk, Koramangala
B'lore - 34

Sir/Madam,

Sub: Survey of Counselling Services in Karnataka- Reg.

The Institute is conducting a Survey of Counseling Services in the State of Karnataka, through which it is intended to collect and compile information on counseling services in terms of number of institutions engaged in, infrastructure available in the institutions, details of services rendered and, the training facilities available in the area of counselling. Based on the information collected, a Directory of Counselling Services in the State would be prepared.

In this connection, please find enclosed a questionnaire, through which we request you to furnish the details of the counseling services rendered by your esteemed institution. We request you to kindly provide us the information in the same format and send it to us so as to reach **on or before 23.5.2003.**

We solicit your kind co-operation in making this exercise a fruitful one.

Thanking you,

Yours faithfully,

Regional Director

Replied. Send extra copy for Library

163
7/5/03

ನಂ 18, ಯಲಹಂಕ, ಉಪನಗರ, ದೊಡ್ಡಬಳ್ಳಾಪುರ ಮಾರ್ಗ, ಬೆಂಗಳೂರು - 560 064.
No. 18, New Town Yelahanka, Doddaballapur Road, Bangalore - 560 064
ತಾರ : ಜನಯಾಲರಸ Grams : NIPCHILD ☎ : 8462818 / 8461355 / 8461793 Fax : 080-8461793
E-mail : nipccdbl@bgl.vsnl.net.in

SURVEY OF COUNSELLING SERVICES IN KARNATAKA

QUESTIONNAIRE

a. Government Institutions ☐
b. Government Aided Institutions ☐
c. Private Institutions ☐

National Institute of Public Cooperation and Child Development
Southern Regional Centre
No.18, Doddaballapura Road, New Town Yelahanka, Bangalore 560 064.
☎8462818, 8461355 🖷 8461793
e-mail: nipccdbl@bgl.vsnl.net.in

PART – I

IDENTIFICATION DATA

1. Name and address of the counselling centre (parent body)

Telephone No. Fax No. Mobile no.

E-mail Website

2. Person/Official to be contacted and contact address

3. Year of Establishment 4. Year of Registration (Reg.No.)

5. Main objectives of the organisation

6. Place where the counselling services are delivered
(Please give complete address with telephone number of all centres)

7. Activities of the institution other than counselling services

8. Please send a brochure/report/any other literature about your organisation

9. Counselling centre mentioned above (in question no 6) is attached to which of the above activities

10. Since when the counselling centre is functioning (year)

P A R T – II

INFRASTRUCTURE OF THE COUNSELLING CENTRE

11. Nature of Building

a. RCC ☐ b. Tiled ☐ c. Temporary shed ☐

d. Any other, please specify ☐

12. Ownership of Building

a. Own ☐ b. Rented ☐ c. Free/donated by parent body ☐

d. Any other ☐

13. Location of the centre

a. Rural

b. Urban

c. City centre

d. Semi urban

e. Slum area

f. Near to railway station/bus station/market area

14. Please mention about the furniture/equipment available in the centre

a. No. of chairs

b. No of tables

c. No of benches

d. No of cupboards

e. No of racks

15. Please provide details on facilities and provisions made to ensure privacy and confidentiality in conducting counselling sessions (please tick the appropriate)

a. Reception counter

b. Separate room/space for telephone

c. Separate office room for registering complaints

d. Record room

e. Staff room/rooms for counsellors to sit

f. Rooms/place for relatives/friends of the complainers/clients to sit

g. Any other, please specify

16. **STAFFING PATTERN**

Please furnish the following details:

a. For Counsellors

Sl.No.	Designation of the Staff	Qualification	Full time	Part time	No.of years of service	Salary	Honorarium Paid
1.							
2.							
3.							
4.							
5.							

b. For Administration and Clerical Staff

Sl.No.	Designation of the Staff	Qualification	Full / Part Time	Salary / Honorarium Paid	Remarks
1.					
2.					
3.					
4.					
5.					

c. Please give details about Resource persons/guest faculty

Serial no.	Designation of the resource person	Number of resource persons
1.		
2.		
3.		
4.		
5.		

(PLEASE NOTE : Trained here refers to whether the counsellor has been trained in conducting counselling sessions in terms of obtaining a degree or diploma course in counselling, or attended some orientation courses wherein they were exposed to practical sessions) Please give details about their professional training, exposures, etc.

d. Please give details of training undergone by counsellors (individual wise details)

Sl.No.	Name of Counsellor	Title of Trg.Prog.	Duration	Trg. Sponsored by	Trg. Organised by	Certificate /degree / diploma awarded
1.						
2.						
3.						
4.						
5.						

e. Quality of training: mention the course of trainers, how are you supervised/trained? Give details.

a. No. of theory classes:

b. No. of practical classes:

c. No. of cases handled independently:

17 Give details about source of funding for the counselling centre (please tick the appropriate)

Sl.No.	Funding Agencies
a.	Central social welfare advisory board
b.	State social welfare advisory board
c.	State government
d.	Central government
e.	National private funding institution
f.	International funding institution
g.	Fee collected from the clients
h.	Any other, please specify

18. Please give information about networking activities, specifically on type of agencies with whom you are networking, and areas of networking.

Sl.No.	Name and Address of Networking Agencies	Area of Networking
1.		
2.		
3.		
4.		
5.		

19. Any problem faced in running the centre? Please give details

PART – III

DESCRIPTION OF COUNSELLING SERVICES

Please furnish details about the following:

20. Presenting problems of clients (please tick the appropriate)

a. HIV/AIDS persons
b. Mental patients
c. Marital problems
d. Domestic / family problems
e. Scholastic problems/Academic problems
f. Alcoholic /Drug related issues
g. Sexual abuse of children/adolescents
h. Dowry related problems
i. Divorce/separation
j. Old age problems
k. Any other, please specify

21. Counselling Services provided

Please list the counselling services delivered in your counselling centre (tick mark the appropriate)

Sl.No.	List of Services given by your centre
a.	Case work
b.	Marital counselling
c.	Family counselling
d.	Individual counselling
e.	Group counselling
f.	Vocational counselling
g.	Educational counselling
h.	Diagnostic psychometry
i.	I Q Assessment
j.	Any other, please specify

22. Profile of clients. Majority of the clients come from (please tick the appropriate)
    a. Higher socio-economic strata
    b. Middle socio-economic strata
    c. Low socio-economic strata
    d. Any other

23. Please describe how clients/people in problem can avail your services?

24. Please provide data on the following.
    Total number of cases registered, year wise, since last 3 years
    a. 2000
    b. 2001
    c. 2002

25. Whether your organization is charging any fee or not. Please give details.

PART – IV

TRAINING

(This part is applicable only for centres/institutions where training on counselling is given)

Profile of the Training Centre

26. Address of the training centre

Telephone No. Fax Mobile no.

E-mail

27. Person/Official to be contacted and contact address

28. Date of starting the training centre

29. Objective of the training centre

Please mention the following:

30. **Duration of the training (If it is more than one, please specify)**

a. One week	b. Two weeks	c. Three weeks
d. One month	e. Three months	f. Six months
g. One year	h. Two years	i. Any other

31. **Nature of training (please tick the appropriate)**

a. Orientation programme	e. Post graduate
b. Diploma course	f. Certificate course
c. Refresher training	g. Degree course
d. In-service training	h. Any other, specify

i. Total no. of persons trained since inception

j. Total no of training programmes organised since inception, year wise

1) 2000
2) 2001
3) 2002

32. **Curriculum followed:**

(Please enclose a copy of the curriculum followed and prospectus)

Specifically mention the following:

33. **Curriculum prepared by:**

a. Your own centre

b. Prepared by other professional bodies and followed by your centre

c. Curriculum offered by professional bodies

34. **Since how many years the curriculum is being followed**

a. Same curriculum since the beginning

b. Changed in the recent past (specify year)

c. Some modifications are effected to the old one

d. Details about total no. theory classes and practical

35. **DETAILS OF TRAINEES**

a. Total number of trainees in a batch:

b. Minimum qualification for Admission:

1) SSLC Passed 2) Intermediate 3) Graduation

4) Post graduation 5) Any other, please specify

c. Selection criteria

- Based on marks in the qualifying exam
- Based on marks obtained on writing exam/entrance exam
- Based on Viva voce/interview/group discussion
- All the above
- Any other criteria

d. Medium of instruction:

1) English

2) Kannada

3) Hindi

4) All the above

5) English and Kannada

6) Any other, please specify

36. **DETAILS OF TRAINERS**

Please furnish details as stated below

Sl.No.	Designation	Number	Full/part time	Qualification	Salary / Honorarium per month	Experience	
						Clinical	Field
1.							
2.							
3.							
4.							
5.							

37. Please give details on Examination / Assessment criteria

38. Please give details on follow-up of training

39. Please give details on linkages with placement institutions

40 Please give details about the fee charged for training programmes/Trainees

41. Problems faced in conducting/organising training programmes

42. Please give any other information that you desire to furnish.

NGO - 8.

Rethinking the Power of Aid

The Crisis of Humanitarian Action

medico international Report 25
english supplement

Die vorliegende Textsammlung ist eine Beilage zur Dokumentation der Konferenz von medico internatonal, Institut für Erziehungswissenschaften Universität Frankfurt / Main und Heinrich Böll Stiftung »Macht und Ohnmacht der Hilfe«, 28. und 29. März 2003 in Frankfurt am Main.

Die Dokumentation ist auf Deutsch erschienen, diese Beilage umfasst die wichtigsten Beiträge im englischen Original oder in englischer Übersetzung.

The present collection of speeches and texts is a supplement to the conference documentation »Rethinking the Power of Aid«, held by medico international, Institute of Pedagogics Frankfurt University and the Heinrich Boell Foundation on March, 28th and 29th 2003 in Frankfurt/Main.

The documentation was published in German, the present enclosure covers the most important contributions, either in their original version (in English) or translated into English.

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BLZ 500 502 01

Content

Thomas Gebauer (Executive Director of medico international, Germany)

The Saving Idea is yet to be Conceived

Notions towards a New Definition of Humanitarian Aid

Relief organizations tend to muster support for their work on huge billboards: »A thousand questions, one answer: Aid«. This is a wonderful, a magnificent promise in a world which threatens to drown in violence and misery. A promise that is refreshingly self-confident as it claims to have the solution for so many uncertainties. It is therefore no surprise that, in the English-speaking world, people do no longer speak of humanitarian engagement when talking about aid, but use the term »humanitarianism«.

History tells us that humans have always helped each other in times of need. Today it seems, however, as if feeling a moral concern for fellow human beings has turned into a veritable philosophy. A philosophy that is omnipresent in the current public debate like no other and that has developed its own very specific practices. For, these days, almost everybody cares for human rights and aid for the poor: politicians, celebrities, industry, trades associations, the media – and, yes, even the military like to lend themselves an aura of charity contending that their future interventions will be humanitarian rather than military. It is certainly true that providing practical help to people in need is highly acknowledged in the public. And, nearly every day, we can see how successful such aid is. See the glamorous charity galas on TV, the brochures of the aid organizations, the images of white 4x4s and aid workers not shirking away from any risk to be right on the scene of terror in order to help the victims.

The world – a global village of those in need of help and their helpers? »Humanitarianism« as the last hope for salvation? – The unique success story written around »humanitarianism« over the last decades has been in for some criticism lately. Some commentators, like US-writer David Rieff are talking about a crisis of »humanitarianism«. »Relief«, as he concludes, »is a saving idea that in the end cannot save but can only alleviate.«

One thing, however, is for sure: the precarious state of the world, calls for relief everywhere. There can be no doubt that, without the humanitarian assistance provided by relief organizations over the last decades, thousands, or maybe hundreds of thousands of people more would have died in wars or from starvation.

It is also true, however, that the number of wars and the gulf between rich and poor has been growing over all these years. The miserable state of the world has long since arrived at the suburbs of the wealthy northern hemisphere. There is no reason to disparage first aid, individual asylum or food aid – they are small improvements frequently helping indi-

vidual people to survive. Nevertheless, we should not ignore the fact that even the most successful humanitarian aid has not been capable of containing the disastrous development let alone having provided a solution. Violence and poverty are the result of the powers that prevail; they do not reflect a lack of humanitarian assistance but the failure of government policies whose aim it should have been to create conditions fit for human beings.

Disaster

Only a few decades ago, Jean-Paul Sartre concluded that there was no such thing as natural disasters, because ultimately all disasters were man-induced. Since then, the consequences of human action have kept backlashing on us with brute force. Pollution, animal epidemics, mass migration, displacement or wars come unannounced, sneak up from behind and seem numb to all attempts at remedying them.

We cannot even say there is a lack of knowledge of what is going on in the world. Nobody would seriously claim that it makes sense to destroy the environment, uproot people or wage war. It is strange, however, how the awareness of impending dangers goes hand in hand with a growing feeling of despair. Is it possible at all to prevent the misery? Has it not become inevitable for a long time, just like a natural disaster? Outrage and sympathy are mingled with feelings of fear and shame. There are signs of a disaster which, like in the times of our ancestors, is perceived as omnipotent and coming from without, and which renders us so helpless that we cannot help but mythologize it.

In a seemingly paradox way, narrowing our perception to individual, particularly blatant cases of disaster appears to help us to cope with an otherwise unbearable reality. Focusing on a spectacular earthquake, a dramatic flood, the war against what we take to be the powers of evil, we lose our awareness for »commonplace« emergencies and terror faced by humans allover the world every day. In fact, dramatizing individual, seemingly inevitable horrors seems to liberate us from feeling ashamed for the fact that, in view of the level of development achieved in the world, we could easily prevent displacement, diseases and starvation for millions of people.

Victims

At the same time, we have whole libraries providing information on who the victims are. What is the significance of these victims? Do they even have some kind of social role to play?

In the mid-80s, the press officer of the International Monetary Fund explained that it was not only an inevitable fact but the intention that there would be losers and that, in order to continue to reap the benefits of the prevailing economic order, it would have to be rid of all the shackles according to the credo of neo-liberalism. He added that consistent liberalization of the market forces was the only way to ensure wealth and well-being and that

this would be taking its toll of victims. The interventions following this announcement were monstrous. One third of the world's population was socially uprooted and excluded from the formal exchange on world markets; there was even talk about a »redundant« population. And even those who were the alleged winners had to make huge concessions: nowadays humans are controlled and assessed right down to their biological substrate, the social dimension has been completely dissolved or is being measured by mere economic standards.

Suffering such losses calls for denial or at least for compensation. What seems to help us in this context is to regularly recall those who are even worse off, that is to say those who fell victim to our efforts to secure our own privileges. Giving aid to the disadvantaged can be compared to a carnival situation where prevailing conditions are reinforced by a periodical reversal of all norms that is limited in time and strictly controlled. There is indeed a trend in the wealthy part of this world to link empathy and charity with selected situations in order to legitimize and declare as normal their absence in everyday life. Moral impulses triggered at the sight of human plight are safely channeled into sporadic fund-raising events. Justice is transformed into the good deed consoling us for the lack of justice as the prevailing norm. »Let us do something good for a change«, confessed Helmut Kohl sticking a note in a collection box when he attended the first Africa Day in the mid-80s.

Aid

Aid in the emphatic sense does no longer seem to be an issue these days. People still seem to pay lip service to the concept of providing helpful assistance with the aim of overcoming poverty and powerlessness in order to create and restore autonomy, but this idea has lost all its practical relevance. Fading hopes for emancipation, the disillusionment with the failure of rigid revolutionary approaches have had a detrimental effect on the idea of social development. The good maxim of »give a man a fish; you have fed him for today; teach a man to fish, and you have fed him for a lifetime« – which used to be very popular until recently, seems strangely behind-the-times, almost obsolete.

For wanting to challenge the status quo is no longer deemed a credible undertaking by the public. The modern heroes of the civil society movement do not indulge in political deliberations, they just knuckle down on it. In the past it was the concept of a different world that motivated people to act; now it is mere apolitical pragmatism, non-interference, impartiality, just making sure the greatest hardship is relieved without, however, questioning the powers that be.

This approach to aid has long since established its own iconography. The white helicopter pilot rescuing a newborn African child from an almost inundated tree is emblematic of »humanitarianism« and epitomizes the kind of »interventionist« aid floating in from the outside (and very likely to disappear

soon, too), which is stripped of any context or social relevance. It is restricted to rescuing individuals, while the catastrophic world order, which would be in heavy need of rescue, seems as if it was cast in concrete and unchangeable.

Incidentally, the increasing importance of private relief organizations does not necessarily reflect the fact that democracy is on the rise, rather the opposite. As those in need can no longer resort to legal rights usually granted by a state government, because their social welfare now depends on the philanthropic »goodwill« of charity organizations or on the efforts of multinational corporations to polish their images, we may rightly use the expression of »re-feudalization« to describe the development we are witnessing.

Depolitization

While the approach to aid was being stripped of its political components, pragmatism defeated idealistic visions, and mere acceptance of a given situation triumphed over hopes for emancipation.

In fact, determining the political root causes or the historic circumstances leading up to a plight almost always comes off worst. Suddenly, those asking for the reasons of the famine at the sight of a starving child are reproached for being inhuman. Reducing war and crises to their humanitarian consequences, however, has considerable implications. Those who are incapable of developing an understanding of a crisis, because they are ignoring the relevant political and cultural conditions, cannot respond to such crisis in an appropriate way.

During the Kosovo crisis, for example, it was the massive presence of foreign aid structures that totally ostracized the remaining part of the local civil society that had escaped Milosevic's expulsion policy. Independent intellectuals, human rights activists and health experts turned into drivers, translators and workers in the employ of the relief organizations. »That's OK, the important thing is that we have provided aid« – said a German politician, for whom it was apparently no problem that aid, originally meant for alleviating the hardship of real human beings, turned into an end in itself.

Indeed it does not seem an obstacle for the members of relief organizations to know very little about the people they are dealing with. Their aid projects obey technical and economic criteria and do not even pretend that the victims of war and poverty are more to them than objects that they provide with supplies with the greatest possible efficiency. Most relief workers do not consider wars political or historic events but rather humanitarian crises requiring relief. And even if it sounds bitter: if Auschwitz were to occur today, the mass media and appeals of relief organizations would be likely to merely call it a »huge humanitarian crisis«.

Capitalization

Such pragmatism easily associates with business interests. The many billions

of US-Dollars raised for humanitarian activities in the world have made »humanitarianism« an interesting industry recently expanding at high growth rates. The market even has its own trade fairs, where foodstuff, lifeboats, mine detectors, tents, body bags, gas masks, water purifying plants and other aid products and services are on display.

The extent to which aid has been successful is measured less and less by social criteria. Econometrics seem much more important, like the number of people reached, the volume of supplies dispatched, the efficiency of aid logistics, the speed in which an organization gets to the scene of the emergency. It is the operative capacity that counts, not the human relationship to the victims. The Humanitarian Aid Office of the European Union (ECHO) says that solidarity with those who suffer is no evidence for the quality of humanitarian aid but rather an obstacle.

Gradually, aid has been removed from its previous social context and transformed into a »product« which, just like any other product, does not necessarily correspond to the needs of the recipients any longer. Donor interests are pushing their way to the focus of attention or, what is worse, the act of providing aid increasingly depends on the extent to which it can be exploited by the media. Governmental donors, but also the relief organizations themselves, insist on their rigid target figures and »controlling« that is supposed to improve the aid's »output«, although social action is neither predictable nor does it obey a business logic. Instead of dealing with the nature and inherent dynamics of aid and its effects, the capitalization of aid offers the possibility to make those aid programs fail which are unwanted for political reasons by simply stamping them with a negative economic assessments. No profit, no aid. But how can you economically assess an approach to aid that is not only aimed at providing relief to refugees but also at ensuring they can return some day? And is it possible to develop at the drawing board, without involving those affected, something like a »result-driven« plan for the process of rebuilding an organic social community in which victims of violence and poverty feel secure again?

There is a risk that degrading aid to a mere »product« is only the beginning of a far-reaching structural change of aid. Within the EU the demand was voiced to withdraw tax advantages from charitable institutions, in order to avoid competitive distortion and to allow private companies access to humanitarian aid markets.

Many companies, among others the German private TV station RTL, have founded their own relief organizations, in order to secure their share of the aid business. They can be seen as the harbingers of a self-referential »humanitarian industrial complex« threatening to evolve in the future. The medium places the topic on the agenda, mobilizes support and raises funds, translates all this into projects supplying the images which ensure a convincing media-based »controlling«.

Instrumentalization

Stripping aid of its social context exposes it to the control of central authorities and instrumentalization in many ways. The depolitization of aid has exacerbated the humanitarian paradox. The more smoothly uncritical aid works, the better can it be instrumentalized for political and military purposes.

Indeed, aid has turned into an economic and political resource much sought-after by the parties to a conflict. Be it taxes on goods imported as aid, or extorting, robbing or plundering the population fed from outside – there are many ways for parties to a war to get there share of the billions of Dollars worth of aid provided to the victims annually. In countries like Angola, Liberia or Afghanistan, humanitarian aid has taken on such an importance that it has to be considered an integral part of the vicious circle of violence.

Aid is also the perfect means to overcome a lack of political legitimation. Warlords or political elites who can hardly legitimize their authority by proper governmental structures, obtain allegiance by combining tyranny with a minimum of social welfare for their people, this welfare being ensured by foreign aid. Public acceptance of military measures increases when relief organizations – like in the Kosovo war – draw the attention of the public to a refugee emergency by staging large-scale campaigns.

These dilemmas cannot be resolved by applying the axiom that aid is to be restricted to the relationship between the victims and those providing aid. The impartiality emphasized quite rightly by the relief organizations must not result in indifference in the face of political reality. It is part of this reality, for instance, that new players appear on the scene who are utterly unscrupulous about misusing aid for their own purposes. Force Protection is the name NATO uses for humanitarian aid programs that military forces carry out simultaneously with military operations in order to raise their public acceptance.

In the course of economic globalization, the old East-West axis of conflict has shifted and now runs North-South, between a rich global north and a global south drowning in poverty. The peace strategies practiced in international crisis management efforts resemble those of the 18th and 19th century. Like in Victorian times in England this is about a repressive kind of poverty relief where there are good victims and bad victims. The »good victims« who deserve every support for their good political behavior – as happened in Yugoslavia only recently – receive so-called »conditioned aid«, while so many »uncomfortable victims« are dragging out a miserable existence in refugee camps, sometimes over generations, or are exploited and disciplined in export zones, which are the workhouses of modern times.

Striving for social justice has been denigrated into an early warning sign, an indicator of system disruptions which need to be contained in order to maintain the existing gulf between the rich and the poor, the powerful and the powerless, the

privileged and the humiliated. Apparently the end justifies every means: the first strike, state-authorized torture, the abolition of democratic legal principles, the continued development of long-since banned chemical weapons, and the misuse of humanitarian aid.

Within the evolving »global civil war order«, aid is bound to fall hostage to a security policy whose only objective is to perpetuate the status quo. This is why humanitarian aid's terms of reference are likely to change completely over the coming years. There are more and more signs suggesting that humanitarian aid may become part of a complex set of policies aimed at bringing about peace and acting like a »foreign social welfare office« to the outside while striving for legitimation at home. In this case, private relief organizations will run the risk of turning into mere service providers to government institutions.

Prospects

True, many attempts are made to defend humanitarian activity against its instrumentalization in the ongoing process of destruction. Some observers, like Rupert Neudeck, demand that aid be purely self-referential. In his view, those providing aid are like modern Sisyphuses who are incapable of bringing about a change, but cannot help but help time and again. This is how those providing aid move to the foreground rather than the intended effect of aid. »Love thy neighbor and act accordingly« is cherished as a moral attitude upheld by each individual. Striving for justice as an ethical principle of society is relegated to the sidelines. Ultimately, the aesthetic exaltation of the aid heroes perpetuates the disaster.

It is high time relief organizations became aware of the dilemmas of their activities. They will certainly have to rewrite a number of myths, one of them being that humanitarian aid serves the victims while the helpers stay impartial. Those who want to help others cannot actually be neutral, but must interfere, taking a stand for the victims and against the perpetrators. Any other course of action would be highly immoral. Those who help others to overcome an emergency and enable them to take action themselves, leave marks that will remain far beyond the moment in which the actual aid was provided.

How powerful such aid is can be observed wherever relief organizations do not restrict their work to short-term interventionist »missions«, but rather try to provide an aid that is tailored to the needs of the partner and the context. Humanitarian crises cannot be eliminated by implementing purely humanitarian solutions. Whoever wants to help must fight for democracy and social development – standing by the victims of poverty and tyranny.

Conclusion

I owe the idea of comparing aid to poetry to the Palestinian writer Mahmoud Darwish. My intention is not to aestheticize aid, but rather to illustrate its political contents.

Aid can never be an ally of war and violence. Just like poetry, aid, in its substance and nature, serves peace and the defense of freedom and solidarity. It springs from mutual empathy and social ethics. Although aid cannot be a party faithful to political reality, it will never be neutral. There is no neutrality between war and peace, between oppression and freedom, unfairness and justice.

However, aid has come under tremendous pressure allover the world lately. When societies persist in the status quo and frustrate any renewal, which is the ultimate goal of aid, aid will turn into an island of solidarity and empathy inundated by increasing irrationality, or it becomes part of what will eventually be renewed: the security machinery installed to protect the status quo.

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The Crisis of Humanitarianism

Not only the CNN-Effect is bringing Humanitarian Aid into Crisis

I would like to not only talk about Iraq. You may think that that is a bit of special pleading on the part of an American, but really it is a special pleading on the part of someone who spent about ten years of his life in Africa and is worried that the emphasis on Iraq, even for the best of political motives, is from a strictly humanitarian point of view, something of a mistake. Let me be much blunter: a great mistake.

Because one of the many perversities of the humanitarian system, and it is a system, it may not be a business, as some of its critics, I think, rather unjustly say, but it is certainly a system. One of the perversities of it is that crises are picked more on the basis of some nexus of popular concern in the West, western political interest and what we call for a lack of a better word the »CNN-effect«, that is 'what is on Television', than for the actual content of the crisis.

As Ulrike von Pilar tried to point out last night, the most interesting thing about the humanitarian situation in Iraq at this moment is that we don't know anything about it. We have no idea, if this is one of the major humanitarian catastrophes of this period in human history in this early part of the 21st century, or whether in humanitarian terms it is actually a comparatively minor event. We simply don't know.

There are a hand full of aid workers who are actually free to move about in Iraq, even to the extent they're free to move about, it is by no means clear what communications they have with each other and therefore what kind of confidence assessments can be made, either of needs or of the potential for harm. So we are blind, to a very large extend blind.

This is obviously not the first time this has happened. Cosovo was a perfect example for this. During the bombing part of the Cosovo war, what was remarkable, and I am a someone who covered the Cosovo war as a journalist and was sitting for most of it on the Albanian-Cosovo border, what was interesting was that we didn't really know what was going on in Cosovo. We knew what was going on in the refugee camps, we knew something about the mass deportations, we also knew something, despite the ways in which both NATO and the Serbs tried to lie about it, about the course of the war, but we did not know, really, what the humanitarian emergency was. And it's the same thing in Iraq.

Whereas we do know that in Angola there is famine. We do know about the AIDS epidemic, not just in Sub-Saharan Africa, but I would remind you in the Caribbean, they are my own country, and now in Eastern Europe, in the former

Soviet Union very close to this country. We know about that. And I think the first thing, if we want to think lucidly and not sentimentally about what we are confronting is to start actually being modest about what we know and trying to separate things out.

One thing that struck me about the discussion yesterday was the degree to which humanitarian issues in their own terms were barely addressed. In other words, we talked a lot about the rights and wrongs of the Iraq war. And as an American I am perfectly going to take the heat from you on this issue. I don't think that it is only as an American, that makes me say, that you in the audience may consider, that the Iraq war is one of the worst political events to happen in the last period, but it is by no means clear, that it is one of the worst humanitarian events.

The Iraqi government for example is claiming 500 dead. That is not on the standards of the horror of the world. I'm sorry about this malign calculus. I apologize for engaging it. But I think it's important because resources are limited.

One other thing that struck me very forcefully last night is that I didn't hear any discussion about money. And yet, money is inseparable from the pursuit of humanitarian action. Humanitarian agencies without money are just people who issue press releases. It's as simple as that. There is no humanitarian action without proper funding. There is political symbolism, there may be political activity, but there is no emergency relief. You cannot break a cholera epidemic, set up a feeding center, let alone, systematic programs of relief in conflict areas, unless you're properly funded. And yet last night we talked as if the money either wasn't a problem or wasn't even an issue, when it's in fact the principal issue.

Let's talk about Iraq. The British Government, which has actually one of the largest contingency funds within its humanitarian structures for humanitarian action, a fund of app. 100Mio pounds, that about 150mio Euro, has now pledged 70Mio of it to Iraq. Now that means, there is 30Mio Pounds left in the fund for all other humanitarian emergencies anywhere in the world, unless the British government pushes through in parliament a supplemental appropriation, which given the nature of politics is probably months away. It doesn't seem very likely, knowing what I know of the way that works (I used to live in Britain), that parliament is likely simply to appropriate in general funds more money for overseas development. So what you are looking at, for example, is in this Iraq-crisis, and I tried to say in my preceding remarks, that it is not clear this is the worst humanitarian crisis around. The humanitarian funding sources are being drained away, like water going down the sewer.

Maybe again, I can see, maybe the humanitarian crisis in Iraq will be as severe, as people say it is. It is certainly the job of humanitarian agencies to be alarmists and I am not one of those critics of aid who criticises agencies for making statements that a lot of people will die and then people don't die, it's their job

to be alarmists, it is correct that they are alarmists. It is much better to be alarmists and then be pleasantly surprised by the fact that one's anticipations have not taken place than it is to be calm about things. The humanitarian workers relief are absolutely right to behave, to work in that register.

But having said that, simply the distortion of what Iraq is going to bring is amazing, impossible. If I may go back for a moment, to take only one agency: when the Cosovo crisis broke out, the world food programme took one official from every one of its programmes in Africa and seconded them to Cosovo. In other words, every single programme in Africa lost a single person. Given the famines in Africa, and I remind you there was no famine in Cosovo, this was a catastrophic blow to African Programmes.

There was some young people standing outside yesterday who belong to the German Attac, who were handing out leaflets saying »in the middle of Iraq, don't forget about Africa«. I think Nuruddin Farah's remarks yesterday are absolutely correct. I don't want to single out Africa, there are other places not to forget about in terms of emergency relief. When I speak about relief work, I am talking about emergency relief, relief in times of war and natural disaster. I am not talking about development aid. I am very admiring of what relief workers do in emergencies.

I am probably almost as sceptical as Nuruddin Farah about what development has done which in my idea is less than nothing.

So I consider first of all the fusion of development and emergency a huge mistake. If think the moral hazards of development which again Nurudin Farrah explained great and subtle and correct, are such that one must be at best extremely sceptical and I think one is legitimately allowed to be more than sceptical. Whereas I consider humanitarian aid for all its weaknesses, all its paradoxes, all its dilemmas to be an unmitigated good thing. Now, that may sound strange to you from someone who is supposed to be a fierce critic of aid.

But from my point of view emergency relief is one of the few activities in this world about which one can be quite unambiguously proud. Having said that, that doesn't mean, that it shouldn't be criticized, viewed sceptically, or that its own fantasies about itself shouldn't be questioned. And may I go even further: its own hubris. Again I want to raise a point, that was raised in a question last night, which is the issue of competence. We heard a great deal yesterday about how humanitarian aid needed to be a vehicle for peace. The first sentence of the conference document, at least in the English translation, reads: »Aid can never be an ally of war and violence. Helping each other requires empathy and enables us to overcome poverty and dependency.«

But I believe almost every word in that is false. Let me be very blunt. Why can aid never be an ally of war and violence? Again in its practice. In its ideal fine, it's perfectly fine to say, »we aid workers or we who give money to aid the world, we

want to put an end to war and violence. We see humanitarian assistance as part of a larger peace process, a larger questing towards justice. A larger part of the good people versus the people who want to continue the neo-imperial order, or whatever political vision of the world suits your fancy.« That may be true. But may I submit that's about us not about the people who get the aid. That's about what may make a person in Oxford or Frankfurt or Lyon or Madrid give money to an aid agency. That is not what aid does.

Again, what is the competence, if what you get from an aid worker is food; I submit to you that the issue is not the motives of the person giving you food, but the amount of food and efficacy of the delivery or that food that counts for you. Again in this discussion it's all about intention, it's not about competences. My friend Rony Brauman, who is one of the leading figures in »Doctors Without Borders«, France has always said, emergency relief groups do not have a monopoly on giving relief. Relief is something that was given long before aid agencies ever came into being and I submit to you that may be given long after aid agencies have be so transformed that in their present form they are no longer recognisable to us.

An army can give food. Armies have always given food. On the domestic level you know this perfectly well. Do you say it's outside the competence of the German Army to cope with the floods here recently? Of course you don't. You don't say, »the floods can't be coped with by the Bundeswehr, the floods have to be coped with by the GTZ«, because you're not thinking in this highly moralized discourse. You are actually thinking about how to do something about the floods. You don't say, the GTZ or the German Red Cross has a monopoly on dealing with this floods, a moral monopoly and the Bundeswehr can never do it because it as a military arm is by definition an ally of war and violence, that after all is what armies are in their essence, however much Europeans may fantasize otherwise (the American shows the sting in his tail).

The fact of the matter is aid comes in all shapes and forms. That is the historical truth. It comes for example historically in the shape of Christian missionary charity, a form that is anything but dead today in the poor world. If you know the American and now worldwide organisation »World Vision«, which has given aid quite effectively in many contexts, it is also a prospertising organisation. And indeed, its former operations head is now the head of the US agency for international development, which after ECHO is the largest single funder of aid. It comes in the form of the Red Cross. No one in his or her right mind would say that the Red Cross is an ally of war and violence. On the other hand every one I have ever worked with in the Red Cross has said to me: »We work in the context of war«. The Red Cross takes the existence, the purenity, the permanence of war for granted, as a great Red Cross official said in Rwanda: »Our aim is to bring a measure of humanity, always

insufficient, into situations that should not exist.« That's another vision of aid. And in many ways the ICRC, the international committee of the Red Cross remains the most coherent of all aid movements.

There is the tradition in my own country, which in its secular version tends to be quite narrowly governmental. American aid agencies have a long tradition dating back actually to the period of the Russian revolution, where the United States mounted a very large and complicated aid effort in Siberia in 1919 and 1920. At the same time that it intervened militarily – shades of the present.

In my own country the tradition of aid is one that ties relief groups to government. It is true, that there is a European tradition, dating back probably to Doctors without Borders, to Médicins sans Frontières, at the time of the Biafra war and after, that has a notion of independent autonomous aid. And also aid that does come closer to what is written in this conference document about aid never being the ally of war and violence. If you will it's aid as a social movement as well as a deliverer of goods and services, an alleviating machine.

That tradition is one of the traditions of aid. But it is just a verbal slate of hand to pretend, that it's the only tradition, or frankly, even the dominant tradition. The fact is, that the relations between governments and aid agencies are very intense, very close and not only in the United States.

You may like your government, you may think »George Bush fuck you«, as it says in half of the windows I pass in Berlin where I'm living at the moment. And you may think »now that he has revealed himself to be a true antibalacist, Gerhard Schröder is a prince of a man.« You are certainly entitled to that view. But don't let the fact that you may like your government and hate mine confuse you about the degree to which aid agencies and governments are in a state of really intense cooperation and linkage. Nor should you think, that the militarisation of aid is simply a phenomenon of the United States.

I remind you, that in the European Rapid Response Force that went into a fact in 2003, the mission of that force was peace enforcement and humanitarian assistance. In other words, you latest attempt at having a military collective security explicitly links military action with humanitarian assistance. So again the idea that somehow aid is sitting out there on its moral high horse refusing steadfastly to be an ally of war and violence while the wicked Donald Rumsfeld subjugates Iraq. I'm afraid it is rather a fantastic vision of reality.

Let me again try and make it even more complicated. What is the core competence of aid? What do aid workers know about. Is an aid worker the person you want to go to for political analysis? Should Oxfam, or MSF, or dare I say medico.de be the people to whom one applies for wisdom about the proper outcome of conflicts.

I heard yesterday someone say that the war must stop on humanitarian grounds. That tells me nothing. Perhaps this is an

unjust war. I in fact am opposed it, but a bit more modestly than most of the people in this room I think, and probably by the standards of most people in this room my opposition would constitute little more than a sort of quibbling. Having said that, think about it for a moment. Let's say the Iraq war is as most of you think of it, a barbarous, colonialist injustice. Is that why the humanitarian criterion should be invoked? What about a just war? Do you think, that the war in Rwanda should have been stopped? Do you for example think that instead of allowing the Tutsi army to take back Kigali we should have intervened and stopped it in place? Do you think WWII should have been stopped on humanitarian grounds?

In other words, it is in the nature of the humanitarian position to want to stop all wars. It tells us nothing about their justice. What it tells us is that war is, always has been, and always will be about the slaughter of innocents. That's what war is. It's other things, too, unless you're a pacifist. If you're a pacifist war is only about the slaughter of innocents. But if you are not a pacifist, war can also be just, it can also be necessary; you can make various arguments. But war is about the slaughter of innocents. That's what war is. So if you're working from your humanitarian perspective, all wars should be stopped on humanitarian grounds.

The reasons to oppose the war in Iraq surely are political and moral. Because to oppose them on humanitarian grounds, again, unless you are a pacifist, is simply to say that war involves hideous humanitarian consequences. If you are not a pacifist, the issue of whether you think that humanitarian issue should take priority depends entirely on the justice of the war. There is nothing new about this idea. But to say simply it's fine, oppose the war, say »the Americans want to re-colonise the Middle East«, say »no blood for oil«, but don't say that it's because of the humanitarian imperative. Because on that basis you must oppose all wars.

This brings me back to the level of competency – core competence. It is right for humanitarians to talk from a humanitarian perspective. There is nothing wrong with that. You don't want medico or MSF, or Oxfam to say: »Well our perspective is this, but looking at it from the point of view of, I don't know, Minister Fischer, we have another point of view.« That would be silly. Of course humanitarians have to argue the humanitarian case. That is right and proper. What is not right and proper, I think, is to accept the premise, that humanitarians are necessarily the only or the best source of wisdom about politics or war, anymore than you should accept that journalists are. We are in the field, too. Are we the best source? I doubt it.

The question is core competency. Why should a water and sanitation engineer, and here I come back again to Nuruddin Farah's very astute remarks about how people in the poor world often view aid workers, perhaps he was a bit sweeping in his account of aid workers. I think there are plenty of aid workers

who don't conform to this kind of bourgeois Europe and North America exploiting the poor world. But there are certainly more than enough examples of such people to make what he says entirely appropriate and well and apt in the context of such a conference – again necessary.

But why should I take the political views of an American water and sanitation engineer who arrived in Burundi three weeks ago. Seriously – why? It isn't graven in stone, that Oxfam is the source of funds and ergo of wisdom about the crisis, in which, I remind you, it delivers services. It helps out, it alleviates, that's what aid does. Aid is this marvellous thing. It's an extraordinary thing.

My idea is, that despite all the talk about the Global Village, the media, the internet, and all the rest, we are in fact as human beings not very good at sympathizing with people we don't know. I think actually that's quite difficult. So I think the success of the humanitarian movement in precisely getting people to sympathise with people they don't know and going out and trying, however inaptly, to do something, is a remarkable if you like to use the famous phrase of Walter Benjamin's 'document of civilisation'. But if I may quote the Benjamin-aphorism in full, he did after all say »every document of civilisation is also a document of barbarism«. And it's that dilemma, that you need to think about. It's the question of whether an alleviating idea, noble as it absolutely is, can become, as it were, the moral center for thinking about the world. And whether aid workers should appropriately make, what I consider extraordinarily hubristic claims, that »aid can never be the ally of war an violence«, when every historical anecdote we know suggested that they have been, they are and they will continue to be.

Is there a possibility of an independent aid? Absolutely! I think there are groups that really are holding out for an independent vision of humanitarian relief. One that might incarnate the kinds of ideals that are contained in the conference statement and in Thomas Gebauer's speech yesterday. I particularly think of the MSF movement, which I think has come as close to exemplifying that view as any group of humanitarian relief workers. Having said that, again, they have been very successful at fundraising, they have private sources, which has made them less dependent on government. It is by no means clear, that that kind of fundraising can be done by many groups. It may very well be that a few groups will succeed in doing this and most will not. In any case the MSF movement is at least at the moment part of the humanitarian system which contains all kinds of other groups, that don't take this road.

Again, yes, there is an independent world of relief, that thinks about the independent 'humanitarian space', to use the term of art, but it is by no means clear, that it's dominant. And it's certainly by no means clear that you can clean up the kind of moral posture of humanitarian assistance by pushing it through the UN.

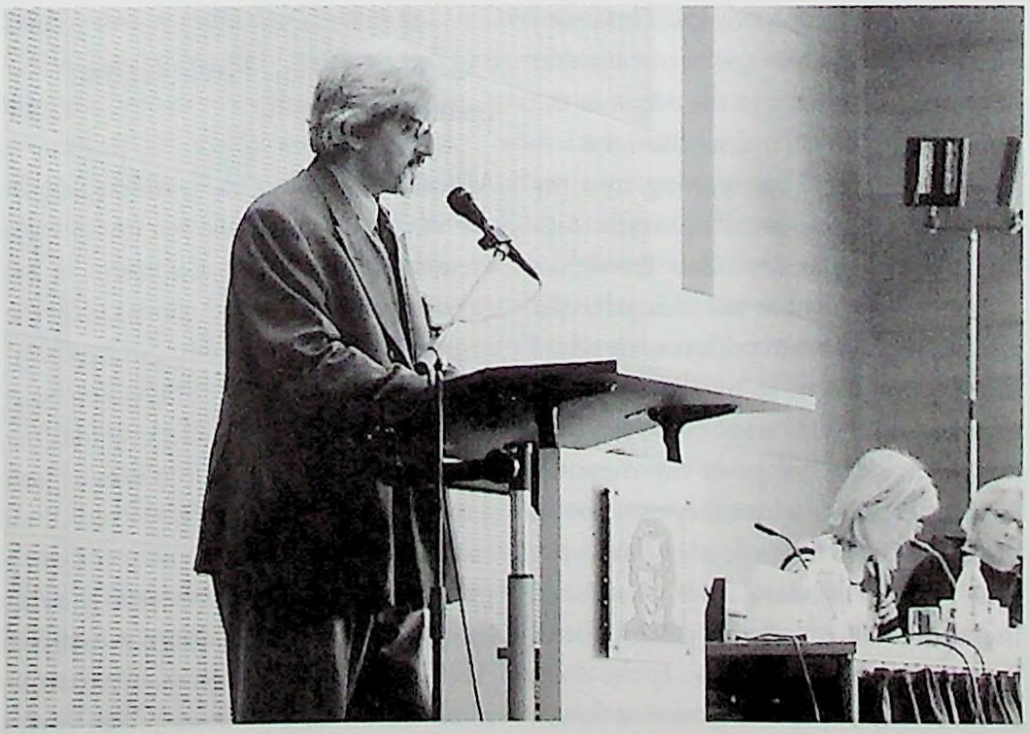
I am very struck, I think Thomas Gebauer talked about this last night, by the degree to which the debate at the moment is whether the United States will run Iraq unilaterally or the UN will, i.e. the UN- Security Council, i.e. the five victorious powers of WWII, who have been granted for reasons no one can now explain control over the political actions of the world, legitimating control.

I don't agree with much the Iraqi government says, but I must say I thought the Iraqi embassador to the UN's remarks in the open media on the Iraq crisis where he said: »Why are we talking about humanitarianism when we should be talking about the justice of the war?«, was absolutely correct. And indeed unassailable as a position. It seemed to me he had it exactly right.

And I actually think, people in Europe are being misinformed, in some sense distracted by the debate about the UN, when the real debate should be elsewhere. The recent debate about the UN is fundamentally humanitarian. It's fundamentally a way of saying: »We're not going to talk about politics, we do talk about humanitarian aid and we are going to talk about our good intentions.«

I know this is a post-christian conference, but as a citizen of a christian country let me just close by saying: »The road to hell is paved with good intentions.«

Translation: Esther Kleefeldt



David Rieff

Nuruddin Farah (Writer, Somalia / South Africa)

Our Problems – Their Gains!

Considerations about Colonialism and Aid

I have a vague memory of a conversation I had recently with a Nigerian academic visiting Cape Town. We were in limb time, because we were at the wake of a mutual friend who had just died. I was there that evening with a specific assignment: to formalise the proceedings of the funerary arrangements at the chapel at which I had been asked to officiate. Everyone was busy with one thing or another, and there were a great deal of comings and goings, with friends and acquaintances joining us and then drifting away after listening to our arguments or making their contributions. Of all the things that were done or said, however, I remember only a couple of phrases that have remained sharp at the edges in the way words spoken in a delirium are.

I recall going away, getting into my car and driving home, all the while mulling over the phrases »Our Problems, Their Gains!« I have no idea why the phrases struck a cord with me, or why I kept reciting them to myself as though they were a mantra whenever I revisited the evening's exchange in my memory. Nor can I identify where they came from, or who uttered them. It may have been the Nigerian academic who had used them; it could equally have been one of the other interlocutors who spoke them in connection with our recurrent debate about the vexed relationship between Europe, the USA and Africa. As it happens, we, in Africa, worry our vexed rapport with the developed world in the same way the weak worry the troubled relationship they have with the strong, who impose their will on them without ever bothering to pay them a moment of their attention.

Which perhaps explains why, when later in the same week I sat at my desk to write my talk, soon after accepting to participate at this symposium, the phrases kept badgering me time and time again and without a letup, until I agreed to use them.

Our Problems, Their Gains, indeed!

Africa's history is a shop-soiled one in the sense that as goods go, our people are a damaged people on account of the continent's centuries old contact with the impure thoughts and unclean hands of the colonialists. By virtue of having been reduced to a fall continent, every failing is blamed on us. We've been turned into a metaphor, the place where everything has allegedly gone wrong, according to a perverse logic in which everyone is helplessly poor, where millions are dying of AIDS or related ailments, where communities are warring »over nothing.« Africa is where the do-gooders go, not so much

to do good as to feel good, following the balancing of their guilt accounts; it's also where do-badders go in pursuit of their own self-serving ends, or those of their governments. Africa is the sewer into which the donor countries' unemployables are conveniently drained, and where mediocre persons can acquire »expatriate expert« status and therefore earn far beyond their reach in their countries. A Somali proverb has it that a hundred cures are on offer whenever one person is sick. That Africa is ailing is an undeniable fact. Many of us are concerned with the ever-present question as to what has brought about this stymied state of affairs. Some of us trace Africa's failings to the »black shadows of disease and starvation« – as Joseph Conrad puts it- these being the consequences of the imperialist's genocidal policies that depopulated whole areas of Africa, and sequestered her future.

Considering the time constraints, I will give a very brief outline of why we are where we are and how we got there. At the risk of sounding simplistic I will divide our vexed relationship with Europe into four main timelines: before the arrival of the colonialists, when the continent was not much different from several other continents when we too ate what we grew and didn't feel beholden to external influences; during the colonial era, when, turned into chattels, we were enslaved, sold and transported across oceans, and when Africa became depopulated, with millions of its able-bodied men and women taken away. The third stage coincides with the decade following our flag independence, when we made great strides in every sphere, especially education and in the creation of viable infrastructures. It was our aim to catch up with the other continents, given that the imperialist's indifference to our well being. (Compare the number of schools and students in the Somali peninsula during the colonial era to those who've gone to schools in the first twenty years after flag independence, and you will comprehend my meaning. To my mind, anyone who argues that Africa is doing worse nowadays that it did during the colonial era is playing hide and seek with the truth!) And lastly the present, when Africa is, admittedly, in dire doldrums, and when we find ourselves at the lowest rung of the world's development ladder. Who is to blame?

I suppose that one of our major failing was that we didn't pay heed to the age old wisdom that who puts all his eggs in one basket had better stand guard over it day and night, if only to kept track of where it is, what is happening to it, and what is going into and out of it too. Rather than watch over our basket, we turned our attention elsewhere, purposefully getting down to the serious business of making up on lost time and lost opportunities. In less than two decades, we increased the school enrolments in our countries five hundredfold, built more infrastructures to enhance the number and quality of our institutions, and developed more of our technological capacities than the colonialists did in two hundred years.

Another failing was that we assumed we had got shot of the colonialists. But

no, our dependence on them took a pathological turn. It was as though we couldn't live without them -more like a woman who says she has a brute for a husband, but who won't leave him, because she is hooked on brutality. In fact, no sooner had the selfsame colonialists quit our territories than they returned, as our technical advisors on fat cheques, supplemented with hardship allowances, charged with the task of working on our five-year-plans of development. A few more of them arrived later as part of a package under the rubric »bilateral agreement,« a byword for doctored falsehoods. And when the purchasing power of our local currencies weakened still further, and we couldn't even pay the salaries of our civil servants, and couldn't run our universities fruitfully, and when the teachers of our schools had no chalk and our pupils no exercise books -and we know how this came about, and can name the institutions that are responsible for the diminution of our buying capacities through rigging our economic potential- another term with a twist in the tail became a la mode: foreign aid, state-managed by men and women who operate in the grey area between compassion for those in need and condescension to the same. As a species, the men and women in the aid business are –my apology to Susan Sontag, from whom I'll borrow the phrase- tourists in other peoples' tragic realities. They fly in looking like boys and girls just out of grade school, and move about showily in 4x4s, talking down to everyone and throwing their weight around. Mere tourists, they are unfamiliar with the ways of the peoples, and are downright offensive to other cultures.

But what is my gripe?

My main gripe is with my people: who are short on commitment, but rich in the rhetoric of the mendicant, and whose response to our problems has been zilch. Nor have we displayed a minimum of self-regard, or made the slightest attempts to solve some of these problems in as honourable, as truthful and as scientific a way as possible. Please do not misunderstand me. I am not displeased in my people or dismissive of them, because they have relied on the sweat and produce of other peoples' labour, but because they've continued to abide by other folks' frames of references. What's more, they have handed our problems that are of our making over to other economists, other scientists and other thinkers with their own agendas or their governments. At the very least, we should have had a shot at them ourselves in the dubious hope of becoming beneficiaries of whatever knowledge or experience one might gain from tacking them. If the problems are ours – which no one doubts they are- why should working the solutions out fall to others, unless there is something in it for them, which they say there are not. To-date, our contribution to the exercise has been limited to us providing the paparazzi with our shock troops in the form of starving millions, many of them children and women, the former with flies feeding on their kwashiorkor,

the latter heavily pregnant and unable to move or breastfeeding and skeletal too, and to then making appeals to the international community. Our problems, Their Solutions!

Before resting my case, let me sidestep the question of foreign aid so as to frame it in a way that takes account of the destructive nature of the rapport between the developed world and ours. In a poem titled »Modern Traveller« and published in 1898, the English poet Hilaire Belloc boastfully says,

»Whatever happens we have got
The Maxim Gun, and they have not!«

One is tempted to exclaim, »What arrogance?« or »So what?« and, leaving it at that, walk away from the entire scene. However, one would do well to pause, heed and then retort that Belloc's arrogance is in part due to the fact that we buy these guns and use them on one another until we raise the famines and the resultant starvation, and thus perpetuate our underdevelopment.

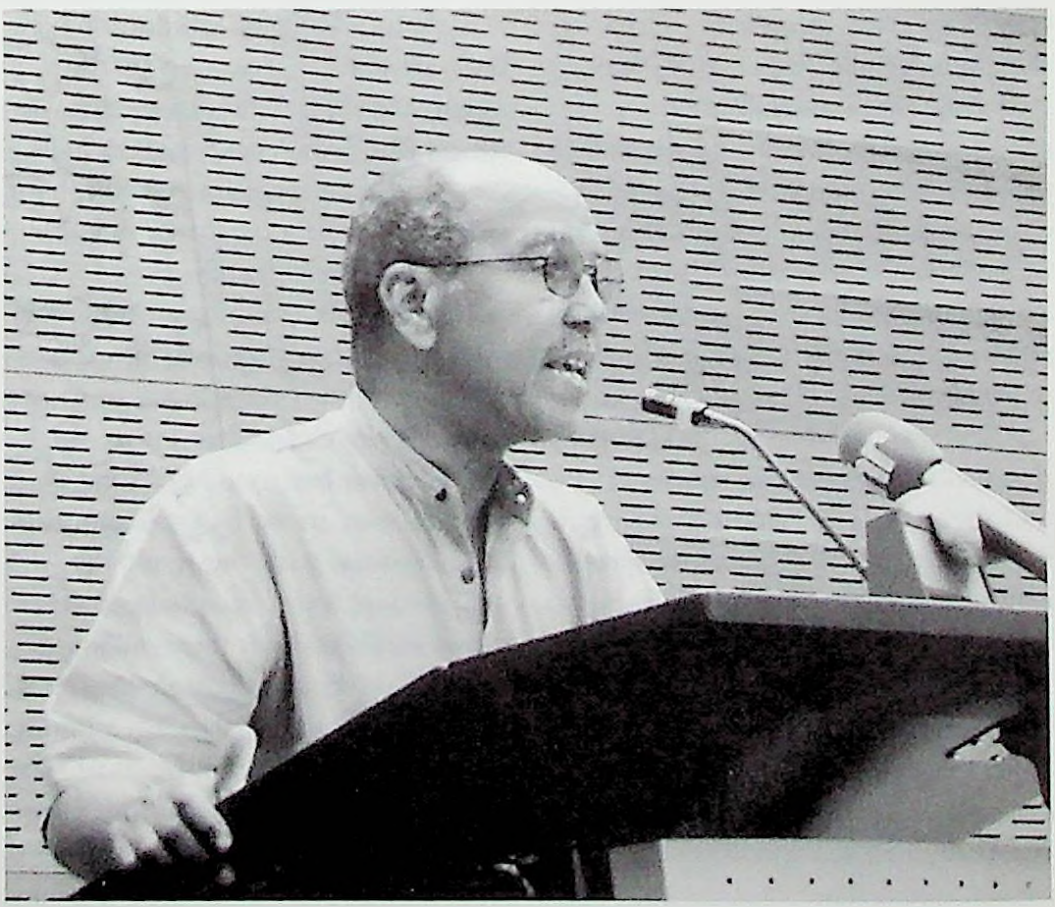
We know that wherever there are guns there will be dire consequences of war, and there is famine. And where there is no democracy, and where state tyranny is as commonplace as malaria is in the tropics, people will feel alienated from themselves. Being alienated and disenfranchised, we sense a false empowerment: that we have more guns than they, and so we attack one another, razing our villages to the ground, with third parties selling more firearms to all the sides. And those that have no guns stay on their haunches forever waiting to be attacked, or expecting help from someone else. Meanwhile, the developed world will dispatch its aid workers and its gunrunners, and before long we're back where we began, with the vicious cycle recurring, and no peace and no democracy on the horizon.

I can think of a country, Ethiopia, which has never known peace and has never experienced democracy, and where famines, wars and centuries-old underdevelopment have worked hand in hand for as long as anyone can recall. Every decade or so, there is either a war feeding on the country, famine, for which the world stage manages an epic performance in a stadium, say, in London or New York, or a state-generated tyranny in which several thousand students are detained. But does anyone care, including the so-called donor countries? Not about peace, nor about democracy, nor about the Ethiopian victims.

No wonder the Ethiopian ruling oligarchy go through life with the expectation that even if they interfere in the political affairs of one countries neighbouring to it by invading it, and then create further havoc by attacking yet a third country, with the result that the wars produce heavy casualty figures close to two millions dead, three million displaced, Ethiopia feels entitled to receiving food aid for its starving millions. I've seen enough African heads of state do what they consider their foot fancywork, blaming the weather, the World Bank and the IM without ever explaining –as in the case of Ethiopia- why they need

a standing army close to a million, and why their arms-purchasing bills come to billions of dollars. You can be sure the Ethiopian Prime Minister, whose creative duplicity knows no bounds, won't admit to being even partly responsible for the upheaval of a region with the population of a hundred million inhabitants, where famines, wars and underdevelopments are the triplets that hold us back.

That Africa has survived is testament to her resilience, especially when you consider what has become of the Australian and the North American native populations whose numbers dwindled through continuous massacres over centuries. But if we want our peoples to be equal partners of the developed, then the world must confront wars, famines and anti-democratic tyrannies with equal venom, discourage gunrunning, and disband the amateur voyeurs who arrive as tourists after a disaster has struck; and no food-giving charities please. Instead, the world must remove the agricultural subsidies put in place to protect the markets that have remained closed to our goods; and no trade embargoes please. This way, we will be able to the redesign our lives, own their problems and will eventually come up with our solutions, and make our gains.



Nuruddin Farah

Dr. Ruchama Marton (Director of Physicians for Human Rights, Israel)

About Loneliness and Radicalism

Israel – Palestine: There is no Reasonable Aid without Political Intervention

In the context of rethinking the power of aid we wish to discuss the unique, if limited, place of Physicians for Human Rights-Israel, (PHR-I): An Israeli NGO that is both a human rights organization and an organization of social solidarity, based on professional-medical co-working.

Our basic defining experience is loneliness, both at home and abroad: certainly not a characteristic global feeling. This is not to say that we do not find support from our colleagues abroad, but rather to stress that loneliness is something we choose. Being part of the perpetrator's society, there are not so many other options opened to us.

An Israeli human right NGO can take the stand of an observer: one that documents and reports the violation of human rights. The language of »objective« documentation is one that is received well by current western-legalistic discourse. Furthermore, it gives the documenter credit in the eyes of international agents that will associate it with reliability. Being »objective«, though belonging to the occupying society, is in itself admirable. Reliability will be attributed to the observer also by certain parts of Israeli society – first and foremost the media, which finds it easier to deal with concise statistics than with long complex arguments dealing with processes.

Another option is to deal with what we in the human rights NGOs community call »cases« – assisting the victims of specific violations – trying to solve their individual problems. Here one would need the knowledge of legal language, a working knowledge of the State structures and authorities, and the willingness to negotiate with the perpetrator case by case.

Practical humanitarian aid does not belong to the human rights organization tradition, but rather comes from charity orientation.

PHR-Israel combines case-by-case intervention with an ongoing struggle against the policy lying at the base of these violations, trying to expose the processes involved.

The character of our work is influenced by the nature of doctors' education that includes the specific bond or connection between time and life. Time wasted can mean death. Doctors are also educated to be very practical – which means dealing with the case at hand. Inherent to their vocation is the sense that they are as God – in their own eyes and their community as well. This bears a huge sense of responsibility. However, in PHR there is another quality – lacking in many doctors – Radicalism.

Radicalism, although it is a choice to many in our organization is not the obvious choice for others. Some of the physicians suffice in responding to an individual's hardship: the patient without treatment or access to treatment, the tortured prisoner, the physician blocked on the way to work. By doing so, they are following the practical aspect of medicine. Gradually, many will turn to the wider point of view that tries to challenge the source and processes that are at the origin of the individual's hardship (occupation, medical infrastructure level, resource redistribution).

There is a tension between the individual and the macro level in our work. Some prefer to give the weight to the individual level and not complicate it by radical thought and action. This radicalism, they fear, is pushing us away from the consensus and thus making our influence on that same consensus and its administration scarce. Furthermore, there is a great temptation in aiding the individual, it makes good pictures on TV and enables empathy and a feeling of identification with the good-doers on the part of Israeli society. We believe it is our duty to be careful not to fall into the warm hug of consensus, and while aiding the individual – never neglect the radical thought that inevitably leads to struggling against the causes of suffering and oppression.

In our understanding PHR-Israel is not allowed to be just an observer to the wounds and destruction of the conflicts. As doctors, we must assume responsibility to heal the sick and the wounded. As an Israeli organization we know the Israeli apparatus of the occupation, and we are aware of its results as social and historical process. It is our duty as Human Rights activists to use this knowledge.

Example: In the UN special delegate to the OT report – Bertini's report – one of the demands from the IDF is to make sure that a Palestinian ambulance will not be delayed at a checkpoint for more than 30 minutes. The International Committee of the Red Cross demanded that this should be no more than 15 minutes. We cannot accept either of these demands: a 15-minute-delay at one checkpoint, excessive in itself, becomes a tour of hours as there are several checkpoints on every route and so the way to or from medical care turns into a nightmare or in other words- a medical crime.

This is why we cannot be satisfied with collecting data on births at checkpoints, or on demanding that soldiers be put to trial. We will insist to show the process by which the occupation has reached these depths: In the past the generally accepted norm was one in which a woman in labor would be allowed free passage to the hospital. In 1991, with the Gulf War, the Gestalt of occupation took over Israeli outlooks to such a degree, that when a curfew was imposed women in labor were no longer an exception in the eyes of the soldiers. Deaths as a result of this approach made it necessary to create written regulations obliging soldiers to allow women in labor passage. It is fair to say that once we found such written regulations necessary (i.e., the

mid-90), we had in fact lost the game.

It is not enough to be an observer or strive for »regulation« that will assist in our dealing with violations case by case. In order to achieve real change, the existence of a group that will demonstrate radical political commitment and intervention is vital. This group – so we see PHR Israel – must not only confront the authorities with the violations defined in the legal language of international covenants but must also demand them to have the moral courage to open their policies to social justice and and basic human morals:

We will give an example

Dr. Hasssan Barghuti, a lecturer in literature at Al-Quds University in Jerusalem, suffered from cancer in deteriorating situation. A hospital in Jordan sent medicine at the recommendation of his physician at Sheikh Zayyed Hospital in Ramalla. A special courier from the Jordanian hospital came to Allenby Crossing with the medicine, but was not permitted to cross to Ramalla. He left the medicine at the Israeli desk at the crossing. The Union of Palestinian Medical Relief Committees contacted PHR-Israel and asked us to help release the medicine for this patient. At first, the Israeli civil administration demanded that we arrange for a vehicle to come to the crossing to collect the medicine.

PHR-Israel insisted that there was no point arranging for a vehicle until authorization was received to release the medicine. The civil Administration then asked whether the medicine was intended for one patient or more, whether it was donated or purchased, whether it was in a box or a bottle, what legend it bore, who sent it and so on. The authorities then demanded medical documents proving that this specific medicine was indeed required of Dr. Barghuti, as well as the precise name of the medicine. While we were attempting to collect all these details – though feeling its absurd – the authorities informed us that the people who were to come from Ramalla to collect the medicine from the crossing must go in a Palestinian vehicle. In Jericho, they must board a bus that would take them to Allenby terminal. There was no point in their doing so, however, since authorization had still not been granted for receipt of the medicine. Our contacts with the Medical coordinator for the Civil Administration, Dalia Bessa, were also unsuccessful, since she also demanded medical documents before approving the passage of the bottle – or box. Two days later, we telephoned our colleagues at UPMRC to update them, only to learn that Dr. Barghuti had died. At the same time, a telephone call arrived from the civil administration, asking for yet another medical document in order to issue the permit for the passage of the medicine. We informed them that the coordination was no longer required.

Could it be that the real factor here was not Israel's security, but rather the habit of controlling the life and death of Palestinians?

How does one report such a violation? How do we translate into an understandable language the sense of medical

emergency (»medical time«), and unveil the shackles placed on each stage by the bureaucracy of occupation? Precious seconds for life are translated into hours of words procedures. How do we bring the seconds back to life? How can we act in what is by definition a system of beaurocratic time whereas in medical time we have no time to waste?

In our medical actions – treating the individual in our Mobile Clinics in the West Bank – which one could wrongly view as humanitarian by nature – we insist on a radical method: We refuse – as medical staff – to ask the army for permits to enter the WB, we refuse their armed escort for »our security«. In this, as well in the very action of crossing into forbidden, segregated territory, we demonstrate a protest against closure, curfew and for freedom of movement. The medical aid itself exists as a part of the act of concrete solidarity enabled by it.

Being an Israeli organization we refuse to treat the crisis in the occupied territories as temporary and as devoid of context. Unlike Israelis who begin the historical account of the current situation from where it is convenient to them (i.e., September 2000 and the breakdown of the Camp David talks), – we are familiar with, and therefore acknowledge, the long historical processes of occupation and dispositions that brought it about. For this reason, we cannot regard the humanitarian crisis in the Occupied Territories as an independent sudden natural disaster. This crisis has led the Palestinian community to rely more and more on the charity of foreign aid. Major General Amos Gil'ad, the Coordinator of Government Activities in the Occupied Territories has said more than once that the Israeli policy in the OT is enabled by the fact that Israel allows the international community to supply the humanitarian needs of the Palestinians. The economic burden of doing so is too high, so says he, for Israel to sustain (12 billion shekels per annum). (Haaretz, July 5, 2002)

The financing of the Palestinian civil systems by international agencies to a large extent funds and supports Israeli occupation policy. In the long run it will abolish the Palestinian economic system, and erode its ability to recover. At the same time it removes responsibility from Israel as an occupier. The demand to accompany humanitarian aid by a constant uncompromising demand to withdraw from the Occupied Territories is not less political than giving such aid without this demand.

Such a demand was presented to MSF Italy by us and also to various delegations – UN included – that operate in the Occupied Territories. It was listened to seriously. Loneliness is therefore not complete. But loneliness is both a choice and a state of mind. It is also the strength to recognize one's unique place in the struggle and use it as a tool.

+ + +

Ulrike von Pilar (Director of Médecins sans Frontières, Germany)

Focusing on Unconditional Humanity

Neutrality Guarantees Room for Manoeuvre for Humanitarian Organizations

I claim it is counterproductive to mix up the different forms of humanitarian aid and to have the same demands on each of them with regard to their political positions. We should be more careful and precise when dealing with the various concepts and competences of aid: Humanitarian aid is only one possible approach – the protection of human rights and development aid are others.

The centre piece of humanitarian aid is the help offered to people in acute situations of violent conflict – that is what it is for and that is the responsibility of humanitarian organizations. They will be judged by their ability to alleviate the lot of these people. This is why the history of humanitarian practice is indeed a history of tragic failure – not necessarily a failure of the humanitarian organizations but rather of the international community, which stipulated at the Geneva Convention that human beings have a right to aid, but who frequently was unable or unwilling to guarantee this right and to impose it. There was no help for the victims of genocide in Armenia. International relief was not provided in Auschwitz, in Cambodia, in China during the cultural revolution, in the Vietnam War or the Gulf Wars, in Kosovo and in Afghanistan at the time of the US bombardment.

The first priority – the most needy

This is the central challenge but it receives far too little attention. The central point is unconditional humanity and the right to aid for survival. This does not come because a person belongs to a particular party but because he or she is a human being. This is expressed in the principle of impartiality: in situations of urgent need there are no good or bad victims. Aid must be offered according to the extent of suffering – first of all to the most needy. Therefore, first and foremost humanitarian work must act independently – only in the interest of the victims, only according to needs. If one mixes these principles, for example, with demands for human rights or for free elections, humanitarian aid will be granted only with political strings. In this case, humanitarian aid would be turned into a political instrument – which it should not be, since it can then justifiably be perceived as outside interference and can lose its humanitarian character and its credibility.

Neutrality, on the other hand, that is, to take no position in a political conflict, is a »tool«, not a value in itself. It guarantees access and acceptance and it pursues no »hidden agenda«.

When one insists that all aid must be political because otherwise the aid becomes an accomplice to existing power, this must then be seen in a more differentiated and clearer way. Medecins sans Frontiers (MSF) has always emphasized that aid never acts nor can take place in a non-political space, that a political analysis of that context and its respective interests (including the interests of aid organizations) is essential. However, MSF generally attempts to stay neutral. We don't have a public position in every conflict and we don't think that every conflict situation calls for a political position. However, first of all we do our best to provide information about the people for whom we work and their reality. Secondly, we do protest publicly whenever there is a massive misuse of humanitarian aid.

But as a humanitarian organization we are not obliged to have a position on all political questions and on all governments.

As catastrophic as the state of human rights was under the Taliban, humanitarian aid was still possible to a certain extend and under difficult conditions.

As MSF we did not directly call for women's rights – others were in a better position to do that. But we were able to document the medical consequences of their incredible restrictions for women and children. Frequently human rights organizations were better able to demand their civil rights than we were – that is their political task and mandate. It is our task to provide practical help for the people on a local level and to insist on humanitarian rights. However, in order to do this we need to reach out with permission of those in power.

Without question there can be no neutrality towards human suffering. But when Thomas Gebauer demands that every aid organization must have a vision of a democratic Iraq, I disagree. As MSF we don't know much about democracy in Iraq, so why should we as an organization have an position on this matter? MSF does call for access for independent humanitarian aid and for the possibility to provide aid. MSF demands protection from violence and the arbitrary use of power for the people. It calls for a system that provides food, water and basic medical care for all. This is the task and the responsibility of a humanitarian organization.

For the people in the midst of war

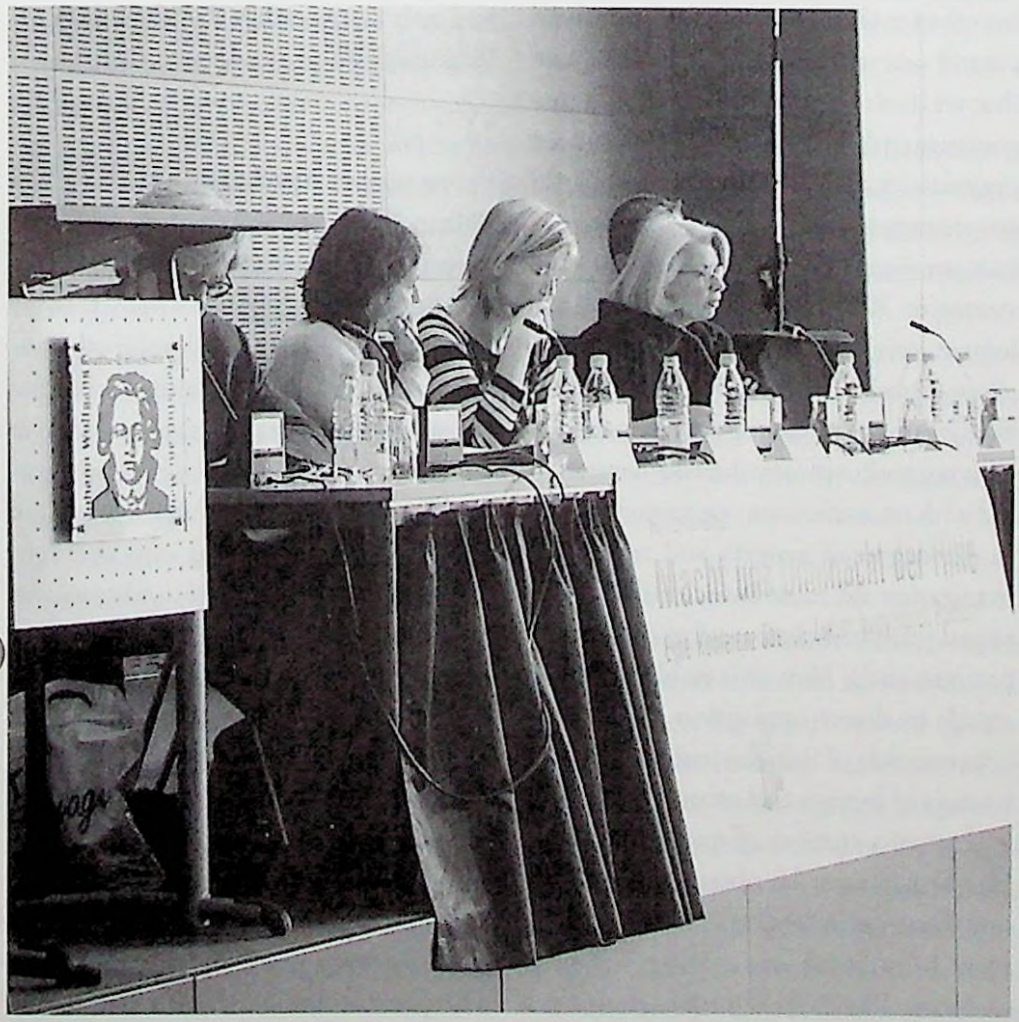
A lot has been said and communicated about humanitarian aid but little is happening. There is plenty of speculation but no one knows exactly what the present situation in Iraq is, yet everyone is talking about humanitarism. In recent years humanitarian aid has increasingly become a communication strategy – terrible political crises are described in the terminology of humanitarian aid, as if this were the only answer to these violence and conflicts. This is not the case. People who are threatened by violence need protection from violence first rather than humanitarian aid. This protection can only be offered by political or perhaps military

actors. But those increasingly offer aid rather than protection – aid as fig-leaf and as propaganda to justify »force protection« or to calm local negative attitudes towards the military.

It is often said that humanitarian aid prolongs war. This might be the case sometimes but thorough, differentiated studies are missing.

Humanitarian aid would humanize war and thereby make it more feasible, is another reproach. But that is precisely the task of humanitarian aid – to help people in the midst of war. The alternative would be the total war. For me this is one of the major achievements of civilization: protection and aid for defenceless human beings in the midst of war. Or would we prefer the following scenario: War starts and the humanitarian organizations leave? This is the solution some would prefer – but for me this would be a return to barbarism.

Translation: Keith Chamberlain



David Rieff, Sabine Eckart, Christiane Grefe and Ulrike von Pilar

Cornelia Füllkrug-Weitzel
(Director of Brot für die Welt / Diakonie Katastrophenhilfe, Germany)

Aid between Humanitarian Service and Social Intervention

Towards a Critical Re-definition of the Political Role and the Ethics of Aid

I shall refrain from making a case against politics and the media. I prefer rather to pose some critical questions to the humanitarian aid organizations ourselves. Questions to us who have committed ourselves to the Code of Conduct, whose central assertion is: »We will take care that we don't become instruments of any government's foreign policy … (we) are organizations which act independently of governments. For this reason we formulate our own procedural and operational strategies. We have no intention to implement government policy … nor will we allow ourselves to become agents of the foreign policy of donor governments«.
This commitment involves humanitarian aid with no exclusions – it responds only to the degree of poverty and need. Humanitarian aid must consciously be protected from being misused to political or partisan ends. Now this noble principle stands in direct opposition to the provocative title of this discussion: »Aid – a hostage of foreign and security policies?« and raises a number of questions.
But first it must be observed generally: one becomes a hostage and an instrument of political power when one feels and acts like a dependent, powerless prisoner who must submit oneself to the political game and its rules; when one doesn't know what political game is being played, what one's role is and how effective one can or cannot be; that is when one remains ignorant and passive and only reacts rather than being knowledgeable and pro-active.

1)

From recent developments since the Balkan Wars we have learned from our western governments and the mass media that in such conflicts in which massive interests are involved and political-military interventions are planned, that the ethical-humanitarian argument is more and more used as a political-ethical justification and that humanitarian aid is increasingly integrated into and subjected to the political war and post-war strategies – so to speak as publicly effective sub-components to ease the painful effects of war. Exaggerating a little, Jens Jessen, writing in »Die Zeit«, recently compared this to the division of labour between a surgeon and an assisting nurse. The former cuts and removes the malignant cancer while the nurse cares that the wound doesn't bleed too profusely.
The present situation gives rise to the claim that humanitarian aid organiza-

tions are increasingly in danger of becoming efficient humanitarian »service agents«, who not only must submit themselves to the logic of war but are also »embedded« into concrete military planning. Humanitarian aid in the entourage of the occupying power is charged with »winning the hearts and minds of the people«. Recently Colin Powell, with unusual candour, called the humanitarian organizations »power multipliers and an important part of our combat forces«. Accordingly guidelines are being prepared to determine who can provide help to whom in accordance with political and military strategy goals.

This sort of cooperation is not the result of argumentative persuasion on the part of governments. It takes shape above all through competition and access to public resources, favourable or unfavourable signals by the mass media and the immense money raising capacity that they provide. The economic logic of humanitarian aid favours an involuntary politicisation. The increasing number of humanitarian organisations who are basically dependent on government support play a central role in these dynamics. In addition, there is an entire range of protection and cooperation offers from the military and governments which enhance the motivation to let oneself be instrumentalised.

Mind you, this is not a moral claim against politics but rather an attempt to describe the real conditions and our weaknesses. Consequently, we have to ask the following questions to ourselves:

- Are we condemned to being »integrated« and dependent? Are we willing to and able to afford to turn down money offered by governments when it is tied to conditions – as recently done in the case of Iraq by members of our own global church network for humanitarian aid ACT (Action by Churches Together) from belligerent countries? Or done by the Diakonie Katastrophenhilfe in the case of Serbia?
- And in any case of doubt, do we put first our own economic interests and market pressure or the principle of humanitarian aid to which we have committed ourselves in the Code of Conduct?
- At what percentage of back-donor-money (government money) in our budgets has the critical limit of our ability been reached to resist a political instrumentalisation?
- Are we in a position to set up counter balances and counter strategies which give us more flexibility not only in Germany but also in the international context?

2)

Our humanitarian credo »not to understand humanitarian aid as a partisan or political act« has not protected us from the fact that in many violent conflicts and wars the humanitarian aid of civilian aid organisations produced clear political effects and emanated political signals. Many of us will remember the accusations from political and media circles that local warlords and despots were maintained and alimented with

humanitarian aid, thus extending senseless wars. Out of the USA emerged the concept »Do no harm« as a guideline for humanitarian organisations to contribute to peaceful solutions through specific and deliberate aid.

Since the Kosovo War and at the latest following the 11th of September we now see in a political roller coaster how western, and especially US policy regards these local conflicts as a global challenge and how a military intervention is perceived as an ethical solution. And the people affected see how humanitarian organisations withdraw their personnel and services in the face of a pending military intervention only to return in the wake of that successful intervention – under the protection of the victorious military forces or even as part of them. Intentionally or unintentionally, humanitarian organisations in these cases also set clear political signals and produced consequences in spite of »Do no harm«, which proves to be obviously inadequate.

Since then we have even seen how humanitarian aid activists themselves called for »humanitarian interventions«. Starting in the beginning as a concept to contain war, humanitarian aid became a legitimisation for war through the emphasis in the so-called »humanitarian imperative«. »Humanitarianism« with the public support of so-called humanitarian organisations became a propagandistic argument for military actions whose real reasons, as we know, were quite different; and barely had the wars begun, and even more after they ended, nobody showed any longer interest in the humanitarian situation of the people – see the Balkan and Afghanistan).

This also raised several questions:

- If it has become clear to us that the action or inaction of aid organisations have political consequences for local conflict parties, the affected populations and international policy, how do we see to it that our activities really »do no harm« (not only in the trivial sense of limiting local conflicts)?
- Should we ignore all of this and, as David Rieff recommended this morning, simply limit ourselves to our »core competence«, deliver the aid and leave the politics to those responsible? I think that the Code of Conduct would not allow this and that impartiality has its price.
- Should we deny this, or at least not mention it, because it is not good for fund-raising? People seems to prefer to give money for uncomplicated humanitarian aid precisely for this reason rather than for long-term development aid, because emergency aid seems to be less complicated as organisations like ourselves (Brot für die Welt and others) have repeatedly called to attention the unjust economic structural conditions which make the success of our help questionable? I think we have to speak about these issues to uncover their abuse. Only that is a useful prerequisite for combating this abuse and for the defence of the good and urgently needed principles of humanitarian aid.

Working in this enlightening way, we cannot simply name the political consequences without assessing their value. But on the basis of which ethical principles shall we do this?

3)

This leads to the last point: I think that it is time to account for our ethical principles as a humanitarian aid organisation, or more generally: to speak about the ethical principles of humanitarian aid. Who are we, the various humanitarian aid organisations and what are our spiritual-intellectual roots? Which religious or political convictions or economic considerations influence the humanitarian evaluation and actions or condition them? What vision and overall strategy play a role in our work, consciously or unconsciously? This has consequences for its quality, too. The Diakonie Katastrophenhilfe (responsible for emergency aid) – as a church aid organisation, definitely not an zeitgeist-organisation and considered by some to be outdated and dismissed like some parts of Europe by George Bush – has never made a secret of the fact that our recognition of the need for non-partisan and neutral aid fits into a comprehensive ethical concept. This concept is not characterized by neutrality but rather by partisan action in favour of the poorest, peace, religious and ethnic understanding, reconciliation, social justice, human rights and human dignity, participation and empowerment and, last but not least, by Christian compassion. All this is part of our evaluation of situations and strategy of aid, as well as our public relations. Being a Christian humanitarian aid organisation which is under the same roof and under the same administration as the development organisation Brot für die Welt and Diakonie Menschenrechtsarbeit and cooperating closely with both, it is probably easier for Diakonie Katastrophenhilfe to relate humanitarian aid with other ethical principles such as, for example, a clear peace and reconciliation commitment without much pondering. (This can also offer some protection from the influence and pressure of a utilitarian and capricious ethic in politics)

As part of a large organisation it is easier for us to make use of the various and specific instruments of long-term development and peace work, lobbying and humanitarian aid through the sharpness which results from this separation, without, therefore, turning blind to the greater challenges and visions, as well as for potential conflicts of objectives without feeling politically powerless. We don't have to realize human rights, peace and development work with our humanitarian aid. But we do have the demands of protection of human rights, as well as peace and development policies in mind when we plan our humanitarian aid strategies. Thus our strategies gain a specific quality which we consider to be indispensable. Humanitarian aid is implemented under the perspectives of sustainability, human rights and human dignity and the promotion of peace. This doesn't impinge upon its neutrality but is part and parcel of its Christian-ethical orientation.

Translation: Keith Chamberlain

Humanitarianism in a state of crisis:

Rethinking the Power of Aid

A Conference on the Future of Humanitarian Aid

March 28–29, 2003
University Frankfurt/Main

Friday, March 28, 2003, 6 pm-10 pm

Opening

Humanitarianism in a state of crisis

- Welcoming address

Katja Maurer (medico international)
Ingrid Spiller (Heinrich Böll Foundation, Berlin)
Prof. Micha Brumlik (University of Frankfurt)

- The humanitarian paradox

Aid in times of war and poverty
Thomas Gebauer (Executive Director of medico international, Frankfurt)

- A win-win situation?

Who is helping whom after all?
Hamsatou Farah (Writer, Cape town/Somalia)

- The case of Israel/Palestine

International Aid and local Human Rights NGO
Physicians for Human Rights – Israel
Dr. Ruchama Marton (President of Physicians for Human Rights, Tel Aviv, Israel)

- Discussion

Aid in times of war
with the participating guest speakers

Saturday, March 29, 2003, 9 am – 9 pm

The reality of aid

- **Welcoming address**

Katja Maurer (medico international)

- **A bed for the night. Humanitarianism in crisis**

David Rieff (Reporter and Writer, USA)

Panel discussion

- **Aid between technical pragmatism and political action**

Sabine Eckart (Project Coordinator, medico international)
Dr. Ulrike von Pilar (Managing Director of Médecins sans Frontières)
David Rieff (Reporter and Writer, USA)
Dr. Martin Salm (Director of Caritas international),
Facilitator: Christiane Grefe (Editor, Die Zeit)

Panel discussion

- **Aid – hostage to foreign and security policy?**

Prof. Lothar Brock (University of Frankfurt)
Cornelia Füllkrug-Weitzel (Director of Bread for the World/ Diakonie)
Horand Knaup (Editor, Der Spiegel)
Claudia Roth (Representative for human rights and humanitarian aid, Federal Foreign Office)

Facilitator: Brigitte Kols (Frankfurter Rundschau)

Satire

- **Brief interlude**

with Matthias Deutschmann

Prospects of aid

3 parallel forums

Forum 1

- **Is there a legal right to aid?**

Keynote: History of humanitarian aid: ethics and interests: Prof. Micha Brumlik (University of Frankfurt)
Input: Right to aid? International law, right and moral: Prof. Dirk Fabricius (University of Frankfurt)
Practice: Human right to aid in theory and practice. Dr. Ruchama Marton (President of Physicians for Human Rights, Tel Aviv, Israel)

Forum 2

- **Aid as social responsibility**

Keynote: Social security needs to be institutionalised in society: scopes in the national and global processes of designing policies: Jürgen Stetten (Friedrich Ebert Foundation, Berlin)
Input: Participative democracy, decentralization, secondary liability – the principles of sustainable societies are also valid in the area of social security: Barbara Unmüssig (Board Member of the Heinrich Böll Foundation, Berlin)
Input: Techniques of aid: Dr. Thomas Seibert (medico international)
Practice: Local and regional models of social welfare: Walter Schütz (medico international, Nicaragua)

Forum 3

- **Can aid be financed?**

Keynote: Financing the 'better world': Which ressources exist? Jens Martens (Board Member World Economy, Ecology and Development (WEED)
Input: The role of ecomomy. Public Privat Partnership: Albrecht Graf von Hardenberg (GTZ, Director of the Public-Private Parnership Programme)
Who wins in win-win-games? Critical reflections on public-private interactions: Dr. Andreas Wulf (medico international, Health Action International HAI)

Concluding discussion and future prospects

- Aid as a challenge to the status quo

Prof. Micha Brumlik (University of Frankfurt)
Nuruddin Farah (Author, Capetown/ Somalia)
Thomas Gebauer (medico international)
Jens Martens (Board Member of WEED)
Dr. Ruchama Marton (President of Physicians for Human Rights, Tel Aviv, Israel)
David Rieff (Writer and Journalist, USA)
Barbara Unmüssig (Board Member of the Heinrich Böll Foundation, Berlin)

Facilitator: Christiane Knauf (Hessischer Rundfunk)

- Closing

Katja Maurer (medico international)

Rethinking the Power of Aid

Aid can never be an ally of war and violence. Helping each other requires empathy and enables us to overcome poverty and dependency.

This idea of aid is subject to enormous pressure these days. Eradicating the root causes of poverty and promoting social development used to be major aims of aid, but today nothing more seems to be left but mere pragmatic action obeying technical and economic criteria rather than social maxims. Donor interests are pushing their way to the focus of attention or, what is worse, the act of providing aid increasingly depends on the extent to which it can be exploited by the media. Aid is bound to become a commodity which is no longer directly linked to those in need, serving as an instrument to mitigate the effects of unsuccessful policies instead. Aid – hostage to global security policy and prevailing informal power structures? It is high time, particularly for aid organizations, to scrutinize their own practices and the ongoing structural change of aid.

The conference »Rethinking the power of aid« hosted by medico international and the Heinrich-Böll-Foundation intended to raise awareness for these issues. A critical analysis was being followed by the question for potential maxims for aid in times of globalisation. Because a different kind of help is possible – and necessary.

medico international

NGO-8.

THE IMPERATIVE OF EQUITY: THE MISSING DIMENSION OF UNCED

STATEMENT OF THE SOUTH ASIA NGO SUMMIT
NEW DELHI
FEBRUARY 17-19, 1992

CENTRE FOR SCIENCE AND ENVIRONMENT

THE IMPERATIVE OF EQUITY: THE MISSING DIMENSION OF UNCED

STATEMENT OF THE
SOUTH ASIA NGO
SUMMIT
NEW DELHI
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CENTRE FOR SCIENCE AND ENVIRONMENT

The South Asia NGO Summit was organised by the Centre for Science and Environment (CSE) in New Delhi from February 17 to 19, 1992, to discuss the agenda of the United Nations Conference on Environment and Development (UNCED).

We are grateful to the following without whose financial help the Summit would not have been possible:

- *United Nations Development Programme (UNDP)*
- *Danish International Development Agency (DANIDA)*
- *Indo German Social Service Society (IGSSS)*

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THE IMPERATIVE OF EQUITY: THE MISSING DIMENSION OF UNCED

Statement of the South Asia NGO Summit
New Delhi, February 17 - 19, 1992

PREAMBLE

South Asia is a region that represents more than one-fifth of the world's human beings. It is today also a region of acute poverty and economic and technological backwardness. But it was not always so.

Less than 300 years ago, it was one of the world's most urbanised and richest regions which attracted traders from all over the world. This wealth was built upon the sustained use of local natural resources which was governed through extensive management systems in which both local communities and the state played critical roles. The extraordinary ecological diversity of the region — ranging from the cold deserts of the Karakoram and Ladakh to the hot sandy desert of the Thar, from the high mountain temperate forests of the Himalaya to the lush tropical forests and vast mangroves of India, Bangladesh and Sri Lanka and from the sharply dissected mountain lands of Nepal and Bhutan to the unending, flood-prone plains of Pakistan, India and Bangladesh — gave rise to an equally extraordinary cultural diversity which embodied within it rich traditions of ecological management and resource use. In large parts of the region, however, colonialism and subsequent centralised interventions completely disrupted and transformed the local economic, ecological and cultural systems and left the region in a state of all round impoverishment.

Economic development of the last four decades also did not take into account either people's own wisdom about their natural resources nor did it hand them back power to manage their environment. The result has been continued exploitation

of the resource base without any discipline or care for future impacts. International banks and agencies have consistently pushed and imposed a Western model of development that is unsuited to the ecological and economic needs of the region and have, as a result, exacerbated pressures on the local resource base. This model is urban elite oriented and the distribution of resources is at the hand of urban elites and bureaucrats. Therefore, the gap between rich and poor has widened in the past and the process is still continuing. The international monetary system has further pushed the region to the brink of economic chaos through rising indebtedness, imposition of unrealistic conditionalities and declining terms of trade.

The main objective of the UNCED conference is to identify and promote a plan of action that will make this earth a better and safer habitat for all to survive and develop. We strongly urge the conference to develop a truly global agenda that responds to the present and future needs of all human beings on earth. We also urge the conference to develop systems of global ecological and economic management that will be equitable and fair, in which all will have equal access to and capacity to influence the global checks and balances that are sought to be created. A fair and safe world cannot be built by using levers of power that rest largely with the rich and the powerful, whose consumption and production is the main cause of global ecological destruction in the first place. Sustainability is not possible or desirable without equity and fairness. We are also firm in our belief that each human society on earth has the capacity to develop its own wisdom and equilibrium and contribute richly to the growth and development of others. An ecologically diverse global habitat demands a multicultural world in which all cultures and societies are equally respected.

It is keeping this in mind that the South Asia NGO Summit has endorsed the following resolutions which we urge individual governments, the proposed Rio conference and other NGOs to consider in all seriousness.

A

THE EARTH CHARTER:

Both equity and sustainability must be stressed.

We call upon the governments of the world to ensure that the Earth Charter endorses the following basic minimum principles:

1. The right of all nations to development.
2. The right of all human beings to a clean and healthy environment.
3. The right of all human beings to equality in access to and use of the global commons like the atmosphere and oceans.
4. The right of all human beings to any information that threatens or affects their health and environment, whether this information exists within or across national borders.
5. The right of all human beings to participate in the governance of their environment on an ongoing basis through participatory democratic institutions, beginning at the community level and going on to higher levels of governance.
   a) At the international level, new mechanisms should be created which allow all citizens of the world equal opportunities to participate in global environmental management. The existing levers of power such as aid, trade and debt, which are available mainly with the North cannot be used as a basis for global environmental management and should not be used to impose new conditionalities on the South. The North should review the indebtedness of the South which in most cases has become an unbearable burden.
   b) All nations at UNCED must take a pledge to develop a new tier of governance within their countries — a tier of community level governance through open, participatory institutions with inalienable rights over their immediate environment to care for, use and manage.
6. The world economic order should be built on the principle that all human beings, and especially the rich, must pay the full ecological costs of their past and present consumption.

B

AGENDA 21:

Action priorities should be set by the poor but only after the rich agree to pay the full costs of their consumption.

The Agenda 21 as it stands today appears to be a donor driven mechanism for aid coordination. It fails to address the needs of the developing world. This summit demands that UNCED must move away from a view of global environmental management which sees it as a question of additional aid funds or technology transfer. The Agenda 21 should emerge out of the rights and obligations of all citizens as enumerated in the proposals for the Earth Charter described above. The South must not ask for aid and charity but for a fair share of the common global resources.

Therefore, we demand that a global consumption tax be levied so that the rich pay for their excessive consumption of past and present world's resources. The tax should be determined and administered by a democratic global institution where every member will have equal voting rights. The revenues so raised should go to poor local communities through a democratic mechanism to manage and improve their environment since it is they who bear the burden of the ecological costs of unplanned development and consumption.

C

FUNDING MECHANISMS:
Reject the GEF and develop an automatic and democratic mechanism.

As an instrument for transferring funds to the South for environmental management, the GEF is undemocratic because its decision making mechanism is donor weighted; and, it is also immoral in that it places control of financial resources in the hands of nations who have created the problem in the first place. The GEF also falsely differentiates between what is 'global' and 'local' and thereby distorts the priorities of the South. It represents not a compensation for the environmental misdoings of the rich, but a continuation of the old aid order. It is like the relief support that the North generally gives to the South after a disaster. We, therefore, forcefully reject the GEF. Instead a new fund should be created at UNCED on the principles enumerated earlier and administered through a democratic and decentralised institutional setup.

D

POVERTY AND ENVIRONMENT:

The South must stress this as a key issue for discussions.

The UNCED process has paid inadequate attention to the key question of poverty in the South and its links with environmental degradation. The poor depend heavily on their immediate surroundings to meet their survival needs of food, fodder, fuelwood and water. Overexploitation, expropriation and degradation of land and water resources by powers beyond their control force the poor to the brink of survival. They then lose their ability to withstand natural disasters and, in sheer desperation, are forced to exploit their natural capital beyond sustainable limits.

For governments of South Asia, poverty alleviation has been a stated priority. Yet they have done little to insist that the UNCED address this crucial issue. It is essential that our governments impress upon those of the North that poverty is a consequence and not a cause of environmental degradation. It becomes a cause only in extremely desperate economic conditions, the trigger for which often lies in unequal and ecologically unsound economic strategies. A world in which a large proportion of the population lives in abject and dehumanising poverty can never be sustainable. Both the national and international causes of poverty must be clearly identified and eliminated if environmental disaster is to be averted and the poor of the world given a fair chance to survive as a matter of human right.

Environmental degradation and poverty in the South are strongly linked to global processes of trade and economic relations. Growing debt and declining terms of international trade for mineral and biomass products make it impossible for developing countries to incorporate the ecological costs of their production. The rich are not even paying a fraction of the ecological costs of their enormous consumption and are being constantly subsidised by the global poor. In addition, the debt crisis has resulted in a situation in which the South today actually transfers US$40-50

billion every year to the North, leaving precious little to invest in environmental management or poverty alleviation through development. The policies of the IMF, World Bank and other North based financial institutions consistently devalue the natural resources of the South and make them ever cheaper.

At the national level, poverty has increased greatly because of:

a) constant imports of inappropriate development paradigms, often under pressure from international agencies like the World Bank;

b) a steady erosion in the rights of local communities to their environment;

c) a widespread failure to develop participatory systems of governance;

d) undemocratic and inequitable distribution of resources in the society; and,

e) widespread corruption and misuse of resources by political systems that are not adequately accountable to the people who vote for them.

If we want to eradicate poverty, then, at the international level, the rich must be made to pay the full costs of their consumption through an international consumption tax. Since it is the poor who suffer most heavily from ecological degradation, the revenues thus generated should be made available to local communities, through a democratic and decentralised mechanism which is accountable to the people, to regenerate and manage their environment. An international employment programme which guarantees survival wages to all poor people across the world would cost only US$30-40 billion every year. But it will not only ensure that nobody goes to bed hungry but also provide an extraordinary opportunity for harnessing the labour power of the poor for the ecological regeneration of their own habitat through afforestation, grasslands development, soil conservation, water conservation etc. Such a global programme should be financed through a global consumption tax on all the world's rich both in the North and the South. The North must take the lead to accept its share of global responsibility.

At the national level, governments must develop systems of participatory governance that ensure that control and management of the environment rests with local communities. Wherever local communities have been involved in the control and management of their resources, it has been possible to protect the environment and regenerate its productivity. We are proud to say that NGOs across South Asia have repeatedly shown through their work that community self governance has invariably led to improved environmental management. Some of the best examples are those of the Orangi Pilot Project in Karachi in the urban context; the villages of Sukhomajri, Nada, Seed, Bhusadia and Ralegan Siddhi in India; and, the Grameen Bank in the flood affected plains of Bangladesh. In Nepal, rural communities continue to manage their fragile Himalayan environment with great care and labour inputs. The enormous labour inputs of the poor in environmental management — such as those of the Himalayan farmers in terracing their agricultural fields — remain an invisible factor in national economic calculations even though their contribution is often far more than official expenditures, whether they result from national funds or foreign aid.

If investments in land, water, minerals and forest resources are to be productive and poverty eliminated, efforts to develop and strengthen democractic and participatory insti-tutions at the grassroots is essential. The nature of effective participatory institutions will be determined by local cultural, social and economic conditions. Experimentation in this area is urgently needed so that appropriate community institutions can be legally empowered to manage local environments.

GLOBAL WARMING:

The Climate Convention should be signed only when equal rights of all to the atmosphere are accepted.

Excessive burning of fossil fuels over the last century has led to a global greenhouse effect which is largely the result of rapid industrialisation and heavy energy consumption in the North. In fact, the North has been able to undertake cheap industrialisation only because it could encroach upon the ecological space of the South without any compensation. In the process, the North has accumulated an enormous ecological debt. If the North continues emitting greenhouse gases in the same way, the earth's atmospheric processes will be further destabilised. It has been argued by the Inter-governmental Panel on Climate Change (IPCC) that the likelihood of global warming is very high and, if no immediate action is taken, it will be too late to reverse the processes of global warming later.

Though caused by the North, the effects of global warming will be borne heavily by the South, which has hardly any financial or technical resources to deal with the problem. With a rise in sea level, South Asia, which has large low-lying areas, will become one of the most affected regions in the world. If the sea level rises by one metre, more than 17.5 per cent of the total land area of Bangladesh will be inundated. Some 40-50 million people will be rendered homeless and infrastructure worth billions of dollars will become useless. Scientists also predict that cyclonic storms will intensify in the Indian Ocean region if sea surface temperatures rise. Increased ice melting in the Himalaya together with changes in rainfall patterns could inundate vast areas of the flood plains of the Ganga-Brahmaputra-Barak basins which will multiply the miseries and sufferings of millions of people. As a large proportion of its population lives at or below the poverty line, and remains heavily dependent on a biomass-based subsistence economy, South Asia will be devastated by the dislocation brought about by global warming. Poverty and global warming will together form a deadly combination for the poor millions living in coastal, arid and semi-arid areas of the region.

We believe that those who have created the problem of global warming must bear the costs of preventive and corrective action and compensate others for the use of their ecological space. The North must adjust its patterns of production and consumption to mitigate the threat to the earth's atmosphere. It is both its moral and legal responsibility to prevent and repair any environmental damage that is likely to be inflicted upon others. The North must also develop mechanisms to speedily communicate the results of its researches on global warming to the South. Developing countries should aim for net zero deforestation through sustained use of existing natural forests and not merely by plantations.

Any management system that is developed to limit carbon dioxide emissions and thus stabilise world climate must be based on the following principles:

a) All of us must learn to live in harmony with nature, that is, reduce our total emissions to a level that is considered to be sustainable in participation with scientists from the South.

b) All human beings should have an equal right to the total emissions that the atmosphere can bear on a sustainable basis.

c) The South must be compensated for the atmospheric space that the North has been using to date.

While we are fully supportive of the firm stand taken by South Asian governments thus far in international negotiations relating to the climate convention, we believe that they must insist upon the above principles in all negotiations. Under no circumstances should the governments of South Asia agree to a framework convention which would dilute the above principles and thus mortgage our future. No framework convention should be signed which does not include the basic minimum principle that all human beings have an equal right to the atmosphere. The governments must remember that they have to protect the interests of both the present and the future generations of South Asia.

The South should not be seen again as holding out the begging bowl for "new and additional resources" or calling for "technology transfer". Instead, the South should demand compensatory measures from the North for errant behaviour as a matter of the South's right over global resources.

F

BIODIVERSITY CONVENTION:

Refuse to sign the convention until major contradictions are resolved.

The proposed convention on biodiversity does not deal only with the subject of biodiversity conservation. In return for its support for biodiversity conservation the North is demanding access to the world's biological resources, which are largely concentrated in the South. Since the convention is attempting to deal with both these issues, it raises numerous complex issues which must be resolved before any convention is signed.

There can be no doubt that biological diversity needs to be conserved both for its own sake — all living species have a right to exist — and for the benefit of all humankind. In an ideal world, given the fact that people all over already use biological resources from far flung corners of the globe, these resources should be commonly available to all to use and conserve. But the principle of 'common heritage' has been misused by commercial interests in the North to monopolise and plunder the biological resources of the South while restricting access to genetic materials and associated technologies based on these resources. This Northern approach is both unfair and ecologically unsound. While the measures taken under the proposed convention would make access to biological resources easier, the new life forms and technologies emerging from these resources would be strongly privatised through powerful patents under the proposals being pursued in the Uruguay Round. Any effort therefore to improve access to the biological wealth of the South would lead to an extremely inequitous situation. It is obvious that we cannot have one set of negotiations that aim to privatise knowledge and biotechnologies while another set seeks to globalise the biological resources on which this knowledge and biotechnology is based.

Recent legal and technological developments in fact threaten the very biological diversity that is sought to be conserved, and also restrict access to biological resources and associated biotechnologies. These include:

a) Intellectual property rights, both as plant breeders rights and patents on life forms and biological processes;
b) Commodification of biological resources for purpose of monopoly and profit; and,
c) Increasing genetic uniformity in cultivated/domestic species.

We also believe that there are strong links between the proposed conventions on climate and biodiversity. Developing countries are being asked to protect forests under both these conventions while the North is not prepared to make any serious commitments on carbon dioxide reductions under the climate convention. If developing countries sign the biodiversity convention they will legally bind themselves to a major committment sought by both conventions without the North committing itself to anything serious in either.

Moreover, we question the legitimacy of our governments to negotiate access to biological resources, without consulting and involving in decision-making, the local communities which have customary rights to these resources. It is these communities which have nurtured these resources and have developed a wealth of knowledge and skills related to their use. Any process of international negotiation must evolve through an internal process of public debate, in particular involving local communities. This has not been done at all in the case of the Biodiversity Convention.

Current strategies for biodiversity conservation, often emanating from Northern agencies, are extremely anti-people, relying heavily on fences and guards. Participatory biodiversity conservation strategies must be developed urgently — an activity that requires enormous experimentation. More of the conventional protectionist approach, resulting from increased global availability of funds through mechanisms like the biodiversity convention, could severely affect local communities living in biodiversity rich areas.

Considering the fact that all these critical issues have not been satisfactorily resolved, we strongly urge upon our governments and those of the North not to rush into signing a convention which does not satisfactorily address and resolve the above issues. Southern governments cannot negotiate away our biological resources — one of our most critical assets — in such a hurry by June 1992, and in the absence of meaningful citizens' participation in the negotiating process and of local communities, especially tribal communities.

NGO Relations:

Northern NGOs must consult Southern NGOs adequately before espousing global causes.

This group is acutely aware of the disadvantage that Southern NGOs repeatedly find themselves in getting access to and influencing international negotiations as compared to Northern NGOs. Most NGOs working in the South have remained uninformed about the ongoing issues in UNCED and the related conventions, for which we hold the UNCED secretariat responsible. The resources needed to attend these conferences which usually take place in Northern capitals are extremely limited. Even information flows to Southern NGOs in terms of official documents have been extremely small. The rapidly changing national positions make it even more difficult for Southern NGOs to keep abreast of and analyse the developments taking place in distant places regardless of their importance to the national and local constituencies they work with. Northern NGOs often form their global perspectives without adequate discussions with and inputs from the South. We therefore call upon Northern NGOs to recognise this inherent imbalance in resources that Southern NGOs suffer from and ensure that global positions are taken only after adequate discussions. A lack of such efforts leads to confrontations which can be easily avoided, and unnecessarily hamper efforts to build up a truly global partnership on environmental issues.

We also call upon our own governments to consult NGOs regularly before they adopt national positions in international environmental, trade and economic fora. National governments and the SAARC secretariat ought to develop mechanisms for consultations with NGOs at the national and regional levels, respectively. The proposed meeting of SAARC Environment Ministers should pay attention to the conclusions of the South Asia NGO Summit on UNCED.

SOUTH ASIA NGO SUMMIT

NEW DELHI, FEBRUARY 17 - 19, 1992

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The World Bank's Private Sector Development Strategy: Key Issues and Risks

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Contents:

Chapter 1 Introduction

The past century has seen unprecedented improvements in the health status and a reduction in mortality rates across the world. However, since the mid 1980s the rate of decline in child mortality rates has slowed substantially. This has been felt most significantly in low-income countries in Sub-Saharan Africa and South-East Asia, where mortality rates have started to increase again in a number of countries (Simms et al., 2001). Whereas since the early 1990s major achievements have been made across the world in the improvement of health status, such as a halving of deaths from diarrhoea among young children and a one third reduction in under-five mortality rates in 63 countries, many targets have remained unfulfilled, especially in the poorest regions of the world. In Sub-Saharan Africa, the region with the highest child death rates, less than half of children under one are fully immunised against DPT, which marks a decline compared to 60% recorded in 1990, while the total number of malnourished children has increased during the 1990s (Hilary, 2001). The road to achievement of the Millennium Development Goals (MDG), agreed at the Millennium Summit of the United Nations in September 2000, calls for a dramatic reduction in poverty and marked improvements in the health of the poor, but there is still a very long way to go to achieve these goals.[1]

There are various interrelated reasons for the continued ill health and the deteriorating situation in the poorest countries. Among the most prominent ones are poor economic performance, continued or increased poverty, health systems failure and the HIV/AIDS pandemic (WHO, 2001; World Bank, 2000; Simms et al., 2001; Hilary, 2001). Health systems failures have been widely attributed to public health expenditure cuts, associated with the economic crises in the 1970s and 1980s; to structural adjustment policies applied in response to those crises, including an even further reigning in of social expenditure; and to a general lack of effective measures to protect the poorest and ensure their access to basic social services. The debt crisis, which in the 1990s has become increasingly an African crisis, has led to large amounts of funds being used for debt service payment at the expense of the provision of basic social services, including health care.

Until the early 1990s the health sector was still viewed as a non-productive sector. This view has been reversed, and it is now firmly established that improving health and health care plays an important role in pursuing economic development and poverty reduction (WHO 2001). This is also reflected in the key role that the Poverty Reduction Strategy Paper (PRSP) framework plays in general development policy in an increasing number of low-income countries, and in the recognition of the importance of increased resource allocation to the social sectors, including health care. Nevertheless, the health care sector in low-income countries remains severely underfunded. Average per capita public health expenditure is estimated below $10 per year in Highly Indebted Poor Countries (HIPC), and has been substantially less than that in many of these countries (World Bank, 1997; Simms, et al. 2001). These figures fall far short of the $12 per capita required to finance the cost of an essential package of clinical services and public health interventions, as defined by the World Bank in its World Development Report 1993; the $13 per capita required to cover the cost of a basic health care package in low-income Africa, as advocated in the World Bank's Better Health for Africa report in 1994; and the $30-40 per capita health spending required for low-income countries as minimum financing to cover essential interventions, according to the WHO Commission on Macroeconomics and Health (World Bank, 1993; World Bank, 1994; WHO, 2001).

[1] Among the MDG are the halving of the proportion of people who live in absolute poverty, and a reduction of child mortality by two thirds and of maternal mortality by three quarters by 2015. The MDG include 17 health indicators.

While in the 1980s the state was seen as the primary player in the health sector, in many countries the government role as a service provider has diminished considerably. A key element in the health sector reforms underway since the late 1980s, promoted by the World Bank and other international organisations, involves a redefinition of the role of the state, promoting a retreat of government from its role as provider, while increasing its role in policy making, financing and regulation. At the same time the share of the private sector in health care delivery has increased. This was first articulated by the World Bank in its 1987 report on health care financing (World Bank 1987), further elaborated in its 1993 World Development Report (World Bank 1993), and again called for in the 1997 World Bank's Health Nutrition and Population (HNP) sector strategy (World Bank 1997).

The World Bank has become the largest external source of financing of HNP activities in low- and middle-income countries, with a total net commitment of $ 9.3 billion in 2000 (IFC 2002). It has recently launched a Private Sector Development (PSD) strategy, which involves support to increase private sector involvement in the provision of basic services, with the aim to increase equitable access. The profile of World Bank lending can be expected to change under the impetus of the PSD strategy and this is likely to have an effect on other lending institutions and donor agencies that have a tradition to adopt new World Bank policies and strategies.

The main purpose of the current paper is to raise and critically assess key issues and risks with regard to the possible effects of the World Bank's PSD strategy on achieving equitable access to health care for all, with a focus on the possible consequences for the poor in low-income countries. The paper intends to provide civil society organisations/NGO's in low-income countries with arguments in the policy dialogue with their governments.

This paper starts from the premise that health is a fundamental human right as defined by the United Nations in article 25.1 of the Universal Declaration of Human Rights: *"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services"*. The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, state parties recognise *"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*, while article 12.2 enumerates, by way of illustration, a number of examples of state parties' obligations. The right to health is not to be understood as a right to be healthy, but rather as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health. These include, amongst others, timely and appropriate health services, which are accessible, acceptable and of adequate quality; other services and conditions, which relate to the underlying determinants of health, such as safe water, sanitation, food and housing; as well as the establishment of a legislative framework, as one of the obligations of the state. The right to health, like all human rights, imposes three types or levels of obligations on the state: obligations to respect, protect and fulfil. The obligation to protect requires the state to take measures that prevent *third parties* from interfering with article 12 guarantees. It includes, amongst others, the duty of the state to adopt legislation or to take other measures ensuring equal access to health care and health-related services by third parties; to ensure that privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; and to control the marketing of medical equipment and medicines by third parties (UN Economic and Social Council, 2000).

After this introductory chapter, chapter 2 contains a description of the PSD strategy, with a focus on its social sector component, which includes health. Chapter 3 discusses key issues and risks related to the strategy. It starts with a number of general observations on two World Bank documents that outline the PSD strategy, and a discussion of the novelty of the strategy. Next, a review is given of the argumentation to focus on private sector development and of the evidence from the public-private mix debate in the literature in relation to the achievement of affordable access to quality health services. We then elaborate on the importance of making a distinction between for-profit and not-for-profit providers, and between various forms of private sector involvement in health care. It discusses the potential consequences of private sector involvement for equity and efficiency, and related issues such as contracting, regulation, and targeting of support to the poor. The discussion concentrates on health care provision more than on financing, since this is also the main focus in the PSD strategy. We further examine the issue of national and international policy coherence, in particular the relationship of the PSD strategy with other international policies and initiatives, such as the PRSP policy framework, and global regulations on international trade, such as GATS and TRIPS. Chapter 4 contains conclusions and recommendations, which may help NGO's strengthen their position in the dialogue with their respective governments.

Chapter 2 Features of the PSD strategy

This chapter provides a summary of the Private Sector Development (PSD) strategy, as laid out in the document issued in April 2002 under the title *Private Sector Development strategy – Directions for the World Bank Group* (World Bank, 2002). It zooms in on the proposed PSD initiatives in the domain of basic social services, including health and education, which seem to concern only a small part of the entire PSD strategy document. This chapter also draws on a document written by the International Finance Corporation (IFC) [2] under the title *Investing in Private Health Care: Strategic directions for IFC* (International Finance Corporation, 2002).

2.1 Overview

The World Bank's PSD strategy starts from the premise that private sector development is key to promoting growth and poverty reduction, in parallel with and complementary to public sector efforts. PSD is proposed as a strategy pursuing a good balance between the complementary functions of the State and the private sector. "It is about judicious refocusing of the role of the state, and not about indiscriminate privatisation." Sound government policies that provide room for private initiative and that set a regulatory framework which channels private initiative in ways that benefit society, are considered critical. The PSD strategy document acknowledges that this requires institution and capacity building and that PSD strategies for individual countries need to be owned by their respective governments. It emphasises that country- and sector-specific PSD approaches should build on country-driven consultation processes. The strategy comprises several components, which are outlined in Box 1.

Box 1: PSD strategy components

A. Extending the reach of markets, by:
   1. Enhancement of the investment climate
   2. Provision of direct public support to private firms

B. Improving access to basic services, by:
   1. Private participation in infrastructure services
   2. Private provision of social services (primary education and basic health care)
   3. The use of output-based aid (OBA) schemes

Enhancement of the investment climate (A-1) would be achieved through continued deployment of lending operations and capacity building, particularly to reduce "unjustifiable obstacles" to private business and to establish secure property rights. In addition, investment climate surveys would be supported. Direct public support to private firms (A-2) would be provided in terms of advisory services and credits, involving both the IBRD/IDA and the IFC. Support for private

[2] The IFC forms part of the World Bank Group, which further comprises the International Bank of Reconstruction and Development/International Development Association (IBRD/IDA) and the Multilateral Investment Guarantee Agency (MIGA). The IBRD/IDA is the Bank's soft (concessional) loans arm, while the IFC is the Bank's commercial loans arm. The MIGA provides investment guarantees.

participation in infrastructure (B-1) focuses on telecommunications, energy, transport and water and sanitation. The current paper does not deal with these types of support. Below we will summarise the main features of World Bank Group support to private provision of social services (B-2) and the use of output-based aid (OBA) approaches in working with the private sector (B-3).

2.2 Support to private provision of health services

The PSD strategy document considers it a challenge to build nation-wide health systems that provide affordable quality access, especially free access to basic health care. It states that it will be important to find the right mix of private and public provision that increases access to services of adequate quality, which is largely determined by country- and sector-specific conditions. It emphasises that work with the private sector will be done side by side with unabated support to public health services. The policy, regulatory and funding role are considered clear and crucial tasks for the state that cannot be fulfilled by private unregulated markets. Major capacity and institution building of public sector agencies is required to fulfil this role. While public provision of basic services is considered a key component of current national health systems, the PSD strategy document asserts that the reality in low-income countries is that poor people often rely on the private sector for the provision of basic services, reflecting either the absence of public services or people's choice to bypass such services. The document suggests that private providers are not in all cases systematically better than public providers, but that under appropriate regulatory regimes they can expand and provide quality services at low cost. It highlights in this regard the clear contracting and regulatory challenges that exist in relation to private provision, which – if not properly dealt with – harbour the risk that private markets may end up providing low quality services.

The private sector for health care, as defined in the PSD strategy document, is a broad concept, which comprises both for-profit and not-for profit service providers. Examples of the latter are religious, NGO-operated and community-financed institutions. For-profit providers comprise modern as well as traditional providers. The document indicates that clients may put a great deal of trust in not-for-profit organisations, enabling them to make a substantial contribution to service delivery, and possibly to out-perform for-profit providers under competitive conditions.

The PSD strategy document further underlines the need to make a distinction between financing and the provision of health services. The government has the undisputed responsibility to ensure that services are affordable to all layers of society and that services with positive externalities are sufficiently provided.[3] To achieve this, it needs to institute appropriate financing schemes. But instead of trying to provide all services through its own public health institutions (hospitals, clinics, health centres, laboratories), the government through its financing role should consider using private institutions and firms for the provision of certain services by providing funding to them. This would be appropriate in areas where private institutions have a comparative advantage over public ones. It would relieve the government from some of its duties and enable it to concentrate on its core functions, namely that of policymaking, strategy development, regulation and resource mobilisation.

[3] Externalities refer to effects on people (or agencies/institutions) that are not directly envisaged by providing a particular service. Immunisation services, for instance, are considered to have large (positive) externalities, since they do not only protect the individual clients, but also the community as a whole by affecting the transmission of infectious disease. Health education is another example of a service with (positive) externalities.

The World Bank sees for itself an important role in assisting governments in the assessment of the potential role of private sector involvement and in establishing an appropriate enabling environment. This would include clarifying the strengths and weaknesses of alternative forms of private participation, market structure arrangements, regulatory approaches, strategies for improving universal access to services and financing approaches. The Bank would focus on developing policies, institutions and capacity to support private participation in the health sector, and it would typically do this through programme lending and provision of advisory services, using IBRD/IDA channels.

The PSD strategy document proposes that in certain cases it may also be possible to *directly* support private firms that engage in the provision of health services. Financial investments should preferably be provided via the IFC. The document supports the continued expansion of IFC involvement in low-income countries and it promotes strong collaboration with the IDA, for example through OBA schemes (see section 2.3 below). While IDA will work with governments to develop policies, institutions and capacity to support effective private forms of participation in the health sector, IFC will increase its involvement in direct lending for the expansion of private firms, in particular *private for-profit firms*, engaged in the provision of health services.

The establishment of a new group [4] (in April 2000) within the IFC and its transformation into the IFC's Health and Education Department (in September 2001) reflects IFC's ambitions in the social sectors. The department elaborated the above mentioned strategy document *Investing in private health care: strategic directions for IFC* (IFC, 2002), which claims that reliance solely on the public sector to address the main challenges in the quest for universal and good quality health care is no longer a viable or sustainable option because of fiscal constraints. The document is more specific than the PSD strategy document, since it deals solely with health care. The desired IFC investments fall into two categories: a continuation of already existing investment activities, predominantly in the hospital sector; and an expansion of investment into new growth areas, including private health insurance, pharmaceuticals, medical devices, biotechnology and health workers education and training. In terms of geographical distribution, the IFC will concentrate on specific countries in seven different regions.[5] So far, IFC financed institutions have tended to cater primarily to the lower-middle and middle classes. The ambition, however, is "... to target a very broad spectrum of the patient population, including poor people, particularly in situations where the private sector is the service provider for the state."

The PSD strategy document asserts that the World Bank's own efforts to better understand the role of the private sector are just starting and that its knowledge is still embryonic. In this regard, it underlines the challenges of strengthening analytical work and broadening the options for engaging with private forms of health service provision in a way that is consistent with overall sector policies. The document also recognises that private participation in the health sector, while widespread in reality, remains "a highly contentious issue", but remarkably *it does not elaborate on the possible pitfalls*. Hence the World Bank does not seem to have put a lot of thought into how such pitfalls could be avoided. Chapters 3 and 4 of the current paper try to address this.

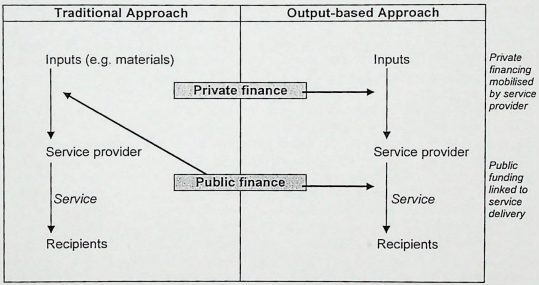
[4] The Global Practice Group for Social Sectors.

[5] The seven regions include South and South-east Asia (with India and Pakistan) and Africa (with Cote d'Ivoire, Kenya, Nigeria and South Africa), along with five others.

2.3 Output-based aid

The PSD strategy document proposes to focus collaboration with the private sector on development results and on improved targeting of government funding schemes, through the application of output-based aid (OBA) schemes. In contrast to traditional approaches whereby support is channelled to inputs consumed by public providers, service delivery under OBA schemes would be shifted to third (private) parties under contracts that tie payment to the outputs or results actually delivered.[6] The two approaches are presented in Box 2.

Box 2: Traditional versus output-based approaches



Such public funding schemes, which could be financed by aid funds (including IDA funding), would be justified where externalities or affordability and redistribution objectives exist. OBA could be used to address affordability concerns through subsidy schemes, which will offset the costs of private services to low-income consumers by making these services available for free or at reduced cost.[7] OBA would shift the responsibility and performance risk to the (for-profit and not-for-profit) private sector,[8] and hence it would help sharpen the targeting of development outcomes, sharpen incentives for efficiency, mobilise private finance, and improve accountability.[9] Subsidies should preferably go to the consumers instead of the providers.

While the IDA would support output funding, providing financing for the subsidy payment in the form of loans or grants, along with assistance to governments in designing effective subsidy schemes, the IFC would help fund private providers through commercial credits without

[6] Where needed, the disbursement schedule for subsidies could be frontloaded somewhat to make financing more manageable; at the same time, adequate financial exposure of the private provider must be maintained to keep incentives to perform.

[7] All forms of subsidy schemes could be supported, ranging from means-tested targeting of specific consumer groups to broad-based subsidies to all consumers.

[8] If service providers fail, investors should suffer rather than taxpayers in poor countries.

[9] Public providers may also compete under such schemes; however, in this case taxpayers instead of the private provider bear the ultimate risk of failure.

government guarantees. This should lead to a better division of labour between the two arms of the Bank.

The PSD strategy document highlights the risks involved in OBA arrangements, which pose design, contracting and regulatory challenges, in particular monitoring arrangements, contracting processes, regulatory supervision and financing schemes.[10] As more experience with OBA is needed and its full potential still needs to be explored, it is proposed to undertake a pilot for OBA schemes, with special emphasis on those supporting the provision of basic public services. This would be done in particular in the domain of infrastructure development. It remains unclear to what extent OBA schemes would be piloted in the health sector.

2.4 Trends in World Bank support to PSD

The PSD strategy document does not provide a clear insight in the volume of support that will be allocated to PSD in the health sector in the coming years. Nor is it clear what the expected relative increase will be compared to current funding levels, or the expected changes specifically for health related interventions. From the PSD Strategy document and the IFC paper some indications can be derived, though, about current lending volumes and past trends.

Total World Bank Group lending and guarantees for PSD (not just health related) doubled in real terms since 1980, largely due to increases in IFC lending and MIGA guarantees. IFC investments increased 4.5 times in real terms since 1980, and in 2000 they accounted for 56% of total WBG lending and guarantees for PSD. IBRD lending for PSD has declined in real terms, and in 2000 it stood at about one third of the 1980 level. In low-income countries, however, real IDA lending for PSD doubled during the same period. In 2000, IBRD/IDA lending for PSD amounted to one-sixth of WBG's PSD-oriented lending and guarantees. The WBG's financial support for PSD has increased at a faster rate in recent years than total lending and guarantees, as a result of which the share of total lending and guarantees going into PSD doubled from 16% in 1995 to 30% in 2000.

Although in recent years more WBG loans have included a private health care component, PSD lending for health is still very limited compared to the Bank's total PSD portfolio. In 2000, IBRD/IDA project lending for PSD in health amounted to about $ 30 million[11] or 0.5% of the total project portfolio for PSD of $ 6.5 billion.[12] The PSD strategy document does not provide any figures for the amount of IBRD/IDA adjustment lending allocated to the private health sector. IFC investment in the social sectors (health and education) grew at an average rate of 23% per annum during the period 1996-2000, but still accounts for not more than 0.8% of total IFC commitments. In October 2001, IFC's total disbursed and outstanding loans in the health sector amounted to $ 77 million.[13] IFC's health care portfolio in Sub-Saharan Africa between 1993 and 2000 amounted to $ 48 million. These figures show that health-related PSD lending has been very limited in relation to the Bank's total portfolio for HNP in low and middle-income countries, which amounted to $ 9.3 billion in 2000.

[10] One way of strengthening monitoring capacity may be by involving NGOs or contracting out monitoring to them.
[11] Most PSD lending goes to three sectors, including social protection, private sector development (support to small and medium size enterprises) and agriculture. It is not clear to what extent support to social protection also covers activities related to the health sector.
[12] The $ 6.5 billion is 6% of total committed loans of the Bank.
[13] IFC lending for PSD is concentrated in three sectors, which account for two-thirds of its lending: the financial sector, infrastructure and manufacturing.

The PSD strategy document specifies that most of the proposed PSD interventions will be financed from *existing* WBG budgets through *internal reallocation*. It is therefore expected that any future increase in lending for PSD activities will be *at the expense of the public sector*.

Chapter 3 Key issues and risks

3.1 The context

Experience across the world shows that health systems generally consist of a *mix* of public and private systems. Rapid private sector growth has occurred in many low-income countries, not so much as a result of explicit policies to promote the private sector, but primarily because of a perceived low quality of care in the public sector.

Initial research efforts on the public-private mix for health care in low-income countries began to take place in the early 1990s (McPake and Mills, 2000). The initial picture that emerged in many countries was of *two-tier* health systems, whereby rich people enjoyed the services of well-resourced private health care systems, while the poor were surrendered to poorly-resourced public health care systems that provided poor quality services. Evidence then started accumulating that private provision and financing in fact played a much greater role in health care than was suggested by the typical characterisation of health systems in low-income countries as being dominated by the public sector. Even in countries with a small formal private health sector, individuals' out-of-pocket payments for health care often exceed one-third of the national health expenditure (McPake and Mills, 2000). World Bank estimates of private health expenditure as a share of total health expenditures (public and private) amount to 59% for low-income countries (as opposed to 40% for low-middle income countries and 48% for high-middle income countries) and 52% for Sub-Saharan Africa (51% for all countries worldwide; World Bank, 1999).

Several countries have seen their private sector proliferate in the past decade and there is strong evidence that the use of private health institutions is not restricted to higher-income groups. The IFC strategy paper suggests that more than 50% of the provision of health services occurs through private institutions in countries such as Cote d'Ivoire, Nigeria, South Africa, Egypt, India and Thailand. Although reliable data for most countries in Sub-Saharan Africa are not available, it is a fact that church affiliated hospitals and health centres traditionally play a prominent role in the provision of health services in countries such as Ghana, Kenya, Malawi, Uganda, Zambia, Zimbabwe and South Africa. In addition, commercial private clinics and surgeries are no longer restricted to urban areas and have started to emerge in semi-urban as well as in certain rural localities in most Sub-Sahara African countries. These facilities are operated either by practitioners that are fully private or by medically trained staff employed in the public sector, who engage in private activities after or sometimes during official working hours, using public resources. While data about the exact size of the private for-profit sector are scant, there is ample evidence that it is significant and there are strong indications that it is expanding rapidly (Hanson and Berman, 1998). In Kenya, for example, 70% of all physicians work in fulltime private practice (Kumaranayake, 1997). In Bénin, exact figures are not available, but regulation and control of the private sector has been identified as one of the major challenges of the Government (Ministère de la Santé Publique, 2000).

The question therefore is not so much *whether* the private sector should play a role in the provision of health services, but rather *how* it should be involved within a public health sector framework so as to contribute optimally to achieving public health goals. Both the general PSD strategy document of the WBG and the IFC paper (that deals specifically with the health sector) start from this premise and they are right in doing so. The problem, however, is that the World Bank uses a rather narrow concept of private sector development in health and health care.

3.2 Concepts of private sector development in health and health care

From the way in which the PSD strategy document and the IFC paper use the term private sector development it becomes clear that they refer to *programmed* privatisation, which should be seen as the result of the implementation of pro-private government policies. They ignore the phenomenon of *incremental* privatisation, which is a largely unplanned response to failures of the public sector (Bennett at al, 1997). Many countries recognise the danger of uncontrolled proliferation of private enterprise in the health sector, as has been the recent experience in almost all urban and peri-urban conglomerations in low-income countries. The technical quality of the services rendered by private providers in a rapidly expanding market is often not up to standard, and this may have adverse effects on people's health. Even though some governments have established minimum standards and regulations for the private sector, they may not have appropriate systems in place to ensure inspection and enforce sanctions. From the perspective of the state, which has the obligation to protect its citizens from violation of their human right to health by third parties (see Chapter 1), the PSD strategy thus has a serious lacuna.

Programmed private sector development is a broad, generic term that merits further specification of the various strategies that may be pursued, such as privatisation of public institutions, outsourcing of good and/or services and granting of autonomy. Box 3 explains the meaning of these concepts.

The appropriate public-private mix for health care, which uses some of the above strategies, depends on the country-specific circumstances. Although the PSD strategy document acknowledges this by explicitly saying so, it actually puts a strong emphasis on direct support to firms and on the disbursement of public funds – under certain conditions – to private providers. From the health care project portfolio of the IFC (presented in an annex to the 2002 IFC paper), it further appears that the bulk of financial loans has so far gone into the construction or expansion of private hospitals and diagnostic centres, and the production of pharmaceutical drugs and other chemicals. These are forms of support to private institutions that may or may not compete with other service providers in the same geographical areas, without necessarily specifying the services that are being purchased. Outsourcing of *particular services* to private institutions, with the government in the role of purchaser (as described in Box 3) thus receives little attention. Section 3.7 will revert to the experiences and in particular the key assumptions for contracting out, which are relevant for any form of private sector involvement in health care.

Box 3: Terminology and concepts

It is useful to make a distinction between different forms of (programmed) private sector development or involvement. In principle the term *privatisation* should be reserved for the transition of an entire functional component of a public institution – such as for instance a hospital or a central medical stores department – into a private company, or its transfer to an already existing private company. It implies that the Government divests itself of its existing infrastructure, as well as its managerial and financial control of the 'business'. This goes much further than two other distinct forms of private sector involvement, namely outsourcing and the granting of autonomy (or quasi-autonomy) to lower levels of the public health system.

Outsourcing refers to a situation in which one party buys/purchases goods or services from another party that provides them. There are two fundamentally different forms of outsourcing, depending on whether the government assumes the role of buyer/purchaser or that of provider. With the government in the role of buyer/purchaser of services from the private sector, it can either provide subsidies (for instance for organising a particular campaign or for the provision of preventive services) or buy services directly (such as maintenance, hospital catering, laundry or security services). With the government in the role of provider, one can think of private pharmacies buying drugs from government medical stores, or industrial companies obtaining health services from government hospitals against payment. The latter arrangement (government in the role of provider) is less contentious, unless the services are provided at a highly subsidised price. The PSD strategy paper seems to focus mainly on the former arrangement, i.e. government in the role of purchaser.

Outsourcing of services with a public benefit to the private sector has been experimented in many low-income countries, often in the form of *contracting out*, a modality through which the services to deliver and the conditions of exchange are defined in a contract (McPake and Ngalande-Banda, 1994). Financial benefits of contracting out of services to the private sector are expected on the basis of a key economic principle, namely that competition between providers increases efficiency.

The *granting of autonomy* is basically a phenomenon internal to the public sector that is usually referred to as decentralisation. It involves either the *deconcentration* of management responsibility by the Ministry of Health headquarters to specific government departments (such as research institutes, hospitals or medical stores) or to regional or district health office level; or the *devolution* of management responsibility to local government institutions (such as district councils or city councils. It usually involves budgetary autonomy, financial autonomy and/or human resources management autonomy ('hiring and firing'). The modalities of such forms of decentralisation are usually laid down in written service agreements that are concluded for a specific period of time. Many national governments in Sub-Sahara Africa have implemented decentralisation as part of larger health sector reforms, aimed at increasing health sector performance. The private dimension comes in, when provisions are made for the participation of non-government representatives in local decision making. In Zambia, for instance, district health boards, which manage public funds (district health baskets) made available by the central government and a number of donor agencies, are made up of representatives from civil society. NGO representatives, in particular representatives from church affiliated health institutions may be members of district health boards and district health management teams, which are responsible for the smooth delivery of health services in their respective districts.

Uplekar (2000) suggests that programmed privatisation, although much described in theory, is not very widespread. When documenting the purchaser-provider relationship many authors use the NHS of Great Britain as an example (e.g. McPake and Hongoro, 1995; McPake and Mills, 2000; Palmer, 2000). Where they were tried, contractual relationships often work out differently and tend to develop into durable partnerships (Palmer, 2000). Waelkens and Greindl (2001) suggest that this is because some of the initial assumptions in relation to contracting out of services proved wrong (section 3.7 will elaborate on this).

3.3 What's new in the PSD strategy?

Overall, the PSD strategy document does not contain many new elements where it concerns interventions in the health sector. It builds on World Bank policy outlined in earlier health strategy papers and should rather be seen as the continuation of a trend of increased World Bank support to private sector involvement in the provision of health services, which started in the late 1980s.[14]

Nevertheless, the PSD strategy involves a stepping up of private sector involvement in the health sector. This will also include increased support through IFC lending. It is relevant to note that the World Bank emphasises a general change in the role of the state towards policy making. But it is ambivalent about the role of the state as a health service provider. On the one hand, the PSD strategy document proclaims a continued role of the public sector in service provision concomitantly with an increased role of private provision. On the other hand, an earlier version of the IFC paper (issued in March 2002) was very sceptical about the capability of the public sector to ensure good quality health services.[15] Similarly, the PSD strategy document itself is not consistent. While in one paragraph it asserts that "... the WBG will continue to provide unabated support to public services in health ...", another paragraph says that "... most of the (PSD) actions proposed are to be covered from existing budgets in IFC, MIGA and the Bank through internal reallocation." This suggests a shift of emphasis from public to private provision of services.

OBA schemes are not new either. The PSD strategy document suggests that pilots of OBA schemes be undertaken under IBRD/IDA project lending, which would provide the opportunity to learn more about the usefulness and pitfalls of this method before considering further expansion. The emphasis for OBA schemes is put on the infrastructure sector (energy, transport, water supply), and it remains unclear to what extent OBA schemes will actually be applied in the health sector. Several countries, however, have experience with OBA-type approaches in the domain of health. Ghana, for example, has introduced the Budget Management Centre (BMC) concept, whereby church-related hospitals, along with government institutions, receive and manage public funds for the provision of a certain package of services (Government of Ghana, 2001). In Zambia, the Central Board of Health (which is a central purchasing agency, separate from the Ministry of Health) concludes annual contracts with Hospital Boards and District Health Boards on the basis of annual plans and budgets (Bijlmakers and Nyarang'o, 2002).

The novelty in the PSD strategy is the shift in the nature and volume of World Bank lending – with an explicit focus on basic social services and on new countries, in particular low-income countries – as well as the institution and capacity building activities that the Bank intends to undertake.

3.4 What is missing?

Meanwhile, three important issues remain pending. Firstly, the PSD strategy document suggests that affordable access to private health services by the poor will be ensured through targeting of subsidies, but it does not address the problems commonly experienced with targeting resources to

[14] See for instance Akin et al. (1987) or Griffin (1989).

[15] The tone of the final version of the IFC paper, issued in June 2002, was less negative after several phrases about the performance of the public sector were altered or deleted.

the poor. History shows that there are no easy solutions. For instance, programmes aimed at protecting poor people against the negative implications of structural adjustment programmes – many of which were supported by the World Bank itself – have not been very successful.[16]

Secondly, the document does not adequately address the issue of regulation of the private sector and adherence of private forms to existing regulation. We have argued above (in 3.2) that it is not sufficient for any government to establish minimum standards and regulate the private sector: systems to ensure inspection and enforce sanctions are required as well.[17]

And thirdly, it does not address the issue of 'market failures', which is not uncommon in the health sector. Hsiao (2000), for instance, argues that macro-economists tend to overlook that the supply side has a far greater impact on health care efficiency, quality and spending, than the demand side. There is plenty of evidence, for instance, that physicians have the market power to induce demand, over-prescribe and practice price discrimination. The notion of market competition thus looses importance, in particular in the setting of low-income countries where the number of suppliers (service providers) is often limited. This then calls for a more prominent role of the public sector so as to answer to these market failures.

Box 4: Experiences with contracting out of services

The most common form of involvement of the private sector in the provision of health services has been through contracting out of specific services to private institutions. Waelkens and Greindl (2001) discuss the evidence in relation to five key assumptions in relation contracting out of services:[1]

(a) Management in the private sector is more effective
(b) A sufficient number of providers allows for competition
(c) Provider competition enhances efficiency
(d) The benefits of a new system that involves contracts exceed the costs of its introduction
(e) The Ministry of Health has the capacity to design contracts and to manage the contractual relationship.

The authors review recent findings indicating that these assumptions are not necessarily valid and that sometimes the reverse is true. As a result, the emphasis on public-private collaboration has shifted from the initial strategies towards the recognition of improving management skills among public health authorities, amongst others to equip them with the knowledge and skills required for the management of contracts and service agreements. While the notion of competition looses importance, the role of the public sector to answer market failure becomes more prominent. Thus, governments tend to make funds available to promote service delivery in underserved areas, and to stimulate the inclusion of preventive services (e.g. vaccination) into existing private facilities.

Furthermore, collaboration with NGOs, in particular church related health institutions, has become more important than with the for-profit private sector. Since NGOs often specifically target vulnerable population groups or underserved areas, and their objectives are closer to those of the government, the public sector has turned towards contracting out to the not-for-profit sector. In fact, the nature of the relationships has changed towards partnerships, characterised by mutual trust and of which the obligations are ideally described in a memorandum of understanding rather than a contract.

[16] The case of Zimbabwe demonstrates this very clearly. See: Bijlmakers (forthcoming).
[17] See the example of Bénin, to which section 3.1 refers. For evidence from Tanzania and Zimbabwe, see Kumaranayake et al. (2000).

The PSD strategy document does not make a clear distinction between for-profit and not-for-profit service providers. While it does recognise that both categories operate in the health sector, sometimes side-by-side, it does not acknowledge the fundamental difference between the two. And hence it does not consider the implications for the manner in which governments and the World Bank itself should engage in public-private partnerships. Not-for-profit providers, such as church-related hospitals and community based NGOs, usually have strong developmental objectives that may strongly overlap with the objectives of the government. For-profit providers are mainly guided by business objectives, and are generally less concerned with development. Developmental and business objectives are not incompatible, but the potential areas of conflict need to be recognised. Box 4 describes some recent trends in relation to contracting out, which the PSD strategy document does not address. It further illustrates that it is far from sufficient to say that the government's regulatory role should be strengthened in order to streamline private sector development.

Another weakness is that the PSD strategy says very little about monitoring and evaluation (M&E). It is too simplistic so say (in relation to output-based aid) that "... public funds will be disbursed when results are achieved, for example when water and electricity are flowing to customers". The reality in the health sector is more complicated, since access and in particular quality of health services cannot easily be measured. The IFC paper claims that for the education sector significant progress has been made in developing baseline indicators that would adequately measure whether the objectives are being achieved. For the health sector work is said to be in progress at the level of the WBG. What is required, though, is that each country adopts its own M&E framework that relates in a very clear fashion to the country's overall health policy and the preset objectives of private sector development/involvement, before any further steps are taken. Only then will it be possible to genuinely assess whether PSD has any public health benefit.

3.5 Why private sector development at all?

While the World Bank admits that support to PSD in health remains "highly contentious", it does not discuss the reasons why this is so. In fact, the PSD strategy document does not even explicitly mention the issues that are at the heart of the public-private mix debate. Some pros and cons of private versus public provision of health services are mentioned in a rather casual manner, but the exact areas of contention and the evidence are not reviewed.

A range of theoretical arguments have been put forward by neo-liberals, including World Bank representatives, in favour of expansion of the private health care sector. Bennett (1997) has summarised these into four main arguments:

(i) Efficiency and quality

The private sector is often considered more *technically* [18] efficient than the public sector. Due to the profit incentive, private providers tend to produce services at lower costs for a given level of output. At the same time, they have an interest in maintaining or raising the quality of services. In a competitive market, firms that do not operate efficiently will incur losses and will eventually be driven out of the market. An expanded role for markets and the private sector would increase efficiency in the provision and financing of care. More recently, the emphasis of the neo-liberal argument shifted to the suggestion that there will be gains in

[18] Technical efficiency refers to the optimal relationship between the inputs (resources) and outputs of a particular (health) service (Green, 1999).

allocative efficiency [19] from private sector growth. If the private sector is able to provide non-essential services, then the resources freed in the public sector can be targeted to priority health interventions, such as public goods and goods with large externalities, and highly cost-effective clinical services.

(ii) Equity
Growth of the private sector and the transfer of demand for services by the rich from the public to the private sector have the potential to increase equity in health care provision because they free up public resources that can be directed to the poor.

(iii) Increased resources for health
A larger private sector implies an overall increase in the total resources available for health care, and hence less pressure on government resources.

(iv) Consumer choice
Increased private provision leads to increased consumer choice.

The PSD strategy document tacitly uses these arguments as an underpinning for the proposed interventions. However, these arguments have been heavily criticised and continue to be the subject of intense debate in the international literature and in public fora.

Bennett (1997) examined the empirical evidence in relation of each of the above four arguments and came to six well-founded conclusions:

1. The evidence on standards of efficiency and quality in the private sector relative to the public sector was inconclusive, but suggested that private *not-for-profit* providers may be more efficient and offer a higher quality of care.
2. Damaging failures in the market for health care services may occur as the result of problems of imperfect information.
3. Promoting the private sector may increase accessibility to services and/or quality of care for the poor in absolute terms, but differences in access and quality of care provided to rich and poor are likely to increase.
4. Government commitment to maintaining existing public funding levels is critical if total health sector resources are to increase.
5. Private providers are likely to bid up certain factor prices, thereby decreasing public sector purchasing power, and possibly adversely affecting standards of care in the public sector. A concomitant shift in inputs from public to private sector will occur.
6. Consumer choice normally increases with privatisation, but with ambiguous implications for consumer welfare.

In the same journal article, Bennett asserts that governments are generally unlikely to be able to fully determine three of the most important contextual factors that affect private sector behaviour, although they do have considerable influence. The three factors are: the market structure, the regulatory framework in which the private sector would develop itself, and the socio-economic environment. More importantly, though, governments need to be aware of existing conditions that will affect the way in which private sector providers operate and they need to adapt their policies accordingly. These conditions include:

(a) The existence of a sub-section of the population who are able and willing to pay for private care;
(b) The absence of great inequities;
(c) Appropriate incentives and regulatory structures for health care providers;
(d) Strong professional ethics;

[19] Allocative efficiency refers to the optimal balance between the allocation of resources in view of the existing health problems and disease patterns (Green, 1999).

(e) Informed consumers and active consumer organisation; and
(f) Relatively high standards of care in the government sector.

It would appear that most of these conditions are not fulfilled in poor countries. The logical and inevitable conclusion would then be that the chances for a successful privatisation programme in these countries are very limited. The suggestion in the PSD strategy document that the Bank would focus on developing policies, institutions and capacity to support PSD in the health sector therefore seems by and large inadequate to render private provision of health services effective and useful.

3.6 Which market?

The PSD strategy document does not specify which markets are targeted for private sector development. The few examples that are given suggest a focus on the provision of hospital services or of specific curative services. It would appear that the IFC concentrates its support on tertiary hospitals and industries that have a longstanding private sector involvement, such as the pharmaceutical, biotechnology, medical supplies and medical equipment industries. But in its strategy paper the IFC shows interest in other markets as well, including primary and secondary levels of care (whether preventive, curative or rehabilitative), private health insurance, support services in areas of patient management and information systems, and new markets such as waste water treatment and medical waste management systems. So far, the IFC has supported a wide range of private initiatives, ranging from hospital management and infrastructure development (outpatient departments, diagnostic imaging and haemodialysis) and the provision of laboratory services to the production of pharmaceuticals, medical equipment, 'managed care' projects and health care information technology and e-health.

The PSD strategy does not prioritise any of these markets, suggesting a rather opportunistic approach and a "we-can-do-it-all" mentality within the Bank. It would appear that a careful analysis of the experiences gained so far, not only with World Bank supported initiatives, would shed more light on which markets are fit for private sector involvement and under what conditions.

3.7 Policy coherence at the national and international level

The PSD strategy would obviously not be implemented in a vacuum. The PSD strategy paper itself elaborates on the relationship with the Poverty Reduction Strategy Paper framework (PRSP), but not on the relationship with global regulations on international trade, such as the General Agreement on Trade in Services (GATS) and the Trade-Related Intellectual Property Rights (TRIPS). Cognisance should also be taken of other international initiatives and new funding arrangements, such as the Global Fund to fight AIDS, TB and Malaria (GFATM), and the recommendations of the Commission on Macro-economics and Health (CMH), which makes a plea for massive financial injections in the health sector in low-income countries

PRSP

According to the PSD strategy paper, the PRSP remains the main framework, into which PSD strategies need to be incorporated. The World Bank and the IMF jointly introduced the PRSP framework in 1999, as an overall development policy framework for at least 78 low-income countries and as a requirement for these countries to be eligible for soft loans from the IMF and the World Bank. Countries participating in the Highly Indebted Poor Countries (HIPC) initiative

were targeted first.[20] A large number of other donor agencies, including the European Commission, have indicated that the PRSP will be the basis for their own contributions.[21] The PSD Strategy document indicates in which ways the WBG can further the treatment of PSD issues in the PRSP process: for example by building capacity among domestic stakeholders to carry out the required analysis; by sharing of knowledge, cross-country studies and best practices; and by commenting on PRSP-related documents prepared in-country. Implicitly, the PSD strategy paper suggests that PSD issues have so far not been adequately addressed in already existing PRSPs. It is not clear, though, whether any specific efforts will be undertaken to ensure integration of PSD issues into existing PRSPs. Neither is it clear whether individual countries are expected to develop their own PSD country strategy papers, separate from the PRSP, and, if so, through which process this would be pursued.

Several citizens' groups in developing countries are of the opinion that their governments collude with the World Bank behind closed doors on the privatisation of services, often in parallel to and without the knowledge or consent of citizens involved in formulating national development strategies, such as PRSPs. These groups feel that decision making on service provision should be the domain of domestic constituencies instead of external actors. They also feel that the World Bank interferes with domestic processes through the medium of public information campaigns, which it undertakes to persuade countries and their citizens of the benefits of private sector participation (Globalisation Challenge Initiative / Citizen's Network on Essential Services, 2002).

GATS

Services first came under the rules of the world trading system in 1995, when the World Trade Organisation (WTO) came into effect. As part of the General Agreement on Trade in Services (GATS) negotiations, the WTO has been drawing up proposals for international trade laws that would imply severe restrictions for the design, funding and provision of public services, including health care. It is thus creating extra pressure for privatisation of public services. The legal tests under consideration would outlaw the use of non-market mechanisms, such as cross-subsidisation, universal risk pooling, solidarity and public accountability as being anti-competitive and restrictive to international trade. The domestic policies of national government will be subject to WTO rules, and if declared illegal, could lead to trade sanctions. Critics believe that an acceleration of privatisation in health care systems will bring disproportionate advantages to multinational corporations in the USA and the European Union and that it will undermine the ability of low-income countries to implement their own public health priorities.[22]

TRIPS

The WTO agreement on Trade-Related Intellectual Property Rights (TRIPS) grants extensive patent rights to pharmaceutical companies. The agreement has been much criticised, amongst others for denying developing countries the right to manufacture or buy generic versions of brand-name drugs, which would undermine the ability of developing countries to provide their population with affordable medicines. More generally, the TRIPS agreement would make governments vulnerable to extraneous political pressure from economically powerful states.[23]

[20] As of October 2002, 22 countries had their PRSP finalised, of which 15 in Sub-Saharan Africa; 45 countries had drafted an interim PRSP (I-PRSP), of which 25 in Sub-Saharan Africa.

[21] For more background information, see Verheul and Cooper (Wemos briefing paper; 2001) or Laterveer et al. (2001).

[22] See for instance Pollock and Price (2000), Hilary (2001) and Sexton (2001).

[23] For more details see Hilary (2001).

Commission on Macroeconomics and Health

The report of the Commission on Macro-economics and Health (CMH), chaired by Jeffrey Sachs on behalf of the WHO, does not elaborate in an extensive manner on private sector involvement in the provision of health services. In order to scale up health interventions and address the health needs of the poorest people in society, the Commission advocates for the development of *close-to-client* systems (health services as closely as possible to the clients), involving a mix of state ad non-state health providers, with financing guaranteed by the state (WHO 2001).

> "The government may directly own and operate service units, or may contract for services with for-profit and not-for-profit providers. Since public health systems in poor countries have been so weak and underfinanced in recent years, a considerable non-governmental health sector has arisen that is built upon private practice, religiously affiliated providers, and non-governmental organisations. This variety of providers is useful in order to provide competition and a safety valve in case of failure of the public system. It is also a fait accompli in almost all poor countries."

The Commission does not touch upon the conditions or the policy requirements for development of private practice in the health sector. It recommends the establishment of a National Commission on Macroeconomics and Health in each country, which would be chaired jointly by the Ministers of Health and Finance, to organise and lead the task of scaling up the provision of health services. If adopted, such a national commission could assume the task of outlining the areas of private sector development and defining the legal framework and the support systems that would be required. The PSD strategy paper, however, does not explore such possibilities and concentrates rather on internal Work Bank dynamics.

It is evident that national governments, including those in low-income countries, need to explore the possibilities how best to make use of the private sector in order to achieve public health goals and to incorporate their views into policy and strategy documents. From the above examples, it is not so evident though, whether national governments should specifically ensure the inclusion of PSD strategies as outlined by the World Bank into their domestic policy frameworks. Neither is it straightforward how they should do that, if at all. Policymaking and strategy development are tedious processes, especially in low-income countries with limited human capacity, and ideally they involve consultation of various stakeholders, both from government and outside government, at different levels. Experience has shown that many national governments have great difficulty in keeping up with the international debate and incorporating new international initiatives into their domestic policies and strategies. The PSD strategy, which is one of many international initiatives, harbours the risk of linking funding modalities to the priorities of the world's major lending institutions (including the World Bank Group), which may be guided largely by the type of activities and services that private providers are prepared to engage in. These activities and services are not necessarily those that are needed most, and may lead to an undue focus on urban localities, hospitals and on a selected number of diseases and specialist services, rather than on nationally defined, integrated policies.

3.8 Risks

The World Bank may go ahead with increased PSD lending without verifying whether adequate regulatory and monitoring capacity is in place at the level of the client countries concerned or whether appropriate measures have been taken to ensure effective targeting of the poor. Implementation of the private sector development strategy as laid out in the World Bank documents reviewed in this paper thus implies a number of risks, in particular for low-income countries.

- A shift in lending arrangements from support to health service provision by the public sector towards service provision by the private sector may not increase the total resource envelope available to the health sector as a whole, which would undermine the position of the state.

- Increased emphasis on private sector development may lead stakeholders to shy away from public health interests and give undue priority to hospitals and specialist medical care to the detriment of primary health care.

- The PSD strategy as laid out by the World Bank may unduly draw away the attention of national governments from the need to bring under control the proliferation of private enterprise in the health sector.

- The PSD strategy is likely to further accelerate the formation of a *two-tier system*, whereby rich people enjoy the services of a well-resourced private health care system while poor people are surrendered to either a poorly-resourced public health care system that provides poor quality services or an unregulated private health care system, that provides equally poor services. Hence, the strategy is bound to lead to increased inequity in the access to quality health care.

- Overall, the PSD strategy will hamper national governments in fulfilling its obligation to protect the right to health of large segments of their populations; as a result, the gap between poor and rich people within one and the same country may widen further; and the gap between poor and rich countries may widen as well.

Chapter 4 Conclusions and perspectives for NGO action

The PSD strategy as laid out by the World Bank for low-income countries has some serious limitations for the development of the health sector and the protection and promotion of people's health, in particular the poorest groups in low-income countries. Several conclusions can be drawn on the basis of the argumentation and the evidence presented in the previous chapter.

- The PSD strategy document concentrates on programmed privatisation, leaving out the widespread problem of incremental privatisation. Some countries might benefit more from assistance to put mechanisms in place to regulate *and control* the private sector than to invest in programmed privatisation. Regulation and capacity building for improved regulation – as suggested in the PSD strategy document as an accompanied measure for programmed private sector development – is not sufficient. Regulation, inspection and enforcement/sanctioning must go together.

- The development objectives of the PSD strategy are clear; however, the precise objectives of any PSD initiative will depend on country-specific or even local circumstances and requires careful definition. The current PSD strategy is too general to allow an evaluation after some time. A framework for monitoring and evaluation is required, with a clear specification of possible key indicators. This could be used by individual countries to develop their own system for monitoring and evaluating any progress in private sector involvement in health care.

- The four basic arguments in favour of private sector involvement in the provision of health services are not explicitly mentioned or discussed in the PSD strategy. They are rather taken for granted, despite the fact that they are highly controversial. As a result, the 'areas of contention' that are at the heart of the public-private mix debate, and that have been articulated so well by analysts like Sara Bennett, have not been discussed either. This suggests that either the World Bank has not done its homework properly or it has chosen to disregard scientific evidence. It is a serious omission not to review the experiences already gained and the lessons drawn by others, especially those that do not belong to the neo-liberal school of thought that predominates at the World Bank.

- The PSD strategy has the ambition to contribute to better private health service coverage worldwide, including in poor countries. However, the PSD strategy document does not attempt to refute the well-documented claim of several analysts that the conditions for a successful privatisation programme (see a. to f. in section 3.5) are not fulfilled in the poorest countries.

- The PSD strategy has the ambition to extend private health service coverage to people of all layers in society. Past experience has shown that well-functioning targeting systems are a key element in ensuring that the poorest have access to (private) health care. The PSD strategy does not address the problems that have been encountered in targeting assistance to those who are most in need, yet most deprived of such support.

- The PSD strategy seems to target *all* health care related markets for private sector development. Before implementing the strategy in any country, a thorough analysis would be

required to clarify which markets are fit and which ones are less appropriate for private sector involvement.

- The PSD strategy does not make a clear distinction between for-profit and not-for-profit providers. Yet, there is a fundamental difference between the two categories and the opportunities for a fruitful public-private partnership of the government with not-for-profit providers seem much bigger than with for-profit providers. In this regard, applying OBA schemes in relation to not-for-profit providers could have clear merits and contribute to the goal of increasing equitable access to health care by all.

What can NGOs do?

Non-governmental organisations concerned with the plight of low-income countries and especially the health situation of the poorest layers in society could undertake action in several ways. Where possible, they should work in close collaboration with public health specialists and researchers/analysts to do the following:

1. *Analyse* what national health policy frameworks and strategies say about private sector involvement in the provision of health services. Are there any intentions to change the public-private mix in health care? In what direction and with which objectives in mind? Similarly, local health policies and strategic plans (e.g. district health plans) should be scrutinised: verify whether the intentions for private sector involvement, if any, are made explicit and what type of involvement is pursued at this level.

2. *Document* the experiences with (programmed) private sector involvement; evaluate these against the four objectives outlined in this paper (efficiency & quality, equity, increased resources, consumer choice); verify whether the basic conditions are fulfilled for effective private sector involvement in the provision of health services; and evaluate the experiences against national/local health policy and strategic frameworks.

3. *Question* national or local authorities about their intentions with regard to development of the private sector for health service provision; ask them for indicators of success. Provide them with concrete experiences (positive and negative) from the field. If applicable, advocate for the establishment of a focal point within the Ministry of Health (preferably close to the Planning Department or the Secretary for Health).[24]

4. *Monitor* the plans of the World Bank and other lending and aid agencies in relation to private sector development; demand participation in any new initiatives right from the planning phase onwards and ask critical questions as to the exact purpose, the intended or unintended effects on the poorest people in society and how these will be measured.

5. *Exchange* the experiences acquired (positive or negative) in national fora or through the appropriate coordinating bodies; among the NGO's, designate a focal point, if appropriate, so as to facilitate the exchange of information.

[24] Ghana could serve as an example: in 1997, the Ministry of Health established a private sector unit within the Planning Department.

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Materials for further reading

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@ Risico's

- ondermijning van de overheid.
- middelen voor curatieve zorg ten koste van P.A.
- minder gedaan aan wilde groei van particuliere diensten.
  - geen minder regeling

- verdeling in maatschappij
  "pro-poor" ? maar hoe
- regeringen gehinderd van RCC te beschermen.
  → markt werking en gezondheidszorg werkt niet

@ APZ - social beleid - gez/aids/voeding
- WB: verschillende benadering
  - landen.

- grotendeels onderschrijft rapport.
(*) - regulator role van de regering !!
  → sectorale benadering - privé sector: moeilijk

@ ~~[illegible]~~ wie gaat de WB lening geven?
- kat. ~~[illegible]~~ bedrijven? → is dit mogelijk? ←
- internat. bedrijven? ↘ wie is garant?

@ regering kan wat reguleren /
(**) Amsterdam !!

- En wat als het mis gaat??

= NGOs meer in discussies !!