dasra

# India @75:

## A Threefold Growth Story

### The Role of Civil Society Organizations in India's Education, Public Health, and Social Justice Sectors

In 2022, during the 75th year of India's Independence, a group of civil society organizations and leaders came together as Coalition CSO@75, with the aim of measuring the quantitative and qualitative contributions of civil society organizations (CSOs) to India's developmental milestones.

***As part of Coalition CSO@75, Dasra has authored three reports to reflect on and commemorate civil society's contribution to nation-building in the areas of education, public health, and social justice.***

These reports shine a light on landmark interventions by civil society organizations, consequent transformations, and ground impact across diverse landscapes and timeframes since 1947 – contextualizing India's growth story as an outcome of unflinching and tireless collaborative efforts anchored by civil society organizations.

While the exercise is not exhaustive in its documentation of the varied and brilliant CSO interventions over the past 7.5 decades, it provides a humble glimpse into some interventions and tries to archetype their work and practices for today's sector practitioners – bearers of the non-profit legacy.

This 3-part report is an extension of the larger Non Profit Sector Report by the Coalition, titled "India's Million Missions: 75 Years of Service Towards Nation Building" launched in January 2023 at the Jaipur Literature Festival.

# In this report

# Glossary

| Abbreviation | Full Form |
|---|---|
| **CSO** | Civil Society Organization |
| **NITI Aayog** | National Institute for Transforming India Aayog |
| **G20** | Group of Twenty |
| **SC** | Scheduled Castes |
| **ST** | Scheduled Tribes |
| **NGO** | Non-governmental organization |
| **FYP** | Five-Year Plan |
| **NCR** | National Capital Region |
| **LGBTQIA+** | Lesbian, Gay, Bisexual, Queer, Transgender, Intersex, Asexual + |
| **CBO** | Community Based Organizations |
| **GIS** | Geographic Information System |
| **GBV** | Gender-Based Violence |

## EDUCATION

| Abbreviation | Full Form |
|---|---|
| **ASER Report** | Annual Status of Education Report |
| **CCS** | Center for Civil Society |
| **DPEP** | District Primary Education Program |
| **HSTP** | Hoshangabad Science Teaching Program |
| **LAHI** | Lend A Hand, India |
| **MV Foundation** | Mamidipudi Venkatarangaiya Foundation |
| **NCERT** | National Council of Educational Research and Training |
| **NCPCR** | National Commission for Protection of Child Rights |
| **RTE** | The Right of Children to Free and Compulsory Education |
| **SSA** | Sarva Shiksha Abhiyan |
| **SWRC** | Social Work and Research Centre |
| **UNESCO** | United Nations Educational, Scientific and Cultural Organization |
| **UNICEF** | United Nations Children's Fund |



## PUBLIC HEALTH

| Abbreviation | Full Form |
|---|---|
| **AIIMS** | All India Institute of Medical Sciences |
| **ARMMAN** | Advancing Reduction in Mortality and Morbidity of Mothers, Children and Neonates |
| **BCG** | Bacillus Calmette-Guérin |
| **CARE India** | Cooperative for Assistance and Relief Everywhere, India |
| **CINI** | Child In Need Institute |
| **CMC** | Community mobilization coordinators |
| **DPT** | Diphtheria, Tetanus, Pertussis |
| **EMPHASIS** | Enhancing Mobile Populations' Access to HIV & AIDS Services Information and Support |
| **EPI** | Expanded Program on Immunization |
| **FPA** | Family Planning Association |
| **HIV/AIDS** | Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome |
| **IEC** | Information Education Communication |
| **IMR** | Infant Mortality Rate |
| **JSS** | Jan Swasthya Sahyog |
| **MMR** | Maternal Mortality Rate |
| **MOH** | Ministiry of Health and Family Welfare |
| **NACP** | National AIDS Control Program |
| **NBE** | National Board of Examinations |
| **OPV** | Oral Poliovirus Vaccines |
| **PLWHA** | People living with HIV/AIDS |
| **SACS** | State AIIDS Control Society |
| **SMNet** | Social Mobilization Network |
| **SNEHA** | Society for Nutrition, Education and Health Action |
| **SRHR** | Sexual and Reproductive Health Rights |
| **STD** | Sexually Transmitted Disease |
| **TEV** | Tamaraikulam Elders' Village |
| **WHO** | World Health Organization |
| **WIA** | Women's Indian Association |

## SOCIAL JUSTICE

| Abbreviation | Full Form |
|---|---|
| **BMM** | Bandhua Mukti Morcha |
| **MARG** | Multipe Action Research Group |
| **MASS** | Mahila Abhivrudhi Mattu Samrakshana Samsthe |
| **NBA** | Narmada Bachao Andolan |
| **NGT** | National Green Tribunal |
| **PIL** | Public Interest Litigation |
| **UNDP** | United Nations Development Programme |

# Foreword

***Spotlighting the journeys of those who have contributed to this intricate tapestry of collective and participative action presents an opportunity for an entire new generation of social development stakeholders to pause, reflect, and learn.***

India at 75 – our struggle for Independence, selfhood, milestones, and emergence as one of the top economies in the world – is a collective effort. Civil society organizations (CSOs), often regarded as a "third" sector, have always been at the frontline of this collective effort: as partners, service providers, facilitators, and torchbearers consistently shining the light on what is fundamental to the idea of India. **Starting with the First Five Year Plan, the government emphasized on the involvement of CSOs in realizing progress, stating that "any plan for social and economic regeneration should take into account the services rendered by these agencies and the state should give them maximum cooperation in strengthening their efforts."**

Five-year plans may have run their course, but the government's think tank, the NITI Aayog, continues to consult with civil society through the NGO Darpan portal and several other consultative processes on the national development agenda and Sustainable Development Goals. G20 Sherpa and former CEO of the NITI Aayog, Amitabh Kant, acknowledging the productive and creative role of the sector in India's development story has said, "India's philanthropy and civil society, noted for its vibrancy, innovation and advocacy, is an important nation building partner for the government."

Echoing this ethos, our report recognizes and celebrates CSOs as important actors in the development ecosystem. It spotlights the especially important role CSOs have played in sectors that directly impact the lives of citizens and the growth of a nation: education, public health, and social justice – cornerstones of the social contract.

In Part I, we look at CSO milestones in India's education sector since 1947, and report on the processes as well as people involved: social workers and volunteers. In Part II, for the health sector, we map the role of civil society in delivering health services and resources, spotlighting the contexts in which huge leaps in health indicators were made. In Part III, in our section on social justice, we focus on landmark judgements with a focus on how civil society organizations contributed to them, strengthening citizens' access to the judicial system.

Undertaking archival research on the multi-fold decadal milestones re-affirmed for us the importance of a strong partnership between CSOs, the government, and the people. This exercise has helped us learn that CSOs have worked closely with all three branches of the state – legislature, executive, and judiciary – resulting in tangible outcomes such as policy reform, service delivery models, behavior change, and judicial precedents for India's most vulnerable communities and individuals.



# Executive Summary

**Across the following three-part report, we have captured India's development milestones, and explored civil society intervention models which contributed to those milestones and continue to offer good practices for the country's growth.**

**The tables on the following pages offer an overview of CSO interventions detailed in the sector reports on education, public health, and social justice.**

# Table 1: Education CSO Models, Interventions, and Good Practices

| CSO's area of work | Intervention | Intervention |
|---|---|---|
| **Process Innovation** | Science Teaching | 1. Use of experiments and demonstrations<br>2. Engagement with students' natural surroundings and lived contexts<br>3. Student and teacher feedback mechanisms for developing new pedagogies |
| | Curriculum development and teaching-learning materials | 1. Development of relatable and culturally responsive instructional material<br>2. Incorporation of vocational skills and life skills-oriented material<br>3. Models for holistic education that encompass mental, physical, and social wellbeing |
| **Governance reform** | Policy advocacy | 1. Multi-stakeholder civil society networks and coalitions to serve as advocacy forums<br>2. External monitoring and evaluation for existing education programs |
| | Program implementation | 1. Capacity-building and teacher training<br>2. Multi-level engagement with the government (schools, districts, states, Center)<br>3. Updating technical and digital capacities |
| **Research and development** | Learning innovations | 1. Prototype-testing and pilot projects to gather monitoring, evaluation, and learning insights<br>2. Operating within existing government school infrastructure<br>3. Cultivation of community-led though leadership and implementation models |
| | Archives and knowledge dissemination | 1. Preservation of cultural and lived experiences as knowledge<br>2. Emphasis on the need for marginalizedgroups to have control over their own representation, visibility, and knowledge dissemination |
| **Last-mile implementation** | School enrolments and retention | 1. Grassroots-level awareness and sensitization campaigns<br>2. Focus on lowering children's workforce participation and preventing child marriage<br>3. Securing access to government schools, schemes, and programs |
| | Early childcare and education | 1. Targeted interventions for at-risk communities that lack access to childcare (e.g., unorganized sector workers)<br>2. Preparing children from under-resourced groups for integration into the formal schooling pipeline |
| | Vocational skills | 1. Integrating education with self-sustaining community-oriented development projects<br>2. Skill training as an alternate form of education for individuals excluded from formal education<br>3. Different modes of hands-on skill learning, such as home-based |
| | Charitable and budget-private schools, scholarships, and funding | 1. Financial support or provision of voluntary education services to marginalized (e.g., women, Dalits, Adivasis) and at-risk (e.g., homeless children, children living in conflict-stricken regions) groups<br>2. Non-formal education centers in high-risk, under-resourced, and remote regions |

# Table 2: Public Health CSO Models, Interventions, And Good Practices

| CSO's area of work | Intervention | Intervention |
|---|---|---|
| Service delivery | Setting up Village Societies/ Cooperatives | 1. Publishing vernacular journals<br>2. Convening regular community meetings<br>3. Networking with professionals in the field<br>4. Involving men and women equitably |
| | Communication for behavior change | 1. Using folk art to communicate modern concepts<br>2. Production and distribution of pamphlets and digital messages for public health best practices |
| | Community-based health insurance scheme | 1. Starting with primary health care support to a catchment community and then move to providing coverage for them<br>2. Running run in-house health isurance services without external partnership with insurance companies |
| | Free service to needy populations | 1. Free food and return transportation for under resourced patients<br>2. Distinct facilities and differential pricing<br>3. Travelling to the community and doing house visits instead of hosting surgical camps |
| Behavior change | Training patient counsellors | 1. Volunteers with good communications skills and high empathy were trained for this<br>2. Creating opportunities for more interpersonal conversation and counselling |
| | Outreach to the non-customer | 1. Spreading the message through word of mouth<br>2. Meeting people where they live, work, and spend time, instead of placing the onus on them to visit<br>3. Monthly meet ups, where stakeholders are encouraged to break biases and air concerns |
| Innovation | Scalable human-centric interventions | 1. Human milk banks for premature babies<br>2. Kangaroo method for keeping newborns warm |
| | mHealth | 1. Free mobile health service voice calls<br>2. Timed and targeted preventive care information weekly/bi-weekly directly to peoples' phone<br>3. Available in local dialects |
| | Open-source software | 1. Designing digital platforms for monitoring and evaluation<br>2. Digital platforms for quality assessment and quality assessment and reporting for government hospitals and health centers |

# Table 3: Social Justice CSO Models and Systems for Change Over the Years

| CSO's area of work | Intervention | Intervention |
|---|---|---|
| **Recognition** | Social Justice movements | 1. Mobilizing and educating critical stakeholders<br>2. Attracting committed activists<br>3. Strategizing plans of action<br>4. Interacting with people across the board and international actors |
| | Community partnerships | 1. Presence of a catalytic agent with knowledge of the issue, and a problem solving mindset<br>2. Organizational transformations to respond to community needs more efficiently<br>3. + Regular community patrols to stay on top of local issues of health, education, environmental issues, issues related to communal harmony etc. |
| | Research and documentation | 1. Setting up education camps where stakeholders can hone reading and writing skills<br>2. Documenting information in languages and dialects known to stakeholders<br>3. Digital dissemination |
| **Advocacy and Social Action Litigation** | Training of paralegals or 'Barefoot Lawyers' | 1. Incubating personnel to support lawyers at lower-level courts<br>2. Training camps for barefoot lawyers to identify the problems of the poor, give voice to their demands and protect them against injustices, alert them against deprivation and exploitation, and give them first aid in law |
| | Training social action groups | 1. Promoting legal awareness amongst people<br>2. Equipping the poor with the knowledge of how law works, and how to use law to assert or defend their rights |
| | Independent, domestic funding | 1. Funding from social service organizations and public-spirited individuals<br>2. Pro bono work by established lawyers<br>3. Self-reliance and availability of easy finances which enables grassroot work, instead of preoccupation with administrative structures and reporting obligations |
| **Access to justice, adjudication, and rehabilitation** | Prison reform initiatives | 1. Training police officials and/ or prison authorities in effective law enforcement<br>2. Monitoring and ensuring accountability of police and prison authorities<br>3. Providing psycho-social and rehabilitative support to inmates, released prisoners and their families |
| | Monitoring judicial pendency (number of pending cases) | 1. Facilitating case management<br>2. Conducting training and sensitization workshops for the judiciary<br>3. Leveraging informal dispute resolution systems |



*Part 1*

# Education

India's civil society sector has been crucial to making "education for all" a reality for generations of Indians. This part of the report looks at India's education milestones from the ground up – how visionaries brought education to the doors of independent India's million children who did not have the means to otherwise attain it – and profiles their best practices.



*"School is something that you learn— reading and writing. Education is what you learn from the family, from the environment, from the community."*

*~ Bunker Roy,*
*founder of Barefoot College*

## What did education look like in 1947?

The conceptualization of education for Independent India was a vast undertaking from the very beginning. The Sargent Report, released before independence in 1944, was the first attempt to envision a national system for education on the subcontinent. However, an official national school system for independent India would not emerge until 1968, with the first National Policy on Education.

It would take five more decades for the Right to Education Act to be legislated in 2009, and for access to elementary education to be made a constitutionally guaranteed fundamental right.

In 1950, the Constitution of India identified two Directive Principles for education.

Article 45 outlined the government's responsibility to ensure free and compulsory education for all up to the age of 14 within ten years of independence, while Article 46 highlighted the need for special care towards promotion of education and economic interests of the Scheduled Caste ('SC') and Scheduled Tribe ('ST') groups.

***These goals have shaped the trajectory of India's education sector in the 75 years since independence.***

## What were the challenges along India's journey towards attaining universal elementary education?

+ Addressing caste, class, gender, and other social and material barriers to education
+ Developing schooling infrastructure and capacity, especially in rural and remote regions
+ Building community-centric education practices that are focused on holistic development

Civil society organizations and actors have worked extensively alongside central and state governments and grassroots communities alike to meet these challenges with innovation and determination. Above everything, CSOs have been able to embed education as the function of the community – be it access, delivery, or innovation.

## Mapping The Stakeholder Ecosystem for Education Delivery

### Government actors: Central, State & local Govts.

+ Policy-making and planning
+ Government schools and HEIs
+ Program funding

### Specialists & Practitioners: Teachers, academic boards & experts

+ Delivering education services
+ Developing curricular and pedagogical frameworks
+ Reviewing public education systems

### Civil Society Organisations, NGOs, volunteers & activists

+ Equitable access to education
+ Quality of learning outcomes
+ Infrastructure and capacity-building
+ Co nsultative policymaking and implementation
+ Advocacy and awareness



# HOW DID CIVIL SOCIETY ORGANIZATIONS STEP UP TO THESE CHALLENGES?

## 1. District-level micro-planning and community linkages

The Indian government's developmental vision for education has prioritized decentralization since its inception. Barring certain functions linked to national institutions of higher education, the Constitution of India, in 1950, placed education on the State List. Despite a 1976 amendment moving it to the Concurrent List, state governments have remained key forerunners in the creation and implementation of policies and government programs linked to education.

***From the 1980s onwards, efforts to further decentralize education planning and delivery led to a focus on district-level programming. The blueprint for the DPEP, launched in 1994, took cues from these models, which have sought to engage local communities in education planning and implementation.***

## #1: Targeting Teacher Absenteeism Through Volunteerism

### The Shiksha Karmi Project, 1984

The Shiksha Karmi model was developed by the Social Work and Research Centre (SWRC), Tilonia in Rajasthan to address the pressing problem of teacher absenteeism in rural primary schools, by engaging volunteers from within the community. In 1984, the model was picked up by the state government of Rajasthan– *shiksha karmis* (education workers) from local communities were engaged as volunteer primary school teachers in 2000 remote villages in the state. The Shiksha Karmi project sought to address the lack of motivation among teachers who were disconnected from local communities and make primary school education more accountable and culturally relevant. SANDHAN, a non-profit resource center, was made in charge of training and supporting the *shiksha karmis*. Other local non-profit organizations were also enlisted as collaborators. The project seeded learning innovations such as the setting up of *Prehar Pathshalas* (night schools) for out-of-school children and emphasized the role of *mahila* (women) *shiksha karmis* in addressing gender gaps in education.

### GOOD PRACTICES:

+ Engaging non-profits as on-ground partners to extend program reach to grassroots communities
+ Empowering communities to address teacher absenteeism through a self-sustaining model
+ Programming to address critical issues such as gender equity and non-formal education

## #2: Women's Self-Empowerment for Gender Equity in Education

### Mahila Samakhya, 1988

Mahila Samakhya was conceptualized as a decentralized intervention into women's participation in education. Launched by the central government in 1988 in districts having low female literacy, the program sought to involve women from local communities in education, planning, and implementation. Under the program, women were organized into collectives known as mahila sanghas, tasked with developing education goals and strategies for their villages. These were implemented with support from autonomous state-level education societies, stewarded by civil society actors. The Mahila Samakhya program has been successful in geographies where it was implemented– women engaged by the program have gone on to become school administrators, board members, educationists, and even local political leaders.

Over the decades, the program's progress has been fostered by support from central and state governments as well as non-profit organizations. As of 2014, it was operational in 130 districts and 679 blocks in India.

### GOOD PRACTICES:

+ Addressing dual goals of empowering women and girls, and increasing literacy in rural areas
+ Enabling women and girls to access leadership training and platforms
+ Increasing civic engagement among rural women (for e.g., Mahila Dakiya, India's first rural all-women news bulletin, was created by Mahila Samakhya participants)



**A newspaper clipping covering a district meeting of the Kerala Mahila Samakhya Society in 2022. In the decades since the implementation of Mahila Samakhya, multiple district and state-level autonomous societies have emerged in regions where the program is active.**

Image source: https://keralasamakhya.org/index.php/imagesjo

## #3: Area-Based Interventions to Eradicate Child Labor and Increase School Retention

### MV Foundation (Ranga Reddy, Andhra Pradesh), Est. 1991

Mamidipudi Venkatarangaiya Foundation (MV Foundation) began its work in the Ranga Reddy district in Andhra Pradesh, which had one of the highest incidences of child labor in India at the time. District-specific data from the 1990s indicates the efficacy of the MV model in using an area-based approach to achieve a decrease in the number of child workers, and an increase in school enrolments and retention. The organization has since secured the removal of 1 million+ children from the workforce, and their subsequent integration into formal schooling. Its founder, Dr Shantha Sinha, was awarded a Padma Shri in 1998, and served as the founding chair of the National Commission for Protection of Child Rights (NCPCR) for three consecutive terms. The MV model has been adopted by non-profits and government programs in Gujarat, Rajasthan, Maharashtra, Bihar, Delhi, Uttar Pradesh, Madhya Pradesh, Jharkhand, West Bengal, Odisha, and Tamil Nadu– states where child labor is a persistent problem.

### GOOD PRACTICES:

+ Identifying the root causes and targeting the links between child labor and school dropouts
+ Prioritizing deep engagement with local contexts and communities through an area-based approach

## 2. Policy and Advocacy Rights

The goal of universal primary education was first articulated at the eve of India's independence– Article 45 of the Indian Constitution places the responsibility of ensuring free and compulsory education for all up to the age of 14 years as a directive principle on the government. Despite this goal being reiterated in policies and Five-Year Plans (FYPs) over subsequent decades, targets linked to its fulfilment were repeatedly pushed back. There was noteworthy policy movement towards this goal in the current millennium. In 2001, the central government launched the Sarva Shiksha Abhiyan (SSA) with the goal of 100% enrolment and retention of children in primary schools.

***The Right of Children to Free and Compulsory Education (RTE) Act was legislated in 2009 to make elementary education a fundamental right. Systemic barriers in the form of gender, caste, class, and other social power differentials have remained a persistent challenge to the materialization of universal access to schooling.***



### #1: Access to Education for Historically Marginalized Groups

#### People's Education Society, Est. 1945

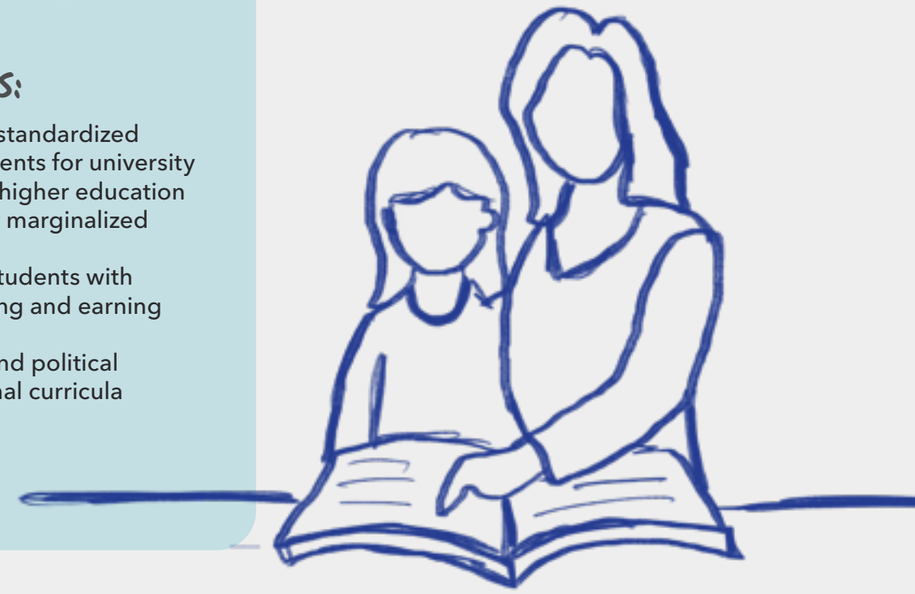
The People's Education Society, set up by Dr BR Ambedkar, had a vision of education that had its roots in anti-caste movements. Siddhartha College of Arts, Sciences and Commerce, Mumbai, was established a year later to materialize this vision. It allowed students from diverse caste, gender, class, regional, and religious backgrounds to study disciplines of their choice irrespective of their past academic performance. The Society has since set up approximately 30 schools and colleges that followed an Ambedkarite blueprint of education, which centered around moral, social, and political education. These institutions provide welfare interventions in the form of freeships and scholarships for SC students and students from other marginalized communities.

#### GOOD PRACTICES:

+ Moving away from standardized academic requirements for university admission, making higher education more accessible for marginalized students
+ Providing college students with the option of working and earning alongside studying
+ Integrating social and political education into formal curricula

**Dr. BR Ambedkar with other members of the People's Education Society, 1945.**

Image source: https://commons.wikimedia.org/wiki/File:Dr._Babasaheb_Ambedkar_with_his_the_cooperatives_of_education_sector_and_the_members_of_People%27s_Education_Society..jpg



## #2: Making Budget Private Schools an Accessible Alternative to Government Schools

### Center for Civil Society, Est. 1997

The School Choice Campaign was launched by CCS (Center for Civil Society) in 2007, with the aim of giving parents from low-income backgrounds the option to enroll their children in budget private schools. Several non-profits, activists, and academics joined this advocacy platform. The push towards privatizing school education in the 1990s led to a proliferation of low-cost private schools, particularly in semi-urban regions both within and outside metropolitan cities. However, these remained inaccessible to highly economically disadvantaged groups. The campaign's advocacy was focused on the provision of school vouchers by central and state governments, on a per-student basis, to families hailing from such contexts. Its pilot project, the Delhi School Voucher Project, led to the parents of 408 students from the city's most underserved and low-income wards being given vouchers for their schooling.

### GOOD PRACTICES:

+ Institutionalizing budget and accessible private schools, which have been rapidly emerging non-urban geographies that are not highly developed
+ Creating a multi-stakeholder advocacy platform with clear policy goals to engage with government stakeholders
+ Advancing the need for a more holistic view of learners' ecosystems by engaging with the role of parents as decision-makers

## #3: Ensuring Equitable Implementation of the Right to Education

### The RTE Forum, Est. 2009

The RTE forum is a coalition of informal alliances of non-profits, activists, and other civil society stakeholders advocating for the just and equitable implementation of the Right to Education (RTE) Act, 2009. Its prominent members include organizations such as Oxfam India, Pratham Education Foundation, Room to Read, and Campaign for Education. Almost 10,000 organizations are engaged with the Forum, operating at the pan-India as well as the state levels. Since its inception in 2009, its members have been involved in monitoring the implementation of the RTE and providing recommendations for its improvement, often in collaboration with government agencies. They have also been engaged in running advocacy programs promoting access to education for marginalized groups, and training and awareness programs on the RTE for teachers and other community members.

### GOOD PRACTICES:

+ Engaging non-profits as independent evaluators of policy implementation
+ Coalition-building to create pan-India as well as state-specific non-profit networks



# 3. Learning innovations

For several decades following independence, progress in the sphere of school education was typically mapped in terms of enrolment numbers and ratios. During this period, policy measures and CSO interventions alike were developed primarily with the goal of improving the infrastructure and capacity associated with schools. A shift towards decentralized education planning in the 1980s-90s was accompanied with a renewed focus on the quality of learning.

***By the time the SSA was launched by the central government in 2001, there was growing consensus that making education a meaningful endeavor for students was contingent on improving its quality.***

While there is a rich history of learning innovations being employed by government actors and CSOs in the country, these interventions have taken on a compelling trajectory in recent decades. Successes in evidence-based learning innovations have been closely associated with scalability and partnerships with government schools.

## #1: Pioneering Low-Cost Learning Innovations in Government Schools

### Pratham Education Foundation, Est. 1995

Pratham Education Foundation has pioneered many interventions towards improving the quality of learning outcomes. Its approach prioritizes low-cost interventions that have the capacity to be replicated across geographies and cultural contexts, and focuses on working alongside government schools, and programs. The organization operates in areas including foundational literacy and numeracy, early childhood education, digital education, and teacher training and capacity building. Pratham pioneered the creation of the ASER Report in 2005, to review learning interventions and outcomes in the country on an annual basis. As of 2017, the organization's programs have been operating in 24 out of 29 Indian states, impacting the lives of millions of children each year.

### GOOD PRACTICES:

+ Setting up low-cost evidence-informed interventions
+ Building scalable models viable for uptake in government schools and programs

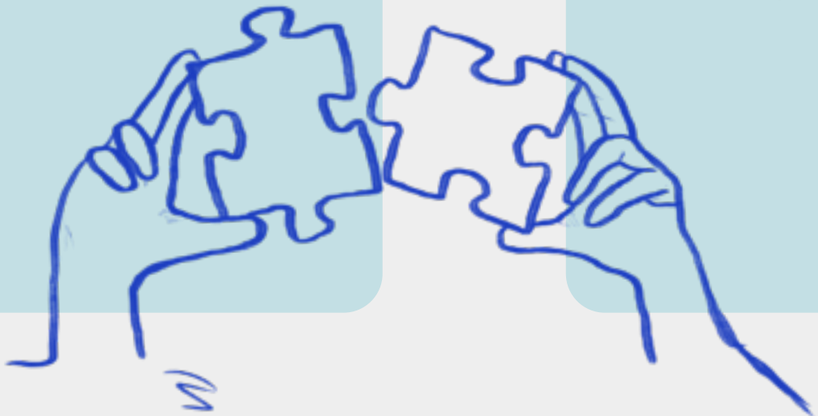
## #2: Integrating Hands-On Skill Learning into the Secondary School Pipeline

### LAHI (Maharashtra), Est. 2003

Lend A Hand is a non-profit organization engaged in developing vocational learning and skill training programs that can be integrated into formal schooling. Since 2003, the organization has been implementing its curriculum for skill training in government secondary schools across the country. Its pilot program involved the inclusion of skill training in curricula in 100 schools across Maharashtra. It has since expanded its footprint to 24 states and union territories in India, covering 10000 government schools and more than 1 million students each year. Successful collaboration with government schools in Maharashtra has led to the inclusion of the organization's Multi Skill Foundation Course within the secondary school curriculum of the state board.

### GOOD PRACTICES:

+ Developing a scalable model that integrates into the existing infrastructure of government schools
+ Innovating hands-on skill learning through home-based programs and a mobile skills lab





## #3: Building Leadership to Enable School Transformations at the Grassroots Level

### Kaivalya Education Foundation, Est. 2008

Kaivalya Education Foundation is a change management organization working to transform schooling ecosystems. A multi-level engagement with education outcomes and processes, at the school, district, and state levels, lies at the heart of their model. One of the organization's pioneering achievements is its focus on building school leadership through training and management programs. It extends this vision of cultivating new ideas and innovations through leadership to its own talent management system, through fellowships for engaging young professionals in the sector. Working alongside government actors to scale these models of school transformation, Kaivalya works in 27 states and 2 UTs, operating in almost 400,000 schools and engaging with more than 40,000 public education officials.

### GOOD PRACTICES:

+ Engaging at multiple levels to create a sustainable model for the scaling of programs
+ Focusing on cultivating grassroots-level thought leadership in education and social development

## #4: Revitalizing the School-To-Work Pipeline for High-Risk Urban Youth

### Antarang Foundation (Mumbai), Est. 2012

Antarang Foundation works on developing the school-to-work pipeline by helping high-risk urban youth from marginalized communities transition from education into the workforce. Their interventions include provision of career awareness and counselling, teaching employment skills, linking students to employment opportunities, and addressing school dropouts through these initiatives. Antarang's programs are designed for the secondary school ecosystem, for students in classes 9 to 12. The organization has impacted more than 120,000 students through its work, which is spread across 35+ communities in Mumbai, and has recently been expanded to Goa, Pune, and Udaipur. It holds 10 partnerships with state and other levels of government in the geographies concerned.

### GOOD PRACTICES:

+ Focusing on the school-to-work pipeline as an underexplored area of education
+ Partnering with state governments for a viable scaling strategy
+ Setting up digital infrastructure (especially after COVID-19) for programs to remain accessible and viable

## 4. Pedagogical interventions and curriculum development

Determining pedagogical and curricular approaches has been a key aspect of national policies on education in post-independence India. The first national-level curriculum framework was released in 1975. Two considerations have been central to the trajectory that policy engagement with curricula has taken in the country.

### First, there has been an emphasis on the use of regional languages for instruction in schools, especially at the primary level.

The three-language formula, first mentioned by the Kothari Commission report in 1964, promotes the teaching of three languages in schools– Hindi, English, and any other regional Indian language in predominantly Hindi-speaking states, and Hindi, English, and the local regional language in non-Hindi-speaking ones. Concurrently, making curricular materials more relevant to Indian cultural and social contexts has also been a priority for these policies.

### Second, beginning from the 1960s, there has been a pushback against pedagogies based on rote learning.

Instead, policies have emphasized the need for cultivating curiosity and critical thinking skills, to improve the quality of learning outcomes. Both these trends indicate a need for making learning materials more accessible, as well as responsive to students' lived realities.



### #1: Linking Education to Social Justice and Sustainability Through Curricular Innovations

**Avehi Abacus Project (Mumbai), Est. 1990**

The Avehi Abacus Project was founded in 1990 in Mumbai, with the aim of building teaching-learning materials that encourage holistic education in formal and non-formal spaces of learning. Their teaching-learning kits and curricular material emphasize the links between education, social justice, and environmental sustainability. They utilize a pedagogical approach that encourages students to be curious and proactive about their surroundings. These materials have been developed through several years of prototype testing, in collaboration with municipal schools and non-formal education centers. The organization is widely recognized for its low-cost curricular interventions, and their positive impact on learning outcomes among students.

#### GOOD PRACTICES:

+ Enriching teaching-learning processes through fostering student engagement with their surroundings
+ Developing community-oriented learning materials through prototype-testing and collaborations with teachers and students

### #2: Developing Gender-Responsive Teaching-Learning Materials for Modern India

**Nirantar Trust (New Delhi), Est. 1993**

Nirantar Trust is a pioneering organization that focuses on gender inequity in education and challenges linked to women's literacy. The development of gender-responsive pedagogical and curricular approaches as well as materials has been at the heart of the organization's interventions. One of the first organizations to address gender gaps within education in India, Nirantar has developed numerous educational materials that focus on gender rights, sexuality, and gender sensitivity, conceptualized through an intersectional feminist lens. It has established over 200 community-based learning centers, impacted the lives of over 50,000 women and girls, and reached over 5,000 teachers through its teacher training and support programs.

#### GOOD PRACTICES:

+ Undertaking long-term interventions to introduce gender rights and justice curricula into school syllabi
+ Developing a multi-stakeholder model that fosters collaborations directly between students and teachers

## #3: Targeting Foundational Numeracy Through Context-Responsive Curricular Materials

### Jodo Gyan (Delhi-NCR), Est. 1998

Jodo Gyan innovates mathematical education and strengthens foundational numeracy in India through curriculum development, learning material creation, teacher training, and partnerships with schools, curricular bodies, and teacher training institutes. Its teaching-learning materials are used across pre-primary, primary, and middle school levels. For over two decades, Jodo Gyan has implemented its methods in government and private schools in the Delhi-NCR region, gathering qualitative insights to inform its interventions at each stage. Notably, the organization's curricular materials are developed with a focus on being rooted in Indian contexts and using vocabularies that are familiar and accessible for students.

### GOOD PRACTICES:

+ Identifying the link between gaps in quality of education and the lack contextually responsive curricular materials
+ Using qualitative insights from schools for devising teaching-learning materials, to adapt and reform content across stages
+ Innovating teaching-learning pedagogies to address specific challenges linked to foundational numeracy

## #4: A Multi-Stakeholder Partnership to Develop the National Curriculum Framework

### 2005

The National Curriculum Framework 2005 was the product of a collaboration between NCERT officials, non-profits, teachers' associations, and academic experts. The focal point of this exercise was to move away from rote learning and adopting critical thinking approaches. It recognized the crucial role played by civil society actors in the education sector and sought to draw on their deep engagement with communities. The framework emphasized the need for constructivist pedagogies that address inequality and provide students with social and political education. Progressive ideals around democracy, human rights, and pluralism were incorporated into it. These features posed a unique opportunity for stakeholders to come together and build bridges between different contexts across the country and the curricula being taught in schools.

### GOOD PRACTICES:

+ Institutionalizing consultative, multi-stakeholder approaches to curriculum-building
+ Emphasizing the link between education and social justice, and the need for more holistic teaching-learning pedagogies geared at multiple areas of individual development



## #5: Platforming Adivasi Voices, Chronicling their Lived Histories

### adivaani, Est. 2012

Since its inception in 2012, adivaani has been engaged in archiving, chronicling, publishing, and knowledge dissemination aimed at amplifying the voices of Adivasi people in India. Through its multiform and multimedia interventions, the non-profit operates as a platform for Adivasi voices to represent their own histories and cultures. adivaani addresses the threat of extinction faced by the lived, intergenerational knowledge traditions that exist among Adivasi groups. Its pedagogical interventions pose critical challenges to the dominant modes of history-writing and knowledge transmission in the country, as well as the privileged gaze with which Adivasi narratives and knowledge traditions have historically been interpreted and disseminated.

### GOOD PRACTICES:

+ Emphasizing on the need for marginalized groups to have control over their own representation, visibility, and systems of knowledge
+ Identifying knowledge dissemination and archival work as a key component to the education ecosystem, to preserve lived and situated forms of knowledge

**'In a country where rote learning has prevailed even at the most elite schools, the new emphasis on critical thinking signals a major shift in pedagogy.'**

*~ Somini Sengupta on the National Curriculum Framework 2005, 'Politics Is the New Star of India's Classrooms' in The New York Times, 15 August 2007*

Source: https://www.nytimes.com/2007/08/15/world/asia/15india.html

## 5. Science teaching

Science teaching has been an area of specific interest for policymakers and service delivery agents in the education sector. In India, revitalizing and transforming science teaching practices became a policy priority, starting in the 1960s. This occurred against the backdrop of scientific teaching-learning practices that prioritized experimentation, demonstration, and interactions with students' natural surroundings becoming increasingly popular across the globe.

***CSO interventions in science teaching have been linked to making this shift from 'listening' to 'doing', and the development of a scientific temperament among students.***




### #1: The Legacy of 'Science For Social Revolution' and Making the Sciences Accessible

***Kerala Sastra Sahitya Parishad, Est. 1960***

The people's science movement in India took shape over several decades, with civil society stakeholders and activists from different sectors and regions advocating for scientific education to be made more responsive to people's needs and contexts. The antecedents of this movement can be traced back to the Kerala Sastra Sahitya Parishad, which has the motto 'science for social revolution'. Advocacy around making science more accessible and people-centered focused on the potential to harness scientific and technological development to address material, social, and political challenges. The movement also pushed back against superstitious beliefs and encouraged individuals to ask critical questions to foster a modern scientific consciousness.

#### GOOD PRACTICES:

+ Leveraging science as an approach for scaling awareness and social justice
+ Aligning scientific education with individuals' everyday lives

### #2: International Collaboration to Revitalize Science Teaching in Government Schools

***Circa 1960***

From the 1960s onwards, the NCERT received external support from UNICEF and UNESCO for the development of science teaching in schools. A commission of experts reviewed science and math education and made recommendations. NCERT received assistance from 8 UNESCO experts in developing curricula, materials, and teacher training, and was supplied with science kits for schools. Activity-based materials were developed through trials in a limited number of government secondary schools from 1967 to 1970. Under the Secondary Science Teaching Project, science kits were supplied to approximately 30,000 government schools in India because of this partnership.

This collaboration brought a new wave of science teaching-learning practices into India which focused on developing innate curiosity and a culture of learning by doing among students.

#### GOOD PRACTICES:

+ Partnering with multilateral organizations for benchmarking science teaching with global standards
+ Introducing and institutionalizing 'learning by doing' pedagogies in science teaching

### #3: Developing Models of Science Teaching for Rural Government Schools

**HSTP, 1972**

The Hoshangabad Science Teaching Program was established in 1972 by non-profits Friends Rural Center and Kishore Bharati to improve science education in rural government schools in the Hoshangabad district of Madhya Pradesh. A pilot project was set up in 16 middle schools in the district, with academic guidance from scientists and experts from across India. The program taught science through experiments and field studies and made innovations in books, kits, curricula, teacher training and exams. The HSTP model was one of the first to demonstrate the efficacy of CSOs working alongside government schools in rural areas. In 1982, Eklavya Foundation was established to expand the model to other parts of Madhya Pradesh and later, rural areas in other Indian states.

#### GOOD PRACTICES:

+ Employing a model of government partnerships to bring non-profit models to scale
+ Building technical capacity in rural government schools through cost-efficient innovations

***'In the HSTP, experiments and observations come first, and out of it, principles of science are expected to be revealed. Indeed, the larger the number of questions from students, the more successful are the lessons considered to be.'***

*~ Sreekant Khandekar, 'Hoshangabad Science Teaching Program makes science fun for school students' in India Today, 15 July 1984*

https://www.indiatoday.in/magazine/education/story/19840715-hoshangabad-science-teaching-programme-makes-science-fun-for-school-students-803149-1984-07-14



## 6. Access to education in remote and at-risk geographies

A national system of neighborhood schools was first outlined in India in the Kothari Commission report of 1966. The National Education Policy, 1968 demarcated the development of such a system as a policy priority. Despite making crucial progress towards this overarching goal in recent decades, India is home to a substantial number of out-of-school children.

***Discrepancies in access to and quality of education are particularly prominent in certain geographies, both urban and rural. These include remote regions facing ecological and developmental challenges, conflict zones, informal settlements and slums, and other similarly hard-to-reach geographies.***

The delivery of education services to communities living in these geographies has been a priority for civil society actors since Independence. Targeted interventions have historically used innovative models to bring these communities within the folds of formal education, as well as to develop alternate non-formal teaching-learning modes.

## #1: Making Early Childcare and Education Accessible to Unorganized Sector Workers

### Mobile Creches (Delhi-NCR), Est. 1969

As urban centers in post-Independence India continued to pursue economic growth, the number of unorganized sector workers residing in informal settlements under precarious conditions also grew at a rapid pace. Mobile Creches, a pioneering organization in the early childcare and education space, set up centers in construction sites and informal urban settlements to address the education needs of these hard-to-reach populations. The organization's initial efforts were focused on establishing daycares for babies. This was followed by setting up schools for older children and literacy centers for adults. At present, Mobile Creches operates 1,000 childcare centers, and has impacted the lives of 8,67,000 children. The organization's advocacy has played a critical role in shaping government programs for training childcare workers, and legislative protections such as the Building and Other Construction Workers Act 1996 for informal workers.

### GOOD PRACTICES:

+ Emphasizing the importance of early childhood care and education in the developmental milestones of children
+ Targeting interventions for at-risk children and women, excluded from the formal schooling pipeline due to the precarious working and living conditions

## #2: Building Skills For Self-Reliance And Resilience Among Rural Communities

### Barefoot College (Tilonia, Rajasthan), Est. 1972

The Social Work and Research Center (SWRC) was established by Bunker Roy in Tilonia, Rajasthan, to pursue integrated development in rural areas. The model for Barefoot College, as the organization later came to be known, was developed through a thorough engagement with how gender, caste, and other social differentiators of power skew individuals' participation in development processes. This model relies on imparting hands-on skills to rural communities, disenfranchised from the formal learning pipeline, to empower them to be self-reliant. This is accompanied with a particular focus on educating women, girls, and other marginalized groups. As of today, Barefoot College has an international footprint of 93 countries, operating in 2,000 villages. Allied priorities include integrated goals of improving water and sanitation, developing systems for safe and renewable energy, and securing access to livelihoods for village communities.

### GOOD PRACTICES:

+ Integrating education with self-sustaining community development projects
+ Focusing on context-specific skilling as an alternative education for individuals excluded from the formal schooling pipeline
+ Developing non-formal models of teaching and peer-learning adapted to remote / rural geographies



**The first Mobile Creches center at a construction site in Delhi-NCR.**

Image source: https://www.mobilecreches.org/our-story

**An archival photograph of the Barefoot College (erstwhile SWRC) center in Tilonia, Rajasthan.**

Image source: https://www.barefootcollegetilonia.org/swrc-old-album?pgid=l3eb83x8-3bb424db-6dac-4a19-98fe-aa93edfcf67d

## #3: Government Schools Scale New Height Through Capacity-Building Interventions in Ladakh

### 17000 ft Foundation (Ladakh), Est. 2012

The Hoshangabad Science Teaching Program 17000 ft Foundation was set up to secure access to quality education for high-altitude frontier communities that are situated in remote regions cut off from other areas. The organization initiated its programs in Ladakh, where it has successfully transformed more than 25% government schools in inaccessible remote geographies and is currently operational in two districts and almost 900 schools. Its interventions focus on equipping schools with quality teaching-learning resources and infrastructure, creating livelihood opportunities for students, and mobilizing digital technologies such as solar power to bring connectivity to off-grid schools. Since 2021, 17000 ft Foundation has expanded its operations to Sikkim through a partnership with the state's education department. The organization's long-term goal is to make quality education at the primary and elementary levels accessible to 500,000 children residing in remote parts of the Indian Himalayan Region.

### GOOD PRACTICES:

+ Transforming government schools in remote geographies to improve learning outcomes for students
+ Bridging the gaps in infrastructure and resources for improving connectivity for the schools
+ Partnering with the government to create impact at scale in schools located within remote areas

Part II

# Public Health

Of India's public health milestones, several have been conceived, enabled, and launched from the ground up by India's civil society sector. Every decade since independence has seen the emergence and success of community interventions, and the ability of civil society groups to shoulder the massive task of achieving public health for all in a newly independent India – be it delivering health services and resources, acting as a supporting institution for the government, or simply carrying people's voices and stories to policymakers and the world at large.



**"The building of India's health depends ultimately on the efforts of devoted Indians. Are there enough men and women of this kind in the country for this purpose? There are enough... However slow may be India's rise, this is the leaven which will one day leaven the lump."**

*~ Henry E. Sigerist*
*The Medical Mission for Experts to India in 1943, advising the Health Survey & Development Committee of the Government of India*

# How did newly independent India look at public health?

In the years leading up to independence in 1947, India was already home to various formal and informal programs for public health – with a mix of homegrown and adapted practices. To chart an organized way forward for India's public health sector, in 1946, the outgoing British Government had commissioned a `Health Survey and Development Committee Report' popularly referred to as the Bhore Committee Report.

**The Bhore Committee Report of 1946 presented a detailed plan for a National Health Service for the country, envisioning universal coverage for the entire population, free of charge, through a comprehensive state-run salaried health service. However, it was not until thirty-seven years later that independent India notified its first policy on health – the National Health Policy of 1983.**

**Until then, the Constitution of India did the job of providing guidelines on public health and its many facets – like the right to life, the health status of young citizens, workers, mothers, the standard of living, and environmental health. Between 1947 and 1983, governments followed these guidelines and the Five-Year Plans to devise health programs for India's varied populations.**

Among those supporting program implementation and delivering health services on the ground were members of civil society: charitable organizations, social workers, volunteers, and researchers. Often, it was the civil society sector that provided information and solutions from the grassroots to inform nationwide (and even international) programs for public health. Consequently, India's national health policies have recognized the role of civil society organizations in overcoming the country's health challenges and crossing new milestones.

*"It has become increasingly apparent that programs cannot be efficiently implemented merely through government functionaries. A considerable change in the mode of implementation has come about with the increasing involvement of NGOs and other institutions of civil society. It is to be recognized that widespread debate on various public health issues has, in fact, been initiated and sustained by NGOs and other members of civil society. Also, an increasing contribution is being made by such institutions in the delivery of different components of public health services."*

*– The National Health Policy (2002)*



## India's Health Specialists and Practitioners: Mapping the Stakeholder Ecosystem for Public Health Delivery

### PUBLIC HEALTH CENTERS –

**Hospitals, Clinics, Dispensaries**

*Eg.: The 1970 Comprehensive Rural Health Program, Jamkhed (Maharashtra) based NGO has almost eliminated child malnutrition, improved child survival, and improved maternal health outcomes*

### GOVERNMENT –

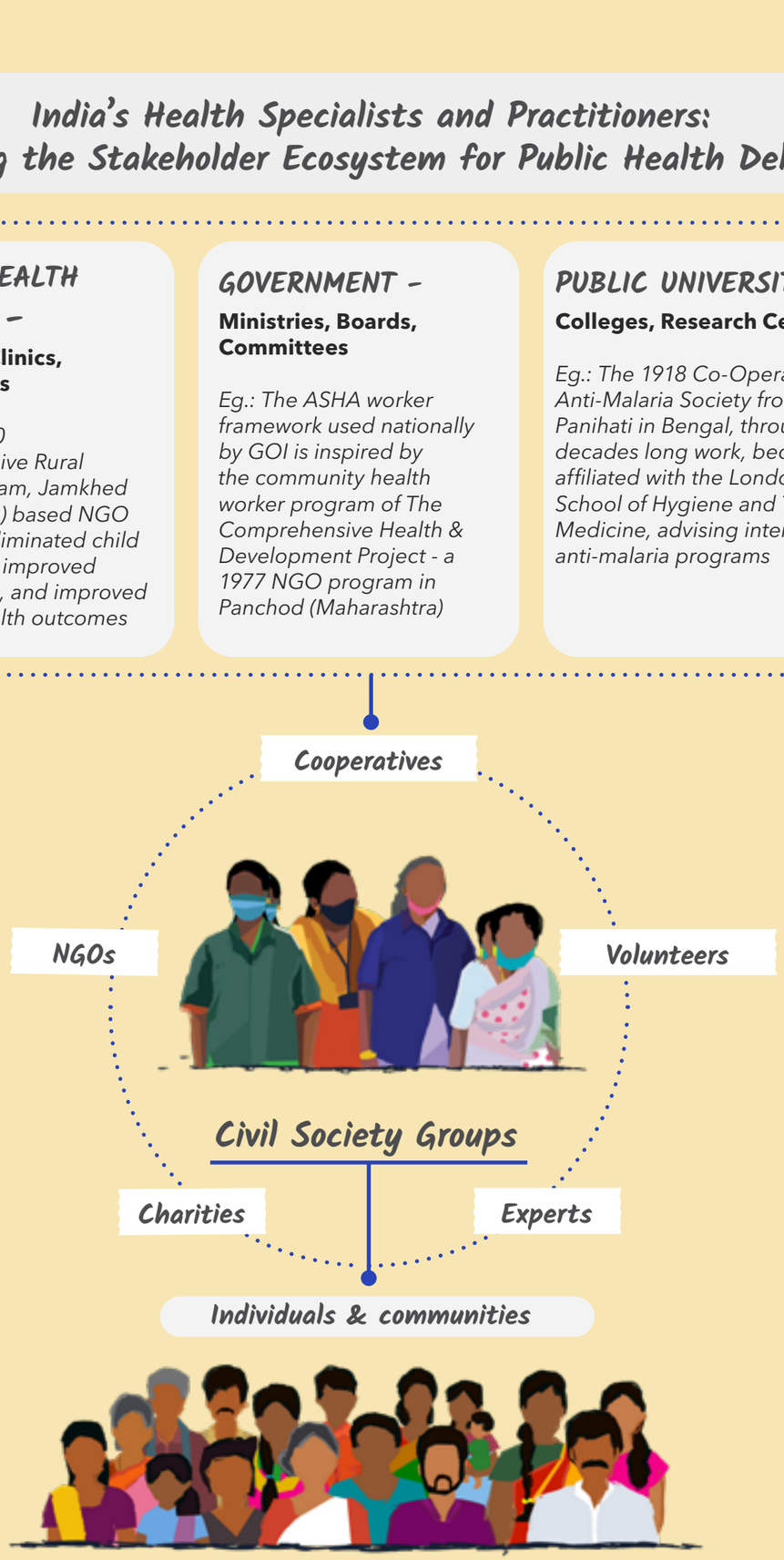
**Ministries, Boards, Committees**

*Eg.: The ASHA worker framework used nationally by GOI is inspired by the community health worker program of The Comprehensive Health & Development Project - a 1977 NGO program in Panchod (Maharashtra)*

### PUBLIC UNIVERSITIES –

**Colleges, Research Centers**

*Eg.: The 1918 Co-Operative Anti-Malaria Society from Panihati in Bengal, through its decades long work, became affiliated with the London School of Hygiene and Tropical Medicine, advising international anti-malaria programs*

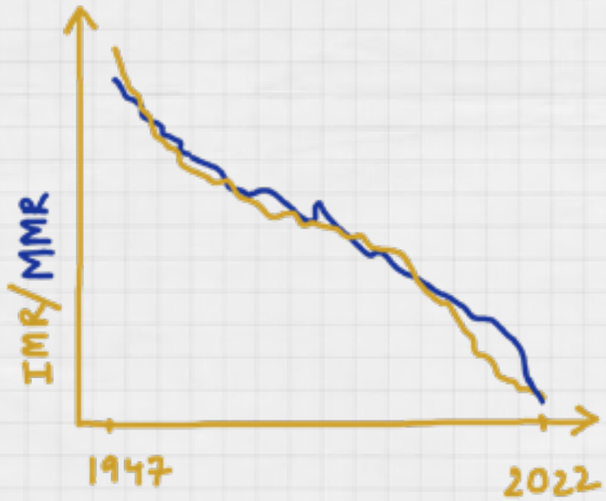


## I. A fighting chance at birth for mothers and infants

One of India's greatest achievements in the health sector is its reduction of infant and maternal mortality rates over the past 75 years. Infant and maternal mortality rates are an indication of the social, economic, and environmental conditions in which children (and others in society) live. Declines in MMR and IMR show that on several levels, inequalities are being bridged, living conditions are being enhanced, and that access to services, despite adversity, is improving.

Since 1947, the role of CSOs in achieving these declines has been significant. Formulating programs geared towards women, demystifying neonatal and maternal healthcare, and protecting women and children from violence and harm are some of many ways in which CSOs have been at the frontline.

***Why are these milestones important? Because both are tied to the overall health of a society and the degree of inequalities in access to quality health services.***




Since 1947, the Infant Mortality Rate has declined from 150 to 27.6 per 1,000 live births, while the Maternal Mortality Rate has declined from 2000 to 103 per 10,000 live births.



### #Addressing Socio-Economic Intersections in Infant Malnutrition

***Child in Need Institute (Kolkata, West Bengal), Est. 1974***

"Much before being a health problem, malnutrition is a social issue. Rooted in social, economic and cultural causes, child malnutrition cannot be solved via a mere clinical solution. On the contrary, it requires a multi-pronged approach, where multi-disciplinary teams of doctors, nurses, nutritionists and social scientists work along with key caregivers, mainly mothers and other women, to address the determinants of child malnutrition, disease and death."
-CINI

Even after independence, stunting and anemia continued to be rampant among infants in India, especially in remote villages and economically disadvantaged urban communities. While the administration of nutrition was key to overcoming these challenges, a long-term need was an overhaul of resource distribution, community health and maternal agency too. The 1970s saw an intervention combining these approaches in West Bengal. Focused on female agency in under-resourced communities, The Child in Need Institute (CINI) began working in 1974 to promote community health best practices through proximate women champions - women from these communities themselves. By setting up institutions and programs like the CINI Chetana Training Center and 'Adopt a mother and save her child', CINI trained the women to become community health workers promoting best immunization, feeding and care practices to the people.

CINI's work and interventions addressing root causes such as poverty, powerlessness, gender discrimination, illiteracy, and inadequate health and sanitation practices played a key part in India's Primary Healthcare Movement, setting several practical precedents for what primary healthcare should look like.

The push for Primary Healthcare, i.e., accessible and affordable essential health services at the community level came from several fronts, especially volunteer medicos and CSOs like CINI who were working with vulnerable under-resourced communities. While on the international level, it was the 1978 Alma Ata Declaration that called on the world to achieve "Health for All by 2000" through Primary Healthcare, the Indian chapter had begun long before with leading CSOs like CINI and Voluntary Health Services (Est. 1957) – whose founder Dr Krishnaswami Srinivas Sanjivi is known as the Father of Primary Healthcare in India. The common link between both organizations was that they demonstrated what quality, accessible and affordable healthcare could do for marginalized communities, and its ripple effects across a developing country.

### GOOD PRACTICES:

+ Deploying proximate women as agents of change
+ Collaborating with universities and think-tanks to build research-backed interventions
+ Advocating for child-friendly governance locally to improve targeted health outcomes

## #Focusing on Maternal and Child Health in Low-Income Settlements

### Society for Nutrition, Education and Health Action (Maharashtra), Est. 1990

"The urban informal settlements are faced with a multitude of health problems such as the increased risk of maternal morbidity and mortality, low birth weight babies, and poor access to health facilities. The period from the start of a mother's pregnancy through her child's second birthday, is a critical window for addressing the long-term consequences of childhood undernutrition."
- National Family Health Survey (2018)

In 1977, while working as a pediatrician and neonatologist at Sion Hospital in Mumbai, Dr. Armida Fernandez saw infant after infant perish in her unit, with almost 70% of premature babies dying of sepsis. Focusing on increasing contact between the new mothers and infants, she simultaneously improved the hygiene of her ward, doing away with incubators, humidifiers, and powdered milk. She also set up a milk bank - the first of its kind in Asia. This worked, and in over two decades, the infant mortality rate in the ward dropped to 12%.

"I said no more hospitals for me, I need to be in the slums. Looking at babies and facing death, I've realized that hospitals are not the answer. They are part of it, but you need to work to keep people out of them in the first place."
- Dr. Armida Fernandez, Founder – SNEHA

Dr. Fernandez quit her job at the hospital, started the Society for Nutrition, Education and Health Action (SNEHA), and began working in Mumbai's slums. Since the early 1990s, SNEHA has addressed the all-round development of the baby and health equity for women through the "continuum of care approach", alongside child health and nutrition, adolescent health and sexuality, and prevention of violence against women and children. Till date, SNEHA has assisted 37,000 women in pregnancy and high-risk deliveries, prevented and treated malnutrition in 25,000 children less 5 years of age, legally supported over 8700 domestically abused women, worked with 13,000 adolescents, and trained over 6000 government officials.

### GOOD PRACTICES:

+ Using electronic data collection methods to collect extensive public health data which informs their programs
+ Building low-touch models, so that community capacity to demand quality public services and systems is built
+ Scaling evidence-based models through strong partnerships with government and funders



## #Innovating Through Gender Sensitive Technology

### Advancing Reduction in Mortality and Morbidity of Mothers, Children and Neonates (ARMMAN) (Maharashtra), Est. 2008

Based on the experiences of Dr. Aparna Hegde, who had witnessed women's lack of access to critical preventive healthcare information and services, and the effects of inadequately trained and supported health workers in the sector during her residency in obstetrics and gynecology in Mumbai, ARMMAN was founded to leverage technology through "mHealth" to create cost-effective, scalable, gender-sensitive, non-linear, and systemic solutions for pregnant women and new mothers. It adopted a "tech plus touch" approach, leveraging the health worker network of the government and partner NGOs along with the deep mobile penetration across India.

Through free, timely, and targeted mobile service calls for enrolled women provided in their preferred language and during their preferred timeslot, mHealth has reached over 36 million beneficiaries. Through mobile health education services, IVR-based Reproductive Maternal Neonatal and Child health training courses for health workers, and Health Entrepreneurship courses for women, ARMMAN has scaled its work to 20 states in India, having trained close to 3,18,986 health workers, in collaboration with 90 hospitals and 40 partner NGOs.

### GOOD PRACTICES:

+ Using public private partnership models widely
+ Identifying high risk pregnancies for timely mitigation through preventive care
+ Leveraging technological advancements for the greater good
+ Training and supporting health workers to strengthen existing systems and knowledge in maternal care

## 2. Longer, more resilient lives

Accompanying the declining maternal and infant mortality rates is another significant milestone in India's health story – the increase in life expectancy, an indicator measuring the average age people within a population are reaching. CSO interventions have explicitly and implicitly addressed life expectancy, ranging from improving access to healthcare for remote and under-resourced communities, family planning programs promoting the health of families, and sanitation.

***An increase in life expectancy is an outcome of rising living standards, improved lifestyle, nutrition, and better education, as well as greater access to quality health services.***

### #The First Comprehensive Cancer Center in South India

#### Adyar Cancer Institute or Cancer Institute (Chennai), Est. 1954

It was in 1922, after Dr. Muthulakshmi Reddy diagnosed, nursed and lost her sister to cancer, that she proposed to build a cancer hospital in Madras. She formed the Cancer Relief Fund in 1949 and established a cancer hospital in 1954 in a small hut - known today as The Cancer Institute (WIA) or Adyar Cancer Institute. Dr. Reddy inspired her son, Dr. S. Krishnamurthi, who had completed his medicine in the US, to stay back in India and serve poor cancer patients. In 1958, the "combined modality approach" for the treatment of advanced oral cancers was introduced for the first time by the Institute, raising the cure rate from a dismal 19% to 58%.

Today, WIA is a public charitable voluntary not-for-profit institution, dedicated to the service of cancer patients. Out of the total hospital beds, only 35% are paying beds. From the rest, about 50% of the patients pay a very nominal amount and the remaining patients are boarded, lodged and treated free of cost. About 15,000 new patients and 150,000 follow up patients are managed at the Institute annually. Besides the medical facilities, services of Adyar Cancer Institute include a free hospice in Kanchipuram district, outreach cancer prevention/screening operations in 6 other districts, and a population-based cancer registry surveillance of the entire state of Tamil Nadu.

### GOOD PRACTICES:

+ Indigenously built therapy units
+ Documenting and monitoring regional urban and rural cancer cases in Tamil Nadu
+ Promoting health education through attached universities

**The first woman from India to graduate in medicine in 1912, a member of the Women's India Institute in 1917, and the first Vice President of a legislative assembly in the world in 1926, Dr Reddy led a group of voluntary women social worker to open the Cancer Institute with the ethos of 'service above self, service without social or economic divide'**

Image source: https://cancerinstitutewia.in/doctor/late-dr-muthulakshmi-reddy/ images

## #Pioneering Family Planning and Population Health

### The Family Planning Association of India (Delhi), Est. 1949

India was the first country in the world to have a family planning program, one which was started by a civil society organization led and built by women in 1949.

**Rau (right) speaking with American birth control advocate Margaret Sanger (middle) and Norwegian-Swedish sex educator Elise Ottesen-Jensen in 1953**

Image source: https://sexandstats.com/2014/10/02/throwback-thursday-dhanvanthi-rama-rau/

Lady Dhanvanthi Rama Rau, a freedom fighter and leading social worker, established the Family Planning Association of India (FPA India) in 1949, an organization instrumental in advocating for family planning to be introduced in the country's first Five Year Plan in 1952. In the 20th century, India's population was high, but public health facilities were minimal – affecting life expectancy adversely. Moreover, having too many children was adversely impacting women's health. In response, FPA India built grassroots models to promote birth control, safe motherhood and child-rearing, nutrition and family welfare, and the abolition of child marriage.

Today, FPA India works on a wide range of SRHR issues encompassing family planning, maternal health, child survival, HIV/AIDS, safe abortion, reproductive tract cancer screening and prevention, gender empowerment and young people, and mitigation of gender-based violence (GBV), reaching 30 million people annually. Presently, FPA India operates through over 100 reproductive health and family planning centers, urban family welfare centers, and satellite clinics across 18 states, supported by more than 4000 community-based volunteers and staff. During the year 2020, SRH services were provided to 4.2 million clients, of which nearly 40% were young people below the age of 24 years.

### GOOD PRACTICES:

+ Utilizing folk art to change attitudes and behavior regarding family planning and women's agency in the decision-making process
+ Population education projects and programs, including a population curriculum in universities
+ Comprehensive family planning centers close to villages
+ Setting up "mahila mandals" or women's cooperatives to address women's socio-economic development, including literacy programs, networking, livelihood skills, and healthcare



## #Caring for the Elderly

### Help Age India (New Delhi), Est. 1978

Elderly care is critical to increasing life expectancy. Until the late 1970s, there were over 30 million older persons in India without a dedicated body to voice their concerns, take an interest in their health or fulfill their potential to lead dignified, healthy and secure lives. Against this context, Help Age International set up offices in Delhi, later spreading operations across 26 states in India.

Today, Help Age India runs Asia's largest mobile healthcare network for elders, providing sustainable healthcare solutions to destitute elders in urban slums and villages along with free monthly health check-ups to monitor their wellbeing. They have conducted more than 35,000 cataract eye surgeries in 15 states, enabling elderly people to go back to work and live a life of dignity. Every year, Help Age India provides more than 148,000 physiotherapy treatments to elders in 15 states, addressing musculoskeletal diseases such as back pain, arthritis and other age-related mobility challenges. Help Age also provides palliative care to end-stage cancer patients, simultaneously spreading cancer awareness and holding cancer detection camps for elderly people. Their work has earned them the 'UN Population Award 2020'.

### GOOD PRACTICES:

+ Collaborating with government and other organizations working in the area, like Senior Citizens Associations, Govt. Ministries, Youth & the public
+ Impacting policy, with the promulgation of The Maintenance and Welfare of Parents and Senior Citizens Act (2007) and the Draft National Policy for Senior Citizens (2011) being their successes
+ Undertaking activism and advocacy to improve policy outcomes, like the Pension Parishad Movement to secure universal old age pensions for the elderly in India

## #Building Hospitals Close to the Community

### Tribal Health Initiative (Tamil Nadu), Est. 1993

Two decades ago, Sittilingi Valley in Tamil Nadu saw one out of five infants die before reaching their first birthday. Their nearest hospital was 48 kilometers away, and the one with a surgical unit was about 100 kilometers away. Buses at that time would run four times a day but even getting to a bus could involve a walk across fields lasting several hours. In this setting, two doctors Regi and Lalitha started THI as a single "hut hospital", which operates today as a full-fledged 35 bed primary care hospital, with services, education programs and outreach clinics in the 25 villages situated in the area. The organization has set up a tribal health hospital which admits patients with medical, surgical, and obstetric problems. It also runs a community health program: providing curative, preventive and ambulance services to 25 villages in the Sittilingi valley, and health training to build a cadre of nurses and auxiliaries.

### GOOD PRACTICES:

+ Collaborating with government and other organizations working in the area, like Senior Citizens Associations, Govt. Ministries, Youth & the public
+ Impacting policy, with the promulgation of The Maintenance and Welfare of Parents and Senior Citizens Act (2007) and the Draft National Policy for Senior Citizens (2011) being their successes
+ Undertaking activism and advocacy to improve policy outcomes, like the Pension Parishad Movement to secure universal old age pensions for the elderly in India

## #Abiding by the Hippocratic Oath and Applying Textbook Learning on the Ground

### Jan Swasthya Sahyog (Chhattisgarh), Est. 1996

Jan Swasthya Sahyog (JSS) was founded by a group of health professionals during their post-graduate studies at the All-India Institute of Medical Sciences (AIIMS), New Delhi. With the goal of improving the health situation in rural India, where communities faced extreme poverty and lacked access to even the most basic care, this group developed a low-cost, high-quality, and community-based health care system. Using creches to address nutritional and developmental needs of children under 3, outpatient and inpatient wards, an operation theatre complex, low-cost pharmacy and a diagnostic library, JSS brought an all-round solution for the region.

Till date, they have directly impacted over 50,000 people with issues "ranging from HIV to advanced tuberculosis, uncontrolled diabetes with a low body weight and a badly infected wound to severe malaria, from cancer of the cervix, a blood pressure reading of 240/140 diagnosed for the first time in life, to burns sustained after falling in the fire after a convulsion." Work by JSS has also helped bring the infant mortality rate down from 86/ 1000 live births to 29.5/ 1000 live births.

"Regardless of the problem, the underlying stories are most often the same: profound susceptibility because of associated undernutrition, delayed healthcare seeking because of difficulties of physical access, dissatisfaction with non-functioning or poorly functioning public health facilities, or problems exacerbated by irrational care by an unqualified practitioner.

In rural areas, there is widespread hunger, high levels of morbidity, and a vast unmet need for curative health care. Without anyone to advocate for the people who live in such conditions, the high numbers of premature deaths lead only to the further marginalization of these populations and trivialization of their problems."
- JSS

### GOOD PRACTICES:

+ Building a nursing school for scheduled castes and scheduled tribes in the region
+ Building a health atlas for the region
+ Practicing in a region with a history of a marginalization, underserved needs of development, and/or people's movements with active groups sharing similar perspectives
+ Setting up offices pre-existing in vacant, abandoned, and neglected premises through government partnerships to optimize on infrastructure
+ Developing health technology for local communities with limited resources
+ Leveraging agriculture to improve health outcomes by promoting the use of organic farming for better yield and food security
+ Training and certificate programs for village health workers and medical graduates from all over India interested in working in rural India, recognized by the National Board of Examinations (NBE)

Before

Work in progress

After

Image source: https://www.jssbilaspur.org/overview/

## 3. Equitable access to vaccines for everyone

Leaps in life expectancy are also thanks to India's rigorous efforts of immunizing its populations against diseases. Declared smallpox-free in 1977, India launched the Expanded Program on Immunization (EPI) in 1978, and subsequently introduced the Bacillus Calmette-Guérin vaccine (BCG), Diphtheria, Tetanus, Pertussis (DPT), and Oral poliovirus vaccines (OPV) vaccines.

***With annual targets of immunizing nearly 3 crore children and 3 crore mothers, India's childhood vaccination rates have consistently improved over the last two decades with the proportion of children who are 'fully vaccinated' reaching 76% as per the latest National Health Family Survey.***

This rate has been achieved and continues due to the amping up of cold chain infrastructure in the country, as well as the training of a cadre of community health workers trained by nonprofits. These workers have successfully trudged the last mile of vaccine delivery, an uphill task across India's length and breadth. Success stories along this last mile are predominantly thanks to their behavior change efforts, unwavering empathy and excellent communication skills.

### #Scaling the Last Mile as Barefoot Volunteers

***Leading women epidemiologists turned volunteers for India through the World Health Organization, 1970***

India's smallpox eradication program, started in 1962 and targeting 609 million people, was faced with stark challenges from the get-go: a deficit of refrigeration facilities, high population density, huge gatherings during festivals, and the remoteness of rural communities and their lack of access to healthcare. There were parts of the country where outbreaks were even more prevalent and severe: Bihar, Uttar Pradesh, Madhya Pradesh, and West Bengal. This was one of the earliest instances during which Independent India's government and CSOs came together to address public health, underserved geographies, and bring an end to smallpox.

"The campaign started in 1962, but despite substantial efforts made by the program, until 1972 it was only partially successful, in mainly the southern states. However, in 1973 a dramatic change occurred. A basic managerial change brought a dramatic solution to the problems, and the remaining objectives were accomplished in a short time. Eighteen months of this intensified campaign accomplished the recording of the last smallpox case in India. Intensive surveillance for hidden smallpox cases continued, maintaining the same number of national and international staff, until April 1977. No more cases were detected."

- Lawrence B. Brilliant, The Management of Smallpox Eradication in India (1988)
Key players in this 'basic managerial change' were volunteers from non-profit organizations who had committed themselves to ending smallpox in India and the world. Two volunteer stories in particular stand out, of women who came to India through the World Health Organization – whose smallpox campaign was adopted by India in 1970.

## *Cornelia E. Davis – volunteer in West Bengal (1968)*

Cornelia Davis, a graduate from University of California's medical school, was first assigned to the hilly districts of Darjeeling, Jalpaiguri, and Cooch Behar in West Bengal. These regions had poor infrastructure and Davis endured considerable hardship, having to walk long distances through paddy fields to reach remote settlements. Davis investigated rumors of smallpox across the border in neighboring Bangladesh, eventually vaccinating all the people living in the border areas to contain the spread of smallpox. She also supervised the work of smallpox workers searching for cases of the disease in the local population. Her timely intervention helped to prevent smallpox being brought into the area.

Davis was eventually promoted and put in overall charge of the desert state of Rajasthan for an 18-month period. She mainly surveyed smallpox search records and hosted the International Certification Team in April 1977, which was monitoring medical documents and conducting surprise checks to ensure there were no new cases of smallpox. India was eventually declared free of smallpox on April 23, 1977.

## *Mary Guinan – volunteer in Uttar Pradesh (1975)*

Mary Guinan broke several barriers in the male-dominated volunteering space of 1975 when she arrived in India to work in the districts of Kanpur and Rampur Matras in Uttar Pradesh. She travelled to remote rural areas, identifying and investigating suspect cases of smallpox and vaccinating people. She worked closely with local health workers, most of whom were men, and encountered mainly rural home-bound women during her travels.

"We would go to the village, and we had these picture postcards that showed cases of smallpox and we would say, "10 Rupees to anyone who can show me a case of smallpox" and 10 Rupees was a lot of money then for the average person. So, if there was smallpox in the village, they would bring you to the person."
- Guinan in an interview to Global Health Chronicles

Guinan employed several ways to deliver vaccination to the people, including dying her hair black, wearing Indian clothes, communicating through photographs and revisiting the villages to ensure smallpox affected people were isolating. Over time, this paid off. A month after she left India, the region was declared smallpox-free.



*Drawings from the "Butterfly Booklet" developed for influential persons to promote elimination of poliovirus transmission in India.*

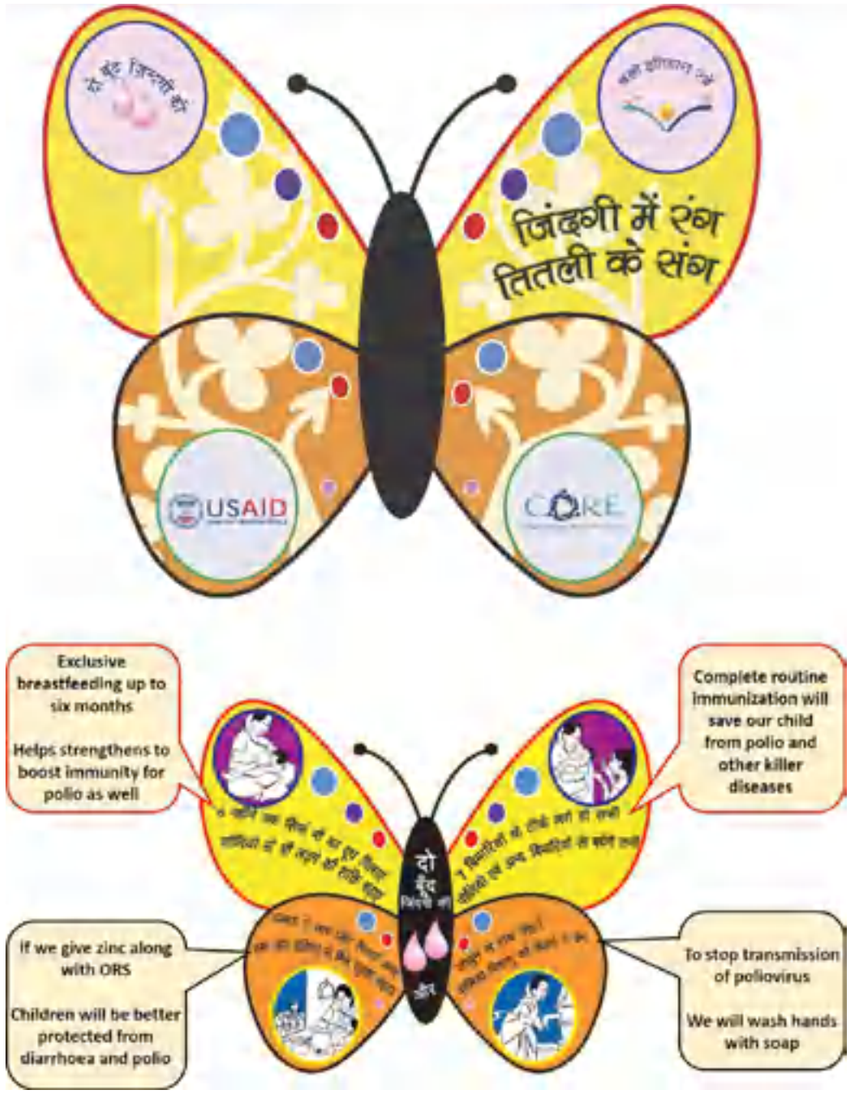



Image source: https://www.ncbi.nlm.nih.gov/core/lw/2.0/html/tileshop_pmc/tileshop_pmc_inline.html?title=Click%20on%20image%20to%20zoom&p=PMC3&id=6776098_tpmd180916f2.jpg

## #Generating Intermediaries from the Community as Ambassadors of Change

### CORE Group Polio Project, Est. 1999

In 1994, when India rolled out the Pulse Polio Program, it accounted for nearly 60% of the global polio cases. There was tremendous vaccine hesitancy on the ground – especially in the villages. Pulse Polio brought together several stakeholders to take collective action and address this hesitancy through novel programs. One of these collectives was The CORE Group Polio Project, a combination of international NGOs and Indian civil society groups supported by USAID.

Working in Uttar Pradesh, The CORE Group mobilized a women-driven network to work with high-risk and resistant communities identified by the government and the National Polio Surveillance Project. This network was led by Community Mobilization Coordinators (CMCs), who marked and visited each house with children, spending time with women, explaining the advantages of immunization, dispelling mistruths, and discussing other health and sanitation issues. The CORE Group also involved religious leaders, holding meetings with smaller groups of both male and female religious teachers who could support their cause and encourage vaccination against polio for the children. "Bulawwa tolies", or groups of volunteer children were also made their ambassadors of change. Being non-threatening, they were able to lend a positive image to the program – carrying positive vaccination messages through communities, even bringing babies to booths for vaccination. School children participated in rallies, with even their teachers managing vaccination booths at their schools.

The result? Between 1999 and 2008, the number of identified polio cases in Uttar Pradesh fell to less than half. Moreover, there were several intangible results achieved by the CGPP by 2009 – the coming together of communities and elected leaders to address chronic problems in addition to time-sensitive polio eradication activities, a holistic approach to newborn care, micro-censuses and better population data, and inclusion of nomadic and mobile populations.

### GOOD PRACTICES:

+ Vaccinating migrant children and sensitizing migrant workers
+ Leveraging cohorts of paid volunteers, community influencers, school children, teachers, and other local change agents to build repeated engagement with communities
+ Holding health camps in areas with very high number of resistors, with female doctors available to address antenatal and gynecological care, helping establish trust with the communities
+ Breaking language barriers by using pictorial messages
+ Creating maps to trace migrant populations who tended to be left out of vaccination drives and surveys
+ Providing mid-day meals to children who came to the booth for immunization



## #Bridging the Trust Gap to Fuel World's Largest Vaccination Drive During the Covid-19 Pandemic

### Adivasi Munnetra Sangam (Tamil Nadu), Est. 1988

During the second wave of COVID-19 in the Nilgiri hills, authorities recognized the need to protect and vaccinate the region's tribal communities – a population of over 20,000 people. Misinformation, lack of awareness, and suspicion towards the government, however, made their vaccination drives challenging. Only 13% individuals had received vaccines despite India's vaccination campaign starting four months earlier. There were instances of entire families and households fleeing or hiding when government doctors visited the villages. To address the issue, the local government brought together various NGOs and divided vaccination targets among them.

Among these was Adivasi Munnetra Sangam, an NGO whose name translates to Tribal Progressive Organization. The NGO identified that there was a mistrust of bureaucratic processes among local communities which added to their mistrust of the vaccine too. AMS workers played a critical role in building trust back, by successfully diffusing tensions and working towards reconciling the relationship between the government and the community. As a result of these efforts, by the end of June 2021, all eligible community members were vaccinated. Furthermore, the process of administering the second dose and booster shots proceeded smoothly in the following months.

### GOOD PRACTICES:

+ Ensuring that vaccine awareness messages were made in the native tribal languages
+ Embeddedness within the community, leading to deep trust and empathy
+ Thorough database building about the village population and tracking processes

*Vaccination drives and health camps facilitated by Adivasi Munnetra Sangam for communities in the Nilgiris, Tamil Nadu*



*Vaccination drives and health camps facilitated by Adivasi Munnetra Sangam for communities in the Nilgiris, Tamil Nadu*

Image source: https://www.gavi.org/vaccineswork/animators-nilgiri-authorities-turn-ngos-bridge-trust-gap-india

## 4. Decline in HIV cases

For years, it was believed that India had the highest number of people infected with HIV in the world, with 5.2 million infections - until new estimates in 2006 nearly halved that number. According to the national AIDS program, annual AIDS-related deaths declined by 54% and new HIV infections dropped by 32% between 2007 and 2015. This was made possible through free antiretroviral medicines, HIV services and greater inclusiveness in India's policy on treatment.

***India is currently working towards free treatment for all the estimated 2.1 million people living with HIV in the country. To achieve this goal and support technological progress in the fight against HIV, CSOs have come together to focus on the economic, political, and social inclusion of communities that are most at risk.***



## #Addressing the Economics of HIV Through Cooperatives

### Durbar Mahila Samanwaya Committee, Est. 1992

In India, the transmission of HIV has predominantly been recorded between heterosexual couples, with transmission from female sex workers to male clients and then to these clients' regular partners, being the most common chain of infection.

With the objective of supporting the weakest link in this chain of infection – sex workers – Dr. Smarajit Jana, a physician and public health scientist, founded the Durbar Mahila Samanwaya Committee in Sonagachi, a red-light zone in Kolkata. This cooperative was founded on three principal components: provision of health services including STD treatment; information, education, and communication (IEC); and condom use programming. The program was pivotal in its 'peer-based approach', where sex workers from the community were trained in health and then promoted as peers and outreach workers.

"Everyone wanted a successful HIV/AIDS project," he replied. "I was sent to do this but soon realized the basic scientific premise was flawed. The entire global scientific community working on HIV/AIDS assumed that the battle could be won using information (awareness) and technology (condoms). I realized fast that the women were not in control of their lives. Their clients, pimps, partners and madams controlled them. They were frequently harassed, arrested and often beaten and raped by the police. The economic exploitation by money lenders was beyond belief. We realized soon enough that only by empowering them collectively, by addressing their economic, political, and social exclusion, could we succeed.

We changed our thinking completely – began addressing women's concerns, not just health. The biggest problem was indebtedness. If we were fighting for the rights of these women based on their needs and perceptions, we had to end their economic exploitation."
Dr. Smarajit Jana, Founder – Durbar


**Dr. Smarajit Jana, Founder - Durbar Mahila Samanwaya Committee, Kolkata**

Image source: https://m.facebook.com/Sanhati.page/photos/a.143340059044754/4222273104484742/

### GOOD PRACTICES:

+ Adopting a holistic approach towards prevention and treatment of HIV and other STDs
+ Addressing economic exploitation among vulnerable communities to solve for health issues

## #Disseminating Information About Sexual Health

### NAZ Foundation, Est. 1994

Naz Foundation works on sexual health issues including HIV and STD awareness, service provision and advocacy. Over the years, Naz has conducted thousands of sessions to help individuals and community-based organizations understand sexuality and mainstream HIV in their program. Naz has worked to strengthen the medical care, referral and counselling services provided to people living with HIV/AIDS and the LGBTQIA+ community.

A key program of the Naz Foundation is the care of children living with HIV and AIDS, referred to them by other NGOs and Self-Help Groups of people living with HIV and AIDS. Another initiative by the Naz Foundation is the 10-month-long program for girls aged 12-20 years, in urban slums and government schools, to provide life skills training and Sexual and Reproductive Health and Rights (SRHR) information. One participant (out of 30) is selected as a peer leader and trained in providing SRHR information to peer groups. One peer leader (out of 10) is then selected as a community coach and trained to conduct awareness programs for the community.

### GOOD PRACTICES:

+ Building safe spaces and providing necessary care for the most vulnerable living with HIV and AIDS
+ Creating awareness on SRHR in vulnerable communities, with youth as ambassadors for change

## #Enhancing Mobile Population's Access to Services

### CARE India, Est. 1950

In 2008, CARE India began functioning as a Technical Support Unit to assist the State AIDS Control Societies (SACS) to achieve the goals of National AIDS Control Program (NACP III). Enhancing Mobile Populations' Access to HIV & AIDS Services Information and Support (EMPHASIS) was a regional project implemented by CARE India to reduce the vulnerabilities to HIV & AIDS among mobile populations crossing Bangladesh and Nepal to and from India.

### GOOD PRACTICES:

+ Addressing safe mobility as a broader theme and developing an effective cross-border models of HIV prevention, care, treatment and support to benefit mobile populations and their families
+ Targeting groups at source, transit and destination locations who were vulnerable to acquiring and spreading HIV and AIDS
+ Building the capacity of partner organizations (including regional authorities, government agencies, border police, customs officials, research institutions, NGO, Community Based Organizations [CBO] and key stakeholders) to deliver improved and integrated services
+ Measuring outcomes scientifically using tools and approaches, for mapping changes in the behaviors of communities



## 5. Eliminating avoidable blindness

In 1976, it was estimated that 1.5% of India's 637 million people, i.e., 10 million were blind. The number of people who could not see "good enough" were a much larger chunk of the population – roughly one out of four Indians – which would translate into every single household having at least one blind person. The efforts of international and national CSOs, private and government partnership culminated in Vision 2020 – the Right to Sight program which was launched in the 6th general assembly in Beijing in 2000.

**With this alignment and resultant public, private and CSO coordination, India's cataract surgery figures rose dramatically from about a million in the early 1990s to more than 6 million by 2010.**

## HIGH-QUALITY HIGH-VOLUME CATARACT SURGERY MODEL

### - Aravind Eye Care, Est. 1976

Dr. G. Venkataswamy was a retired government employee, had the vision to "eliminate needless blindness." At a rented house, in Madurai, he opened an eleven-bed hospital to provide free of charge services for populations from lower income groups. The initiative has now grown into a network of eye hospitals and has had a major impact in eradicating cataract related blindness in India. It is in alignment with Government of India and WHO standards. Key initiatives that the organization took up at scale were mapping vulnerable populations, offering free screening and surgery to those who needed it, ensuring free food and return transportation was made available, and helping patients with counselling support.

Image source: https://aravind.org/our-story/

"These frequent forays into the community to screen people and refer those needing surgery to the hospital were both practical and cost effective when contrasted with surgical eye camps – which was then the norm. In addition to high costs, quality at the surgical camps was also an issue on account of makeshift facilities where patients had to be operated on and housed. Evidence favoring superior outcomes of screening the community and operating them at hospitals was growing; this approach has now become the global standard, recommended by WHO and the Government of India."
- Aravind Eye Care

## GOOD PRACTICES:

+ Targeting outreach to the local communities and underserved populations for spreading the word in person and using technology like GIS mapping
+ Providing free food and return transportation based on community needs for cataract patients resulting in 65% of those recommended surgery showing up
+ Addressing the last mile of 40% who still needed convincing, a cadre of patient counsellors and advocates from the local communities was set up, moving the surgery completion rate to 80%

*Part III*

# Social Justice

Social justice in the Indian context is enshrined in constitutional values that secure social, economic, and political justice, along with liberty, equality, and fraternity for all its citizens. Equality, legal aid, living wages for all, good health and environment, and education are some social justice provisions featured in the Constitution's Directive Principles of State Policy. The underpinnings of the term social justice in this section emphasize the equal right of all citizens towards meeting their basic needs and accessing opportunities, while eliminating unjustified inequalities, hierarchies, and discriminatory practice.



**"The economics of poverty affects the receipt and delivery of justice. Democratic India has tried to tackle this very knotty issue from the bottom up."**

*- Aruna Roy, Co-founder of the Mazdoor Kisan Shakti Sangathan*

## How did free India integrate principles of Social Justice?

Social Justice – or the redistribution of the material and moral benefits of society to each one, particularly its weakest sections – remains a fundamental norm of India's Constitution. The constitutional vision of ensuring social justice in India chiefly involves three aspects:

+ The provision of political and socio-economic rights in the form of Fundamental Rights and Directive Principles of State Policy, which collectively foster the principle of equal liberty
+ The adoption of a model of development which goes on to attain the goal of socialism by reducing disparities and provides for equalization of opportunities for all
+ The provision of safeguards and affirmative action for disadvantaged sections of society

In India, while the government has the chief mandate of ensuring social justice through its policies, several social action groups – consisting of the judiciary, media, and civil society organizations – have been instrumental in helping it realize and solidify the key principles of social justice in the Indian setting. For example, one of independent India's first social justice issues to receive judicial redressal was a case filed by a member of civil society, wherein a journalist's right to free speech was upheld. Another early case in 1977 by the CSO People's Union for Democratic Rights set precedent for workers' rights.

**India's history is full of such milestones; given its diverse and often disparate population demographic, CSO contribution to help people live a life of social, economic, and political justice has always been strong. Over time, CSOs have helped contextualized India's social justice sector into the following thematic areas:**

+ **Social justice movements**
+ **Social action litigation**
+ **Community partnerships for social justice**



## 1. How did civil society organizations uphold principles of social justice through the decades?

CSOs have been involved in active advocacy campaigns for both the urban and rural poor, pushing for macro-level structural changes, and the establishment of policies to safeguard the poor simultaneously.

***Protecting informal and migrant workers, who form over 90% of India's total workforce, was a common theme across many of these interventions. A few noteworthy case studies are outlined below.***

## #Addressing Poverty and Economic Injustice for Informal and Migrant Workers

**People's Union for Democratic Rights, Est. 1977**
People's Union for Democratic Rights, a CSO working for the protection of democratic rights, spotlighted the exploitation and living conditions of workmen working for the Asian Games to be held in India in a writ petition, setting a precedent for poor workers to directly approach the Supreme Court of India, expanding the Right to Live with Fundamental Human Dignity.

**Shramjivi Sanghatana, Est. 1996**
To obtain redressal for bonded agricultural laborers in Maharashtra, Shramjivi Sanghatana, a social organization, mobilized 300 bonded laborers into registering complaints against the exploitative landlords with local authorities, which led to the first conviction in the country under the Bonded Labour (Abolition) Act. The year 1987 saw the first conviction in the country under the Bonded Labour (Abolition) Act.

**Bandhua Mukti Morcha (BMM), Est. 1981**
BMM, an organization working to abolish bonded labor in India, filed a PIL in 1997 against the exploitation of children employed in the carpet industry in Uttar Pradesh. The ensuing judgment directed the state to stop the employment of children in this industry, and further provided directives to prevent child labor and increase children's access to health and education facilities. In 1997, the Supreme Court issued welfare directives for children under the age of 14 to be protected from participation in labor.

**Peoples' Union of Civil Liberties, the Committee for the Protection of Democratic Rights, 1985**
Petitions by the Peoples' Union of Civil Liberties, the Committee for the Protection of Democratic Rights, and civil society actors like Olga Tellis, Indira Jaisingh, and Prafulla Chandra Bidwai helped spotlight the rights of pavement dwellers in Mumbai, the State's duty to provide them with housing sites close to their workspaces, and experiences of forced evictions. This 1985 landmark judgement led to the inclusion of the Right to Livelihood under the purview of the right to life.

### GOOD PRACTICES:

+ Promoting the use of courts to hold government authorities accountable for violation of rights
+ Fact-finding and on-ground investigations to gather legal evidence for PILs and legislative action
+ Setting precedents for independent judicial involvement in rights' claims and safeguards against violations



## #Creating Spaces for Environmental Reform and the Protection of Natural Habitats

### The Narmada Bachao Andolan, Est. 1985

**The Narmada Bachao Andolan (NBA)** mobilized 250,000 people who faced submergence during the construction of big dams along the Narmada River. The organization's biggest triumph was in 1993, when the World Bank withdrew its loan for the project and published an independent review of the project. This effort spotlighted internationally environmental and rehabilitation issues due to big dam projects, raising awareness about issues faced by tribal and underprivileged people, most affected by such projects.

**Medha Pathkar spearheading the movement with the Narmada Bachao Andolan. Together, the voices of farmers, native tribals and environmentalists sparked a global debate against large-scale development projects and their disregard for the environment and communities.**

Image source: https://rightlivelihood.org/app/uploads/2016/08/portrait-Narmada-Bachao-Andolan_Medha-Patkar-with-rural-villagers.jpg

*'The organisation's biggest triumph was in 1993, when the World Bank withdrew its Narmada loan and also published an independent review of the project. Patkar's strengths lay in mobilising and educating the oustsees, attracting a group of committed activists, strategizing plans of action, and interacting with people across the board from district collectors to international leaders. The Andolan brought the national spotlight on environmental and rehabilitation issues raised by big dam projects, raising awareness of tribal and underprivileged people most affected by such projects.'*

*– Frontline, '1985: Narmada Bachao Andolan', 15 August 2022*

Source: https://frontline.thehindu.com/environment/india-at-75-epochal-moments-1985-narmada-bachao-andolan/article65730806.ece

### The National Green Tribunal (NGT), 2010

Discussions at the NGT showed the active collaboration between environmental NPOs and environmental advocates, who played the roles of both attorneys and environmental activists. Outside the courts, some of these lawyers were associated with national and international environmental initiatives to promote better legal access to justice and environmental protection. Although the NGT allowed citizens to depose directly before the Bench, appeals were often channeled by advocates supporting environmental causes at low fees. As a case in point, Betty Alvares, a resident of Goa, filed a High Court petition in 2012 claiming instances of illegal construction in the Coastal Regulation Zone of Candolim. The petition was transferred to the National Green Tribunal, which examined Alvares' locus standi to put forth the petition as a foreign national. In a landmark judgment, the Tribunal declared in 2014 that any individual could file a petition linked to environmental disputes, irrespective of nationality and citizenship.

### Save Mon Region Federation v Union of India, 2012

The Save Mon Region Federation, an organization representing the indigenous Monpa community in Arunachal Pradesh's Tawang region, petitioned the National Green Tribunal against a hydroelectric project on the Naymjang Chhu river basin. The petition challenged the environmental clearance granted to the project due to its location in an eco-sensitive stretch which was a wintering site for the endangered, black-necked crane, which is revered by the Monpas. Considering the cultural significance of the bird, the Tribunal ruled that the project must be halted while a fresh environmental review is undertaken by the Ministry of Environment and Forest.

### GOOD PRACTICES:

+ Institutionalizing the need for legal recognition of environmental rights and ecological risks
+ Raising consciousness around human-centric environmentalism by involving affected communities
+ Mitigating environmental harm and protecting vulnerable and marginalized groups simultaneously



## 2. Empowering women and gender minorities

The Indian Constitution guarantees equality to all citizens irrespective of gender and other social factors. However, gender-based discrimination and violence have continued to be pervasive in different forms. The pursuit of gender justice advances the liberation of gender minorities from patriarchal systems and norms, recognizing their inherent worth and agency, and creating a society that values their contributions and experiences.

***India has a rich legacy of movements advocating for the rights of women, the LGBTQIA+ community, and ending gender-based violence. Civil society contributions to gender rights have spanned redressal against violence, access to education and economic opportunities, equality in institutions, and equitable representation in political and discursive spaces.***

## #India's First All-Women Rural News Bulletin

### Mahila Dakiya, Est. 1993

From 1993 onwards, a four-page newsletter titled Mahila Dakiya began circulating in rural Uttar Pradesh. The newsletter was born under the aegis of the Mahila Samakhya Program for increasing literacy among rural women. It disseminated easy-to-read news bulletins in local languages, envisioning an audience of new learners who were women. Mahila Dakiya was initiated in collaboration with Nirantar Trust, a gender and education non-profit. In 2002, Nirantar spearheaded the launch of Khabar Lahariya, based on the Mahila Dakiya model. The community-focused newspaper is created and marketed by rural women from Uttar Pradesh's Chitrakoot and Banda districts.

### GOOD PRACTICES:

+ Leveraging rural women's journalism to improve their participation in democratic processes
+ Increasing women's literacy to improve agency, expression and document local realities via news
+ Platforming the voices of marginalized women and programming in local languages

## #Landmark Judgment on Sexual Harassment at the Workplace

### Vishaka and Ors vs State of Rajasthan, 1997

In the 1990s, a group of landowners in rural Rajasthan raped Bhanwari Devi, a community worker employed by the state government's Women Development Program, while she was trying to prevent a child marriage as part of her duties. When the Rajasthan High Court failed to provide the survivor with justice, a group of civil society organizations and activists, spearheaded by non-profits Vishaka and Sakshi, filed a PIL in the Supreme Court. In 1997, the resulting judgment came up with a set of procedural guidelines known as the Vishaka Guidelines, addressing the issue of sexual harassment in the workplace for the first time in the country's history. These guidelines formed the basis and were enacted into law in 2013, as part of the Sexual Harassment of Women at Workplace (Prevention, Prohibition, and Redressal) Act.

### GOOD PRACTICES:

+ Building awareness around sexual harassment and violence at the workplace faced by women
+ Coalition-building as an effective tool for unified advocacy to mobilize legal and policy change
+ Creating prevention and redressal strategies to improve women's safety in the workplace
+ Utilizing the PIL as a tool for seeking legal protections and safeguards
+ Highlighting overlaps among sexual violence, gender, and caste through centering Bhanwari Devi's narrative



## #The Decriminalization of Homosexuality and the Triumph of LGBTQIA+ Activism in India Navtej Johar Vs Union of India

### Navtej Johar vs Union of India 2018

Starting from the colonial era, consensual homosexual sex acts were criminalized in India under Section 377 of the Indian Penal Code. The reading down of Section 377 in 2018 was the culmination of decades of civil society activism against the law. Non-profit organization 'AIDS Bhedbhav Virodhi Andolan' was among the first groups to challenge the legality of Section 377 in 1994, through a petition in the Delhi High Court. In 2001, queer rights organization Naz Foundation petitioned the Delhi High Court against the law again, leading to a Delhi High Court judgment that declared it to be violative of fundamental rights. However, this judgment was overturned by the Supreme Court in 2013. Finally, in 2018, a five-judge panel of the Supreme Court heard pleas from various LGBTQIA+ rights activists, organizations, and members of the public. The judgment read down Section 377 and declared it inapplicable to consensual homosexual acts.

### GOOD PRACTICES:

+ Engaging with marginalized communities ground up for developing legal awareness programs linked to their issues
+ Helping marginalized individuals access legal empowerment by training them as paralegals and legal volunteers
+ Creating literacy materials built with a focus on accessibility and ease of use


**One of the first ever protests for gay rights protests by ABVA from 1992.**

Image source: AIDS Bhedbhav Virodhi Andolan

## 3. Enabling access to justice for marginalized groups

A strong and independent judiciary has been a cornerstone of India's democracy since independence. Access to justice serves the functions of protecting individuals against human rights violations, allowing them to hold governments and other bodies accountable for the materialization of legal provisions, and creating avenues for every person to seek an expansion in the scope of rights and protections accessible to them.

***Over the last 75 years, civil society organizations have played a critical role in connecting marginalized groups to legal systems and services, providing them legal aid and legal awareness programs, and promoting judicial involvement in their upliftment and empowerment.***



### #The Genesis of the Public Interest Litigation (PIL)

#### Hussainara Khatoon v State of Bihar, 1979

In 1979, lawyer Kapila Hingorani filed a writ petition in the Supreme Court to address the condition of undertrial prisoners with pending suits who had been languishing in jails in Bihar. This marked the first instance of a court petition being filed by someone other than the aggrieved party or a relative in India. The court directed the Bihar government to release the prisoners represented in this habeas corpus petition, which eventually led to the release of approximately 40,000 undertrial prisoners across the country. Additionally, the judgment also observed the need for providing prisoners with free legal aid. Many petitions were filed similarly in the 'public interest' in the aftermath of this judgment. The Supreme Court later defined the term 'Public Interest Litigation' (PIL) and its application in the Indian context in SP Gupta v Union of India and Anr in 1981.

### GOOD PRACTICES:

+ Creating a new avenue for enabling civil society actors to aid marginalized individuals' pursuit of justice
+ Promoting the role of lawyers in enabling greater access to justice through a public-spirited mindset shift

**Known as the 'Mother of Public Interest Litigation', Kapila Hingorani represented the rights of undertrial prisoners. She went on to champion the causes of societies most underserved, playing a pivotal role in shaping policies against dowry, female foeticide and workers rights.**

Image source: https://en-media.thebetterindia.com/uploads/2022/08/Kapila-Hingorani-Feature-1659522847.jpg?compress=true&quality=80&w=900&dpr=1.0

## #Legal Awareness as a Pathway to Empowerment

### Multiple Action Research Group (MARG), Est. 1985

MARG is a non-profit organization set up in 1985 to provide socio-legal services to marginalized groups. It operates primarily in areas of legal literacy and awareness, legal aid, and legal empowerment through capacity-building. The organization works with marginalized groups including the rural poor, women, children, unorganized sector workers, and people displaced by development projects. MARG, supported by the National Human Rights Commission has legal booklets on basic laws, human rights, and rights of marginalized groups. It has also set up a project for providing grievance redressal mechanisms against sexual harassment for garment factory workers.

### GOOD PRACTICES:

+ Engaging with marginalized communities ground up for developing legal awareness programs linked to their issues
+ Helping marginalized individuals access legal empowerment by training them as paralegals and legal volunteers
+ Creating literacy materials built with a focus on accessibility and ease of use

## #Establishment of a Social Justice Bench in the Supreme Court

### 2014

In 2014, the Supreme Court of India set up a Social Justice bench to hear matters concerning marginalized groups and social justice. Civil society organizations like Mahila Abhivrudhi Mattu Samrakshana Samsthe (MASS), Narmada Bachao Andolan (NBA), and We the Citizens have represented marginalized groups before this bench. Some of the issues raised by them have included the rehabilitation of Kashmiri Pandits, exploitation of children in orphanages in Tamil Nadu, monitoring of rehabilitation of those impacted by the construction of the Sardar Sarovar dam, monitoring of the Nirbhaya Fund, and the fund for rehabilitation of Devadasis in Karnataka.

### GOOD PRACTICES:

+ Identifying the need for social justice to be given a distinct space in the country's legal consciousness
+ Streamlining and expediting proceedings on critical social justice matters

# Way forward

These stories of India over the past 75 years, told through the recounting of milestones, movements and interventions, stand testimony to the tireless work of civil society organizations and practitioners. Today, as we build back from the pandemic, facing multidimensional challenges of climate change, socio-economic disparity and rising human conflict, civil society organizations are placed to play a critical role in addressing these challenges. By providing empathetic, tailored, localized responses in layered and dynamic systems, CSOs possess the ability to remain connected to the ground where lasting change is the need of the hour.

*Moving forward, there is a need to count the work, value, and equity of CSOs in the narrative around nation building. Development agendas and plans must incorporate CSOs more intentionally in the conception and implementation of programs across sectors.*

Moreover, to continue the legacy of collaborative social work, it is imperative that the government, judiciary, media, businesses, and philanthropists also extend their support to CSOs and lead with trust. On the other hand, the CSO sector itself must simultaneously double down on documentation, transparency, consistency, and human resources too. Here are a few ways in which key stakeholders can help strengthen the CSO sector:



## Government

+ **Enabling greater cooperation:** collaboration between CSOs and governments leads to more dynamic, efficient and effective program development and implementation; cooperation, however, can be challenging due to structural incompatibilities, legal barriers, diverging professional interests, different expectations, and a lack of methodological knowledge on how to cooperate. Accepting each other's different roles, setting guidelines and standards for cooperation, implementing confidence building and conflict resolution methods, and allowing CSOs to have autonomy – the right to act independently and advocate positions different from the authorities with whom they may otherwise cooperate – can lead to greater cooperation.

+ **Social contracting:** Governments at all levels can explore contracting government tasks to civil society organizations – bolstering welfare programs, public services, social protection, law, order and regulation by formally enlisting CSOs in delivering these to the most vulnerable and marginalized at the community level. This can be done by way of budgetary support and well-defined contracting services.

+ **Safeguarding CSOs:** CSOs require funding to carry out their work, including funding from grants, donations, and charity from domestic and international entities; governments must ensure that resources to CSOs are not stopped, but regulated to prevent organizations from being held to ransom by international agencies with their own agendas, or by sources that seek to destabilize the country.

## Funders

+ **Supporting capacity building:** Providing support to CSOs requires assessing their wide range of needs, like critical sector requirements, hiring and human resources, budget building, institutional knowledge building, documentation and monitoring, and the capacity to retain funders is also a critical skillset CSOs must build. Alongside, local and citizen capacities should also be built, to maximize local engagement and impact.

+ **Supporting CSO access to data:** CSOs need access to data and information related to their areas of focus to enhance their understanding and improve their communication skills. Donors can support this by offering resources such as data analysis tools or facilitating internet access. However, it is important to note that providing greater support to larger, more established NGOs in accessing information can inadvertently widen the gap between them and smaller, less professional organizations that may have stronger grassroots connections.

+ **Enabling engagement with governments:** owing to their extensive and influential networks, funders can leverage their influence to create opportunities for CSOs to participate in government processes and convenings. They can also involve CSOs as participants in their own funding procedures, thereby incorporating voices of marginalized populations into policy decisions and promoting accountability among governments and donors. However, simply creating these spaces does not guarantee meaningful participation, it is equally crucial for donors to support engagement in political spaces, which may be more complex but hold

significant importance, especially in cases where governments are resistant to formal civil society involvement. Donors must intentionally address disparities in engagement, including the location of dialogues, funding travel for individuals from non-urban areas, providing translators at meetings, and ensuring that a diverse and representative group is invited and able to participate.

+ **Bolstering CSO autonomy:** based on a funder's rapport with the government, there is a possibility for them to contribute to enhancing the institutional environment for CSOs. This can be achieved by strengthening governing bodies, exerting political influence to establish legal protections for CSOs, or facilitating dialogue at the national or international level. In restrictive environments, donors can also play a crucial role in defending and advocating for the freedom of expression, assembly, and association, which may be constrained.

+ **Providing core support to CSOs:** in contrast to the common practice of providing restricted project support or imposing funding conditions, which can exert control over CSOs' agendas and restrict their autonomy, funders can enhance their inclination to offer core support to CSOs, including unrestricted funding for various purposes such as supporting administrative operations (e.g., covering salaries and rent) as well as programmatic work.

## *Media*

+ **Building strategic alliances:** objective media and active CSOs both ensure healthy democratic processes and can be of tremendous use to one another - while the media can cover the implementation of various CSO programs, research and opinions on specific topics and basic service delivery problems for dissemination to the public, CSOs can design capacity-building programs targeted specifically at journalists in the local media. On the one hand, the media need CSOs as sources of information and capacity building and, on the other, CSOs need the media's information provider role to make the public aware of their work.

+ **Amplifying voices:** a strong relationship between CSOs and the media creates more opportunity for the voices of the people most affected by these stories to be heard. Practitioners from both sides, therefore, must come together to tell lesser-known stories and amplify the voices of the most marginalized and vulnerable.

+ **Playing a role in advocacy:** mass media can play a valuable role in enhancing CSO capacity and fostering public acceptance of its role. It can achieve this by providing citizens with sufficient information to enhance their comprehension of government policies and CSO interventions. Additionally, the media can support CSOs in advocacy in the interest of the public. This helps ensure accountability, positioning CSOs as agents of public support, and encourages state responsiveness by drawing attention to societal issues.



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