Joint Context Analysis: India

September 2015

Disclaimer/neutrality

The text of the JCA is meant to reflect the exchanges among organisations about their point of view from a technical and operational perspective.

Specific viewpoints, based on the information in this context analysis, are only binding whenever it's explicitly referred to as an organisation's viewpoint; hence they are no shared points of view for all participating organisations.

Moreover, the information that is cited cannot be considered as a political or ideological judgment of the organisations.

List of abbreviations

ACV / CSC	Algemeen Christelijk Vakverbond / Confédération des Syndicats Chrétiens
ASHA	Accredited Social Health Activists
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
AZG / MSF	Artsen Zonder Grenzen / Médecins Sans Frontières
BHCS	Basic Health Care Support project
BRICS	Group of 5 major emerging national economies (Brazil, Russia, India, China, South Africa)
CHC	Community Health Centre
CRC	Committee on the Rights of the Child
CSO	Civil Society Organisation
CSR	Corporate Social Responsibility
DFIT	Damien Foundation India Trust
DG	Disability Grading (for leprosy) = DG0, DG1, DG2
DHO	District Health Officer
DIFID	Department for International Development
EIA	Environmental Impact Assessment
EPHP	National conference on bringing Evidence into Public Health Policy
EU	European Union
FCMCB	Foreign Contributions (Management and Control) Bill
FCRA	Foreign Currency Regulation Act
FRA	Forest Rights Act
FUCID	Forum Universitaire de Coopération Internationale et de Développement
G8	Group of 8 leading national economies (not including India, see O5)
G20	Group of 20 major national economies (including India)
GDP	Gross Domestic Product

GUK	*Gram Utham Kendra*
HiAP	Health in All Policy
HLEG	High Level Expert Group
IFAG	Indian First Aid Guidelines
IFAM	Indian First Aid Manual and materials
IIM	Indian Institutes of Management
IIT	Indian Institutes of Technology
ICDS	Integrated Child Development Scheme
ICPS	Integrated Child Protection Scheme
IMR	Infant Mortality Rate
IPH	Institute of Public Health
IT Act	Information Technology Act
ITC	Industrial Training Centres
ITI	Industrial Training Institutes
ITM	Institute of Tropical Medicine
JCA	Joint Context Analysis
JVM	*Jeevan Vikas Maitree*
KIYO	Kids & Youth
LE	Life Expectancy
MdM	Médecins du Monde
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
MSMEs	Micro, Small and Medium Enterprises
NCPCR	National Commission for Protection of Child Rights
NDA	National Democratic Alliance
NGA	Non-governmental actor
NGO	Non-governmental organisation
NHM	National Health Mission
NITI *Aayog*	National Institution for Transforming India *Aayog*
NPSD	National Policy on Skill Development
NREGA	National Rural Employment Guarantee Act
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
O5	Outreach Five (Brazil, China, India, South Africa) of the G8
OPAC	Optional Protocol for the involvement of children in Armed Conflict

OPSC	Optional Protocol to the Convention of the Rights of the Child on the sale of children, child prostitution and child pornography
PC	Planning Commission
PDS	Public Distribution System
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PM	Prime Minister
PPP	Purchasing Power Parity
RSBY	*Rashtriya Swasthya Bima Yojana* (free health insurance for the poor)
RTE Act	Right To Education Act
RTI Act	Right To Information Act
SC	Scheduled Castes
ST	Scheduled Tribes
TB	Tuberculosis
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UPA	United Progressive Alliance
VET	Vocational Education and Training
VLIR-UOS	Vlaamse Interuniversitaire Raad – Universitaire Ontwikkelingssamenwerking
WBVA	West Bengal Voluntary Health Association
WSM	Wereldsolidariteit / Solidarité Mondiale

Table of contents

1. Legal context, NGAs involved & process flow

Legal context

This Joint Context Analysis of India (JCA India) leans on the law on Belgian Development cooperation (19/03/2013 altered by the law of 09/01/2014) art 2- 6°/7 and the Royal Decree of April 24th 2014, art 14 § 1 & 2. The Law on Development Cooperation art. 2-6°/7 states: "The context analysis aimed at civil society, the decentralised administrations and public institutions and the conditions which enable their strengthening, prepared by several ANGC based on their own context analyses and similar exercises conducted in the country or the region".

This Joint Context Analysis aims at an analysis of the context in India and of the opportunities to collaborate for the non-governmental actors (NGAs) from 2017 until 2026. This document should primarily be seen as an opportunity to identify possible ways of cooperation, complementarity and synergy. This document is not a presentation of specific programmes or projects but a projection exercise for the mid- to long-term.

If this document will be approved, this JCA will become an important reference for:

- The programmes that will be submitted to DGD, in which each specific objective will need to demonstrate how it takes into account at least one JCA;
- A report on the implementation of the, in this document identified, opportunities for complementarity and synergy, to be submitted in 2019;
- The allocation of DGD funding related to synergy initiatives.

Together the participating NGAs submit this JCA for approval to the Belgian minister of Development Cooperation.

NGAs involved

AZG / MSF (Artsen Zonder Grenzen / Médecins Sans Frontières)

Dupréstraat 94, 1090 Brussel
Kristel Eerdekens Kristel.EERDEKENS@brussels.msf.org 02/474.74.35

Indian partner: **Ministry of Health and Family Welfare**

FUCID (Forum Universitaire de Coopération Internationale et de Développement)

7 Rue Bruno, 5000 Namur
Rita Rixen rita.rixen@unamur.be 081/72.50.84

Indian partners:
St. John's Medical College
Sarjapur Road, Koramangala, Bangalore 560034 (Karnataka)
St. Xavier's College
30 Mother Teresa Sarani, Kolkata 700016 (West Bengal)

Handicap International

Spastraat 67, 1050 Brussel
Eva Lecat (until June 15) elecat@handicap-international.org
Anne Barthès (June 15 onwards) abarthes@handicap-international.org
Anthony Vautier avautier@handicap-international.org +33 4 486 96 763

Indian partners:
She Hope / Hope Disability Centre
Wayil, Ganderbal 191201 (Jammu & Kashmir)
Gramoday Seva Sansthan
Traival Colony, Dantewada 494552 (Chhattisgarh)
Ekta
1st Lane, Gautam Nagar, Koraput 764929 (Odisha)

ITM (Institute of Tropical Medicine)

Nationalestraat 155, 2000 Antwerpen
Werner Soors wsoors@itg.be 03/247.65.15
Bart Criel bcriel@itg.be 03/2476293
Jan Coenen jcoenen@itg.be 03/247.62.37

Indian partner: **IPH** (Institute of Public Health)
250 2C Cross 2C main, Girinagar 1st Phase, Bangalore 560085, Karnataka
N Devadasan deva@iphindia.org +91 94 484 91 355
Upendra Bhojani upendra@iphindia.org +91 93 123 49 121

Damiaanactie

Leopold II-laan 263, 1081 Brussel
Luc Comhaire luc.comhaire@damien-foundation.be 02/422.59.18

Indian partner: **Damien Foundation India Trust**
14, Venugopal Avenue, Spurtank Road, Chetput, 600031 Chennai
M Shivakumar shivakumar@damienfoundation.in +91 11 654 92 609

JCA Decent Work Asia

Thematic group 'Decent Work' for all Asian JCAs

Members of the group are:

1. **WSM** (Wereldsolidariteit / Solidarité Mondiale), lead
Haachtstesteenweg 579, 1030 Brussel
Jeroen Roskams jeroen.roskams@wsm.be 02/426.36.75
2. **IIAV / IEOT** (ACV / CSC)
3. **IVSI / IFSI** (ABVV / FGTB)
4. **Oxfam Solidariteit**

KIYO (Kids & Youth)

Brogniezstraat 46, 1070 Brussel
Iris Bogaerts iris.bogaerts@kiyo-ngo.be 02/510.61.93

Indian partner: **none at present**

Médecins du Monde

Rue Botanique 75, 1210 Bruxelles
Stéphane Heymans, stephaneheymans@medecinsdumonde.be/ 0470045649

Indian partner: -

Memisa Be

Kerkstraat 63, 1701 Dilbeek
Elies Van Belle Elies.Van.Belle@memisa.be 02/454.15.46

Indian partner: **WBVHA** (West Bengal Voluntary Health Association)
WBVHA Tower, 3rd floor, 580 Anandapur, Kolkata 700107, West Bengal
Biswanath Basu biswbvha@gmail.com +91 98 307 27 175
Ramnath Ballala ramnathballala@gmail.com +91 944 83 83 555

Rode Kruis Vlaanderen Internationaal

Motstraat 40, 2800 Mechelen
Toon Wets Toon.Wets@rodekruis.be 015/44.35.30

Indian partner: **Belgian Red Cross - Flanders India delegation, Indian Red Cross Society**
1 Red Cross Road, New Delhi 110001, Delhi
Hugo Geuvens Hugo.Geuvens@rodekruis.be +91 88 266 00 708

VLIR-UOS (Vlaamse Interuniversitaire Raad – Universitaire Ontwikkelingssamenwerking)

Bolwerksquare 1a, 1050 Brussel
Christophe Goossens Christophe.Goossens@vliruos.be 02/550.19.65
Koen De Koster Koen.DeKoster@vliruos.be 02/550.19.69

Indian partners: **various academic institutions** in Jaipur (Rajahstan), Mangalore (Karnataka) & Ranchi (Jharkhand)

Process flow

Following the meeting for JCA leads on January 29, 2015, the ITM team started a *first round of consultations* with all potential JCA India members. Out of 17, 13 NGAs confirmed their intention to participate and provided essential information on themselves and their Indian partners (if any).

Need for more detailed information led to a *second round of consultations* in the month of March. Seven out of 13 potential JCA India members participated, including the JCA thematic group Decent Work Asia. On March 18, the lead had invited all members for a *meeting at ITM*, to which only three JCA India members could assist. The need for more comprehensive information and analysis was recognised, and all members were kindly requested *to complete the information provided* no later than March 27 to allow the lead to start drafting the JCA.

With the requested information and analysis coming in piece by piece in the months March-April, complemented with *contributions of Indian partners* (such as WBVHA partnering with Memisa, and IPH with ITM) and *relevant scientific and grey literature* (e.g. the EU India country roadmap for engagement with civil society 2014-2017, the DFID India country plan 2008-2015, and a range of publications from ITM unit's 'Equity & Health' database), *drafting of the JCA* only took a definitive start in May. This made it practically impossible to provide a timely feedback (announced for April) to all JCA members and to submit a first full draft on June 15.

Between May and September the JCA was further build up, completed and consulted. This included a consultation with Indian development experts in Trivandrum and Bangalore, in August. Furthermore, we also refer to the NGAs that participate in the regional/continental JCA Decent Work. With regards to the continental thematic JCA Decent Work Asia, the participating NGAs are: WSM (lead), IIAV/IEOI (ACV/CSC), IVSI/IFSI (ABVV/FGTB) and Oxfam Solidariteit. Decent work is one of the three priority themes for Belgian actors worldwide. As a result, Decent Work is included in chapter 3 of this JCA as part of an analysis of the political, economic and social situation in India. For the common context analysis of India related to this topic we kindly refer to the thematic JCA Decent Work Asia. In the course of the process of the present JCA, possibilities of complementarity and synergy with regards to Decent Work were further investigated. They are discussed in chapter 10. The present JCA India and the thematic JCA Decent Work are, thus, complementary and need to be read at the same time. Together they form one complete analysis on India.

2. Projects & programmes in period 2010-2014

ITM

2008-2016 (Framework agreement DGD – ITM)	Capacity building of the Institute of Public Health (IPH), Bangalore	Programme designed on the basis of IPH's demands and concentrating on building individual, organisational and institutional capacity at IPH to provide quality research, training and service delivery to the Indian people. Central in this endeavour is a close collaboration with public health authorities and civil society organisations

KIYO

2008-2010 (Program DGD)	From integration to self-determination of children	In the tribal states of Jharkand and Chhattisgarh, the two most disadvantaged states in India, KIYO collaborated with partners *Jeevan Vikas Maitree* (JVM) and *Gram Utham Kendra* (GUK). Amongst the staff most are from local Tribals (ST) themselves. Concerning the Dalits (SC), KIYO collaborated with two organizations DACA and FLR. Tamil Nadu is the state where caste discrimination is the most rigid. The staff of DACA consists of Dalits and FLR is a network-partnership between 10 smaller NGOs, all working for and with Dalits
2011-2013 (Program DGD)	Children of excluded populations (Tribals and Dalits) in India get chances of a full-fledged social integration	

Memisa Belgium

2011-2013 (Program DGD)	Basic Health Care Support Project (BHCS) in West Bengal State	In collaboration with the West Bengal Voluntary Health Association (WBVHA), the Institute of Tropical Medicine, Antwerp, and the Institute of Public Health, Bangalore.
2014-2016 (Program DGD)	Basic Health Care Support Project (BHCS) in West Bengal State	In collaboration with the West Bengal Voluntary Health Association (WBVHA), the Institute of Tropical Medicine, Antwerp, and the Institute of Public Health, Bangalore.

Rode Kruis Vlaanderen Internationaal

2013-2016 (co-funded by DGD since 2014)	Indian First Aid Guidelines (IFAG) and Indian First Aid Manual and Materials (IFAM) project	In collaboration with the Indian Red Cross Society

Damiaanactie

2008-2010	Support of the TB control programme in Bihar	Bihar, India
2011-2013	Promote and maintain high quality and sustainable TB services for drug sensitive and drug resistant TB patients in selected areas in Bihar, Nellore and Delhi in India	Bihar, Nellore and Delhi (India)
2014-2016	Development of an effective TB detection system in 15 districts and of MDR-TB diagnostic services in 6 districts in Bihar	Bihar, India

3. Political, economic, social & environmental situation

The Republic of India (hereafter India) is a paradox of sorts. Since independence in 1947, the country – a federation of 29 states and 7 union territories – is characterised by a combination of impressive progress and persistent hardship. Life expectancy has doubled and education levels have risen steadily[1]. With a population of over 1.25 billion – of a variety of ethnic groups, cultures and languages – India is one of the most diverse and the second most populous country in the world. Its lauded constitution[2], a parliamentary system and regular elections make it the largest democracy in the world. Aid dependency never has been an issue, and net official development assistance reached a low of 0.1% of gross national income in 2013[3]. Economic growth lifted India to the status of middle-income country, member of BRICS, G20 and O5. Today, the economy is the 7th largest in the world by market exchange rates[4], and India has become a global power.

All the same, India ranks a shocking 135th in human development[5] and is home to over 900 million poor and 288 million extreme poor measured by international poverty lines[i]. Indeed, measured by international poverty lines, India's number of monetary poor exceeds that of the whole sub-Saharan Africa (692 million) and Latin America (79 million) combined[ii]. It should be noted that India's national poverty lines present a more propitious picture. There are good reasons however to stick to international benchmarks in the present analysis: India's national poverty lines – be it the earlier ones based on minimal caloric requirements or the actual ones based on minimum expenditure – are below international ones, can be considered "abysmally low"[6], are subject of debate both in India and internationally for decades already[7–10], are not consistently applied[iii], and make comparison over time[iv] and between states[v] difficult and international comparison impossible.

While the number of monetary poor in India is declining over the last five years (but was increasing in the first decade of the millennium)[vi], there is little to celebrate, as annual per capita income growth of the bottom 40% lags behind that of the total population, which itself

[i] Under $2.5 and $1,25 a day (PPP) respectively, latest figures available (2011) as mentioned in the World Bank's 2015 World Development Indicators, http://data.worldbank.org/products/wdi (accessed July 15, 2015).

[ii] Under $2.5 a day (PPP), latest figures as available in the World Bank's Poverty and Equity Database, http://databank.worldbank.org/data/reports.aspx?source=poverty-and-equity-database (accessed July 15, 2015)

[iii] Eligibility for PDS (the subsidised Public Distribution System of food and non-food items for the poor) and a range of social assistance programmes is not necessarily based on the official poverty line but on the possession of BPL (below-poverty-line) or ration cards. Federal and state governments may apply different criteria, as may do different ministries and programme implementers within a government. Inclusion and exclusion errors are frequent[106,107].

[iv] This is not only the case since India's Planning Commission shifted to and adapted the Tendulkar Committee's basket of goods poverty line[8,10]. Already in the 1990s – still with a calorie-based poverty line in place but with changing questionnaire design between the 1993-1994 and 1999-2000 National Sample Survey – judgment of evolution over time had become tendentious[7,9].

[v] Indian poverty lines are state-specific, with pre-defined thresholds for each state. They are also sector-specific (urban/rural). The evidence used for state- and sector-specific lines and thresholds is highly debated[8–10].

[vi] Evolution of number of poor at $2.5 a day (PPP), 2000-2014, World Bank's Poverty and Equity Database, http://databank.worldbank.org/data/reports.aspx?source=poverty-and-equity-database (accessed July 15, 2015): 872 million Indian poor in 2004, 976 million in 2009, 901 million in 2011. In this respect, India is doing better than sub-Saharan Africa – where this number has been increasing steadily over the whole period (from 590 million in 2002 to 692 million in 2011) – but much worse than Latin America – where this number has nearly halved since the beginning of the century (from 144 million in 2002 to 79 million in 2011).

is significantly lower than annual inflation or than annual growth of the economy[vii]: most poor thus actually grew poorer[3]. This is in sharp contrast with the positive evolution of India's economy as a whole.

It is worth mentioning however that the Indian government, throughout the years of stable growth in the first decade of the century, made several efforts to provide equitable access to education and/or skill development, health and social protection, among other priority areas. Key measures included a first National Policy on Skill Development (NPSD, launched in 2009 by the Ministry of Labour and Employment)[11], the National Rural Health Mission (launched in 2005 by the Ministry of Health and Family Welfare)[12] and the free health insurance for the poor programme Rashtriya Swasthya Bima Yojana (launched in 2008 by the Ministry of Labour and Employment)[13], and the National Rural Employment Guarantee Act (launched in 2005 by the Ministry of Rural Development)[14].

Decent work

Despite economic performance and policy measures taken, India continues to face a range of persisting challenges in its labour market. Most notably, the vast majority of workers are in informal employment. Between 2004-2005 and 2009-2010, the share of workers in the unorganised sector fell marginally from 86.3 to 84.3%. Including workers in the organised sector not benefitting from social security, this figure would raise to 91.2%. Today, according to the Ministry of Skill Development and Entrepreneurship, 93% of India's workforce is in the unorganised sector. The 2015 draft National Policy for Skill Development and Entrepreneurship, developed by the new government to replace the 2009 NPSD, recognises the difficulty of sustainable livelihood for the unskilled, notes the job growth in the informal sector to be twice that in the formal sector, and wants to facilitate more entrepreneurship and self-employment. Ultimately, it wants "to ensure sustainable livelihoods for all citizens and to place India in the comity of front ranking entrepreneurial and innovative nations"[15]. It can be argued however that decent work for Indian women and men, especially for youth and those working in the unorganised sector, will require specific interventions. Among other obstacles, discrimination of women and severe caste-based discrimination persist and reinforce each other. Exclusion and discrimination is also persistent against ethnic and religious minorities. Paradoxically, participation in the labour market is higher for scheduled tribe (ST) and scheduled caste (SC) populations than for other social groups, but mainly so because their employment is of lower quality, both in terms of regularity and income[16]. Despite inclusion being a key theme of a range of policies so far, a large majority of vulnerable groups still needs specific attention.

Translating the existing positive macroeconomic growth into the creation of more decent jobs is an enormous challenge, as became evident in the second half of the last decade: from 2004-2005 till 2009-2010, total employment in India increased from 457.9 million to 459.0 million. This period has thus been described as one of jobless growth. Transitions were however taking place: employment in construction went up by 18.1 million, while the number of agricultural workers dropped by around 14 million. Employment has been growing somewhat stronger since, reaching 472.9 million in 2011-2012[17,viii]. Over the longer term, a fundamental issue is the speed and nature of structural transformation in India. In this respect, around half of all workers continue to be engaged in agriculture, whereas only around 11% are in

[vii] Per capita annual income growth of 3.3% for the bottom 40% vs. 3.8% for the total population, in the period 2004-2011. Inflation was above 6% from 2005 onwards (above 9% from 2009 onwards). Average annual growth rate of GDP was 7.6% (until 2009) or 6.9% (2009 onwards). See http://data.worldbank.org/products/wdi (accessed July 15, 2015).

[viii] Even if employment grew only slowly, unemployment was and remained low (2-5% chronically unemployed in 2011-2012), mainly due to the contingents of self-employed and casual labourers in the unorganised sector.

manufacturing[18]. According to 2009-2013 estimates, the share of firms with a female top manager is 14% (half the Belgian figure, 1.5 times the South Asian average)[3].

The decent work challenge in India is best reflected by the fact that informal employment has not declined, but keeps rising. The increase in contract labour has been a major driver of this trend. Equally problematic is the situation of persons engaged under a number of schemes – like the ASHAs (accredited social health activists[ix]) and the Anganwadi workers[x] – for lack of a decent minimum wage, of social security benefits, of basic amenities in the working space, and of the right of collective bargaining. First and foremost, the fixing of a national minimum wage is considered a priority to respond to a number of prevailing labour market challenges[18].

India has the largest youth population in the world with around 66% of the total population under age 35. In this context, many observers often refer to a demographic dividend[18]. For successive governments, "harnessing the demographic dividend through appropriate skill development efforts" is seen as an opportunity and an imminent imperative[11]. However, young Indians, like their counterparts around the world, are particularly vulnerable to unemployment. In the case of young women in urban areas aged 20-24, the unemployment rate reached nearly 19% in 2011-2012[17]. While there has been a significant decline in the employment of children (up to age 14), concerns remain with the over four million children in employment, and with the much larger number of children who cannot be accounted for in either school or employment.

The 2012-2017 12th 5-year plan 'Faster, more inclusive and sustainable growth'[19] puts forward industry and enterprises of all sizes as key drivers of inclusive growth and job creation, while stressing the need to further modify the business environment for enterprises to overcome a range of constraints. India's 'Decent work country programme 2013-2017'[18] calls for a rethinking of the role of human resources and indicates that, although refurbishing of India's labour laws is necessary, the improvement of industrial relations and collaboration between employees and management, beyond mere deregulation, is also needed. It goes further saying that sustainable enterprises are necessarily the principal source for employment creation. It also states that the promotion of entrepreneurship, with a focus on the self-employed, small producers and home-based workers, is of particular relevance for women and youth. In India today, most micro, small and medium enterprises (MSMEs) operate informally, and their competiveness is limited by the lack of sustainable markets, technology, skills, timely and affordable credit, and infrastructural changes. The 2006 MSME Act contemplates a number of provisions to correct this situation, but keeps silent on the applicability of labour laws. The focus of recent policies is to propel the manufacturing sector as an engine of job creation, especially through employment-intensive activities, as in textiles and garments, leather and footwear, and food processing. In the service sector, hospitality and tourism, transport, IT and financial services are envisaged as major generators of employment[18].

Recognising the importance of domestic workers, most of whom are women, the government started drafting a National Policy for Domestic Workers back in 2008. Today, in 2015, the draft contemplates a 9,000 rupee (about 120 euro) monthly minimum wage, but is still unapproved[20]. The delay in providing effective protection is significant for India's neglect of domestic workers, and recurrent violations of core conventions on this issue are frequent.

The unfinished 12th 5-year plan recognises migrant workers – both inter-state migrants and non-Indians – as a vulnerable group, along with child and bonded labour. In theory, bonded

[ix] ASHA's are community health workers under the National Rural Health Mission (NRHM). Though recognized by the MoHFW and receiving minimal performance-based remuneration, they are considered volunteers, not staff.

[x] Anganwadi workers, also at community level, provide pre-school activities and care under the Integrated Child Development Scheme (ICDS). Though considered workers and having a minimal wage, their working conditions are unsatisfactory and highly contested.

labour was abolished and bondage became punishable in India since the 1976 Bonded Labour System Abolition Act[21]. In practice, as the National Human Rights Commission repeatedly makes clear, implementation of the act is piecemeal and dependent on the goodwill of the individual states, and bonded labour is still widely practiced[22].

In fact, various labour inspectorates have responsibility for ensuring compliance of more than 150 laws at both central and state levels. There is need for strengthening and modernising these existing labour inspection systems. At the same time there is need to revive social dialogue to reduce decent work gaps. India has tripartite bodies for consensus building and social dialogue in place since 1942, but at state and local level most of them are rather ineffective and challenged by an ever more informal labour sector[18]. Under the current national government, prospects for advancing the decent work agenda are bleak and even the labour laws themselves[xi] are under pressure. As part of his economic reform package, the Prime Minister proposes a revision that would reduce social dialogue, the right to strike and the power of unions[xii], make it easier to hire and fire labourers, and ultimately deepen the existing deregulation. On September 2, 2015, 150 million workers all over India went on strike against the proposed reforms[23].

Environment

India's environmental issues are manifold and were largely unattended in the first decades after independence. Only in 1985 a Ministry of Environment and Forests was created, renamed Ministry of Environment, Forest and Climate Change in 2014. Land, water and air pollution are all serious issues. India is the world largest consumer of fuel wood and biomass; its carbon dioxide emissions (over 2000 million metric tons in 2010) rank 3rd after China and the USA. Major efforts at central level to improve environment are noticeable from the 1990s onwards. Still, average exposure to pollution is increasing, impacting both health and overall development[3]. Environmental degradation in India is a major causal factor in enhancing and perpetuating poverty, particularly among the rural poor[24]. Besides, India is a disaster-prone country with frequent earthquakes, floods, cyclones, tsunami's, droughts and landslides[25]. A national disaster management framework was formulated in 2004; a Disaster Management Act was promulgated in 2005[26].

Environmental impact assessments (EIA) were first implemented for river valley projects in 1978-1979, were institutionalised by the 1986 Environment Protection Act, and became a regulatory requirement for major projects in 1994 and for small-scale projects in 2006, when regulatory functions were decentralised from central to state level. Possibly to a greater extent than in other domains however, divorce between central efforts versus state and local implementation has been frustrating. This led to a remarkable amount of interventions of the Supreme Court to enforce environmental protection, and to the establishment of the National Green Tribunal[xiii] in 2010. Besides, over the last years, tensions have grown between the newly elected central government favouring relaxation of environmental laws to foster economic growth on the one hand and the Supreme Court, the National Green Tribunal and environment activists on the other hand. In 2014, the Supreme Court ordered the establishment of an independent national regulator to oversee the EIA process[24,27–29].

[xi] Among others, the 1948 Factories Act, the 1961 Apprentices Act, the 1970 Contract Labour Act, and the 1988 Labour Laws Act.

[xii] From a political perspective, the central government's action against labour unions can be seen as part of a wider trend, with government taking actions against grassroots organisations, social movements, and national and international non-governmental organisations.

[xiii] A specialised national government body, with expertise and jurisdiction over cases relating to environment including forest conservation and natural resources. See http://www.greentribunal.gov.in/

In addition to the current growth versus environment debate – termed a misconstrued dichotomy by environmental scientists arguing for a negotiated middle ground[30] – the case of the Forest Rights Act (FRA) is worth particular attention. The 2006 FRA[xiv] was meant to correct the historical discrimination of forest dwellers – mainly tribal populations – by recognising their rights to forest land and resources. As these resources are key for livelihood of most tribal populations, conscientious implementation of the FRA can be expected to foster tribal wellbeing and health. Implementation has however been very partial[31] and Forest Department officials in many cases even deny the existence of the FRA to the rights holders. A 2010 independent report stated that "all of the key features of this legislation have been undermined by a combination of apathy and sabotage during the process of implementation (…) Unless immediate remedial measures are taken, instead of undoing the historical injustice to tribal and other traditional forest dwellers, the Act will have the opposite outcome of making them even more vulnerable"[32]. As of 2015, effective implementation and benefits for the tribal populations are still to be seen[33].

Health

Health is a highly controversial issue in India, with lots of conflicting voices: those who feel very strongly about strengthening government services versus others who promote privatisation of the entire health sector; those who propagate their own vertical disease control programmes versus those (a resistant minority) who want to strengthen the general health services; and those who swear by indigenous systems of healing versus the champions of modern medicine. To understand the reasons for these conflicting voices, one needs understanding of the origin of India´s health services.

India had an indigenous system of medicine (*Ayurveda*) and surgery which was codified as early as 3,000 BC[34]. Since then various invading armies brought with them their own systems of medicine, e.g. *Unani* from Persia[35] and modern medicine from Britain[36]. Modern medicine in India started flourishing after the Indian Mutiny in 1857 and the great famines in 1870 and 1890, when the colonial state increased investments in health services, primarily to protect their citizens and the Indian army[37]. The main focus was on curative services in the cities and cantonments (where the British citizens resided), while also providing preventive care (campaigns for eradication of various communicable diseases) for the possibly contagious surrounding rural population. Today, India still faces a strong divide between curative and preventive health services. Civil societies actors, read Christian missionaries, were encouraged to provide curative services in the rural areas, as the government considered it a cheaper option as well as a strategy to convert the Hindus to Christianity[37].

On the eve of independence, the Bhore Committee laid out an elaborate plan to strengthen India's health services[38]. However, the post-independence government was keener on creating an economically strong India and spent most of its revenue on infrastructure and industries. Health service provision were limited to some primary health centres, high-end hospitals for the urban elite, and disease eradication campaigns for the rural population. Even these campaigns were seen more with an economic perspective rather than a health perspective. Most of the budget was spent on malaria control and family planning at the expenses of general health care. While the government favoured the British model of financing service provision through general taxation, it also allowed the private sector to grow, first by default and later proactively.

It was only with the advent of Alma Ata and the subsequent primary health care movement that the Indian government realised the importance of general health services. In its first ever

[xiv] 'The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act', usually referred to as Forest Rights Act (FRA).

health policy document in 1983, the government explicitly stated that "the demographic and health picture of the country still constitutes a cause of serious and urgent concern. (…) The hospital based disease, and cure oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially those residing in urban areas"[39]. It advocated setting up of a network of primary health centres (PHCs) that would provide preventive and promotive care. With this policy the divide between preventive and curative care was further emphasized: primary health care centres in rural areas for preventive care and hospitals in towns and cities for curative care. National health programmes for many disease conditions were developed that would be vertically implemented through these PHCs. The PHCs became decentralized units for implementation of vertical programmes rather than for providing comprehensive primary health care. Vertical programmes at that time in order of priority included the family planning programme, the safe motherhood programme, the malaria control programme, the TB control programme and the leprosy control programme.

At the turn of the century, the government realised that it had still a long distance to go to achieve Health for All. In is second health policy document, in 2002, the government documented some of the achievements of its first health policy. Life expectancy had increased from 54 years (in 1981) to 65 years, the infant mortality rate (IMR) had fallen from 110 to 70, leprosy cases per 10,000 had reduced from 57 to 4, Guinea worm infestation was eradicated, the number of PHCs had tripled from 57,363 to 163,181 and nurses had increased from 143,887 to 737,000. For two decades no impact was made on malaria, TB or under-nutrition; HIV and non-communicable diseases had become news threats. Failures were attributed to the limited financial allocations to health[40]. To this added structural adjustment that resulted in even less public health expenses and the active promotion of the private healthcare sector[41,42]. Indian government then proposed a range of significant changes, including increasing public allocation for health care from 1 to 6% of GDP, integrating the vertical programmes into the general health services, creating a cadre of public health managers and giving importance to urban health as well as mental health. It also explicitly recognised existing health inequities, and identified states and population groups that needed extra inputs to redress these inequities.

To operationalize its policy, and in keeping with the socialist politics of the coalition in power, the UPA government launched the National Rural Health Mission (NRHM) in 2005, which became operational in 2007. The main objective of NRHM is to provide effective health care to the rural population, with a focus on disadvantaged states, by increasing financial allocation for health, making architectural corrections of the health system, deploying village health workers (accredited social health activists, ASHAs) in each of the 600,000 villages and by strengthening public health management[43]. Over the last decade much has happened. Indeed more than 600,000 ASHAs have been recruited, trained and placed in the villages, new ways of financing including health insurance were extensively tried out[xv], decentralization of decision-making was initiated, and standards were elaborated to measure performance. However, despite this, the health status of the average Indian has not changed much.

The health status of Indians is the outcome of many factors. Indian society is undergoing demographic, epidemiological, nutritional and sociological transitions. While there is a very large young population (30% under age 15), the number of older people is also steadily rising.

[xv] RSBY – *Rashtriya Swasthya Bima Yohana*, the national free health insurance for the poor since 2008 – is the best known but not the only example: India has seen a plethora of subsidised health insurance schemes over the last decade but effective financial protection is limited[108,109]. RSBY, while lauded for its massive population coverage, has a biased service coverage and ultimately benefits insurance companies more than the populations it is meant for. RSBY is currently under revision and its future is unclear. Responsibility for the scheme has shifted from the Ministry of Labour and Employment to the Ministry of Health and Family Welfare as of April 2015[110]. Private insurers would be replaced by a public trust in September 2015[111].

Malaria and TB still kill, but so do cardiac conditions and road traffic accidents. While half of Indian children are under-nourished (48% are stunted), obesity among urban adolescents becomes problematic. A growing middle class has high expectations vis-à-vis health services, leading to frequent confrontations between patients and service providers.

India's infant mortality rate is still 38 per 1000 live births, significantly higher than most of its poorer neighbours Nepal, Bangladesh, Bhutan and Sri Lanka. India's score for maternal mortality ratio (MMR) and life expectancy (LE) are equally shameful: MMR is 190 maternal deaths per 100,000 live births, LE at birth no more than 66 years[3].

Health services in India are today mainly provided by the private sector, which accounts for 79% of all outpatient care and 61% of all inpatient care[44]. At all private facilities, patients have to make out-of-pocket payments at the point of care on a fee-for-service basis. The average amount spent for outpatient care ranges from 11 to 15 euros per episode while the average amount spent on inpatient care is 360 euros per admission.

The government has nevertheless an extensive network of primary health centres (PHCs), 1 per 30,000 population, each staffed by a doctor and a nurse. However, the PHC teams' focus is still on preventive care, mainly maternal and child health, family planning, malaria and TB control, among a total of 33 national health programmes. Ambulatory care is neglected and most PHCs lack adequate supply of medicines[45]. Three to four PHCs refer their patients to a community health centre (CHC) that is supposed to have specialists and to provide among other services comprehensive emergency obstetric care and basic surgery. However, most CHCs are not fully functional and most surgical and emergency care is provided at the district hospitals, 1 per 2 million population.

The PHCs are supervised by a district health officer (DHO) and a team of health programme managers, while the CHCs and the hospitals come under the control of the district hospital. Districts in turn report to the State Directorate, which is the nodal department for managing health services in each state. Governance is not only complex; it is also poor. Health departments at the state level are headed by general administrators, coming from Central Services and posted in each department for a maximum tenure of three years. It is common to have an administrator who was previously in the Labour Department or the Oil and Natural Gas Department being posted as health secretary. By the time this person understands the technical details of the department, it is time for her or him to move to the next department. Rarely is there a long-term vision for the sector and even less effort to implement the vision of the previous incumbent, as everybody is interested in leaving behind a 'legacy'. So an activity or a programme introduced in the previous secretary's term may be neglected with the arrival of a new head. The weakest link in the department is the personnel at the district level. The District Health Officer (DHO) – a key component of the health system – is usually appointed on the basis of seniority. Thus a well-established orthopaedic surgeon may be suddenly promoted as DHO, without public health knowledge, nor the experience to manage a district of 2 million people, more than 1,000 personnel and millions of rupees worth of equipment and consumables. Professional management of the sector at the government level thus becomes negligible and leads to ineffective and inefficient delivery of services.

Government health services are publicly financed (by centre and state government) and are supposed to be free, but patients still incur costs either for informal fees or for purchasing medicines and consumables from outside[44]. Public spending on the network of PHCs and CHCs over the last three years was 74% less than the National Rural Health Mission (NRHM) had foreseen, the CHCs are still 70-80% short of trained physicians and surgeons, and a free generic drugs programme – basic requirement of a universal healthcare model – was never started up[46]. Underfunding of the health sector has been a constant. At the time of the first health policy, the government was spending 1.3% of GDP on health care. Today it is still stuck

at 1.3% of the GDP, with a per capita expenditure of about US$20 per year[47]. Meagre funds and the unwillingness and inability of state governments to shoulder responsibility for comprehensive care led to the dominance of the private sector in service delivery[48,49]. The dominant private sector has become powerful and has managed to escape the shackles of regulation for the past 68 years[50,51].

Amongst both private and public service providers, there are practitioners of modern and of Indian systems of medicine (AYUSH). Amongst private provides, there are many informal providers. According to one estimate, more than 90% of all providers are informal providers[52]. The latter are the first contacts for many patients, especially among the urban and rural poor. Despite producing more than 50,000 doctors and more than 200,000 nurses every year, the number of doctors and nurses per 1,000 population are 1 and 2 respectively[3]. Besides, more than 70% of doctors are concentrated in the urban areas.

Service performance indicators are mixed, following an inequitable gradient[xvi], as illustrated by data from the 2012-2013 District Health and Family Survey[xvii]:

	Worst performing district	Best performing district	Median for the country
Antenatal coverage (3 or more)	4.4%	98%	73%
Child exclusively breast feed for 6 months	0%	100%	66%
Low birth weight (< 2.5 kg)	34%	0%	9%
Full immunization of child	0%	100%	65%
Unmet contraceptive needs	76%	4.3%	21%

Beyond the disparities between districts – as highlighted above – there are wide variations across states, within rural and urban areas and between social and religious communities, in terms of health and access to healthcare services. For example the performance of northern and eastern states in terms of health indicators is worse than of the southern states. The situation is worse for rural areas (still the majority of the population) in general and poorer states like Bihar, Chhattisgarh, Orissa, Uttar Pradesh, and Madhya Pradesh in particular.

The dismal state of health in states like Bihar becomes painfully clear when looking at its state of leprosy control. While India as a whole already contributes to more than 55% of all leprosy cases worldwide (58% in 2013), the state of Bihar (with less than 9% of the Indian population) contributes around 20% of all Indian cases. India's poor performance in leprosy control so far is illustrated by the fact that the highest proportion (40% in 2013) of maximum impairments[xviii] among newly detected cases globally was reported in India.

The Indian healthcare delivery system is a complex one, riddled with multiple powerful players, no common vision, very low funding and a host of inefficiencies. This results in poor health outcomes for the population, further exacerbated by the inherent inequities in Indian society at large. Increasingly, Indian health activists and researchers are aware of the need to also tackle the inequities outside the health sector if eventually Health for All wants to be achieved[53,54]. Some of them today advocate a multisectoral, comprehensive Health-in-All Policy (HiAP) approach for faster and more sustainable progress[55,56].

[xvi] The gradient shown is geographical. To this adds inequitable distribution according to wealth, caste, ethnicity, …

[xvii] Accessed from https://data.gov.in/catalog/district-level-household-and-facility-survey-dlhs-4#web_catalog_tabs_block_10 on 29/09/2015

[xviii] Maximum impairments, or DG2 in the WHO Disability Grading (DG). The DG distinguishes DG0 (no disability), DG1 and DG2. Presence of DG2 at diagnosis indicates late diagnosis.

Discussions at national level on health policy have intensified but are inconclusive. In 2011, the government commissioned a High Level Expert Group (HLEG) on universal health coverage. The HLEG delivered its report within a year[57], indicating a roadmap to achieve UHC in India by 2022, but follow-up was minimal[58]. The 2014 shift in national power to the NDA, under Prime Minister Modi, brought new changes, more uncertainties and more challenges. A 'health assurance' mission was announced[59] and a draft National Health Policy was unveiled[60], but none of both became operational so far. Apart from the National Rural Health Mission (NRHM) that was rechristened National Health Mission (NHM)[xix], what became real was a 15% budget cut and a shift of responsibility toward the state governments[61,62].

Education

Education is considered a priority by India's central and state governments and public spending on education has expanded since the early 1990s by 6% on average, in line with GDP. Overall, public spending on education is still low, at 3.9% of GDP[63,xx]. Since 1976 education has been listed as a concurrent item in the Constitution, making funding and regulation the shared responsibility of central and state governments[xxi]. State governments generally have authority over the schools sector with responsibility for curricula and exams as well as teacher recruitment. Both the central and state governments have authority over vocational education and training (VET) and tertiary education[64].

The school system comprises primary and upper primary, which together constitute compulsory elementary education, as well as secondary and upper secondary terminating in grade 12. The higher education system offers undergraduate bachelor's degrees in general and specialised programmes of varying lengths, as well as postgraduate qualifications including masters and doctor of philosophy degrees. In addition a technical training stream commences following the completion of elementary education. VET is provided through a diverse network of institutions. The point of entry is at the secondary school level. In the post-secondary segment more than 2,000 state-owned Industrial Training Institutes (ITI) and nearly 6,000 private Industrial Training Centres (ITC) from the backbone of the VET system, offering certificate level courses and a pathway to professional apprenticeships. As in the school system, a number of institutions are privately managed but publicly funded. More advanced vocational training leading to diplomas in technical disciplines is provided by Polytechnics. Standards for most technical training are regulated by the National Council for Vocational Training and state-level authorities[64].

Public universities are funded and managed either by the central or state governments. Private universities, besides usually receiving government support in the form of land grants or capital, are self-financed. A further distinction concerns 'deemed universities', which are accorded

[xix] While the NRHM applies to rural India, the NHM would cover rural and urban India. A National Urban Health Mission (NUHM) had been drafted in 2008[112] and approved in 2013[113], but never became operational.

[xx] Public expenditure on education was as low as 0.6% of GDP in the immediate post-independence period, rose to 2.3% in 1970 and peaked at 4.3% in 2000. Though the stated target was reaching 6% of GDP, it declined again to 3.5% in 2005.

[xxi] This was later confirmed by the inclusion of Article 21A ("The State shall provide free and compulsory education to all children of the age of six to fourteen years in such a manner as the State, by Law, determine") in a 2002 constitutional amendment and by the 2009 Right of Children to Free and Compulsory Education Act (RTE Act), which clarifies that 'compulsory education' means obligation of the appropriate government to provide free elementary education and ensure compulsory admission, attendance and completion of elementary education to every child in the six to fourteen age group and that 'free' means that no child shall be liable to pay any kind of fee or charges or expenses that may prevent him or her from pursuing and completing elementary education. The RTE Act also confirms and widens (to private institutions) the constitutional reservations for ST and SC groups. The right to education of persons with disabilities (under 18 years of age) is laid down under a separate legislation, the Persons with Disabilities Act.

university status by the University Grants Commission, a central statutory authority. The bulk of undergraduate training is undertaken in colleges, most of which are affiliated to universities. Public colleges are funded and managed either by the central or, more commonly, state governments while 'aided colleges' are funded publicly but privately managed. Private 'unaided colleges' are entirely self-financed, mainly through tuition fees. India today counts over 500 universities, most of them public, and over 25,000 colleges. In addition to universities and colleges there exist specialised institutions, including the Indian Institutes of Technology (IIT) and Indian Institutes o Management (IIM) established by central government[64].

Reported enrolment rates for compulsory education are high, up to 93%. Quality of primary education however suffers from shortage of infrastructure and resources, high pupil-to-teacher ratios (35:1) and poor levels of teacher training[3]. As of 2011, 74% of Indians 7 years and above were considered to be literate. Between 2001 and 2011, literacy growth was 9.2%, less than in the previous decade. When looked at more in detail, literacy rates show considerable disparities. Behind the average of 74% is a huge gender gap: 65% of women versus 82% of men. The decadal literacy growth among women however was 12%, for men 7%, which suggest a narrowing gender gap. Kerala, India's most literate state, scores as high as 94% (women 92%, men 96%), but Bihar as low as 64% (women 53%, men 73%). The remaining 26% illiterate Indians make India the country with the largest illiterate population in the world. Most of the left behind are to be found among the rural and – despite constitutional reservations – in ST and SC populations[65], where also lowest enrolment and highest dropout rates are to be found[66,67].

Children's rights

With over 360 million children[xxii], India is the country with the largest children population in the world. India is home to 20% of all live births in the world, 20% of the 0-4 years population, yet more than 20% of all child deaths: every year nearly 1.5 million Indian children die before completing their fifth birthday. Current under-five mortality rate is 53 per 1000 (55 for girls, 51 for boys). One third of under-five deaths is attributable to under-nutrition. Of under-fives, 20% are wasted, 44% underweight and 48% stunted. Child labour is estimated at 12% (equal for girls and boys). Poverty is widespread and half of all poor children belong to ST and SC populations. Child marriage as married by age 15 is 18%, as married by age 18 it amounts to 47%[68,69].

India has adopted a number of laws and formulated a range of policies to ensure children's protection and improvement in their situation, including the UN Convention on the Rights of the Child (UNCRC) and the optional protocols (OPAC, OPSC). India's 1974 National Policy for Children declared children the nation's "supremely important asset". The 2003 National Charter for Children confirmed every child's inherent right to be a child and to enjoy a healthy and happy childhood. In 2006, the Ministry of Women and Child Development proposed the Integrated Child Protection Scheme (ICPS), which became operational from 2009 onwards. The ICPS searches to protect children in difficult circumstances, and to reduce the risks and vulnerabilities children have that lead to abuse, neglect, exploitation, abandonment and separation[70]. The revised 2013 National Policy for Children[xxiii] reiterates that every child has universal, inalienable and indivisible human rights: survival, health, nutrition, development, education, protection and participation[71]. Laws and policies however have not resulted in much improvement. Poor law enforcement frequently makes a mockery of laws and protecting measures.

[xxii] The 2011 Census of India recognised only age 0-14 as children.

[xxiii] The 2013 National Policy for Children recognises age 0-17 as children.

In its 'Concluding observations on the combined third and fourth periodic reports of India', in 2014, the UN Committee on the Rights of the Child (CRC) expresses it concerns about a range of issues: disparity in access to basic services including health and education), persisting discrimination (ST, SC, but also children with disabilities, children with HIV/Aids, street children, and simply girls), corporal punishment, violence and abuse (including sexual abuse), harmful practices (including child marriage), child labour and child trafficking.

The CRC also notes that budgetary allocations do not adequately take into consideration child protection needs and that allocated resources are frequently mismanaged, a problem still exacerbated by low awareness for child rights among the general public, high levels of corruption and the lack of effective monitoring and evaluation systems. It urges the government to take necessary actions and recommends the systematic involvement of communities and civil society actors in planning, implementing, monitoring and evaluating all policies, plans and programmes related to child's rights[72].

In *Box 1* (below), a summary of the main points presented and discussed in Chapter 3 are listed.

- India is the world's largest democracy and seventh largest economy
- Ranks 135 in human development and has 900 million poor
- 93% of India's workforce is in the informal sector
- Employment rate is stagnant with more than half the jobs in the agriculture sector
- Issues in 'decent work' are the discrimination in employment for women, the SC and ST, religious and ethnic minorities; lack of rights for migrant workers and the continued presence of bonded and child labour
- India is the largest consumer of fuel wood and biomass and its carbon dioxide emissions rank 3rd after China and the USA
- The government has put in place various safeguards to protect the environment, including the National Green Tribunal and mandatory environment clearances for all development projects
- Chronic underfunding of the health sector has led to a weak government health sector that provides only 20% of outpatient and 40% of inpatient care. The rest are provided by the private health sector but at a cost. Patients have to make out-of-pocket payments at the point of care, resulting in impoverishment
- There is inequity in the coverage of health services, both in terms of regional variation as well as differences between social and economic groups
- The government has announced various policies including one on universal health coverage, however, this is not supported with public financial resources. On the contrary, the budget allocation has been cut by 15% between 2014 and 2015
- Education has been made free and compulsory for children between 6 and 14 years. While literary rate is high – 74%, this average hides huge gender gaps as well as gaps between the SC/ST population and the rest of India
- Rights of children are an issue especially in terms of child labour (12% of all children), under-nutrition (48%) and mortality (53 child deaths per 1000). Recognising this, the government has a created a commission for Protection of Child Rights with branches in the states

<u>Box 1:</u> Political, economic, social & environmental situation (summary)

4. Description of local civil society, decentralized authorities and governmental institutions

Civil society

'Civil society' is not a term commonly used in India until recent years. This does not mean that civil society is a recent phenomenon, nor of minor importance. Civil society in India is largely equated with 'voluntary organisations' or with the more colloquial term 'non-governmental organisations' (NGOs)[73,74].

Voluntary organisations – organisations that are voluntary in spirit and without profit-making objectives – have been active in India since medieval times, rooted in religion and philanthropy. All major religions in India have had their contributions[xxiv] to a range of philanthropic activities and charitable institutions in the fields of education, health, culture and natural disaster relief, concerns that continue to dominate the Indian NGO sector today. To these added in the 19th century voluntary organisations linked to Christian missionaries and to the Indian freedom movement[75,76].

The Charter Act of 1813, besides asserting British sovereignty over India and allotting some money to promote education in Indian masses, permitted Christian missionaries to propagate English and preach their religion in India. They choose to do so by setting up schools and hospitals, and organising marginal communities. Until today, a substantial part of development activities for vulnerable populations – particularly scheduled tribes (ST), is linked to church-related voluntary organisations[76].

During the second half of the 19th century, nationalist consciousness spread across India and self-help emerged as the primary focus of socio-political movements, leading to the establishment of a range of organisations aiming at mass mobilisation and social reform. This led the British government to enact the Societies Registration Act (SRA) in 1860. The SRA was a first step in the state regulating structure and role of India's voluntary organisations and is still at the core of the actual NGO legislation[74–76].

Secular voluntary action gained force first with the establishment of 'Servants of India' in 1905, then with Mahatma Gandhi's adoption of the *swadeshi* (self-sufficiency) movement in his *swaraj* (self-rule) concept (1917-1947)[xxv]. This added an economic focus to voluntary action, advocating economic self-sufficiency at village level based on local production for national prosperity. Its political counterpart was Gandhi's insistence on *gram panchayats* (village councils) for development, which would be institutionalised by the end of the century[75]. In parallel with the Gandhian brand of voluntarism, the Indian Muslim League (1906) and regional caste-based organisations saw the light in the early 20th century. What they all had in common was their emphasis on empowerment and transformation of existing inequities, beyond charitable activities. At the same time, women's leadership emerged as a critical force[76].

In the early post-independence period (1947-1960), government priority – within a Nehruvian framework – was to put economic reconstruction on a fast track. Social issues like health, education and welfare tended to take a back seat and voluntary organisations were encouraged to cover these gaps[76]. While government-supported Gandhian-based voluntary

[xxiv] Roots of Indian charitable action and voluntary organisations are found in the concepts of *dhaan* (giving in charity) and *dhakshini* (giving to a teacher in return for knowledge) in Hinduism, *bhiksha* (giving to a monk) in Bhuddism, and *zakat* and *sadagah* (obligatory and voluntary sharing of income and wealth) in Islam[76].

[xxv] The *swadeshi* movement originated in 1850 and became prominent in reaction to the 1905 partition of Bengal.

organisations actually became parastatal agencies, voluntary organisations as a whole became a core element of Indian development[74]. From then on they have played three significant roles: first, in filling gaps in the government's welfare systems, such as delivering basic services like health care, education, water and sanitation to the most remote locations in the country; second, in research-based advocacy, such as analysing the efficacy and reach of government projects to provide guidance for policy improvement; and, third, in working on a rights-based approach and entitlements[73]. In the mid-1960s international NGOs started entering India in significant numbers. Many of them established permanent local operations, and foreign funds began flowing to domestic NGOs[75].

The decade of the 1970s was one of important positive and negative changes for India's voluntary organisations. On the positive side, the influx of foreign-trained Indians led to professionalization of the sector. Also, increasing concern about poverty and marginalisation, and focus on community participation, granted the sector recognition as a core development partner. On a less positive side, the 1975-1977 Emergency reduced the action of many voluntary organisations to a less developmental and more technological, instrumental role[76]. Sheth and Sethi would later describe this new role as a "focus on cost-efficiency, greater ability to involve people in 'development projects', innovation in programme and planning processes, and strengthening delivery systems"[74]. At the same time, a number of organisations emerged that assumed a confrontational role with the state. Sheth and Sethi describe them as "radicalised middle class and subaltern organisations"[74]. Most importantly, the government in 1976 enacted the Foreign Currency Regulation Act (FCRA), which enabled the state to control the flow of foreign funds to the sector but also to impede supposed political activities of voluntary organisations. The FCRA has been a headache for the voluntary sector ever since, was somewhat softened when amended in 2005 – resulting in the Foreign Contributions (Management and Control) Bill (FCMCB)[76], but became again a sword of Damocles for the sector under the current federal government.

Starting in the 1990s, and fostered by politics of decentralisation and public-private partnerships, voluntary organisations (from then on increasingly termed NGOs[xxvi]) mushroomed and ever since their responses to the state "cover the range from strongly oppositional to closely collaborative, with the majority keeping an uneasy, sometimes reluctant, but pragmatic and often sophisticated partnership with the Indian state in its various forms". The second half of the 1990s also saw the emergence of a new kind of philanthropy under the form of what came to be known as 'Corporate Social Responsibility', well resourced and usually in close collaboration with the state[76].

Over the last decades, although a rights-based approach has increasingly been the declared focus of action, the earlier voluntarist spirit and the concept of a mass movement have been diluted. Two collateral phenomena can be noted: first, a growth of network and corporate NGOs at the cost of grassroots organisations; second, a reduced ability to bring about transformation in the socio-political sphere. A noticeable exception is the NGO-driven political agenda setting that led to the promulgation of the Right to Information Act and the National Rural Employment Guarantee Act (both in 2005)[76].

[xxvi] Sheth and Sethi, in 1991, had described the ongoing process as "the conversion of voluntarism into primarily a favoured instrumentality for developmental intervention (that) has changed what once was an organic part of civil society into merely a sector – an appendage of the developmental apparatus of the state"[74].

Non-governmental organisations (NGOs) today are omnipresent in India, but their reality is difficult to express in figures. The Central Statistics Institute counted 3.3 million NGOs in 2009; by contrast, the Foreign Contribution Regulation Act has 43,000 NGOs registered[73,xxvii].

Decentralized authorities

India being a federal republic, government since independence and as laid out in the 1950 constitution is based upon a two-tier administration: a union government at the centre and state governments. Despite this federal structure and for half a century after independence, the power balance in governance was highly centralised[xxviii]. Not until the 1993 73rd and 74th constitutional amendments was local government given a constitutional status, with the introduction of a third tier of government at the sub-state level. This decentralisation was meant to bring about local self-rule, *panchayati raj*, and institutionalised the village councils (*gram panchayats*), block councils (*panchayat samitis*) and district councils (*zila parishads*). The 73rd constitutional amendment also specified reserved quota for women and representatives of scheduled castes (SC) and scheduled tribes (ST) in the *panchayat raj* institutions, whereas the 74th amendment widened the scope of decentralisation to urban India and specified which competences should be transferred to the local governments[77–79].

In *Box 2* (below), an overview of the main points presented and discussed in Chapter 4 are listed[xxix].

- India has a long history of charity and philanthropy embedded in the religious beliefs of the people. This was formalized during the colonial period with state support to Christian missionaries for providing educational and medical services
- The independence movement saw the rise of empowered communities fighting for liberty. After independence, these morphed into organisations for the delivery of services to the community. This was supported by the government that was more interested in economic growth
- Some of these 'non-governmental organisations', evolved from service delivery organisations into right-based ones. To curb their expansion, especially those funded by foreign donors, the government of India introduced the Foreign Contribution Registration Act in 1976. This act has been used to curtail the activities of NGOs to a certain extent
- In the 1990s, the government of India amended the Constitution to empower local governments both at the rural and urban regions. *Panchayats* were recognized as legitimate elected bodies and were given resources to develop their villages and wards. These are still in place with varied progress. In Kerala for instance, most of the development activities are driven by the *panchayats*, while in most other states, their role is limited
- Funding from CSOs is limited in India. Most of them have to rely on local philanthropy or on external donations. The government per se hardly invests in these organisations

<u>Box 2:</u> Description of local civil society, decentralized authorities and governmental institutions (summary).

[xxvii] Indian NGOs can register at state and federal level as 'public charitable trust', as 'society', or as 'company'. Rules and legislations vary from state to state. Only NGOs receiving contribution from 'foreign sources' have to register under the Foreign Contribution Regulation Act.

[xxviii] Characteristic historic examples at the political level are the abrupt dismissal of elected state governments in the Patiala and East Punjab States Union (1952) and Kerala (1959) by central government[77]. India's first prime minister, Jawaharlal Nehru, saw centralised politics as a condition to match the aims of a liberal democracy with those of a planned economy[77,79].

[xxix] The JCA Vademecum provides two broad categories of actors: 'civil society' and 'decentralized authorities and public institutions'. As most higher education institutes are autonomous organisations with a public interest, and cannot be considered as purely governmental institutions, they are categorized as civil society.

5. Analysis of local civil society, decentralized authorities and governmental institutions

As in other countries, political decentralisation and increasing influence of non-state actors – including but not limited to civil society – went hand in hand in India, and followed market liberalisation[80]. India's decentralisation process has been described as the result of popular pressures, of the breakdown of dominance of the Congress party, of the fragmentation of political parties, but at the same time as the result of market reforms and structural adjustment policies[79].

India's particular form of decentralisation – based on *panchayati raj* institutions at village/ward, block and district level – still faces serious difficulties to deliver the improvements in local and democratic governance it was meant for. Implementation varies from state to state and from locality to locality, transfer of competences is an incomplete process, and lack of dedicated financial resources further limits optimal decision making at peripheral level[81]. Moreover, and despite the constitutional reservations made for vulnerable groups, the composition of many a *gram panchayat* reflects and confirms the dominance of powerful groups in a village[82].

It is worth noting that while *panchayati raj* self-rule is still an unfulfilled promise, under the current federal government a new wave of decentralisation is making headlines. In January 2015, Prime Minister Modi dissolved the 65-years old central Planning Commission, replacing it with a National Institution for Transforming India (NITI *Aayog*) composed of state representatives but under his personal lead[83]. In February 2015, the Finance Commission presented a report in which it recommended a centre-state devolution in the form of tax transfers[84]. Lauded by the central government as a way "for states to decide on schemes they would want to implement", this proposal is met with unrest by the poorer states and by the social sector, as the risk is real that both will be affected if the proposal will be implemented[85]. It is still unclear what this proposed devolution will mean for health and education budgets, but given the already extremely low public investments in these sectors[86], prospects are indeed worrying. As a recent 'India EU country roadmap' stresses, "While India is most often perceived from outside, and increasingly so in the last 15 years, as a booming, shining or emerging economy, and while both economic growth and progress in many sectors are undeniable, the sheer size and intensity of poverty, marginalisation and inequalities in India are no less a reality that slows down social and economic progress. No less troubling are (…) the very high levels of population mal-nutrition and under-nutrition reflecting, at least partly, inefficient public policies in the food, agriculture and nutrition sectors. So, while one often hears that India does not need money but competence-based technical cooperation, one also needs to acknowledge that the actual and relative low levels of financial investments in key social policy sectors like health, education and nutrition severely constrain, and slow down, India's social and economic growth. The sudden slowing down and reduction of GDP growth in the last 3½ years after 20 years of constant, dynamic economic growth is a stark reminder that India, though an increasingly important global player, faces very real poverty, social exclusion and inequity problems, at a size, depth and complexity often ill-understood or acknowledged from outside". The European Union concludes from this that engagement with Indian civil society "as policy influencer, advocate, watchdog, capacity builder but also as direct service provider or innovator remains very much relevant", today and in the years to come[86]. The question then rises if Indian civil society today (and in the years to come) has the means and the space to fulfil these roles.

There is little doubt that Indian civil society has enormous capacities as service providers and innovators. Its capacity for policy influence however is strongly dependent on the space it is given. And precisely that environment has become less enabling in India over the last years. As the earlier mentioned EU roadmap mentioned already in 2014, "Space for CSO[xxx] work is (…) very much shrinking"[86].

Overall, the picture is mixed. On the positive side, "The environment is conducive in the sense that there are laws, rules, procedures and institutions dealing with civil society, hence an overall legal and administrative framework which enables any CSO, or citizen, to contribute to society from an organisation or individual perspective"[86].

The EU roadmap goes on mentioning that "the 12th 5-Year Plan (2012-2017), to which a number of civil societies have contributed, in various forms and through various committees, on different sectoral or cross-cutting issues, offers a progressive inclusive growth and sustainable development policy framework, within which most if not all human rights, social justice and development issues can be addressed, by all types of civil society actors"[86].

The EU roadmap also mentions vibrant mass media, unrestricted internet access and the 2005 Right To Information (RTI) Act as enabling factors[86]. Regarding the latter, it should however be noted that – 10 years after the Act was passed – its implementation remains inefficient with penalties imposed on government departments denying information in less than 3% of cases[87]. Equally worrying, of people seeking information based on the RTI Act – termed 'RTI activists' in India today – between mid-2005 and mid-2015, 39 suffered a violent dead and another 275 were assaulted or harassed[88,xxxi]. The amended 2015 Whistleblowers Protection Bill is unlikely to change this situation. According to a prominent human rights group, "The original intention of the whistleblower protection law was to protect citizens disclosing information regarding wrongdoing in the larger public interest. But the proposed amendments have turned the law into a 'Whistleblower Prevention and Victimisation Act'"[87].

Further on the negative side, the EU roadmap notifies that "challenges are numerous and complex. For every positive example cited (…), there are numerous counter-examples, most of them quite serious. On the legislation front, a recently updated law (Foreign Contribution Regulation Act 2010 and related Foreign Contribution Regulation Rules 2011) regulating foreign transfer of money into India, therefore not just "NGO money", has clearly stated that no agency receiving foreign funds is allowed to engage in political activities. The problem starts from the fact that this does not limit to "party politics" work but, much more broadly, to a very large part of community mobilisation work, in particular capacity building"[86]. This new environment is obviously at odds with what global development experts today call the much needed "return to politics in the broadest sense"[80], made explicit by Carothers and de Gramont as "efforts by development aid actors intentionally and openly to think and act politically for the purpose of making aid more effective in fostering development (…): the pursuit of political goals and the use of politically smart methods"[89,xxxii]. It is equally incompatible with the EU Communication on strategic engagement with local civil society[86].

[xxx] Civil Society Organisation.

[xxxi] The EU roadmap also notes that "in India today, the right to access public information, or interventions for more transparency, can be a life-threatening enterprise"[86].

[xxxii] Carothers and de Gramont, in their 2013 book 'Development aid confronts politics: the almost revolution', define the pursuit of political goals by international development assistance actors as "using aid to advance explicitly political goals – which aid organizations usually frame at a general level as better governance (…), democratic governance, or democracy itself". They describe the use of politically smart methods by international development assistance actors as "moving away from the dream of development change as a mechanical process in which supplying technocratic inputs (…) will produce desirable socioeconomic outcomes. It requires recognizing that developmental change is an amalgam of complex, inherently political processes in which multiple contending actors assert their interests in diverse societal arenas, trying to reconcile them into shared positive outcomes. To be

Besides, as the EU roadmap also draws attention to, "The 2014-15 Budget confirmed the trends towards a tighter control of NGOs. It brings in a series of amendments in the Income Tax Act that seem to give sweeping powers to the government ranging from withdrawing tax benefits to cancelling their registration. In addition to the existing provisions, which earlier led to cancellation if an organisation was deemed "not genuine" or if its "activities were not being carried out in accordance with the objects of the trusts or institutions" there are now four additional grounds for cancellation. These are: if the organisation's "income is not for the benefit of the general public", "is for the benefit of any particular religious community or caste", if "any income or property of the trust is applied for the benefit of specified persons like author of trust" and if "its funds are invested in prohibited modes" (which are not defined)"[86].

The 2013 Companies Act – which mandates major companies the spending of 2% of annual net profit on social issues as Corporate Social Responsibility (CSR) – leads to one more ambiguity. In theory, it is an opportunity for increased funding of civil society initiatives. In practice however, three caveats appear: "(i) many companies set up their own foundations and manage directly most of the funding, making the CSR financing space for CSOs smaller and more restricted than at first glance; (ii) many of the sensitive human rights and governance issues are not and will not be addressed by corporate funding; (iii) several contradictory rules and procedures between several laws of various ministries – in particular FCR Act, Companies Act and laws relating to income tax – will make, de facto, corporate funding to CSOs quite challenging, not to say a real disincentive at times"[86]. Perverse effects of the Companies Act are already visible, such as the tobacco industry's appropriation of now legal CSR activities to promote its image and, indirectly, that of tobacco consumption[90].

Domestic funding for local civil society working on human rights is particularly limited, making them dependent on foreign funding for their existence, which has an impact on the sustainability of their work. This situation is further compounded by increasing restrictions being placed on foreign funding to Indian NGOs. The 1976 Foreign Contribution Regulation Act (FCRA), which made permission from the Ministry of Home Affairs mandatory for receiving funds into NGO accounts, was amended in 2011 to place stricter controls on eligibility criteria, registrations and renewals. The amended FCRA has raised concerns among civil society that it can be used to curb its activities – on grounds of being political in nature or being detrimental to national interest – and limit the space available in India for democratic protest and political lobbying. The amended FCRA has also made it mandatory for NGOs to apply for renewal of their registration every five years[xxxiii]. Besides, Indian human rights defenders come under regular threat and harassment from state authorities[86]. In November 2014, an American Amnesty International researcher (Christine Mehta) was deported from India[91].

A report by the Indian Intelligence Bureau to the Prime Minister's Office, leaked to the media in June 2014, highlighted that Indian NGOs funded in part through foreign funds and focusing their interventions on challenging power plants, mining or other projects boosting economic growth are perceived as having a negative influence, impacting GDP growth by "2 to 3%". Some of these NGOs, like Greenpeace India, have had their bank accounts frozen[86]. In January 2015 then, a Greenpeace India staff member was barred from boarding a flight to London, where she would have a presentation on mining projects. In April 2015, the Home Ministry again blocked Greenpeace India's account, a decision partly reversed by the Delhi High Court

---

effective in helping advance development, aid actors need to operate from a genuine understanding of the political realities of the local context, engage with a diverse array of relevant actors both inside and outside the government, and insert aid strategically and subtly as a facilitating element in local processes of change"[89].

[xxxiii] The impact of this measure will become visible from 2016 when the existing FCRA registrations come up for renewal.

in May. In June 2015, a Greenpeace International staff member was denied entry into India despite having a valid visa[92]. Impediments on activities of non-Indian researchers can be added to this list: following the Christine Mehta case, a Ministry of Home Affairs official in July 2015 stated that "all research visa applications will henceforth be thoroughly scrutinised. An applicant has to submit a brief note in advance about the project in which the research work will be conducted. If we find it appropriate, non-controversial and beneficial to India, then only the applicant will be given a visa"[91].

Hostility toward national and international NGOs is clearly rising under the actual federal government, led by Prime Minister Modi who repeatedly referred to foreign charities as "five-star activists". Deeply worried, a panel of civil society organisations early May 2015 released an open letter to the Prime Minister ('Hear the message; don't shoot the messenger') "urg(ing) the PM and his office to create the necessary space and mechanism for strengthening the relationship between government and CSOs"[93]. The impact was limited. Two months later, the Ministry of Home Affairs put the Ford Foundation on a watch list over funding it had given to a Modi critic 6 years earlier. Days later, the Central Bureau of Investigation raided the activist's home after filing a criminal case against her for allegedly misusing the Ford Foundation's grant. In reaction, a Ministry of Home Affairs official told Reuters that the government had no intention of forcing NGOs to close, yet underlined "But we have every right to streamline their work. This attitude that nobody can question influential foreign donors must be put to an end"[94].

On the other hand, in March 2015 India's Supreme Court declared Section 66A – providing punishment for sending offensive messages through computers or communication devices – of the 2008 Information Technology act (IT Act) as unconstitutional and struck it down. Section 66A had been widely misused by police in various states to arrest innocent persons for posting critical comments about social and political issues on social networking sites. The Court delivered its judgment on petitions filed by a social media company, NGOs, civil rights groups and an individual law student. The Court however uphold the validity of Section 69B and the 2011 guidelines for the IT Act that allow government to block websites if their content has the potential to create "communal disturbance, social disorder or affect India's relationship with other countries"[73,95,96].

As the EU roadmap reminds us, "While the higher judiciary in India is considered to be effective in protecting human rights, the lower judiciary suffers from high levels of corruption and significant caste/class/gender/religious and other biases. This affects both CSOs and human rights defenders, whose access to justice in the case of violations is either denied or delayed, demoralizing a number of them from continuing work in the human rights sector"[86].

In summary, there is every reason to confirm in 2015 what the EU roadmap had already concluded in 2014: "the picture is mixed, globally speaking, and varies from state to state and, within each state, from district to district, and even further down right to villages. Basically, on the whole, at each level the powerful tend to do well but the underprivileged tend to suffer and remain excluded or with little or poor access to (often weak quality) public resources and services. And civil society working for the poor and marginalised can be easily faced by a locally not so conductive, not to say threatening, environment. Alongside government's often weak capacity and corrupt practices at the local level, both the caste system and patriarchy play a strong role, throughout institutions, be they governmental, private sector, community or family, and even within many CSOs themselves. Power dynamics tend to be quite effective at resisting change and making sure change does not happen, or only extremely slowly. So, despite an active and vibrant civil society, and despite evident economic progress and larger access to basic services like primary education, for instance, it is important to acknowledge that the highly structured, caste-based social fabric in India remains a key "un-conducive" social change "environmental" factor[97]. Caste inequalities, coupled with systemic class, ethnic,

community and gender disparities (India ranks 105th out of 135 countries as per the World Economic Forum Gender Gap Report 2012) make societal, transformational changes extremely hard to achieve in India. It does make the role of civil society actors working for more social, political, economic and environmental justice still very much relevant, but progress remains, unfortunately, often frustrating. Besides, Indian government funding rules and processes (…) appear to offer room for improvement and opportunities for more constructive collaborations between the state and civil society"[86].

In *Box 3* (below), an overview of the main issues discussed in this Chapter are presented.

- Political decentralization in the form of *Panchayats* is nearly two decades old. However, it is yet to achieve its potential, with limited competencies and resources and capture by the elites still being the norm
- The Indian civil society organisations have enormous capacities and have an important role to play as a watchdog to protect the interests of the vulnerable
- However, the space for CSOs to act is becoming limited. The government uses various legal measures to restrict the NGO activities
- Funds from corporates' profits under Corporate Social Responsibility are limited in amount and in scope, most of them restricted to furthering the company's interests. Sensitive human rights issues are rarely funded
- An active media and a vibrant social media have contributed to make Indian society more transparent and open. However, the steady rise of religious bigotry in recent times has led to acts of violence against religious minorities

<u>Box 3:</u> Analysis of local civil society, decentralized authorities and governmental institutions (summary)

6. Identification of the relevant actors with regard to development

Identification of all relevant actors with regard to all aspects of development in the huge, diverse and dynamic India would be a Sisyphean task. Instead, we have focused on three development intervention domains in which Belgian NGAs are already active: **health**, **education**, and **child rights** (as a particularly relevant sub-domain of human rights). Within these three domains, given the fact that – despite all difficulties – most of the influencing policy work in India is conducted directly by domestic civil society[86,xxxiv], we have further focused in the first instance on Indian civil society actors and in the second instance on those Indian government actors with which they inherently or potentially connect. Obviously relevant international, multinational, European or Belgian actors were not explicitly mentioned.

In identifying and evaluating local civil society actors we have taken into account three lessons learnt from past experience with Indian civil society, as expressed in the EU Roadmap for engagement with Indian civil society: (1) "programmes that help influence policies and their implementation at state and district level – rather than at national level – tend to be more effective"[xxxv]; (2) internal South-South partnerships – that is between Indian states – are highly relevant; (3) "There appear to be three critically important capacity needs for Indian civil society organisations, whatever their size, large, medium or small: (i) their capacity to build teams having diverse skills, characteristics and profiles, not just on technical competence grounds, but on social diversity grounds, too; (ii) their capacity to raise local resources in a sufficient and sustainable manner in order to help them fulfil their mission and vision in a local context, meaningfully as well as (iii) their capacity to remain genuine, independent and competent organisations, able to compete on fairer terms in particular with international civil society and UN agencies"[86].

Relevant actors in health

Civil society		
Actor	*Importance*	*Relation with NGA*
State and national CSOs	Policy advocacy & support, including health governance Health systems research & critical analysis Training for health systems strengthening Links with federal and state government	Capacity building Networking
Local and community CSOs	Access to local communities Understanding of local situation	Capacity building

[xxxiv] In the broad sense of the term, not just NGOs.

[xxxv] Mainly because, as per the Constitution of India, state governments – not the central government – are responsible for core social policies, and because of the importance of local context and governance for their implementation.

	Monitoring Links with local government	
Health activist networks	Strengthening of policy advocacy & support	Networking
Media	Awareness raising & policy advocacy	Through Indian CSOs only

Government		
Actor	*Importance*	*Relation with NGA*
Ministry of Health and Family Welfare	Core authority for health at national, state and district level	Capacity building, networking & through Indian CSOs
National and state commissions	Agenda-setting & policy-making	Through Indian CSOs only
Gram panchayats	Local monitoring	Through Indian CSOs only
Other Ministries than MoHFW	Core authorities for comprehensive health policies and/or Health-in-All policies; e.g. Ministry of Women and Child Development *(protection of women and children)*, Ministry of Social Justice and Empowerment *(empowerment, including of people with disabilities)*, Ministry of Rural Development *(NREGA, rural livelihood)*, Ministry of Environment, Forests and Climate Change *(environment, tribal livelihood)*, Ministry of Commerce and Industry *(food processing, tobacco)*, Ministry of Drinking Water and Sanitation	Networking & through Indian CSOs

Relevant actors in education

Civil society		
Actor	*Importance*	*Relation with NGA*
State and national CSOs	Policy advocacy & support Links with federal and state government	Capacity building Networking

Local and community CSOs	Access to local communities Understanding of local situation Links with local government	Capacity building
Higher education institutes[xxxvi] and schools	Adapt and execute educational programmes Educational research & critical analysis	Capacity building

Government		
Actor	*Importance*	*Relation with NGA*
Ministry of Human Resource Development	Core authority for education at national, state and district level	Capacity building, networking & through Indian CSOs
Ministry of Social Justice and Empowerment	Core authority for empowerment of culturally or educationally vulnerable groups	Capacity building, networking & through Indian CSOs
Higher education institutes and schools	Adapt and execute educational programmes Educational research & critical analysis	Capacity building
Gram panchayats	Local monitoring	Through Indian CSOs only

Relevant actors in children's rights

Civil society		
Actor	*Importance*	*Relation with NGA*
Children's rights state and national CSOs	Policy advocacy & support Links with federal and state government	Capacity building Networking
Children's rights local and community CSOs	Access to local communities Understanding of local situation Awareness raising, policy advocacy, monitoring Links with local government	Capacity building
Higher education institutes and schools	Awareness raising & training	Through Indian CSOs only
Media	Awareness raising & policy advocacy	Through Indian CSOs only

[xxxvi] Through Education, Research and Extension, higher education institutes can also be important development actors in other sectors.

Government		
Actor	*Importance*	*Relation with NGA*
Ministry of Law and Justice	Core authority for justice and human rights	Capacity building, networking & through Indian CSOs
Ministry of Social Justice and Empowerment	Core authority for empowerment of culturally or educationally vulnerable groups	Capacity building, networking & through Indian CSOs
High Court of Justice	Protects human rights	Through Indian CSOs only
Higher education institutes and schools	Awareness raising & training	Through Indian CSOs only
Gram panchayats	Local monitoring	Through Indian CSOs only

7. Identification of the possible types of partners of the non-governmental actors

Health

In civil society: state and national CSOs, local and community CSOs, health activist networks.
In government: Ministry of Health and Family Welfare, any other ministry relevant for Health-in-All Policies.
All other actors in civil society or government mentioned under 6.: only through the NGA's partner CSOs.

For the NGAs participating in the present JCA with main activity in health, this can be summarised[xxxvii] as follows:

AZG / MSF: Ministry of Health and Family Welfare
Handicap International: state and national CSOs, local and community CSOs, health activist networks, Ministry of Health and Family Welfare
ITM: state and national CSOs, local and community CSOs, health activist networks, Ministry of Health and Family Welfare
Damiaanactie: state and national CSOs, local and community CSOs, health activist networks, Ministry of Health and Family Welfare
Médecins du Monde: state and national CSOs, local and community CSOs, health activist networks, Ministry of Health and Family Welfare
Memisa Be: state and national CSOs, local and community CSOs, health activist networks, Ministry of Health and Family Welfare
Rode Kruis Vlaanderen: Indian Red Cross Society, Ministry of Health and Family Welfare

Education

In civil society: state and national CSOs, local and community CSOs, higher education institutes and schools.
In government: Ministry of Human Resource Development, Ministry of Social Justice and Empowerment, higher education institutes and schools.
All other actors in civil society or government mentioned under 6.: only through the NGA's partner CSOs.

For the NGAs participating in the present JCA with main activity in education, this can be summarised as follows:

FUCID: state and national CSOs, local and community CSOs, higher education institutes and schools, ministries
VLIR-UOS: state and national CSOs, local and community CSOs, higher education institutes and schools, ministries[xxxviii]

[xxxvii] For the actual partners, see list of partners, pp 7-8, and current projects & programmes, p 10.

[xxxviii] As of 2015, one of the two participating NGA active in formal education in India (VLIR-UOS) – without denying that all others are involved in training or capacity-building – identified 'Liveable Cities' as appropriate and relevant theme for its India country strategy, identified a range of sub-themes to refine further, limits the scope of action to second- and third-tier cities and (for the next five years or until a first evaluation has been completed) to the cities of Jaipur, Mangalore and Ranchi, where possible partners were already identified. See VLIR-UOS 'India Strategy Identification Mission Report'[114] and 'India Strategy Document'[63].

Children's rights

In civil society: children's rights state and national CSOs and children's rights local and community CSOs, including networks and lawyers' organisations.
In government: Ministry of Law and Justice, Ministry of Social Justice and Empowerment.
All other actors in civil society or government mentioned under 6.: only through the NGA's partner CSOs.

For the NGAs participating in the present JCA with main activity in children's rights, and for the NGAs participating in Decent Work, this can be summarised as follows:

KIYO: state and national CSOs, local and community CSOs, NCPR, Ministry of Law and Justice, Ministry of Social Justice and Empowerment
JCA Decent Work India: state and national CSOs, local and community CSOs, NCPR, ministries

8. Identification of the future intervention domains of every non-governmental actor, taking into account the relevant actors

Building on the EU roadmap's pertinent conclusions that (1) most of the influencing policy work in India is conducted by domestic civil society[86]; (2) that additional capacity needs for India's CSO are identified[86] (see 6.), and that the actual environment for domestic civil society is rather hostile yet dynamic and possibly improving in the future, we:

1. Posit as theory of change that the **opportunity for Belgian NGAs to contribute to improvement in the domains of health, education and children's rights in India lies primarily in offering capacity building and networking to Indian CSOs**.
2. Deem it wise – under present conditions – not to detail this theory of change further.

For the NGAs participating in the present JCA, the main interventions domains are the following:

AZG / MSF: health
FUCID: education
Handicap International: health
ITM: health[xxxix]
Damiaanactie: health
JCA Decent Work India: decent work
KIYO: children's rights
Médecins du Monde: health
Memisa Be: health
Rode Kruis Vlaanderen: health
VLIR-UOS: education[xxxix]

[xxxix] Given the inherent academic triad of education, research and service, the intervention domains of academic NGAs (ITM and VLIR-UOS) cannot be interpreted restrictively. ITM for instance defines a "multi and interdisciplinary approach, (and) the close links between research, education and services" as core strengths within its mission document (see http://www.itg.be/itg/GeneralSite/Default.aspx?WPID=228&MIID=647&L=E). Its activities in health cover all three elements of the academic triad. VLIR-UOS specifies its domain as higher education and research. Within its over-arching theme ('Liveable Cities'), it has identified public health as a sub-theme[63].

9. Analysis of the risks and opportunities per intervention domain

Without doubt, the major risk in all three domains but particularly in health and children's rights is a further deterioration in the policy space for the Indian CSOs and in the relationship between Indian (and non-Indian) civil society and Indian government. This risk entails the need to update the environment, which is dynamic and can thus change at any moment, and make intelligent use of windows of opportunity.

Major opportunities, in all three identified development intervention domains (health, education, children's rights), are:

1) Improvement in the relationship between Indian (and non-Indian) civil society and Indian government, which would lead to more constructive and fruitful collaboration;
2) Essential contributions to the capacity and networking needs of the Indian CSO, which would lead to equitable improvements in health, education and children's rights in India.

For the priority domains (decent work, environment) and identified intervention domains (health, education, children's right), risks and opportunities can be further specified as follows:

Decent work

Risks	Opportunities
One of the major risks against decent work is stagnant employment. Most of the recent increases in employment opportunities are in the informal sector, meaning that the employee and her/his family still lack social protection. This is further compounded by the steady dilution of labour laws. The trade unions have recognized this and have been using industrial action to highlight the perils of weakening employee benefits[98]. However, the government has been very keen to dilute these laws and present a more favourable environment for investors. The government has proceeded even to dilute the child labour laws in the country, permitting children to work in 'family enterprises'. This will now push children into rolling *beedis* (local cigarettes), weaving carpets and polishing gems[99].	The current government has launched the 'Make in India' campaign in an effort to attract foreign investments, especially in the manufacturing sector. Hopefully, this will create more jobs and promote better working conditions for the employees.

Environment

Risks	Opportunities
In an effort to stimulate economic growth, the government has freed up the restrictions on the mining industry. Unfortunately, most mineral resources are located in environmentally fragile regions. This results in frequent conflict between vulnerable groups and government, and between environmentalists and industry[100]. It has been noted that the current government has expedited the clearance of many mining proposals with scant regard for the environmental impact. This is a source of major concern for the country[101]. Other than the macro-environment, the micro-environment in terms of emission of gases and pollutants remains unchecked. According to a study by the Max Planck Institute, India's capital New Delhi will have the maximum premature deaths in the world due to air pollution[102].	The current government is keen on promoting renewable sources of energy. In a recent declaration, the Indian environment ministry has pledged to source 40% of its electricity from renewable sources by 2030[103]. On Independence Day 2014, the Prime Minister himself launched *Swachh Bharat Abhiyan* (Towards a Cleaner India), a national mission for waste management[104].

Health

Risks	Opportunities
One of the most important risks that the health sector faces is its political neglect by the current government. While most of the government's attention is diverted to the economy, it has nevertheless made a substantial cut in its allocation for health: -15% from 2014 to 2015[61]. Another worrying trend is the unbridled promotion of the private health sector with minimal regulatory frameworks. This combined with the neglect of the public health sector is leading to more and more people seeking care in the private facilities and facing higher out-of-pocket expenses[105].	While the Indian Constitution only implicitly recognizes health as a human right, the draft 2015 National Health Policy does so explicitly[60].

Education

Risks	Opportunities
India's performance at primary school level is not praiseworthy, especially not for vulnerable sections of society like the ST and SC. This situation might even become worse with the government permitting children to work in 'family enterprises', most likely resulting in millions of children being forced to roll	Education has been declared a right under the Constitution and the right of the child to free and compulsory education is formally recognized in the RTE Act[xl]. This will hopefully ensure that all children below 14 years of age will be in schools. Where there are no government schools, the

[xl] For the RTE Act, see http://mhrd.gov.in/rte

beedis and incense sticks, weave carpets and repair motor vehicles.	private schools are expected to share the burden. The National Education Policy is being revised. It is looking at both school education and higher education[xli].

Children's rights

Risks	Opportunities
See above under 'Decent Work' and 'Education'	The country has a National Commission for Protection of Child Rights (NCPR) with similar structures at individual state level. The main objective of these commissions is to protect the rights of the child (now defined as 0-18 years). It has the power to inquire into violations of child rights and recommend initiation of proceedings in such cases[xlii].

[xli] Open government data https://data.gov.in/community/national-education-policy-theme-based-data-available-at-open-government-data-portal-india/

[xlii] http://www.ncpcr.gov.in/index1.php?lang=1&level=1&&sublinkid=5&lid=600

10. Analysis of the opportunities for synergy and complementarity

Opportunities for synergy and complementarity are present between the three intervention domains (health, education and children's rights), between the NGAs, and between the NGAs and all other relevant actors.

Between intervention domains

The three identified development intervention domains – health, education and children's rights – have significant overlaps, as was made clear in the respective sub-chapters in the situation analysis (chapter 3). Indeed, it can be argued that the development objectives in none of the three domains can be achieved without progress in the other domains.

Health might be the clearest example, with progress on health dependent not only in improvements in the health sector, but also in education (female literacy and empowerment being a core element), the realisation of children's rights, and a range of other domains influencing the structural determinants of health, as proponents of a Health-in-All Policy approach rightly argue. Advancement in education is instrumental and much needed for both better health and the realisation of children's rights. Children's rights categorically include the right to survival, health and nutrition (all related to health) and to education and participation (related to education)[xliii].

The interrelations between the three intervention domains should not be seen as a difficulty per se. Instead, they are a compelling reason for all development actors in all three domains to strive for optimal synergy and complementarity.

Between NGAs

Within the actual efforts of the NGAs in India, activities *of Indian partners* that transcend the boundaries of the domains and sectors can already be distinguished. The Institute of Public Health in Bangalore (IPH, ITM's institutional Indian partner) for instance, though being a health partner, is actively involved in education, for years already in the training of district health officers and – as of 2015 – in additional training for medical postgraduates before starting their rural practice, on demand of the Karnataka state government. Increasingly, the Bangalore-based IPH is also effectively cooperating with educational institutes such as the Azim Premji University (in Bangalore), the Indian Institutes of Public Health (in Bangalore, but also in Gandhinagar) affiliated to the Public Health Foundation of India (PHFI), and the Achtha Menon Centre for Health Science Studies (in Trivandrum). Exploring these opportunities is perfectly in line with the importance of internal South-South partnerships as identified by the EU in its road map.

[xliii] The same case can be made for the priority themes Decent Work and Environment, which influence and are influenced by each of the identified development domains.

As of today however, exchange of information and logistical or project-based cooperation *between NGAs* is limited[xliv]. Core findings of the present Joint Context Analysis – namely the central role of Indian civil society for advancement in health, education and children's rights in India, and the need for capacity building and networking to facilitate effective action of Indian civil society – are an opportunity and a clear call for more exchange of information and cooperation between NGAs in India, without which influence on policy would be a distant dream.

Between NGAs and other actors

Given the already existing relationships between NGAs and a range of Indian CSO partners, and the complementarity between the three intervention domains, the opportunities for synergy are huge – and particularly so through facilitating improved networking between the Indian CSO partners. This task would obviously benefit from synergy efforts between the NGAs.

Given the accordance between the analysis of the EU (as expressed in the EU roadmap) and the present JCA, and the adherence of the Belgian governmental development actors to the EU analysis, there is also an opportunity for more synergies – in terms of exchange of information and cooperation – between the NGAs and the Belgian and European governmental development actors in India.

[xliv] It should however been noted that links between Belgian NGAs through Indian partners are already present, and efforts are made to make optimal use of these links. For instance, Memisa Be's main partner in India is the West Bengal Voluntary Health Association (WBVHA), which also has links to the Belgian platform BeCause Health; ITM's main partner is the Institute of Public Health (IPH), which also provides support to the WBVHA. Continuing its efforts to improve health in India, IPH together with ITM will organise its third national conference on bringing Evidence into Public Health Policy (EPHP, see http://iphindia.org/) under the theme 'Equitable India: All for Health and Wellbeing', 8-9 July 2016, to which in cooperation with BeCause Health a third day for field practitioners will be added.

11. References

1. DFID. Three Faces of India. 2008:20. http://webarchive.nationalarchives.gov.uk/+/http:/www.dfid.gov.uk/pubs/files/india-cap.pdf.

2. Government of India. *The Constitution of India (As Modified up to the 1st December, 2007)*. New Delhi: Ministry of Law and Justice; 2008. http://lawmin.nic.in/coi/coiason29july08.pdf.

3. World Bank. *World Development Indicators 2015*. Washington, DC; 2015. https://openknowledge.worldbank.org/bitstream/handle/10986/21634/9781464804403.pdf.

4. IMF. *World Economic Outlook: Uneven Growth - Short- and Long-Term Factors*. Vol April 2015. Washington, DC; 2015. http://www.imf.org/external/pubs/ft/weo/2015/01/pdf/text.pdf.

5. UNDP. *Human Development Report 2014: Sustaining Human Progress - Reducing Vulnerabilities and Building Resilience*. New York; 2014. doi:ISBN: 978-92-1-126340-4.

6. Kannan KP. *Interrogating Inclusive Growth: Poverty and Inequality in India*. New Delhi: Routledge; 2014.

7. Deaton A, Drèze J. Poverty and Inequality in India. *Econ Polit Wkly*. 2002:3729-3748.

8. Subramanian S. The poverty line: getting it wrong again. *Econ Polit Wkly*. 2011;26/11/2011(48):37-42. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2800891&tool=pmcentrez&rendertype=abstract.

9. Deaton A, Kozel V. Data and dogma: The great Indian poverty debate. *World Bank Res Obs*. 2005;20(2):177-199. doi:10.1093/wbro/lki009.

10. Patnaik U. Poverty Trends in India 2004-05 to 2009-10. *Econ Polit Wkly*. 2013;xlviii(40):43-58.

11. Ministry of Labour and Employment. National skill development initiative. 2009. http://labour.nic.in/upload/uploadfiles/files/NationalSkillDevelopmentPolicyMar.pdf.

12. Ministry of Health and Family Welfare. National Rural Health Mission (2005-2012) Mission document. 2005. http://www.nird.org.in/brgf/doc/Rural HealthMission_Document.pdf.

13. Ministry of Labour and Employment. Health insurance scheme for workers in the unorganised sector. 2008.

14. Ministry of Law and Justice. *The National Rural Employment Guarantee Act, 2005*. New Delhi; 2005. http://nrega.nic.in/rajaswa.pdf.

15. Ministry of Skill Development and Entrepreneurship. Draft national policy for skill development and entrepreneurship 2015. 2015;(May):1-37. https://mygov.in/sites/default/files/master_image/Draft_National_Policy_for_Skill_Development_and_Entrepreneurship_2015.pdf.

16. Papola TS. *Social Exclusion and Discrimination in the Labour Market*. New Delhi; 2012. http://isidev.nic.in/pdf/WP1204.pdf.

17. National Sample Survey Office. *Employment and Unemployment in India: NSS 68th Round (July 2011 - June 2012)*. New Delhi; 2014. http://mospi.nic.in/Mospi_New/upload/nss_report_554_31jan14.pdf.

18. Government of India, ILO. India: Decent work country programme 2013-2017. 2013:36. http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-new_delhi/documents/genericdocument/wcms_232655.pdf.

19. Planning Commission of India. *Twelfth Five Year Plan (2012–2017): Faster, More Inclusive and Sustaible Growth*. Vol I. New Delhi: Sage; 2012. http://planningcommission.gov.in/plans/planrel/12thplan/pdf/12fyp_vol1.pdf.

20. Press Trust of India. Govt readies domestic workers policy , proposes Rs 9k min pay. *Business Standard*. http://www.business-standard.com/article/pti-stories/govt-readies-domestic-workers-policy-proposes-rs-9k-min-pay-115081600147_1.html. Published August 16, 2015.

21. Government of India. *Bonded Labour System (Abolition) Act*. Vol 2. 1976.

22. National Human Rights Commission. Keynote address on bonded labour. 2012. http://nhrc.nic.in/Documents/SPEECH_2012_10_25.pdf.

23. Dhar S. Millions strike in India to protest against Modi's labor reforms. *Reuters*. http://www.reuters.com/article/2015/09/02/us-india-reforms-protests-idUSKCN0R21ZG20150902. Published September 2, 2015.

24. Government of India. National Environment Policy 2006. 2006. http://www.tnpcb.gov.in/pdf/nep2006e.pdf.

25. ADRC (Asian Disaster Reduction Center). Information on Disaster Risk Reduction of the Member Countries: India. http://www.adrc.asia/nationinformation.php?NationCode=360&Lang.. Accessed September 17, 2015.

26. Government of India. *The Disaster Management Act 2005*. New Delhi; 2005. http://www.ndma.gov.in/images/ndma-pdf/DM_act2005.pdf.

27. Chalakkal K. Country report: India. *IUCN Acad Environ Law eJournal*. 2015;(6):234-242. http://www.iucnael.org/en/documents/1228-india-2.

28. Chowdhury N. Environmental impact assessment in India: reviewing two decades of jurisprudence. *IUCN Acad Environ Law eJournal*. 2014;(5):28-32. http://www.iucnael.org/en/component/docman/?task=doc_download&gid=1140.

29. Sethi N. NDA govt to dilute environment rules for projects. *Live Mint*. http://www.livemint.com/Politics/7GH72uyKdZnrIxBcgfgYQM/NDA-govt-to-dilute-environment-rules-for-industry.html. Published June 6, 2014.

30. Krishnadas M, Velho N. Misconstrued dichotomies. *Seminar*. 2015;665:102-106. http://www.india-seminar.com/2015/665/665_m.krishnadas, n.velho.htm.

31. Sarker D. The implementation of the Forest Rights Act in India: critical issues. *Econ Aff*. 2011;31(2):25-29.

32. CSD. *State of Implementation of the Forest Rights Act - Summary Report*. New Delhi; 2010. http://www.forestrightsact.com/component/k2/item/15.

33. Saxena N. Are tribals really benefitting from the Forest Rights Act? *The Economic Times*. http://articles.economictimes.indiatimes.com/2015-08-09/news/65379826_1_forest-rights-act-forest-lands-forest-villages. Published August 9, 2015.

34. Ayurveda. *Wikipedia*. 2015.

35. Unani. *Wikipedia*. 2015.

36. Amrith SS. *Health in India Since Independence*. London; 2009.

37. Baru R. Missionaries in Medical care. *Econ Polit Wkly*. 1999;34:24-31.

38. Bhore J. *Report of the Health Survey and Development Committee Survey Vol I*. Vol I. New Delhi: Government of India Press; 1946.

39. Ministry of Health and Family Welfare. *National Health Policy*. Vol 1. New Delhi: Government of India; 1983.

40. Ministry of Health and Family Welfare. *National Health Policy 2002*. Vol 1. New Delhi: Government of India; 2002.

41. Mai S, Sood N. *A Comparison of the Health Systems in China and India*. Santa Monica; 2008.

42. Qadeer I. Health care systems in transition III. India, Part I. The Indian experience. *J Public Health Med*. 2000;22(1):25-32. doi:http://dx.doi.org/10.1093/pubmed/22.1.25.

43. India G of. NRHM. Devadasan N, ed. March 2005.

44. National sample survey organisation. *Key Indicators of Social Consumption in India - Health*. New Delhi: Government of India; 2015.

45. Kotwani A, Ewen M, Dey D, et al. Prices and availability of common medicines at six sites in India using a standard methodology. *Indian J Med Res*. 2007;125(5):645-654.

46. Ghosh A. NRHM 10 yrs on: short of centres by 20-30%, of doctors by 70-80%. *Indian Express*. May 21, 2015.

47. Central Bureau of Health Intelligence. *National Health Profile 2015*. New Delhi: Ministry of Health and Family Welfare; 2015.

48. Bali A, Ramesh M. Health care reforms in India: getting it wrong. *Public Policy Adm*. 2015;30(3-4):300-319. doi:10.1177/0952076715590697.

49. George B. India's public health: a financial aetiology. *Econ Polit Wkly*. 2011;xlvi(9):20-22.

50. Peters D, Muraleedharan VR. Regulating India's health services : To what end? What future? *Soc Sci Med*. 2008;66(10):2133-2144. doi:10.1016/j.socscimed.2008.01.037.

51. Centre T. Indian healthcare needs regulation , reform. 2015:4-6.

52. De Costa A, Diwan V. “Where is the public health sector?” Public and private sector healthcare provision in Madhya Pradesh, India. *Health Policy (New York)*. 2007;84(2-3):269-276. doi:10.1016/j.healthpol.2007.04.004.

53. Sanneving L, Trygg N, Saxena D, Mavalankar D, Thomsen S. Inequity in India: the case of maternal and reproductive health. *Glob Health Action*. 2013;6.

54. Kilaru A, Saligram P, Nagavarapu S, Giske A. *“Some Health Care for Some People, Some of the Time.”* Bangalore; 2013. doi:10.1007/s13398-014-0173-7.2.

55. Bhojani U, Rao N, Hebbar P. *Towards Health in All Policies: Health Impact Assessment of Policies of Select Ministeries of Government of India with Reference to Non-Communicable Diseases*. Bangalore; 2015.

56. Kurian O. *Financing Healthcare for All in India: Towards a Common Goal*. New Delhi: Oxfam India; 2015.

57. Planning Commission of India. High Level Expert Group Report on Universal Health Coverage for India. *Work Pap*. http://ideas.repec.org/p/ess/wpaper/id4646.html. Accessed November 21, 2014.

58. Devadasan N, Ghosh S, Nandraj S, Sundararaman T. Monitoring and evaluating progress towards Universal Health Coverage in India. *PLoS Med*. 2014;In press(9):11-13. doi:10.1371/journal.pmed.1001691.

59. Mudur G. India’s health assurance plan will offer free medicines, diagnostics, insurance, and traditional medicine. *BMJ*. 2014;349(oct03 7):g6023-g6023. doi:10.1136/bmj.g6023.

60. Ministry of Health & Family Welfare. National Health Policy 2015 Draft. 2015:0-57. http://mohfw.nic.in/showfile.php?lid=3014.

61. Sharma DC. India’s BJP government and health: 1 year on. *Lancet*. 2015;385(9982):2031-2032. doi:10.1016/S0140-6736(15)60977-1.

62. Reddy KS. India’s aspirations for Universal Health Coverage. *N Engl J Med*. 2015;373(1):1-5. doi:10.1056/NEJMp1414214.

63. VLIR-UOS. *India Strategy Document*. Brussels; 2015. http://www.vliruos.be/media/6374589/cs_paper_india_final.pdf.

64. Goossens C. *Country Sheet India (India and Flemish University Cooperation for Development)*. New Delhi; 2014.

65. Government of India. State of Literacy. In: *Census of India*. Vol New Delhi; 2013:97-136. doi:00-001-2011-Cen-Book (E).

66. Jenkins R, Barr E. *Social Exclusion of Scheduled Caste Children from Primary Education in India*. New Delhi; 2006. http://www.unicef.org/files/Social_Exclusion_of_Scheduled_Caste_Children_from_Primary_Education_in_India.pdf.

67. Sedwal M, Kamat S. *Education and Social Equity with a Special Focus on Scheduled Castes and Scheduled Tribes in Elementary Education*. New Delhi; 2008. http://sro.sussex.ac.uk/1867/.

68. UNICEF. *The Situation of Children in India: A Profile*. New Delhi: UNICEF India; 2011. http://unicef.in/Uploads/Publications/Resources/pub_doc57.pdf.

69. Unicef. *The State of the World's Children 2015: Reimagine the Future: Innovation for Every Child*. New York: UNICEF; 2014. http://www.unicef.org/publications/index_77928.html.

70. Ministry of Women and Child Development. *The Integrated Child Protection Scheme (ICPS): A Centrally Sponsored Scheme of Government-Civil Society Partnership*. New Delhi; 2009. http://wcd.nic.in/schemes/icps.pdf.

71. Ministry of Women and Child Development. *National Policy for Children*. New Delhi; 2013. http://wcd.nic.in/icpsmon/pdf/npc2013dtd29042013.pdf.

72. CRC. *Concluding Observations on the Combined Thrd and Fourth Periodic Report of India*.; 2014. doi:10.2307/4065371.

73. International Center for Not-for-Profit Law. NGO Law Monitor: India. 2015. http://www.icnl.org/research/monitor/india.html.

74. Sheth DL, Sethi H. The NGO sector in India: historical context and current discourse. *Voluntas*. 1991;2(2):49-68. doi:10.1007/BF01398670.

75. Asian Development Bank. India: overview of civil society organizations. 2009. http://www.adb.org/sites/default/files/publication/28966/csb-ind.pdf.

76. Nair P. *Whose Public Action? Analysing Inter-Sectoral Collaboration for Service Delivery: Historical Analysis of Relationships between the State and Non-Governmental Sector in India*. Birmingham; 2007. http://www.birmingham.ac.uk/Documents/college-social-sciences/government-society/idd/research/non-state-providers/india-history.pdf.

77. Sathyamurthy T. Centralised state power and decentralised politics: case of India. *Econ Polit Wkly*. 1996;31(13):835-843.

78. deSouza PR. The struggle for local government: Indian democracy's new phase. *Publius*. 2003;33(4):99-118. doi:10.2307/3331198.

79. Singh MP, Verney D V. Challenges to India's centralized parliamentary federalism. *Publius*. 2003;33(4):1-20. doi:10.2307/3331193.

80. Banks N, Hulme D, Edwards M. NGOs, states and donors: too close for comfort? *World Dev*. 2015;66:707-718. doi:10.1016/j.worlddev.2014.09.028.

81. Johnson C. Decentralisation in India: Poverty, Politics and Panchayati Raj. *ODI Work Pap*. 2003;(February):1-66. http://www.odi.org.uk/resources/docs/2440.pdf\nhttp://kms1.isn.ethz.ch/serviceengine/Files/ISN/100557/ipublicationdocument_singledocument/65099763-074a-45c5-9ee4-b4e4dfd11ca0/en/wp199.pdf.

82. Teltumbde A. India's (Jati) Panchayati Raj. *Econ Polit Wkly*. 2011;xlvi(36):10-11.

83. ENS Economic Bureau. NITI Aayog replaces Planning Commission, Prime Minister Modi bids farewell to “one size fits all” approach. *The Indian Express*. http://indianexpress.com/article/business/business-others/niti-aayog-to-replace-plan-panel/. Published January 2, 2015.

84. FC-XIV. *Report of the Fourteenth Finance Commission*. New Delhi; 2015. http://finmin.nic.in/14fincomm/14thFinanceCommission.htm.

85. Sidhartha. States are now free to decide how to spend: Centre’s view. *The Economic Times*. http://economictimes.indiatimes.com/news/economy/policy/states-are-now-free-to-decide-how-to-spend-centres-view/articleshow/47944146.cms?prtpage=1. Published July 5, 2015.

86. EU. India country roadmap for engagement with civil society, 2014-2017. 2014.

87. Venkat V. 10 years after RTI, transparency under cloud. *The Hindu*. http://www.thehindu.com/news/cities/Delhi/10-years-after-rti-transparency-under-cloud/article7213480.ece. Published May 16, 2015.

88. Chauhan C. 10 years of RTI Act: 39 activists dead, 275 assaulted, says report. *Hindustan Times*. http://www.hindustantimes.com/india/10-years-of-rti-act-39-activists-dead-275-assaulted-says-report/story-mwEjPtaUDXthPQZ6293BYL.html. Published July 8, 2015.

89. Carothers T, de Gramont D. *Development Aid Confronts Politics: The Almost Revolution*. Washington, DC: Carnegie Endowment for International Peace; 2013.

90. Bhojani U, Soors W. Tobacco control in India: a case for the Health-in-All Policy approach. *Natl Med J India*. 2015;28(2):1-4. http://www.nmji.in/Online-Publication/08-28-2-MS_Corrected-2015.pdf.

91. Bhatnagar GV. “Strict scrutiny” awaits all foreigners wishing to do research in India. *The Wire*. http://thewire.in/2015/07/06/strict-scrutiny-awaits-all-foreigners-wishing-to-do-research-in-india-5591/. Published July 6, 2015.

92. dna Web Team. International Greenpeace staff member denied entry into India despite having valid visa, alleges NGO. *dna India*. http://www.dnaindia.com/india/report-international-greenpeace-staff-member-denied-entry-into-india-despite-having-valid-visa-alleges-ngo-2093460. Published June 8, 2015.

93. Commonwealth Human Rights Initiative. Hear the message, don’t shoot the messenger. 2015. http://www.humanrightsinitiative.org/pressrelease/Hear the Message Donot Shoot the Messenger.pdf.

94. Nair RJ, Macaskill A. Ford Foundation funding dries up as Modi clamps down on NGOs. *Reuters*. http://in.reuters.com/article/2015/07/15/india-politics-ngo-idINKCN0PO15U20150715. Published July 15, 2015.

95. Internet Desk. All you need to know about Section 66A of the IT Act. *The Hindu*. http://www.thehindu.com/news/national/all-you-need-to-know-about-section-66a-of-the-it-act/article7027459.ece?css=print. Published March 23, 2015.

96. Choudhary A, Mahapatra D. Supreme Court strikes down Section 66A of IT Act which allowed arrests for objectionable content online. *The Times of India*.

http://timesofindia.indiatimes.com/india/Supreme-Court-strikes-down-Section-66A-of-IT-Act-which-allowed-arrests-for-objectionable-content-online/articleshow/46672244.cms?prtpage=1. Published March 24, 2015.

97. Drèze J, Sen A. A new India. In: *An Uncertain Glory: India and Its Contradictions*. Vol Princeton: Princeton University Press; 2013:1-16. http://press.princeton.edu/chapters/s10175.pdf.

98. ANI. Govt. diluting labour laws to favour the industrial lobbies. *Business Standard*. http://www.business-standard.com/article/printer-friendly-version?article_id=115090200255_1. Published September 2, 2015.

99. Nöhrlind R, Oonk G. Diluting India's child labour law will trap families in cycle of poverty. *The Guardian*. http://www.theguardian.com/global-development/2015/may/18/india-child-labour-law-families-poverty. Published May 18, 2015.

100. ERM India. *Sustainable Development Framework (SDF) for Indian Mining Sector*. New Delhi; 2011. http://mines.nic.in/writereaddata/UploadFile/Sustainable_Development_Framework.pdf.

101. Vashishta A. Environment ministry relaxes mining procedure. *India Today*. http://indiatoday.intoday.in/story/environment-ministry-mining-procedure-relax/1/428575.html. Published April 6, 2015.

102. Sinha K. Delhi will record world's largest number of premature deaths due to air pollution. *Times Of India*. http://timesofindia.indiatimes.com/india/Delhi-will-record-worlds-largest-number-of-premature-deaths-due-to-air-pollution/articleshow/49000678.cms?prtpage=1. Published September 17, 2015.

103. Vaughan A. India unveils climate change plan. *The Guardian*. http://www.theguardian.com/world/2015/oct/02/india-pledges-40-percent-electricity-renewables-2030. Published October 2, 2015.

104. PM India. Swachh Bharat Abhiyan: Towards a Cleaner India. 2014. http://pmindia.gov.in/en/government_tr_rec/swachh-bharat-abhiyan-2/.

105. Ghosh S. Equity in the utilization of healthcare services in India: evidence from National Sample Survey. *Int J Heal policy Manag*. 2014;2(1):29-38. doi:10.15171/ijhpm.2014.06.

106. Ram F, Mohanty SK, Ram U. Understanding the distribution of BPL cards: all-India and selected states. *Econ Polit Wkly*. 2009;xliv(7):66-71.

107. Drèze J, Khera R. The BPL census and a possible alternative. *Econ Polit Wkly*. 2010;xlv(9):54-63. http://eprints.cscsarchive.org/248/1/BPL_Census_and_a_Possible_Alternative.pdf.

108. La Forgia G, Nagpal S. *Government-Sponsored Health Insurance in India: Are You Covered?* The World Bank; 2012. https://openknowledge.worldbank.org/handle/10986/11957.

109. Devadasan N, Seshadri T, Trivedi M, Criel B. Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. *Health Res Policy Syst*. 2013;11(1):29. doi:10.1186/1478-4505-11-29.

110. Press Trust of India. Labour Min to transfer RSBY to Health Ministry from April. *Business Standard*. March 9, 2015.

111. Saraswathy M. RSBY scheme to continue till September. *Business Standard*. May 2, 2015.

112. Ministry of Health and Family Welfare. National Urban Health Mission (2008-2012): meeting the health challenges of urban population specially the urban poor: draft for circulation. 2008. www.uhrc.in/downloads/Reports/NUHM-Draft.pdf.

113. Ministry of Health and Family Welfare. National Urban Health Mission (new scheme). 2014. doi:10.1007/s13398-014-0173-7.2.

114. Butcher N. *India Strategy Identification Mission Report*. Brussels; 2015. http://www.vliruos.be/media/6367753/report_india_southern_mission_march_2015_final.pdf.

12. Annex: executive summary (Dutch)

Oorsprong & doel

Deze gemeenschappelijke contextanalyse (GCA) India vindt haar oorsprong in de wet betreffende de Belgische ontwikkelingssamenwerking (van 19 maart 2013, zoals gewijzigd door de wet van 9 januari 2014), artikel 2- 6°/7, en het Koninklijk Besluit van 24 April 2014, artikel 14 §1 & 2. Artikel 2- 6°/7 beschrijft contextanalyses als "gericht op de civiele maatschappij, de gedecentraliseerde besturen en de openbare instellingen en de voorwaarden om hun versterking mogelijk te maken, opgemaakt door meerdere ANGS vertrekkende van hun eigen contextanalyses en gelijkaardige oefeningen in het land of de regio".

Met deze GCA India streven de deelnemende Belgische actoren van de niet-gouvernementele samenwerking (ANGS) een dubbel doel na: enerzijds een analyse van de Indiaase context – zowel de politieke, economische sociale en milieusituatie, als de lokale civiele maatschappij, gedecentraliseerde autoriteiten en overheidsinstellingen, en pistes ter bevordering van hun versterking, anderzijds – en voortbouwend op de landanalyse – de identificatie van specifieke interventiedomeinen, risico's en opportuniteiten per interventiedomein, relevante actoren, type partners, en mogelijkheden voor synergie en complementariteit voor de ANGS over de periode 2017-2026 in India. Deze GCA India is dus een analyse van context en perspectieven, geen presentatie van programma's en projecten.

De deelnemende ANGS dienen deze GCA India ter goedkeuring voor aan de minister van ontwikkelingssamenwerking. Indien goedgekeurd, wordt de GCA India een referentie waar tegenover toekomstige programma's en projecten van de ANGS in India zich zullen positioneren.

Werkwijze

Van januari tot september 2015 hebben 13 Belgische ANGS – zowel ANGS die reeds activiteiten in India ontwikkelen, als ANGS met toekomstplannen in India – onder leiding van ITG aan de oefening deelgenomen die tot de GCA India heeft geleid. Daarbij werd uitgegaan van bestaande analyses van de deelnemende ANGS, aangevuld met bijdragen van Indiaase partners en relevante wetenschappelijke en grijze literatuur (waaronder de *EU India country roadmap for engagement with civil society 2014-2017*). De informatie werd samengebracht en gecomplementeerd, de specifieke interventiedomeinen gezondheid, onderwijs en kinderrechten werden geïdentificeerd, en een eerste draft werd in augustus 2015 aan een selectie van Indiaase ontwikkelingsactoren voorgelegd en besproken. In september 2015 werd de GCA India verder afgewerkt.

In de loop van het proces werd in toenemende mate gefocust op drie specifieke als relevant beoordeelde interventiedomeinen: gezondheid, onderwijs, en kinderrechten. Gedurende het hele proces werd aandacht besteed aan de door de wetgeving omschreven verplichte rubrieken, doelstellingen en basisprincipes van de Belgische ontwikkelingssamenwerking. Binnen de analyse werd dan ook apart gefocust op mensenrechten (met kinderrechten uiteindelijk opgenomen als derde interventiedomein) en waardig en duurzaam werk, en de gender- en milieudimensies werden geïntegreerd in de analyse van elk van de geselecteerde interventiedomeinen. Een systemische aanpak van elk van de domeinanalyses maakte de integratie van het prioritaire thema maatschappijopbouw mogelijk.

De combinatie van een beperkt aantal Belgische ANGS binnen de enorme context die India is, maakte de uitwerking van een uniek strategisch kader onmogelijk en weinig zinvol. De systemische aanpak van elk van de domeinanalyses daarentegen maakte de identificatie mogelijk van potentiële en zinvolle complementaire actie in de interventiedomeinen. Daarbij dient zich een opportuniteit aan voor meer synergie tussen de Belgische ANGS, ter ondersteuning van de Indiaase civiele maatschappij – geïdentificeerd als belangrijkste motor voor maatschappijopbouw in India vandaag.

India, een sociaaleconomische paradox

Sinds zijn onafhankelijkheid combineert India indrukwekkende vooruitgang met aanhoudende ellende. India is vandaag 's werelds grootste democratie en een economische topspeler. Maar gemeten naar internationale normen zijn 900 miljoen van zijn 1,25 miljard inwoners arm, en op de index voor menselijke ontwikkeling moet het 134 landen laten voorgaan. Terwijl armoede afneemt, neemt ongelijkheid nog toe. In het eerste decennium van dit millennium heeft de Indiaase regering nochtans een reeks initiatieven genomen om die ongelijkheid terug te dringen: een basisinkomen via de *National Rural Employment Guarante Act* (2005), verbeterde kwaliteit van de gezondheidszorg via de *National Rural Health Mission* (2005), gratis ziekteverzekering voor de armen via *Rashtriya Swasthya Bima Yojana* (2008) en een *National Policy on Skill Development* (2009).

Waardig werk

Met 93% van de arbeidskrachten in de informele sector is waardig werk voor de meeste Indiërs een verre droom. De Indiaase regering streeft naar een duurzaam bestaan voor alle onderdanen door de promotie van zelfstandig ondernemerschap. Aan structurele hinderpalen voor waardig werk daarentegen – discriminatie van vrouwen, lagere kasten (SC, *Scheduled Castes*), tribale groepen (ST, *Scheduled Tribes*), religieuze en etnische minderheden; rechteloosheid van migranten; lijfeigenschap en kinderarbeid – wordt weinig gedaan. India heeft een goed ontwikkelde maar weinig toegepaste arbeidswetgeving. Onder de huidige regering, voor wie economische groei een prioriteit is, staat de arbeidswetgeving sterk onder druk en worden sociale dialoog, vakbonden en het recht op staken in vraag gesteld.

Milieu

Sinds de jaren 1990 doet de Indiaase federale regering pogingen om het milieu te verbeteren, en in 2010 werd een *National Green Tribunal* opgericht. Toch blijft India 's werelds grootste verbruiker van brandhout en biomassa; zijn CO_2 uitstoot moet enkel onderdoen voor die van China en de Verenigde Staten. Een consensus voor duurzame groei is ver te zoeken; voorstanders van economische groei (een meerderheid) en milieuactivisten (een minderheid) zijn sterk gepolariseerd.

Gezondheid

Decennia van chronische onderfinanciering hebben het aandeel van de publieke sector teruggebracht tot 20% van de ambulante zorg en 40% van de intramurale zorg. Gezondheidszorg in de privésector leidt voor veel Indiërs tot verarming. Ongelijke toegang tot gezondheidszorg – met enorme regionale verschillen en binnen elke deelstaat sociaaleconomische gradaties – is problematisch. Pogingen om kwaliteit van en toegang tot de gezondheidsdiensten te verbeteren gaan onvoldoende gepaard met financiële inspanningen: de overheidsuitgaven voor gezondheidszorg stijgen niet boven de 1,3% van het bruto nationaal product; voor het fiscaal jaar 2014-2015 werd de begroting voor gezondheid met 15% teruggeschroefd. De gezondheidsindicatoren zijn beduidend slechter dan die van de armere buurlanden: zuigelingensterfte is 38/1000, moedersterfte 190/10.000. Voor de zwaksten in de samenleving (SC, ST) liggen deze cijfers nog hoger.

Onderwijs

Onderwijs is vrij en verplicht voor kinderen van 6 tot 14. Gemiddeld zijn 74% van de Indiërs geletterd, maar vrouwen en SC/ST bevolkingsgroepen scoren lager. Kwaliteit van het basisonderwijs is benedenmaats. Hoger onderwijs heeft het moeilijk om jongeren met gepaste kwalificaties voor de dynamische Indiaase arbeidsmarkt af te leveren.

Kinderrechten

India heeft nog een lange weg te gaan inzake kinderrechten: kindersterfte piekt nog op 53 per duizend, waarvan 1/3 te wijten aan ondervoeding; op 18 is 47% van de Indiaase meisjes al getrouwd; 12% van alle kinderen werken. Wetgeving voor kinderbescherming en promotie van kinderrechten is aanwezig maar

wordt nauwelijks geïmplementeerd. De situatie is slechter dan gemiddeld voor SC/ST kinderen, straatkinderen, en – binnen alle bevolkingsgroepen – meisjes.

Civiele maatschappij & overheidsinstellingen

India heeft een eeuwenoude traditie van niet-gouvernementele initiatieven, meestal van filantropische origine en leidend tot massabewegingen in de onafhankelijksstrijd. Sinds enkele decennia neemt het belang van basisbewegingen af in het voordeel van commerciële NGOs. Restrictieve controle van de staat op financiering en activiteiten staan het emanciperend karakter van de civiele maatschappij verder in de weg. Desondanks staat de Indiaase civiele maatschappij mee aan de wieg van belangrijke initiatieven (zoals bvb de *Right to Information Act* en de *Rural Employment Guarantee Act*) en wordt ze beschouwd als de belangrijkste motor voor een meer rechtvaardige maatschappij.

Politieke decentralisatie is grondwettelijk verankerd in het *panchayati* (zelfbestuur) systeem, met gegarandeerde rechten voor minderheden, maar is in de praktijk weinig doeltreffend.

Identificatie van interventiedomeinen & relevante actoren

Gezondheid, onderwijs en kinderrechten werden door de ANGS weerhouden als interventiedomeinen voor de toekomstige werking. De eerdere analyse in acht genomen, is het duidelijk dat de focus daarbij op het versterken van de actoren binnen de Indiaase civiele maatschappij moet liggen. In lijn met de conclusies van de *EU Roadmap for engagement with civil society* moet daarbij vooral aandacht besteed worden aan projecten en programma's die het beleid en de toepassing ervan in elk van de domeinen op lokaal vlak kunnen verbeteren, aan netwerking binnen de Indiaase NGOs (*internal South-South partnerships*), en aan capaciteitsversterking die de technische aspecten overstijgt en de NGOs de kans biedt om hun emanciperende rol ten volle te vervullen. Dit laatste zal evenwel slechts mogelijk zijn indien de houding van de Indiaase overheden ten overstaan van de Indiaase civiele maatschappij in de nabije toekomst merkbaar versoepelt en tot een constructieve relatie leidt.

Synergie & complementariteit

In geen van de drie weerhouden interventiedomeinen – gezondheid, onderwijs en kinderrechten – is substantiële vooruitgang mogelijk zonder interventies in de twee andere: synergie en complementaire actie zijn dus een sine qua non. De embryonale samenwerking tussen Indiaase civiele actoren vandaag kan en moet zeker versterkt worden, en het stimuleren van netwerking – over de grenzen van de interventiedomeinen heen – is daarvoor een nuttige piste. Informatie-uitwisseling en elementaire samenwerking tussen de Belgische ANGS in India, en tussen de ANGS en de Belgische en Europese gouvernementele actoren in ontwikkelingssamenwerking, kunnen daartoe bijdragen.