

Pathways to Inclusion: Social Protection and Public Services for Informal Workers in Pune, India

Poornima Chikarmane
with Sia Nowrojee and Kalkidan Shebi



3D Program
FOR GIRLS & WOMEN

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The [3D Program for Girls and Women](#) advances gender equality and girls and women's empowerment by helping local governments work more efficiently across departments, and with civil society and the private sector, to increase economic opportunities for girls and women and address their health, education and safety needs. We call it good governance through convergent action: when government comes together across departments to develop a shared vision and accepts joint accountability for their policies and actions, the result is greater than the sum of its parts. The 3D Program is currently working in Pune City and rural Pune District in Maharashtra, India to demonstrate a convergent approach to programming to meet the multiple, intersecting needs of girls and women. In a second phase, the 3D Program will move to two counties in Kenya. Drawing from lessons learned in India and Kenya, we will develop tools for global application for a scaled-up convergent response for gender equality.

[Kagad Kach Patra Kashtakari Panchayat \(KKPKP\)](#) is a trade union registered in 1993, bringing together waste pickers, itinerant waste buyers, waste collectors and other informal recyclers, all self-employed workers. These workers recover, collect, categorise and sell scrap materials for recycling. They pick up what someone has discarded as having no value and give it value through their labour. Typically treated like the trash that they collect, KKPKP has successfully argued that the work of materials recovery and handling by waste pickers is environmentally sustainable, socially inclusive, economically productive, and saves municipalities millions of rupees in solid waste management. This position, after years of struggle and engagement with various stakeholders, has ensured that the waste picker members of KKPKP have a visibility, voice and validity that is unique in the city and in the country. Their struggle to enhance the conditions of their work and living continues.

[SWaCH Pune Seva Cooperative Society](#) was established in 2007 as the first waste picker owned co-operative in India. It grew out of the grass-root mobilization work of the Kagad Kach Patra Kashtakari Panchayat, a registered trade union of informal waste-pickers having membership of more than 10,500. SWaCH's 3541 waste picker members current collect waste from 8,10,000 properties across Pune. SWaCH holds a 5-year contract for door step collection of waste with the Pune Municipal Corporation (PMC) ending December 2020. The PMC covers administrative costs of the co-operative for coordinating collection service whilst waste pickers received their income from monthly user fees paid by citizens directly. Waste-pickers then segregate the recyclables from other dry waste, sort it finely and channelize it for recycling through scrap traders. The collected organic waste and non-recyclable waste is then taken by the municipality to one of their decentralized / centralized waste management plants or the landfill. This service effectively bridges the gap between households and the municipal waste disposal services.

Acknowledgments

My heartfelt thanks to the unflappable 3D team, Dr. Geeta Rao Gupta, Sia Nowrojee, Vanessa Coello and Kalkidan Shebi, for giving me the opportunity to do this work. I thank you for your patience, encouragement and support.

Writing up a report detailing what does not work is relatively simple, because in actual fact much does not! Holding to account in order to ensure that benefits reach is far more challenging. I thank with deep humility waste pickers and other informal workers who kept the faith, taking the costs of the struggle to push for what was rightfully theirs. My colleagues at the Helpdesk, Sayali Pradeep, Yogesh Manjula, Shrenik Mutha, Aditya Vyas and the many coordinators of SWaCH who willingly chipped in to help, providing vital connectivity to waste pickers, a warm thanks to you. You kept trying, often in adverse situations, at all hours of the day and night to ensure that waste pickers benefitted from the schemes and services that they were entitled to. Maitreyi, Suchitra, Pravin and all the members of the enrolment team, a big thank you to you. Poorvi, thanks for your suggestions after reading through the report. My thanks to the officials and staff of various government departments and institutions and allies who understood the import of the task at hand and contributed to it. Aparna, Harshad, Lakshmi and Maitreyi, fellow travellers on the journey for a more just and equitable society, thank you for questioning and supporting and for being there. This report documents our collective persistence.

- Poornima Chikarmane

We would like to express our sincere gratitude to Poornima Chikarmane, who inspires us with her untiring commitment and advocacy to improve the social inclusion of waste pickers in Pune City. It was a privilege to work with her on this report to capture the findings of her study and the resultant advocacy, recommendations and actions already taken to improve access to social programs, benefits and entitlements by waste pickers. We are also grateful to the KKPKP and SWaCH teams, as well as those officials and frontline workers in local government who are committed to the social inclusion of waste pickers and other informal workers. Finally, heartfelt thanks to Geeta Rao Gupta for the support and critical inputs she provided on this report and Vanessa Coello for her exceptional report design and support in the production and dissemination of this report.

- Sia Nowrojee and Kalkidan Shebi

Abbreviations

AABY	Aam Aadmi Bima Yojana
ASHA	Accredited Social Health Activist
CGHS	Central Government Health Scheme
CHS	Charitable Hospital Scheme
DLSA	District Legal Services Authority
EMS	Emergency Medical Services
FIR	First information report
GDP	Gross domestic product
INR	Indian rupee
IPF	Indigent Patients Fund
IT	Information Technology
ICDS	Integrated Child Development Services
ICU	Intensive care unit
JAP	Jan Aarogya Yojana
KKPKP	Kagad Kach Patra Kashtakari Panchayat
KSK	Kashtakari Seva Kendras
MJPJAY	Mahatma Jyotirao Phule Jan Aarogya Yojana
NABH	National Accreditation Board for Hospitals & Healthcare Providers
NHG	Neighbourhood Groups
PMC	Pune Municipal Corporation
PMJAY	Pradhan Mantri Jan Aarogya Yojana
PMJJBY	Pradhan Mantri Jeevan Jyoti Bima Yojana
PMSBY	Pradhan Mantri Suraksha Bima Yojana
RCV	Resident Community Volunteers
SMS	Short message service
SDD	Social Development Department
SECC	Socio Economic and Caste Census
SHG	Self-help group
SGVSY	Shahari Garib Vaidyakiya Sahayak Yojana
SWaCH	Solid Waste Collection and Handling
SOP	Standard operating procedure
TPD	Tons per day
USD	United States dollar
WCD	Women and Child Development

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Introduction and Context

The decade of the nineties marked a shift in the provision of social services in India from the public sector to the private sector. The liberalization of the Indian economy allowed for, and indeed encouraged, private participation in the provision of health, education and social services. The role of the state changed from being the provider of services to operating as a regulator of services. The decline of state-provided services was concomitant with the decline in public expenditure on these services, in real terms. The services market expanded for those able to pay for it but shrank for those with limited resources.

Maharashtra, among the more developed and prosperous states in the country, wholeheartedly embraced the private provision of services. In Pune District for example, in 2017-18, less than a third of the children enrolled in elementary school were in government-run schools. The rest were in state aided or unaided schools under private management.¹ Similarly, today, private health services far exceed government health services. For example, the Pune Municipal Corporation (PMC) runs 41 dispensaries, 15 maternity homes, one general hospital and one for infectious diseases. The city also has two government-run district hospitals with a combined sanctioned bed strength of 1,576. In contrast, there are 664 private hospitals registered with the PMC, with 12,003 general beds and 2,764 maternity beds.

India's economic growth over the last few decades has not translated into investment in health, education, social security and services. India spends 1.2 percent of its gross domestic product (GDP) on health care, less than Sri Lanka or Thailand. The expenditure on education declined from 3.1 percent of GDP in 2013 to 2.7 in 2018. Infrastructure and public services established in the first few decades after independence have fallen into decay, been dismantled or have been transferred to the not-for-profit or for-profit private sector. The commodification, commercialization and corporatization of health care and education systems is all but complete.

At the same time, the private sector is not completely market financed and driven. Private establishments

that provide health, education and social services are often directly or indirectly financed with public funds. The health sector broadly comprises public hospitals and hospitals run by public charitable trusts, as well as private hospitals and those that are part of corporate hospital chains that also receive public funds. The education sector is structurally more or less similar. The modalities vary and are often complex. Private promoters may invest a proportion of their own resources, but they also access loans from financial institutions to support their growth. Those resources are also public funds. Land, other infrastructure and electricity are provided at concessional rates to private educational institutions and hospitals. Customs and excise concessions are also available for import of hospital or laboratory equipment. Public charitable trusts and companies may be awarded contracts to supply mid-day meals or materials. Concessional tax rates may apply in certain cases. Additionally, there is publicly financed private health insurance, such as the Mahatma Jyotiba Phule Jan Arogya Yojana (MJP-JAY), which covers families earning an annual income of less than INR 100,000 (USD 1,393)² for expensive surgeries and procedures at selected or 'empanelled' government and private hospitals.³ Similarly, the state government reimburses a specified amount to private schools that do not receive government grants but admit socially and economically disadvantaged children under section 12(1)(c) of the Right to Education Act.⁴ Finally, there are financial assistance schemes meant for specific vulnerable groups.

It is within this broader social, political and economic

¹ Unified District Information System for Education (UDISE), 2017-18, www.udise.in

² All USD conversion rates are based on September 2019 estimates and are rounded up to the nearest whole number.

³ Empanelled hospitals are those that fulfil the eligibility criteria and volunteer to provide services under the scheme and are bound by an agreement or a memorandum of understanding.

⁴ https://accountabilityindia.in/sites/default/files/state_of_the_nation_-_section_12_1_c_csf_march_2015.pdf

context that I conducted this action-based study in Pune City, Maharashtra State. The study focused on the barriers and opportunities to increase social inclusion of waste pickers in Pune City, 80 percent of whom are women. As low-income Dalit women who reside in slums, most waste pickers face multiple, intersecting vulnerabilities and are representative of the most marginalized urban informal workers. Their work provides them with critical livelihoods, but also exposes them to considerable economic, environmental, social and occupational risks, including not being able to ensure payment for their services, exposure to hazardous waste and harassment and the risk of accidents.

As many as 10,500 waste pickers are currently organized into the trade union Kagad Kach Patra Kashtakari Panchayat (KKPKP), and in 2008, the Solid Waste Collection and Handling (SWaCH) cooperative was created through a formal agreement with the PMC. SWaCH is India's first wholly owned cooperative of self-employed waste collectors and currently has over 3,500 members. Through SWaCH, waste pickers provide reliable, reasonably priced and accountable garbage collection and materials management services to 810,000 properties, collect 1,100 tons per day (TPD) of waste, divert 200 TPD of waste from landfills, compost 3 TPD of waste and are often the sole breadwinners of their families. Depending on their work schedule, waste pickers earn a range of INR 5,600-13,000 (USD 79-184) a month.

In 2015, the Government of Maharashtra enacted the Maharashtra Right to Public Services Act to increase access to government services and to make government departments accountable.⁵ The Act pertains to

the provision of notified services to citizens transparently and efficiently within a prescribed time frame. The prescribed services are usually the issue of certificates and documents, such as a disability certificate, or enrolment under schemes such as the social assistance pension schemes mentioned in this report. The list of authorities responsible for providing the service and the appellate authorities in case of grievance are also specified. The implementation is overseen by the Maharashtra Commission for the Right to Services. The online *Aaple Sarkar* (our government) portal and app also facilitates provision of specified services. For those without access to the Internet, the services can be availed through various kinds of citizen service centres. A report for 2017-18 shows that the urban development department provides the highest number of services (57) followed by the labor department. The departments of public health, social justice and education lag behind.⁶

This study was conducted because of the exclusion of waste pickers from welfare schemes even two years after they were specifically approved for waste pickers by the PMC general body. The basket of schemes includes educational assistance for children of waste pickers in high school, health benefits, life insurance benefits, and contribution to a contributory pension fund. A wide range of factors described in this report contributed to restricting waste pickers' access to these schemes.

Over the years, through my work with KKPKP, I had already noticed that the widespread *inclusion* of waste pickers in providing waste management services to the city of Pune was at odds with the widespread *exclusion* of waste pickers from the welfare

⁵ <https://aaplesarkar.mahaonline.gov.in/en/CommonForm/RigthToServiceAct>

⁶ <https://aaplesarkar.mahaonline.gov.in/pdf/Anual-Report-17-18-English.pdf>

services and schemes of the PMC. I sought to correct this contradiction by focusing on waste pickers as a priority group among informal workers because they have multiple structural vulnerabilities that intersect, including gender, caste and low socio-economic status. This is consistent with the Socio-economic Caste Census (SECC)⁷ that categorizes those engaged as ragpickers/waste pickers as the most vulnerable.

In conducting this study, I examined schemes and services in the five sectors of health, education, social protection, violence against women and financial inclusion. Implementation of schemes is usually sectoral through the relevant department within the district or the municipal administration, depending upon how the scheme is financed. Schemes financed by the PMC are directly implemented by the respective departments within the municipal body, such as Social Development, Health, and Solid Waste Management. Schemes financed by the state or the central government are implemented by the municipal body, by the Zilla Parishad (district administration), or by the respective departments or special entities established for that purpose.

The next section describes the methodology of the study and the section that follows documents the barriers informal workers face in the enrolment process for various schemes and services across the five sectors, and the difficulties they face, following enrolment, in receiving benefits. Recommendations for policy and practice are presented in the fourth section. The fifth section describes KKPKP's responses and programmatic interventions to address the barriers to access, reach and utilization of schemes and services, and ultimately to increase social inclusion,⁸ and the final section offers conclusions.

⁷ <https://secc.gov.in/reportlistContentUrban#>

⁸ Consistent with the methodology of this study, these responses were both informed by the findings and piloted during the course of the study.

Methodology

KKPKP has always believed in and worked by seamlessly connecting bottom-up mobilization, research and evidence-based advocacy, targeting appropriate levels of decision-makers for implementation changes and policy review as required. The approach used in this study is consistent with that approach and this report is an experiential account of how delivery systems work and how they can be made to work better from the perspective of the individuals and families that seek to avail entitlements and services provided by the government.

The methodology I used, therefore, followed a path of listening, reflection, review and intervention. The process was not linear, but rather exploratory and iterative. The study was conducted between January 2018 and May 2019 in the city of Pune, and I explored a range of questions related to the social inclusion of informal workers: What are some of the key sectoral schemes and services in place for the urban working poor? What is their availability? How do intended participants access these? What are some of the barriers they experience? What strategies might be effective to address these barriers? Are there any grievance and redress mechanisms in place that participants can use? The methodology included a review and analysis of schemes and services from five sectors, outreach to and conversations with waste pickers by KKP KP advocates, a review and analysis of calls to the KKP KP helplines, and engaging with stakeholders in government and other organizations and service providers at points of service.

Review and Analysis of Schemes and Services

A broad review of schemes and services was conducted, after which some were selected for in-depth review to inform advocacy and implementation based on inputs by women member leaders and activists. These included schemes that are financed and implemented by the municipal government, the state government and the central government (see Table 1: Summary of Selected Sectors and Schemes).

Schemes were selected based on the following criteria:

- Those linked to issues of importance to waste pickers, such as health and education

- Their potential to cover large numbers of waste pickers
- Out-of-pocket expenses incurred by members in accessing services
- Potential for changes through executive orders
- Their universal applicability for waste pickers, such as the health and life insurance schemes for the urban poor
- Those that address specific vulnerabilities, such as violence against women (including rape and acid attacks), disability, old age, and illnesses, such as tuberculosis, HIV and cancer

The supply, policy and implementation issues related to the selected schemes and services were also examined in relation to the needs and priorities of waste pickers. This informed the recommendations to facilitate greater access to services and benefits for waste pickers.

Outreach to and Conversations with Waste Pickers

Outreach to waste pickers and conversations with them were organized through thematic orientation sessions for KKP KP members on health and education schemes and services. The sessions were participatory, and provided opportunities for waste pickers to share their knowledge and experiences, improving upon earlier attempts that only provided written information about schemes.⁹

The health session had 1,362 participants and covered six schemes. The session revealed that very few waste pickers were aware of the schemes, even fewer had

⁹ In 2017, KKP KP had prepared a folder with written information about the union's programmes, as well as information on schemes and services of government and other private bodies. The folder was provided to KKP KP members. In addition, SATHI, a health research and advocacy organisation in Pune, had developed a valuable resource on health services in the city that was provided to all the members of the Representatives Council during the training. However, simply sharing information on the schemes and services had not increased KKP KP members' access to and understanding of them.

utilised them. While 81 participants reported that they or their family members had been hospitalized during the preceding year only 15 had utilised a government scheme. Less than five percent had heard about the widely advertised state government EMS (Emergency Medical Services) ambulance and the Mahatma

Phule Jan Arogya scheme or Yojana.¹⁰ Both of these were launched within the past five years. The responses were similar in the cases of the older schemes, such as the State Aided Charitable Hospital Scheme (CHS)¹¹ and the Jan Arogya Insurance Scheme. The orientation session on health was followed up with a

Table 1: Summary of Selected Sectors and Schemes

Sector	Schemes and Benefits			
Health	Jan Arogya Bima Policy. ¹² <i>INR 5,000 (USD 70) insurance coverage for hospitalization</i>	Charitable Hospital Scheme. <i>Required services and reserved beds*</i>	Urban Poor Health Scheme. ¹³ <i>INR 150,000 (USD 2,088) insurance coverage for hospitalization</i>	Mahatma Phule Jan Arogya Yojana. <i>INR 150,000 (USD 2,088) coverage for hospitalization*</i>
Education	Assistance for children of parents in cleaning work. ¹⁴ <i>Annual INR 5,000 (USD 70) for children in Stds 8-10</i>	Assistance for children of parents in cleaning work. ¹⁵ <i>Annual INR 3,000 (USD 42) for children in Std 1-10</i>	Merit scholarship for children in Stds 10 (<i>INR 15,000; USD 209</i>) and 12 ¹⁶ (<i>INR 25,000; USD 348</i>)	25 percent reservation under the Right to Education Act*
Social Protection	PMJJBY and PMSBY life and disability insurance. ¹⁷ <i>INR 200,000 (USD 2,784) insurance</i>	Social assistance pensions. <i>INR 600 (USD 8) monthly*</i>	Atal Contributory Pension scheme. <i>INR 3,000 (USD 42) annual contribution</i> ¹⁸	National Family Benefit Scheme. <i>INR 10,000 (USD 139)*</i>
Violence Against Women	Manodhairya Scheme. <i>Compensation to rape and acid attack survivors. Not exceeding INR 1 million (USD 13,920) per beneficiary*</i>	One Stop Crisis Centre Scheme. <i>Integrated support to survivors of violence to facilitate access to a range of medical, legal, psychological counselling services*</i>	Special Cell for Women and Children. <i>Comprehensive, client-centered services for survivors of violence, located within the police system*</i>	Provisions of Protection of Women from Domestic Violence Act, 2005*

* Schemes that are not specifically for waste pickers but for members of low-income groups

¹⁰ <https://www.jeevandayee.gov.in/#>. This scheme was previously known as the Rajeev Gandhi Jeevanday Yojana.

¹¹ <http://indiankanoon.org/doc/156317189/>

¹² Jan Arogya Bima Policy is a nominal defined benefit medical insurance scheme for waste pickers for which the Pune Municipal Corporation pays the premium.

¹³ While the urban poor health scheme applies to all the urban poor, the enrolment and renewal fee of INR 200 (USD 3) and 100 (USD 1), respectively, is paid by the PMC Solid Waste Management Department to the Health Department.

¹⁴ This financial assistance to children of waste pickers and cleaning workers is paid out of the PMC budget.

¹⁵ This is a centrally sponsored scheme in which children of waste pickers are included as beneficiaries.

¹⁶ The eligibility threshold for this merit scheme has been reduced to 65% for children of waste pickers who have completed Standards 10 and 12. The merit scholarship is open for all young students in Pune who secure 80% in their high school examination.

¹⁷ The Janashree Bima Yojana, a life and disability insurance scheme under which the PMC paid the premium (as per a general body resolution) for waste pickers was withdrawn by the central government and the scheme has been merged into the PMJJBY and PMSBY, with a hike in benefits and premium.

¹⁸ The PMC is to contribute INR 3,000 (USD 42) per annum to each waste picker towards her Atal Pension Yojana account.

more detailed orientation for 126 members of the KKPKP Representative Council to train them to serve as volunteer peer educators.

The session focused on education schemes had 1,326 participants. It covered schemes for school- and college-going children of waste pickers, as well as tips on how to negotiate the admission process. Unlike the health session, this session was only relevant for members with school-aged children. Many of those who were grandparents resented the fact that their grandchildren were not entitled to benefits because neither of their parents was a waste picker. The few whose children or grandchildren had previously received benefits were aware of one or two schemes. Almost all were uninformed about the college admission process or the academic subjects which their children were studying. They were unaware that government financial assistance was available for children who belonged to the scheduled castes, even without caste certificates. All aspired to a college education for their children but were not aware of the complexities that they would have to negotiate in facilitating the process and choosing colleges for their children.

Review and Analysis of Calls to the KKPKP Helpline

In 2018, KKPKP began compiling a record of members who called the office helpline for assistance. The problems communicated to the office were classified by areas of concern (see Table 2: Summary of Calls to the KKPKP Helpline in 2018). Notably, many of the concerns were related to waste pickers' inability to access government services and benefits. Medical issues accounted for over a third of the complaints. After health, the inability of widows, the elderly and the

incapacitated to access social assistance pensions was the most reported issue. Education-related calls focused on school and college admissions and the receipt of financial assistance under municipal and state schemes.

Death-related calls were usually related to inquiries about insurance claims. They assume significance in this particular period because the Government of India terminated the Aam Admi Bima Yojana (AABY) and replaced it with the converged Pradhan Mantri Jeevan Jyot Bima Yojana (PMJJBY) and Pradhan Mantri Suraksha Bima Yojana (PMSBY). Those enrolled in the AABY scheme were covered for life and disability under the group insurance scheme. Since the terms and conditions of the new schemes are different, there is a time lag for enrolment into the new schemes, and as a result those who had enrolled in AABY have no coverage until the new schemes are operational.¹⁹

Table 2: Summary of Calls to the KKPKP Helpline in 2018

Area of concern	No. of complaints
Health	421
Pension	175
Work	153
Education	151
Legal	130
Finance	74
Death	43
Housing	15
Other	147
TOTAL	1,309

¹⁹ For more details on this, see the next section: Barriers to Inclusion.

Barriers to Inclusion

Based on the review and analysis of schemes, the feedback provided by waste pickers in the orientation sessions, and the analysis of helpline calls, three types of barriers to inclusion were identified and are discussed in this section: lack of information, enrolment challenges, and systemic failures.

Lack of Information

Lack of knowledge about schemes and benefits

Most informal workers do not receive useful and consistent information about existing schemes and benefits. The orientation sessions on health and education schemes revealed that very few waste pickers were aware of health and education schemes. There was relatively better awareness of housing and slum improvement schemes, such as those providing individual water connections and toilets, implemented to scale through the mediation of municipal councillors.²⁰

In the last few years, there has been an explosion in information dissemination about government schemes and programs across different media. Information about central and state government schemes is usually conveyed to the public through print and electronic media, as well as through television and radio spots and billboards, and more recently, through social media. For populations with little or no access to internet services, accessing the information digitally is a challenge and television and radio spots have recall value but do not necessarily provide useful information. Clear public education for prospective users on how they might benefit from a particular scheme or service is critical. Informed users will be able to access and use the benefits and if satisfied, to spread the word. Word of mouth is in fact the best form of publicity. Increased demand means the creation of a critical mass of users who will demand more resources and better quality services. The information pro-

cess then becomes cyclical rather than one-way or top-down.

More targeted dissemination of information about municipal schemes takes place through the Social Development Department (SDD)²¹ of the PMC, which is tasked with formulating and implementing welfare schemes for vulnerable sections of the population such as low-income households, slum dwellers, the homeless, Scheduled Castes and Tribes, women and children, and the disabled. The SDD started Neighbourhood Groups (NHGs)²² of women, in addition to self-help groups (SHGs), to address local issues and to popularize schemes and identify beneficiaries. Currently the PMC has about 75 NHGs across its 15 administrative wards, led by *Samuh Sanghatikas* or community outreach workers who are contract workers of the PMC. Resident Community Volunteers (RCVs) also share information about various schemes with the urban poor. However, conversations with waste pickers revealed that they had little or no interaction with the *Samuh Sanghatikas*. Waste pickers were not actively involved in the PMC SHGs or NHGs, and because they were out working during the working hours of the *Sanghatikas*, they remained on the margins of those community processes. Similarly, only about five waste pickers were engaged as RCVs.

Lack of information translates into lack of knowledge of entitlements and as a consequence, informal workers bear the social and financial costs. For example, the Maharashtra State Health Assurance Society implements and administers the Mahatma Jyotiba

²⁰ Municipal Councillors and their party workers have political stakes in ensuring that the benefits of government schemes reach the residents of their constituency. Their focus is usually on infrastructure, including roads, toilets and drainage, community centers and housing.

²¹ The Social Development Department (formerly the Urban Community Development Department) was started as an urban community outreach initiative by the United Nations Children's Fund (UNICEF) in the late 1980s. It was institutionalised following the enactment of the 74th Amendment to the Indian Constitution as part of democratic decentralisation processes.

²² The 74th constitutional amendment was passed in 1994 which decentralized and devolved responsibilities to urban local bodies. The formation of neighborhood groups of women, in addition to SHGs, in slum communities was part of the effort to increase their participation.

Phule Jan Arogya Yojana (MJPJAY)²³ as well as the recently launched Pradhan Mantri Jan Arogya Yojana or Ayushman Bharat (AB-PMJAY). Services under these insurance-based schemes are delivered by empanelled network hospitals which are reimbursed through a third-party administrator of the insurance company. All details of the scheme, including the procedures which are covered, participating hospitals and their specialisations are available on the website. However, at the present time, it is unlikely that an informal worker could or would access a website. Most waste collectors and informal workers do not own android phones or smartphones, laptops or computers. Additionally, online information provided on the website of the Charity Commissioner regarding the availability of beds under the Charitable Hospital Scheme (CHS)²⁴ cannot be accessed at the point of service. Neither can information on the speciality hospitals empanelled under the MJPJAY. While disseminating scheme-related information online the government needs to factor in the digital divide and the exclusion of informal workers that this creates. Therefore, as the government moves towards online dissemination of information, a parallel and an equally robust offline information infrastructure is also needed.

Primary care doctors are most likely to refer clients to a private hospital or to inform them that they require further investigation, surgery or some other secondary treatment. Typically, a waste picker is unlikely to be enrolled into the MJPJAY and has no knowledge of the scheme, nor does she have an identification card that would enable her to seek benefits under

Box 1: Lack of knowledge can further set back the poor financially

Rajiv²⁵ and his wife Laxmi are both SWaCH members. The couple called KKPKP in October 2018 to seek assistance in getting surgery for their daughter due to a lump on her leg. KKPKP referred them to the public district hospital. When the district hospital informed them that the type of surgery required could not be performed there, the couple took their child to AM Hospital, a private charitable hospital that is expected to inform patients about the Charitable Hospital Scheme (CHS) through which charitable hospitals are mandated to provide free or concessional treatment to poor patients. The couple did not inform KKPKP they had gone to AM Hospital. They were not aware of the scheme and the hospital did not inform them of it. The parents spent INR 20,000 (USD 278) that they could ill-afford for their daughter's surgery and the four-day stay in the hospital.

that scheme. She is most likely to visit the nearest private hospital and get a paid service. If she feels she cannot afford it, she is likely to visit one of the large, well-known charitable hospitals across the city. The patient is usually unaware of whether the hospital is a charitable hospital, whether it is empanelled under the Urban Poor Health Scheme *Shahari Garib Vaidyakiya Sahayy Yojana* (SGVSY)²⁶ (Urban Poor Health Scheme), whether it is a network hospital under MJPJAY, or even whether schemes for the urban poor are in operation at the hospital. A regular patient

²³ The MJPJAY is a state funded private insurance scheme of the Maharashtra State Government. It is implemented through a network of empanelled private and public hospitals. The hospitals have to be accredited by the National Accreditation Board for Hospitals and Healthcare Providers (NABH). The hospitals are free to apply for, as well as to sign out of, empanelment and to choose the specializations and the packages that they will offer. Hospitals are directly reimbursed by the insurance company for the cashless services they offer.

²⁴ https://charity.maharashtra.gov.in/Portals/0/Files/Hospital_scheme_document.pdf?ver=2018-03-06-172333-383

²⁵ All names have been changed to protect the privacy of KKPKP members and their families.

²⁶ The SGVSY of the PMC is a defined benefit health assurance scheme that covers inpatient care in empanelled hospitals for any ailment, disease or illness. The maximum permissible reimbursement is INR 150,000 (USD 2,088) annually on a family floater basis and the remaining cost has to be borne by the patient. The PMC reimburses the hospital directly up to 50 percent of the costs incurred as per a schedule of rates.

has to pay a deposit and for the cost of treatment. If she does not have the means, she borrows money and pays the bill at a private facility even though she may have been told to go to a government hospital because there is widespread distrust of the overstretched and poorly resourced public health system.

Similarly, in the banking sector, most low-income clients have poor financial literacy and are unfamiliar with the system, including the different types of accounts and the associated fees for services. Banks are quick to pro-actively push customers to avail of paid

Box 2: When banks make money off the poor

Mariavva is a waste picker who entered the banking system as part of the financial inclusion initiative of the Reserve Bank of India. Started over a decade ago, it has been extensively promoted during the past few years. During the same period, banks started charging for services and instituted automatic debit fines for those not complying with minimum account balance requirements. Mariavva, a single mother, whose monthly income is INR 11,000 (USD 153) is required to maintain a balance of INR 3,000 (USD 42) in her account to avoid banking fines. If the minimum balance is not maintained, the fine is levied, even if it means taking money from the financial assistance that is credited to her account.

A rapid study of 150 waste pickers' bank pass books revealed that penalties of INR 44,239 (USD 616) were debited from 121 accounts over a period of six months in 2017-18 for non-compliance of the minimum account balance rule. The highest amount debited was INR 646 (USD 9).

additional services such as ATM cards. They do not exercise the same diligence to ensure that poor customers change their accounts from regular bank accounts that have minimum account balance requirements to zero-balance savings bank deposit accounts that do not carry penalties if there are no balances.

Changes to schemes

The rules of individual schemes can change without much publicity or notification to beneficiaries. For example, the insurance regulator permitted general insurance companies to change the rules regarding informing beneficiaries and submitting documents for medical insurance schemes. Waste pickers enrolled in the Jan Arogya Yojana were accustomed to a seven-day application period, and a 30-day claim submission period, which were reduced to one and seven days, respectively. This change impacted the ability of waste pickers to access benefits they were already qualified for.

Every change in political leadership leads to minor or major changes in existing schemes, leading to confusion. Sometimes it is just a change in the name and as a result, waste pickers are not always familiar with the names of the schemes. Swavalamban Yojana, a contributory pension scheme for unorganised workers, started about ten years ago and was renamed the Atal Pension Yojana by the subsequent government. The Rajeev Gandhi Jeevandayi Yojana, an insurance-based health scheme, was renamed the Mahatma Phule Jan Arogya Yojana. The one exception was the Sanjay Gandhi Niradhar Yojana, a social assistance pension that had been in existence for several decades and was not renamed. Not surprisingly, every waste picker was aware of the scheme and the benefits offered under it.²⁷

²⁷ Unfortunately, this consistency and awareness of waste pickers, did not translate into increased enrolment and access to benefits because the eligibility conditions are difficult to meet.

Sometimes, when the name of the scheme is changed, there may also be substantive changes in eligibility requirements or the required documentation. In such cases the consequences are more dire. The substantive revamping of the Aam Admi Bima Yojana (AABY) into the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) and Pradhan Mantri Suraksha Bima Yojana (PMSBY) two years ago resulted in significant losses of life and disability insurance coverage for thousands of unorganised workers, including waste pickers who were enrolled. The AABY provided for life and disability coverage of INR 30,000 (USD 418) in the case of natural death, INR 75,000 (USD 1,044) in the case of accidental death and proportionate coverage in case of disability. The PMJJBY provides for coverage of INR 200,000 (USD 2,784) in the case of natural death, coverage of a similar amount in case of accidental death, and a proportionate amount in case of disability. Reconciling the old and the new versions of these schemes has been a long, drawn-out and tedious process and is not yet complete. While there is an increase in coverage, the changes and reenrolment requirements resulted in families losing out on insurance benefits. For instance, since 2005, waste pickers in Pune were insured for life and disability under Janashree Bima Yojana, prior to which it was known as the Social Insurance Scheme (IGSS) where the scheme applied to unorganized workers in 122 occupations. After the implementation of the 2017 PMJJBY and PMSBY, the number of occupations covered has been reduced to 48. Previously, trade unions, cooperatives and NGOs were admissible as nodal agencies; now only government organizations are allowed to be nodal agencies. However, as of January 2018, waste pickers of Pune will not be covered by life and accident insurance because of these changes. The families of 20 waste pickers who died in 2018 and eight who died in 2019 are not eligible for any insurance benefits because the enrolment negotiations for the revised

scheme are still going on. Even assuming the cause of death was natural, this amounts to a collective loss of INR 840,000 (USD 11,693) as per the terms of the AABY and a staggering INR 5.6 million (USD 77,951) as per the terms of the PMJJBY.

Finally, there is currently no provision for applicants to know the status of their application to municipal and state government schemes, once it is submitted. Since most application processes are now online, disclosure of the status of the application would be useful for the applicant and their advocates. Proactive disclosure of lists of beneficiaries of various PMC schemes on the PMC website would also make for more responsive governance.

Lack of outreach to informal workers

The enrolment process can serve as a key entry point for outreach to scheme participants to both learn about and access services and benefits. However, more often than not, it can be cumbersome, confusing or difficult. Additionally, although over 20 percent of Pune residents reside in slums, there is no pro-active enrolment of slum dwellers into schemes. They usually learn about them and enrol when they need assistance with a serious health problem, which is not ideal, and even then, they are not always given the information they need.

The PMC SDD relies on *Samuh Sanghatikas* to spread the word about its education schemes, which include scholarships and fee subsidies but they do not do pro-active enrolment of those outside of the SHGs and NHGs. Enrolment is now online but the online enrolment process is challenging. Most applicants do not have access to a computer and do not know how to complete the forms. The SDD have assigned trained computer operators in the 15 municipal ward

Box 3: Lack of awareness has devastating consequences

KKPKP-SWaCH member Sarita lived with her husband, three children and mother-in-law, earning INR 4,000 (USD 56) a month as a waste picker. Unfortunately, Sarita lost her job and has serious family problems. Her husband was caught molesting their daughter multiple times, and he left with his mother to avoid repercussions from the law.

Sarita suffers from bipolar disorder and her eldest son is diagnosed as having schizophrenia. Both are being treated at Sassoon General Hospital, the largest district hospital in Pune. Sarita is able to lucidly explain what triggers episodes for herself and her son and expressed that she is nervous that her son will lapse into an episode if his father does not return soon. Sarita says she spends INR 850 (USD 12) on medication for herself and her son every month. She used to get it for free from the hospital, but her son needs medication that is not available at the hospital, so she buys prescription drugs from the market.

Mental illness is treated as a disability under the Persons with Disability Act, 1995 and Sarita and her son are both eligible for a disability pension. She may also have been entitled to free medication under the PMC's Urban Poor Health Scheme (SGVSY). Sarita, however, was not aware that she was eligible for a disability pension and neither was the KKPKP activist who was assisting her at the time. This lack of awareness has been financially ruinous for Sarita and her children, to a point where the family often skips meals because she simply cannot afford even the subsidized food grain she is entitled to.

offices to assist with enrolment. Municipal ward offices, however, are open and accessible usually from about 10 am to 5 pm which is when informal workers are at work. Visits to the municipal offices also mean loss of wages. Since the documentation requirements are also not clear and publicly known, informal workers reported that they are reluctant to miss days of work to enrol, since there is no guarantee they can actually access the benefits.

Some schemes such as the SGVSY and the MJPJAY require the formal enrolment of intended beneficiaries for them to access benefits. Only those in physical possession of an SGVSY enrolment card, for example, can access benefits under the scheme. The card is only valid for a year and the annual renewal requirements are cumbersome, so application at the time of medical need is the most common process

that is followed.

The MJPJAY requires insurance companies or third-party administrators to enrol beneficiaries into the scheme and provides a card. However, possession of the MJPJAY card is not mandatory to avail benefits. Possession of a ration card or a self-declared income certificate that records income below a particular threshold is adequate. While the alternatives to the MJPJAY card favor inclusion, enrolment is still required at the point of service. The patient may not have pre-existing knowledge of the scheme and the specific benefits that it offers at various locations. The burden is on the patient to be able to match the specialisation and the hospital with the particular packages it offers, which can be a difficult and confusing task. Without clear accountability mechanisms in place, it can also result in a hospital claiming

it does not provide a particular specialization or services within their service package to avoid serving a low-income client.

The SGVSY has a fairly simple and open enrolment process based on certain eligibility criteria. If the applicant's documentation is accepted, the enrolment process is smooth. However, applications are only accepted at the Health Department at the Municipal Headquarters, not at municipal ward offices or in the slum communities in which most waste pickers reside. This requires waste pickers to incur the time and financial cost of traveling to headquarters, creating barriers to access. Further, the patient has to bear 50 percent of the expenses. The rates payable to the hospital by the PMC are based on the Central Government Health Scheme (CGHS) and approved by the municipal general body. If the rates of the hospital are higher than those permissible for reimbursement, the patient has to make up the difference.

Enrolment Challenges

Challenging eligibility criteria

The annual income threshold for accessing social assistance pension schemes in Maharashtra is INR 1,000 (USD 292) for widows and other single women, the destitute and the elderly, and absence of a male adult over the age of 25 years in the household.

The establishment of vulnerability and eligibility for all targeted or means tested schemes such as the Sanjay Gandhi Niradhar Yojana for widows, deserted and destitute women under the age of 65 years and the Shravan Bal Vrudhapakal Nivrutivetan Yojana, for the elderly destitute, pose an insurmountable challenge. Informal workers living in slums or in slum-like conditions, with poor educational and employment documentation, find it near impossible to prove eligibility and access the schemes that are meant for them. A

woman with young children who has been deserted by her husband, finds it very difficult to establish her single status to be eligible for a pension scheme because registration of marriages is not enforced and commonly done. What finally happens is that Municipal Ward Officer, the officer designated under the Registration of Marriage Act, 1998 issues a certificate. In a country where registration of births have not been the norm, establishing age can be difficult. The adult is required to specify the purpose of age certification and medical officers, who certify age, tend to be conservative when the purpose relates to employment or social assistance pensions. It is not surprising then that less than 20 percent of Maharashtra's elderly are covered by social assistance pensions. In fact, there has been no increase in the number of beneficiaries since 2015. The most stringent conditions for eligibility and unwritten quotas are impossible to meet and as a result, far too many are excluded from what they are entitled to.

Under the schemes mentioned above, the central government provides social assistance pensions amounting to a meagre INR 200 (USD 3) per month to widows/single women, the disabled and the elderly from families living below the poverty line. Maharashtra State provides another INR 400 (USD 6) to the pensioner for a total monthly sum of INR 600 (USD 8). The amount is not indexed to the Consumer Price Index, as it is for pensions to government employees. Neither is it periodically revised. The amount is paltry, and the coverage pitiful, for a state that contributes 15 percent of the country's GDP.

Cumbersome documentation requirements

Most schemes have cumbersome documentation requirements that compound the barriers that waste pickers face in accessing services and benefits and result in an unfair opportunity cost imposed on the most vulnerable segments of the population. Like eli-

gibility criteria, document requirements can vary both within and across schemes. For example, the ration card is adequate to establish eligibility for the MJPJAY, but the patient is asked to present an income certificate at the point of service. The problem of providing documentation each year for the annual renewal of the SGVSY health scheme card and for educational assistance has been raised with municipal authorities as an issue that needs to be addressed. Additionally, officials and clerical staff often add to documentation requirements in an ad hoc manner.

Box 4: Documentation requirements do not reflect the realities of the poor

Waste picker Apsara's daughter wanted to open a bank account. She had her Aadhaar card, which is technically sufficient to open an account. The bank however, insisted on proof of address. She was living in rented accommodation, so the bank then demanded a rental agreement. Few slum landlords provide rental agreements, since most arrangements are informal. Apsara would have had to spend up to INR 2,000 (USD 28) to get such an agreement. A letter detailing various Reserve Bank of India orders on financial inclusion was issued to the bank by the KKPKP. The bank then relented because Apsara, who already had an account in the same bank, served as the referral. Similarly, those who do not have their own electric connections but use neighbours' connections do not have bills with their names, which are required to access municipal education schemes. The bank was demanding documents that were beyond their own requirements and are difficult for the poor to provide, given the realities of their living conditions, creating unnecessary barriers to Apsara's daughter's ability to open a bank account.

Inaccessible application processes

The 2015 Maharashtra Right to Public Services Act specifies types of services provided by designated authorities, as well as the time limits for applying and the grievance redress options. This is accompanied by an online portal²⁸ to facilitate enrolment. However, intended beneficiaries are poor, less literate populations with little access to Internet connectivity. *eSeva Kendras* were established by the Maharashtra Government, as part of the digital initiative MahaOnline Limited, a joint venture of the Government of Maharashtra and Tata Consultancy Services, to facilitate document provision and the issue of relevant certificates, based on the production of the original documents.

As a result, digitization is happening across municipal offices. However, since building new technological capabilities takes time, it is often the most vulnerable who are left behind. Applications for most schemes went online in 2018-19. The PMC was unable to arrange for uploading the documents, so there was a hybrid system of online applications which had to be printed and submitted as hard copies, with all the supporting documentation. It took two months for the PMC to recruit and train the staff and place them in the municipal ward offices. That the officials planned decentralised centres is creditable. There were, however, major technical issues with the online processes. In the case of admissions under Section 12(1)(c) of the Right to Education Act, the help centres provided by the government are poorly resourced and parents prefer to visit cyber cafes and pay for the service.

Prior to digitization, the schemes had been modified for waste pickers, but those modifications were not included in the digitized version. In response, delegations of waste pickers submitted letters and petitions

²⁸ <https://aaplesarkar.mahaonline.gov.in/en/CommonForm/CitizenServices>

using democratic grievance redress mechanisms. On *Lokshahi Din* (Democracy Day), over 40 applications were submitted by waste pickers. Since *Lokshahi Din* applications are treated very seriously because the reports are sent to the state government, the technical matters were resolved and submission dates were extended to accommodate the applications.

The online application process for the centrally sponsored Pre-matric Scholarship Scheme for children of those in cleaning occupations, two years ago, is an example of an ill-conceived decision that had to be revoked because school staff were not sufficiently computer-literate. This caused hardship to scheme recipients and implementing authorities. Ultimately, the district administration reverted to applications in hard copies and the backlog is still being dealt with.

High opportunity costs

It stands to reason that the working poor weigh the opportunity costs of availing a benefit or taking a risk, against the actual benefit. The cost of taking time from work, as well as the cost of transport to secure documents or enrol in a scheme, can outweigh sometimes unreliable benefits.

Systemic Failures

Inadequate and problematic financing of schemes

Whether it is the 10 percent reservation for indigent patients and weaker sections in hospitals or 25 percent reservations in schools because of concessions from the government received by the respective institutions, it is the government's responsibility, codified under law, to ensure that every Indian has access to quality education, health care and social security in

old age. Unfortunately, this obligation is not always backed up with adequate financing and with timely transfer of funds to the implementing departments. For example, Sangita, a waste picker, spends INR 1,000 (USD 14) a month on her blood pressure and diabetes medication. It is not available at the nearest municipal hospital, which is supposed to stock it, because the tender-based procurement process was not completed. In denying services, one hospital alleged that the PMC had not reimbursed the hospital for INR 80 million (USD 1.1 million) for the SGVSY.

Similarly, the state directorate of primary education disbursed only INR 700 million (USD 9.8 million) of the INR 1.05 billion (USD 14.6 million) that had been given for reimbursement to the schools. A sum between INR 14,000 (USD 195) and 17,000 (USD 237) per child admitted under Section 12(1)(c) is reimbursed to the schools under the scheme. Some schools have not received reimbursement since the inception of the scheme, and others since 2017.²⁹ As a result, schools obligated to admit underprivileged children under Section 12 (1)(c) of the Right to Education Act did not register themselves on the website since the Maharashtra Government had not paid their dues to the schools for almost five years. Private schools are expected to reserve 25 percent of their seats for children from the Scheduled Castes and Tribes and economically backward classes. The state government is expected to reimburse a proportion of the costs to schools, but there is no annual schedule against which this reimbursement is made, and schools retaliate by not admitting children under this quota.

Additionally, the insurance-based model of health financing needs reconsideration. It is improving the profitability of the general insurance companies rath-

²⁹ Swati Shinde Gole, Times of India March 5, 2019 <https://timesofindia.indiatimes.com/city/pune/schools-await-rte-refund-as-edu-dept-sits-on-rs-35cr/articleshow/68261993.cms>

er than ensuring better medical services to the working poor. Private hospitals are notoriously unwilling to empanel themselves as service providers and the regulatory authorities are powerless to act against them on behalf of patients. For example, a city hospital opted to do only cardiac surgeries for the poor because the 'package' of subsidies from the government was good. The same hospital was unwilling to provide gastrointestinal treatment, although it had the facilities. Study after study concludes that out-of-pocket expenditure of the working poor on health care results in a rapid descent down the slippery slope of poverty.³⁰

Between July and December 2018, 2,606 complaints were lodged by patients across Maharashtra for the recovery of out-of-pocket expenses they had incurred

at the almost 500 hospitals in Maharashtra empanelled under the cashless health insurance scheme MJPJAY. Most complaints came into a dedicated 24-hour call center from Pune (1,138) and Mumbai (725). MJPJAY officials initiated an inquiry which resulted in the recovery of INR 13.8 million (USD 192,094) that participating hospitals had to pay to the patients. Notably, almost half (44 percent) of the cardiology patients had been asked to pay over and above what the hospital stated to the government was the cost of the service.³¹

Finally, there are persistent issues around billing. According to the Charter of Patients' Rights issued by the Indian Ministry of Health and Family Welfare, under their right to information, all patients should receive an itemized bill for services received.³² Unfortunately,

Box 5: Informal workers bear the cost

Jagdish, a headload worker's nine-year old son had a fever for three days and had to be rushed to the intensive care unit (ICU) for suspected meningitis. The charitable hospital asked him to deposit INR 50,000 (USD 696) before they would treat his child, which he borrowed and paid. The bills kept mounting and when KKP assisted him to access the schemes, he had to make judgment calls because his son's life hung in the balance. He stood his ground and demanded treatment for his son. The hospital that refused to treat his son without any further payment finally had to comply. He spent a total of INR 72,000 (USD 1,002) for two weeks of specialised treatment in the ICU. After the Charity Commissioner issued a letter warning the hospital of action for non-compliance, the hospital administrator finally called the father to say that all further treatment would be provided free of cost. Informal workers are unaware that they can approach the authorities and even if they are informed, they may choose not to pursue it because negotiating the system means loss of time, earnings and dignity.

³⁰ For more information see: Wagle, S & Shah, N. (2007) Government Funded Health Scheme in Maharashtra: Study of the Rajiv Gandhi Jeevandayi Yojana, Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai; <https://thewire.in/health/who-is-paying-for-indias-healthcare>; https://www.business-standard.com/article/current-affairs/out-of-pocket-health-expenses-plunge-55-mn-indians-into-poverty-in-2017-118071900115_1.html; <https://www.outlookindia.com/outlookmoney/insurance/out-of-pocket-expenses-in-healthcare-in-india-stands-at-62-per-cent-report-2554>; <https://www.thehindu.com/business/out-of-pocket-spend-makes-up-62-of-health-care-costs/article21860682.ece>; <https://www.dnaindia.com/mumbai/report-maharashtra-government-has-schemes-but-public-education-is-lacking-2663277>; <https://www.dnaindia.com/mumbai/report-maharashtra-government-has-schemes-but-public-education-is-lacking-2663277>; and <https://www.thehindu.com/opinion/op-ed/not-a-prescription-for-the-poor/article2277746.ece>

³¹ <https://indianexpress.com/article/cities/mumbai/out-of-pocket-expense-under-mjpay-2606-complaints-lodged-by-patients-in-6-months-rs-1-35-crore-refunded-5563891/>

³² For more information on the Charter of Patients' Rights, see: <https://mohfw.gov.in/newshighlights/draft-patient-charter-prepared-national-human-rights-commission> and <https://www.thebetterindia.com/158829/patient-right-hospital-law/>

this does not happen. For example, under the SGVSY, which is implemented by the PMC's Health Department, a patient is expected to approach an empanelled hospital and ask for an estimate. If the family is already enrolled in the SGVSY, the estimate is approved, and a letter is issued to the patient. Depending on the scheme, hospital and treatment, payment may be covered in full or partially by the PMC, the Indigent Patients Fund (IPF)³³ or the patient themselves. After the patient is discharged, the bills are sent to the PMC Health Department for reimbursement and are retained by the PMC. The patient is not provided with a bill, so does not know the overall cost of their treatment and how the bill is paid. This contributes to a lack of financial transparency and accountability in the system.

Complex implementation architecture

The implementation architecture refers to the system designed for the delivery of a scheme or service by the central, state or municipal government. Schemes and services are implemented by the state departments, either through the district or municipal administration. The applicant is expected to negotiate various steps and interact with different functionaries and that often leads to gaps and inefficiencies.

Implementation of the Centrally Sponsored Scheme of Pre-matric Scholarship for children of those in cleaning occupations, held by the Department of Social Welfare of the Ministry of Social Justice and Empowerment, is more complex. The scheme is centrally sponsored, which means it is implemented by the

state government and the expenditure is reimbursed to the state by the central government. The state government issues calls for applications from the Zilla Parishad (district administration) for the scheme. The Zilla Parishad in turn notifies the PMC School Education Department, which in turn notifies schools. It is the schools who are finally expected to identify students who qualify for the scheme and fill the forms and submit them to the Zilla Parishad, yet they are informed at the very end.

Failure to act

There are instances in which the responsible agency simply does not undertake its responsibilities. For example, the Manodhairya Scheme³⁴ is a compensation scheme for women and child survivors of rape, child sexual abuse and acid attacks. Following public interest litigation regarding implementation delays, the scheme was recast by a court-appointed committee in consultation with the government of Maharashtra. Implementation of the scheme was handed over to the State Legal Services Authority (SLSA) or District Legal Services Authority (DLSA) which for Pune is housed within the District Court premises. The disbursement of funds was to be done by the DLSA from a dedicated Manodhairya Assistance Account on receipt of the relevant papers from the police machinery. The police investigation officer is expected to inform the DLSA by email or any other means within an hour of the first information report (FIR) being filed and then submit a copy of the FIR, the medical examination report and the survivor's statement recorded in court under section 164 of the Criminal Procedure

³³ The IPF is a fund into which all charitable hospitals should contribute 2 percent of their revenue. The fund is used to provide free and concessional treatment to patients who are below the poverty line and those of the weaker sections, respectively.

³⁴ <https://womenchild.maharashtra.gov.in/content/homecontent/schemes.php>

The Manodhairya is a victim compensation scheme for survivors of rape, sexual abuse and acid attacks (women and children). Financial assistance ranging from INR 100,000 to 1 million (USD 1,392 to 13,920) is provided to the survivor for shelter, medical care and rehabilitation by the Department of Women and Child Development, Maharashtra. The scheme is implemented by the District Legal Services Authority.

Box 6: Victimization by the system that is mandated to help

Three cases pertaining to the rape, sexual abuse and brutalization of minors have been pending for a period of between one and two years due to delays in the system, further victimizing the survivors of violence.

Raj is blind and his young mentally challenged daughter was raped by a neighbour. Currently in a residential institution, the survivor bore a child that was given up for adoption. She has only received the first instalment under the Manodhairya Scheme. Raj has made several trips to the DLSA to ask for the balance. The DLSA continues to procrastinate without citing any reasons.

The required papers have not been submitted by the police in two other cases, one of a girl who was raped by her neighbour, and another of girl repeatedly brutalized by her landlord. Since the police claimed lack of knowledge of procedures, representations were made to the Office of the Police Commissioner following which instructions were issued to all police stations. When that had no effect, the DLSA was approached to use its powers to call for the documents from the appropriate courts. Since the matter is still stalled, each set of parents were assisted to file an application to the District Court that is hearing the prosecution case, to provide a certified copy of the papers. Those, they were told, can be used to file the compensation claim.

The documents are yet to reach the applicants. What is ironic is that the DLSA, which was intended as a single window to expedite compensation under the scheme has not done so, leaving it to the families of survivors to procure the documents for the DLSA. They have gone from the DLSA to the police and finally to the courts for the documents. The burden is on the family of the survivor rather than on the body that was entrusted with this responsibility, and the survivors do not receive the funds they need to deal with the trauma they have experienced or seek justice.

Code. The first instalment of INR 30,000 (USD 418) for the immediate care of the survivor is to be released within seven days of receipt of the documents, and the remaining amount is to be released within 120 days after a detailed investigation. Additionally, compensation rates were revised, and the court committee directed that compensation be granted retrospectively at the revised rates. However, despite these changes and specifications, delays persist.

Lack of accountability mechanisms

Local, state and national governments formulate schemes and offer services for the benefit of informal workers and other urban poor. The intent to avoid

wastage of resources translates into stringent eligibility conditions and documentation requirements. The attempt to address wilful and accidental exclusions is less in evidence. In a highly unequal society where privilege and patronage are accepted as given, greater attention needs to be paid to accountability mechanisms for the government so that no needy recipient is excluded on any grounds and that no ineligible recipient is included. Public disclosure of lists of beneficiaries and the benefits received by the government would be one way of tracking beneficiaries of each scheme. The onus of preventing fake applications under a scheme must not be placed on the marginalised by formulating stringent eligibility criteria and

demanding biometrics and numerous documents. Instead, the effort to effectively weed out undeserving beneficiaries must be made by the government through public disclosure and physical verification.

For example, hospital administrators allege that ineligible patients drive up in their personal cars to claim free treatment under the CHS. The website of the Charity Commissioner Maharashtra already displays information about the CHS and provides information on the number of reserved beds that are vacant for each category. In the digital age, it would be a fairly simple exercise to add the lists of beneficiaries treated in each hospital in each category along with the amount debited to the IPF for treatment provided to them. A column showing the total IPF of each hospital would also enable tracking of balances when hospitals apply for exemption from the scheme on grounds of having exhausted the IPF.

According to a news report,³⁵ the former Joint Charity Commissioner Dighe is reported to have said, “So many poor people are still deprived of treatment”. The report also mentioned that 50 hospitals in the Pune region had spent INR 1.2 billion (USD 16.7 million) to treat 275,000 patients between 2006 and 2013. He also stated that patients had filed 35 complaints against hospitals between January and June 2014. There is little recourse for a patient who is denied inclusion under any scheme at the point of service. While there are complaint systems (one member recently made a representation to the regulatory

committee for charitable hospitals and got relief), requests by members for recovery of excess charges by hospitals are still pending.³⁶ A more recent news item³⁷ reports on the amendment to the Bombay Public Trusts Act, 1950 wherein the trustees of charitable hospitals are liable to be prosecuted and will face three-year prison terms if found guilty for denial of treatment to poor patients. These are laudable efforts to increase accountability which must be immediately and transparently implemented.

There are few systems of accountability in place when an empanelled hospital does not comply after receiving its compensation. Recently, the District Collector slapped an INR 1 billion (USD 13.9 million) fine on a city hospital for contravening the terms of its charitable purpose and overcharging patients.³⁸ It is noteworthy that the hospital had been awarded prime plots of land in the city, due to its charitable designation, for an annual rent of just INR 1 (USD 0.01).

The Report of the Comptroller and Auditor General (CAG) of India on General and Social Sector for the year ended March 2017³⁹ carried out a performance audit of the Rajiv Gandhi Jeevodaya Yojana scheme (later renamed as the MJPJAY). The findings echoed many of the points raised above. The audit found that the authenticity of the beneficiaries could not be verified because the ration card details were not obtained. Further, the CAG report found that “As against the premium of INR 30 billion (USD 416 million) paid to the Insurer Company until November 2016 cover-

³⁵ <https://indianexpress.com/article/cities/pune/complaint-fake-certificate-to-benefit-from-scheme-for-poor-patients/>

³⁶ <https://mohfw.gov.in/sites/default/files/PatientCharterforcomments.pdf>

³⁷ <https://punemirror.indiatimes.com/pune/cover-story/3-yr-jail-term-for-trustees-of-charitable-hospitals-for-refusing-the-poor-treatment/articleshow/62213917.cms>

³⁸ <https://www.hindustantimes.com/pune-news/pune-hospital-established-by-lata-mangeshkar-issued-rs-100-crore-notice-for-norms-violation/story-IMdbTIWPSYrHqpjeSfVvQP.html>
<https://punemirror.indiatimes.com/pune/civic/deenanath-hospital-served-notice/articleshow/68470380.cms>

³⁹ <https://cag.gov.in/content/report-no6-2017-general-and-social-sector-government-maharashtra>

Box 7: Who is accountable for people who fall through the cracks?

In February 2018, in the early morning hours, Aditi was found unconscious and bleeding on the ground on Jangli Maharaj Road in the heart of Pune City. An identified vehicle had hit her head and fled the scene around 6:30 am as she was wheeling her push cart to work. No one paid her any attention, not even the police on duty at the post a few yards across from where she lay, until a good Samaritan stepped in to help. The Samaritan picked up her cell phone and called her 19-year-old daughter. Aditi's children rushed to the scene, put their unconscious mother in an auto rickshaw and sped to Kamala Nehru Municipal Hospital, about five kilometres (three miles) away. When they arrived, they were told that the hospital did not have the equipment to treat their mother. The hospital provided an ambulance which took Aditi to Sassoon General Hospital, a Government District Hospital.

The Sassoon General Hospital admitted Aditi but informed her children that there were no vacant beds in the ICU and that she needed to be placed on an air mattress, which cost INR 4,500 (USD 63) at the hospital, until an ICU is available. Her son managed to get an air mattress at a lower price (INR 1,900; USD 27) outside the hospital, placed his mother on the mattress and continued to wait for the ICU. During the wait, Aditi regained consciousness and showed signs of improvement, until her condition suddenly deteriorated and she died two weeks after the accident.

Aditi died at a poorly managed general hospital waiting to be admitted into the intensive care unit (ICU). There were at least four private hospitals run by public charitable trusts located less than one kilometre (half a mile) from Sassoon General Hospital where she could have been treated using medical assistance from government schemes, but no one took her there. Not the police who neglected her at the accident scene, not her children who did not know that the other hospitals could provide her care, not the service providers at the hospital, nor the KKPKP and SWaCH activists who later got involved but were also poorly informed about the services that were available for her. So, who is accountable for the death of Aditi?

ing 93.5 million beneficiaries under the Scheme, the claims received for settlement were a meagre INR 119 thousand (USD 1,676) due to absence of wide publicity to the Scheme, shortfalls in conducting health camps and non-appointment of *Arogyamitras* at primary health centres. Thus, the Scheme benefits were not commensurate to the expenditure incurred on the premium paid to Insurer".⁴⁰

⁴⁰ <https://cag.gov.in/content/report-no6-2017-general-and-social-sector-government-maharashtra> pp.17

Recommendations

The exercise of studying the schemes, examining the barriers, and piloting interventions to address those barriers unequivocally established that enabling access and inclusion is about staking claims. Claims that very often the invisible, the excluded and those on the margins do not even know that they can make. Examining the barriers also highlighted the reality that the most vulnerable bear the opportunity cost of making those claims, without any assurance that the claims will be fulfilled.

It is critical that the state machinery be held accountable for ensuring last-mile delivery. In the case of this study and intervention, the relevant state machinery is the urban municipal body, the PMC. The PMC is responsible for access to services, benefits and opportunities offered by government schemes. It also houses the Social Development Department (SDD), which is tasked specifically with reaching out to the urban poor and other vulnerable populations.

This section includes practical recommendations for the PMC and its partners to increase access to social benefits, entitlements and opportunities, and in so doing to fulfil its obligation to foster social inclusion.

Facilitate Convergence to Enable Inclusion

Convergence across PMC departments and with KKPKP

A first step to facilitate inclusion and ensure the seamless delivery of benefits is to work towards convergence between various PMC departments that already implement schemes and programs for waste pickers, as representatives of the vulnerable urban poor.

SWaCH's partnership with the PMC is a good example of how the institutionalisation of interdepartmental convergence can foster inclusion. SWaCH was established through convergence between the then-Public Health Department and the SDD (formerly urban community development) of the PMC. There was convergence between the PMC's obligation to provide solid waste management (SWM) services to all sections of society in the interest of public health and its responsibility for poverty alleviation and employment generation. That SWaCH continues

to operate and expand, 15 years after the pilot and 11 years after its formal incorporation, is testimony to the efficacy of this approach.

Moving forward, core departments that should coordinate efforts to increase social inclusion include the following: SWM, Social Development, Health, Education, Information Technology, and Finance and Accounts. This convergence could be further strengthened with inputs from the waste pickers' union KKPKP, which would also increase the accountability and credibility of the PMC among waste pickers.

The respective roles of the PMC departments should be as follows:

- The Social Development and SWM departments, along with KKPKP, should prepare the Standard Operating Procedures (SOPs) to be followed by the concerned departments for the implementation of schemes for waste pickers. The SOPs should be approved by the Pune Municipal Commissioner, who has the powers for implementing schemes based on each relevant PMC general body resolution.
- The Social Development and SWM departments should play a pivotal role in providing welfare services and upgrading livelihoods, respectively. KKPKP should assign a person to be embedded within PMC, to liaise with the departments of the PMC and support the effective implementation of schemes.
- The Finance and Accounts Department should make budgetary provisions in the PMC budget as per the resolution of the PMC General Body to provide welfare benefits to waste pickers. The expenditure against budget line items should also be tracked annually.
- The IT Department should provide back-end

support to create the framework for the enrolment of waste pickers into those schemes specifically approved by the PMC general body for waste pickers. Reports should be generated on a regular basis to track the inclusion of waste pickers in each scheme.

- The SDD and KKKPKP should promote the formation of SHGs of waste pickers, so that they are integrated into departmental schemes for the urban poor and have easier access to benefits.

Inclusion should be further strengthened by putting in place a tracking system on official department websites for each scheme, to track each individual beneficiary from the application phase to the receipt of benefits. An SMS (short message service) should be sent to the applicant, communicating the status of the application at each stage, as well as the name and mobile number of the next processing officer, because often multiple government and private agencies are involved at different stages of scheme delivery.

Convergence across government programs and schemes

PMC departments implement state and nationally administered programs which provide important resources for vulnerable populations, such as the National Urban Health Mission and the National Urban Livelihood Mission. There is scope for convergence between PMC programs and for these programs to increase access by improved clarity and efficiencies. For example, the PMC provides a sum of INR 10,000 (USD 139) to widows upon the death of a husband who

is deemed to be the earning member. The centrally sponsored National Family Benefit Scheme provides a sum of INR 20,000 (USD 278) for the same purpose but also states that the family will get the amount in the event of the wife's death, recognizing that more often than not, she is also an earner, based on 2010 guidelines. There should be more clarity about the two schemes and ultimately, the PMC should work with the District Collector to streamline the process and implement the more comprehensive national scheme.

Additionally, there are various schemes to improve the health and nutrition of the urban poor. Some, such as the SGVYS (Urban Poor Health Scheme), are funded by the PMC; others, such as the Pradhan Mantri Matru Vandana Yojana (PMMVY)⁴¹ and the Integrated Child Development Services (ICDS)⁴² are centrally funded; and others, such as the Revised National Tuberculosis Programme (RNTCP), are centrally funded but implemented by the PMC Health Department. Each has a common mandate to improve the health and nutrition of the urban poor. Yet, each scheme employs its own field staff. For example, PMC schemes have *Samuha Sanghatikas* and SDD social workers, and national schemes have ICDS workers and ASHA (Accredited Social Health Activist) community health workers, none of whom share data on beneficiaries with each other. There is an opportunity here to achieve greater efficiency by having the PMC's SDD serve as the lead agency for maintaining a data base of all urban poor who live in slums and informal settlements that can be the basis for enrolling beneficiaries into all the schemes. The SDD could begin with waste pickers, since there is

⁴¹ <https://pmsma.nhp.gov.in/maternity-benefit-programme/>
<https://pib.gov.in/newsite/PrintRelease.aspx?relid=181761>

⁴² <https://icds-wcd.nic.in/>
<https://icds-wcd.nic.in/icdsimg/snrules2017.pdf>

already a PMC resolution on health schemes for waste pickers, with the goal of reaching all informal workers and ultimately, all urban poor.

Convergence between the PMC, the Charity Commissioner and the Maharashtra State Health Assurance Society

The analysis revealed the relative powerlessness of the patient with multiple vulnerabilities who is trapped in the untenable situation of not having the wherewithal to pay the full costs for health care, coupled with an inability to negotiate the complexities of the medical establishment. Currently, the Charitable Hospital Scheme (CHS) is mandatory for charitable hospitals, whereas to participate in SGVSY, MJPJAY and PMJAY, charitable hospitals have to choose to apply and get empanelled. We recommend that like CHS, participating in the SGVSY, MJPJAY and PMJAY schemes should be made mandatory for charitable hospitals, because otherwise the propensity to withdraw from government or insurance schemes is very high. This would simplify and improve access to medical assistance for the poor by increasing the number of facilities available to them and reducing the distances they have to travel and costs they incur in accessing hospitals that are currently part of the scheme. If each hospital disclosed expenditures under each scheme, this would help with accountability. It could, of course, be argued that doing so would defeat the purpose for which the CHS was formulated. However, charitable hospitals were established with the specific purpose of providing medical care to the poor. In fact, if a hospital is facing financial constraints that makes it difficult for it to serve the poor, participating in reimbursement schemes, such as SGVSY and the MJPJAY, should be more desirable.

Convergence between the PMC Health Department and the Maharashtra State Department of Women and Child Development (WCD) to improve the One Stop Centre Scheme for women

The state funded One Stop Centre designated to provide women and child survivors of violence refuge and a range of support services has not functioned because no organization responded to the tender to run it. The State WCD Department is the implementing agency for the scheme, responsible for the range of medical, law enforcement, legal and social services provided under the scheme. However, since the two designated One Stop Centres in Pune are located within PMC municipal hospitals premises, joint oversight of the services by the PMC Social Development and Health departments would make sense and would lead to greater accountability and better monitoring. It would also facilitate local linkages to key agencies, including the District Legal Services Authority and the Pune City Police Commissioner's Office, as well as outreach to non-governmental organisations to raise awareness about tenders to ensure that the One Stop Centres are functioning.

Convergence between the PMC Education Department and Pune Zilla Parishad

Some educational financial assistance and scholarship schemes are implemented by the Zilla Parishad or rural district administration, with the Education Department of the PMC functioning as the intermediary for schools within its jurisdiction. Others, such as provisions of the Right to Education Act, the mid-day meal program and Direct Benefit Transfer Programs, are implemented directly by the PMC's Education Department. To provide clear oversight and

easy access to information for PMC residents needing to access the schemes, information and data about all relevant educational schemes should be disclosed on the PMC website. In addition to the online processes, offline processes could also be deployed, including banners in slums and in markets, newspaper releases, *in situ* enrolment processes, or putting a canopy and a table in the slum with announcements on a public address system.

Engage in Targeted Outreach, Education and Enrolment

Conduct targeted outreach and onsite enrolment by coordinating with *Kashtakari Seva Kendras*

Currently, *Samuha Sanghatikas* or extension workers of the PMC are placed geographically in slum communities and are responsible for popularizing schemes and programmes of the SDD. Engaging the *Kashtakari Sanghatikas* of the KKPKP Helpdesk (see next section for more information) with specific responsibilities for reaching underserved populations, such as informal workers, to help informal workers access government services and entitlements would be a logical and more inclusive approach. This does not mean that *Samuha Sanghatikas* should be replaced by the *Kashtakari Sanghatikas*, but rather that they could coordinate efforts to ensure that the most vulnerable do not fall through the cracks of the system. With a mandate to reach informal workers such as waste pickers, street vendors, construction workers and domestic workers, *Kashtakari Sanghatikas* will have different work hours to reach informal workers, who are often at their work sites while *Samuha Sanghatikas* are working in communities. Onsite enrolment would be an added advantage.

For health and pension schemes, special planning and strategizing may be required to increase access for extremely vulnerable target populations. A system of home visits by government officials for scheme enrolment and delivery should be introduced, such as those recommended by the World Health Organization (WHO) for the provision of neonatal and postnatal care.

Institutionalize a robust and accessible information system

IT-enabled delivery of benefits is actively promoted by the government as part of the Digital India campaign. However, the online application process creates exclusions that need to be addressed through proactive onsite enrolment assistance for those who lack digital access. There is a need for a parallel, robust offline information infrastructure, using SMS and phone calls. Additionally, there is a great deal of focus on the online application process, but no reverse flow of information to the applicant on the status of the application. There is a need to develop a system through which the applicant is able to access information about the status of the application, and the reasons for rejection, as well as be able to register grievances or provide feedback with the assurance of a timely response. This, along with disclosure of the names of applicants and amounts allocated and expended under each scheme in each year, would make for a robust system.

Increase Accountability

Increase accountability through grievance redress mechanisms

A robust grievance redress system within the PMC that is easily accessible and usable by applicants of various schemes and services is required, along with the steps to be followed in case the complaint is not resolved. Posting complaints received on the website of the government, together with notice on the time within which a response can be expected on the action taken, would also be a useful intervention. Without this, the applicant is left with no recourse other than to keep complaining. The feelings of helplessness and futility that the complainant experiences may be a major deterrent to demanding redress or seeking further government services.

Establish a social audit department within the PMC

In early 2019, the Pune Municipal Commissioner announced that the PMC would carry out a social audit of its work and programmes to enable city residents to easily monitor progress and the expenditure of funds. He is reported to have said that while the concept of social audits has taken root in rural areas, that was not the case in urban areas. The initiative, Jalyukt Shivar Project, was conceived by the district administration for water conservation and will soon be implemented for all PMC projects. Using social media platforms, citizens will be asked to share feedback and suggestions. Local corporators will be asked to connect with constituents and work together to create a plan of action for the civic body. The Municipal Commissioner also emphasised that one of the objectives of this initiative is to implement need-

based civic projects based on the specific feedback of citizens, in the place of supply projects. The people have a right to know how the INR 60 billion (USD 835 million) budget of the PMC is being spent and what difference it makes in the lives of Pune residents. The fact that the Municipal Commission sees the need for the participation of ordinary residents in assessing the work of the PMC is promising. The initiative should be institutionalized in a social audit department within the PMC. Furthermore, to ensure this initiative impacts the social inclusion of the most vulnerable, the PMC should officially disclose the lists of beneficiaries of various schemes and programs. Putting in place procedures for recording and redress of grievances and satisfactory tracking of progress from application to completion should also be implemented. Finally, organising platforms for and moderating public hearings should also be the responsibility of the social audit department, in order to reach the most vulnerable sections of the community.

Interventions

The recommendations focus on the responsibilities and accountability of government systems and service providers, with a view to increasing the effectiveness and accountability of government services. It also highlighted ways in which KKPKP, as the union of waste pickers, can improve its services and outreach to its membership. Using the findings from the study, KKPKP has already begun to implement programmatic solutions for its members, with the goals of improving member services and support, increasing social inclusion of waste pickers, and providing solutions and lessons learned to increase the social inclusion of all informal workers.

These include creating a central helpdesk with a decentralized network of help centers located in communities in which waste pickers and their families live, piloting onsite enrolment in schemes, again in communities in which waste pickers and their families live, engaging with service providers and intervening at the point of service to ensure services are delivered as promised, supporting the use of grievance redress mechanisms by claimants, networking with non-governmental and private sector organizations to identify and help waste pickers access a range of services, and continuing to support the backbone of KKP KP's advocacy and action – collective action. These changes by KKP KP over the past year have shown increased inclusion in government schemes and better access to services.

Kashtakari Helpdesk

A preliminary understanding of the major barriers to inclusion led the team to conceptualise a practical intervention to address them - the Kashtakari Helpdesk mechanism. A hub-and-spoke model is conceived as a mechanism to efficiently link waste pickers and public and private service delivery systems (see Figure 1: The Kashtakari Helpdesk Hub and Spoke Model).

The hub of the Kashtakari Helpdesk, the central *Kashtakari Sadhan Kendra*, includes the next iteration of the KKP KP helpline, the Kashtakari Helpline, and a team of responsive advocates who provide back-end support to the spokes, which are up to ten community-based *Kashtakari Seva Kendras* (KSKs) that facilitate problem solving and inclusion, and engage waste pickers in advocating for their own entitlements and services.

The KSKs serve as decentralised resource centres located within or close to the slums where there are

large enclaves of waste pickers, serving as the locus for education and service delivery to waste pickers. They are managed by *Kashtakari Sanghatikas*, the educated daughters or daughters-in-law of waste pickers and locally governed by groups of their representatives. They seek to ensure last-mile delivery of services and government schemes to underserved informal waste pickers, particularly women, who are difficult to reach, on account of their multiple vulnerabilities and responsibilities, the nature of their work and working hours.

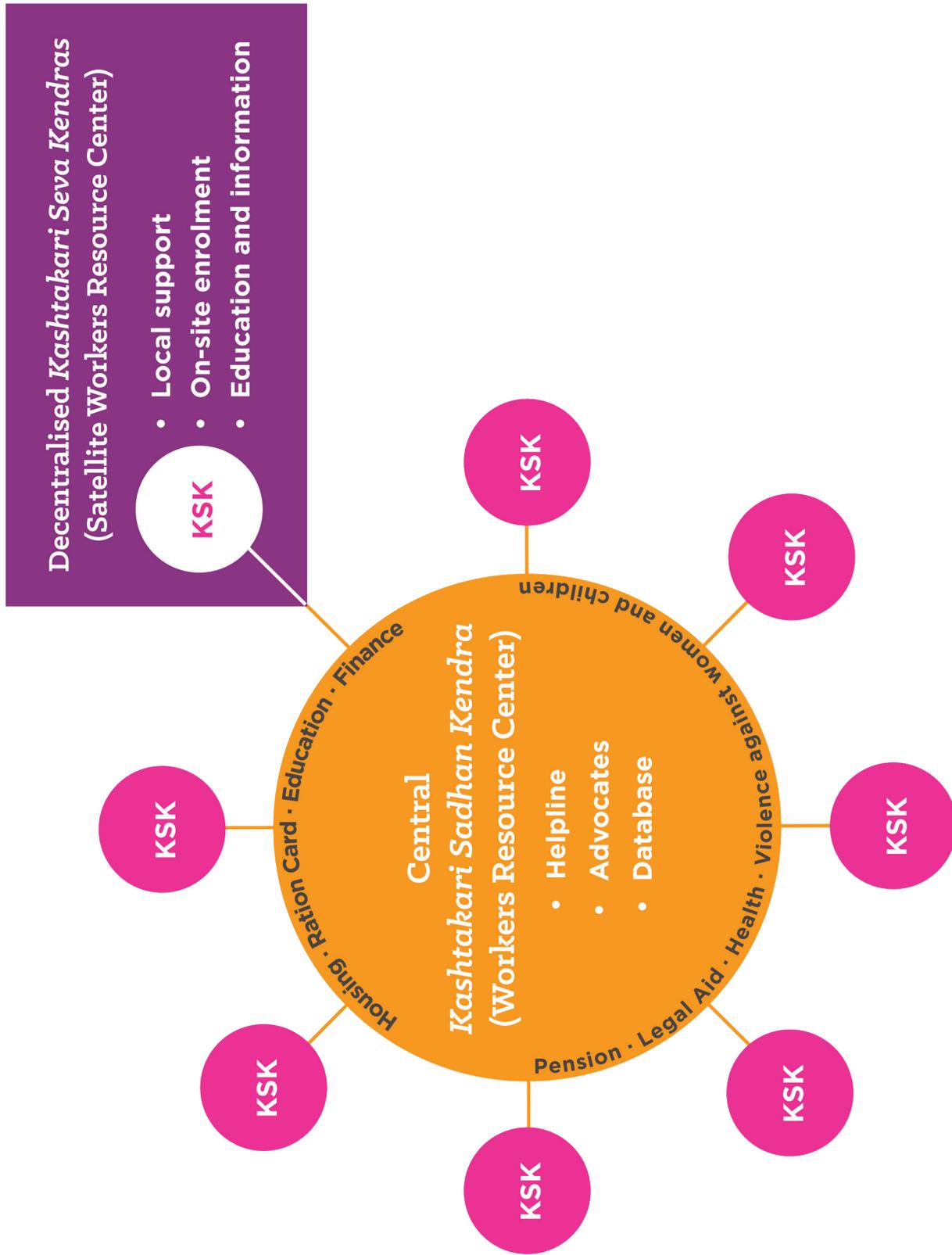
The KSKs are premised on the belief that poverty is multidimensional and layered, and that there is a hierarchy among informal workers that renders certain categories of workers more vulnerable to exclusion, and that special efforts are required to reach them. The final objective of the KSKs is to create a replicable model of facilitation for waste pickers that can be accessed by other informal workers with multiple vulnerabilities within the jurisdiction of the PMC. Elements of the intervention have been progressively initiated from August 2018 (see Table 3: Components and Features of the Kashtakari Helpdesk Model).

The intervention is already making a difference. For example, the Kashtakari Helpline received 811 calls in the first five months of 2019, of which a third were related to health issues. Other calls, in order of frequency, were related to education, credit and legal issues. Medical issues that were reported were mostly about non-communicable diseases, conditions or ailments. Occupation-related accidents and injuries constituted two percent of the cases reported. Once issues were registered, they were followed-up. Access to health schemes and benefits was facilitated by the Kashtakari Sadhan Kendra, and two-thirds of those who needed hospitalization were diverted from private hospitals to more affordable charitable and

Table 3: Components and Features of the Kashtakari Helpdesk Model

Central Kashtakari Sadhan Kendra (Workers Resource Center)	
HELPLINE	<ul style="list-style-type: none"> • An immediate response service to register and respond to waste pickers' problems, concerns and complaints
	<ul style="list-style-type: none"> • The helpline currently operates for 8 hours daily, and will ultimately be extended to 12 hours a day
	<ul style="list-style-type: none"> • Waste pickers and their representatives are encouraged to call the helpline number to report their problems
	<ul style="list-style-type: none"> • Information/guidance is provided over the telephone or in-person, based on the nature of the problem and the resolution process
ADVOCATES	<ul style="list-style-type: none"> • Problems are recorded in a prescribed format, creating a valuable database to better understand the recurrent needs of informal workers, and provide a feedback loop to public and private services
	<ul style="list-style-type: none"> • Staffed by KKPKP advocates who provide information, resources and support to facilitate access to services and benefits in health, education, financial inclusion, violence against women, housing, work, legal assistance, rations and social protection
	<ul style="list-style-type: none"> • Engages with implementation authorities and at points of service to ensure easier access and effective implementation of government schemes
	<ul style="list-style-type: none"> • Engages with enforcement agencies for effective implementation of municipal; state and central government schemes and services
	<ul style="list-style-type: none"> • Identifies NGO and CSR programs that could benefit waste pickers and their families
	<ul style="list-style-type: none"> • Facilitates convergence between government departments, private agencies, schemes and services
DATABASE	<ul style="list-style-type: none"> • Facilitates worker registration, worker education and participatory social accountability processes
	<ul style="list-style-type: none"> • Creates a dynamic repository of information (collect and collate information of government and private schemes and services)
	<ul style="list-style-type: none"> • Maintains and analyzes data and generates reports on the types of problems encountered by waste pickers and the enabling process
	<ul style="list-style-type: none"> • Provides evidence-based feedback to appropriate authorities for implementation and policy
Decentralised Kashtakari Seva Kendras (Satellite Workers Resource Centers)	
	<ul style="list-style-type: none"> • Staffed by Kashtakari Sanghatikas, community-based advocates who provide information, resources and support to access services and benefits
	<ul style="list-style-type: none"> • Located close to homes and workplaces of waste pickers and other informal workers
	<ul style="list-style-type: none"> • Open during the hours that are suitable for workers (12 noon to 8 pm or 1 to 9 pm, including Sundays, with an alternate weekly holiday)
	<ul style="list-style-type: none"> • Locally provides information and facilitates access to government schemes and programs
	<ul style="list-style-type: none"> • Carries out targeted on-site enrolment including online enrolment
	<ul style="list-style-type: none"> • Provides worker education, including health literacy, legal literacy, financial literacy and literacy to illiterate waste pickers
	<ul style="list-style-type: none"> • Facilitates collective action to demand access, inclusion and accountability, building on the established platforms of waste pickers

Figure 1: The Kashtakari Helpdesk Hub and Spoke Model



government hospitals. These actions resulted in a significant number of waste pickers and their families receiving services, with significant financial savings for them.

With support from the PMC, including an endorsement, financial resources and the necessary infrastructure, the Kashtakari Helpdesk model can be scaled up to reach other informal workers and excluded populations in the slums and low-income settlements of Pune city.

Piloting Onsite Enrolment

KKPKP's pilot for decentralised onsite enrolment for educational assistance schemes was designed to counter barriers to access. A dedicated team equipped with basic computer skills, a laptop, an internet connection and a printer was trained and assigned to visit waste picker enclaves in slum locations to fill out the applications for educational assistance schemes onsite.

Onsite enrolment of children of waste pickers in municipal- and state-funded education assistance schemes resulted in the inclusion of 1,636 children in 2018-2019 (see Table 4: KKPKP Education Scheme Onsite Enrolment Drive (2018-2019)).⁴³ In contrast, in 2017-2018, without on-site enrolment, the number of enrolled children was a quarter of that due to an inability to meet documentation requirements. For example, for the 'Pre-matric Scholarship to the children of those engaged in occupations involving cleaning and prone to health hazards', the application

process is carried out by schools, but parents have to provide eligibility documents and link the child's Aadhaar card⁴⁴ to the child's bank account for the state scheme. The municipal scheme requires linking the parent's Aadhaar card to the bank account. These requirements place an additional burden on the child and on the parent, who must forgo wages or earnings during the time required to do this.

Intervening at the Point of Service

KKPKP decided to engage with stakeholders and service providers at points of service and had some successes. This involved KKPKP advocates engaging with service providers in hospitals and orienting the service providers about the nature of work and specific vulnerabilities of waste pickers. Often hospital service providers either did not know about particular provisions or feigned ignorance about them, but clearly many were acting on the instructions of the hospital administration. Every hospital that is empanelled under the MJPJAY appoints an *Arogya Mitra* or Health Friend who works in three shifts. They are expected to guide the patient through the process and are supposed to ask for the ration card which the patient has to produce within 72 hours. Treatment proceeds concurrently. Similarly, the charity hospital appoints a *Dharmaday Arogya Sevak* or Charity Health Worker to assist the patient. While these are in place, they often do not have the authority or information they need to effectively serve as patient advocates.

KKPKP activists engaged with these service providers to ensure they did their jobs and waste pickers' needs

⁴³ In the case of the PMC, there were changes in the online process and IT issues that had to be resolved. The beneficiaries are verified by two departments. Changes within and across PMC departments and within KKPKP led to delays in the processing of applications. Disbursal of assistance is still in process.

⁴⁴ Aadhaar is a 12-digit unique identification number issued by the Indian government to every individual resident of India.

Table 4: KKPKP Education Scheme Onsite Enrolment Drive (2018-2019)

Scheme	No. of applications filled	Status of applications (as of January 2019)
Pre-matric Scholarship for children of those working in cleaning occupations	1,182	All data and documents collected using Kobo Toolbox. ⁴⁵
PMC educational assistance for high school children of those in cleaning occupations	433	All forms filled online 162 passed for payment 189 completing documents submission 75 awaiting endorsement of schools 7 forms submitted for students studying outside Pune
<i>Maulana Abul Kalam Azad</i> (Std 10) and <i>Annabhau Sathe Merit</i> (Std 12) Scholarships	15 students for Secondary School Certificate (SSC) 5 students for Higher Secondary Certificate (HSC) 6 students who scored above 70% and had caste certificates filled forms at the ward offices	20 forms submitted 4 being reprocessed due to lack of electricity bills
Subsidy for private tuition fee of 12th Std	1	Submitted and in process

were addressed. Persistent case-by-case intervention with these service providers resulted in some of them being more willing to provide solutions and facilitate access for waste pickers. Additionally, a protocol was established to facilitate access that is now followed by the Helpdesk, and much of it can be achieved through the helpline. In April 2019, a list of hospitals that had yielded and provided services was developed and geographically disaggregated. The list was provided to waste picker members who now know their options and which hospitals that they can go to for free treatment.

Supporting the Use of Grievance Redress Mechanisms

When a claimant of a service or an entitlement can seek redress for denial, it is immensely empowering. Members who approach the Helpdesk are encouraged to file both on- and off-line complaints. In fact, almost every member who has been treated in a charitable hospital has had to approach the Charity Commissioner's office to seek interventions, which

⁴⁵ KoBo Toolbox is a free open source tool for field data collection for mobile data collection. For more information see: <https://www.humanitarianresponse.info/en/applications/kobotoolbox>

has proved beneficial. However, members whose applications for victim compensation have been pending also filed grievances but have not had much success.

Section 12 (1)(c) of the Right to Education Act requires 25 percent of the seats in private schools to be reserved for those from socially and economically weaker sections. No fees are to be charged to children admitted under this provision, and uniforms, books, educational materials and services and extra-curricular activities are to be provided free by the schools. Applications are filed online, and students are selected through a lottery process. Through the Helpdesk parents are assisted with the online application process and encouraged to report a violation of the rules. Many waste pickers have filed such applications with the grievance authorities of various government departments for the denial of entitlements.

Networking with Other Organizations

KKPKP's networks and partnerships with non-governmental and private sector organizations implementing their own programs, government schemes or government-mandated programs have helped to provide waste pickers and their family members access to a range of services across sectors, such as education and legal services. This includes vocational training and job placement services under the Light House Project of Pune City Connect, science and technology sessions for girls with Mastercard, the

Box 8: Accessing legal aid services

KKPKP member Navin was an itinerant waste buyer from 2010 to 2015. Since the scrap trade was not paying well, he started work as a contract laborer doing construction work. In April 2017, he fell from the 9th floor of a building where he was working. It was his first day of work with that contractor and he died the next day. Since he was insured under a KKP group insurance programme, his wife Masuma received the insured amount. The matter was then referred to the Legal Aid Centre of the ILS Law College, since law colleges are expected to offer free legal assistance services.⁴⁶ Free legal services were provided to Masuma for filing a compensation claim. She followed up diligently and was present at each hearing. In March 2018, the contractor paid INR 300,000 (USD 4,186) to Masuma as part of a court settlement.

Foster Care Scheme with Shishu Adhar, legal services with the India Law Society's (ILS) Law College, psychiatric care for members or their families with the Institute of Psychological Health (IPH) and the Bapu Trust, deaddiction referrals to Alcoholics Anonymous and Muktangan Deaddiction Centre, and residential care with Maher and Maharshi Karve Stree Shikshan Sanstha.

⁴⁶ Clause 11 of the Rules of Legal Education of the Bar Council of India under the Advocates Act, 1961 states that Legal Aid Centre: Each institution shall establish and run a Legal Aid Clinic under the supervision of a Senior Faculty Member who may administer the Clinic run by the Final year students of the Institution in cooperation with the Legal Aid Authorities with list of voluntary lawyers and other Non-Government Organizations engaged in this regard in the locality generally from which the student community of the Institution, hail from.

Supporting Collective Action

KKPKP and SWaCH were founded on the principle of collective action, with the idea that the most vulnerable sections of society are stronger when they have collective power. KKPKP supports collective action both in its capacity as a trade union, collectively negotiating to protect the livelihoods and occupational safety of its members, and as an advocacy body that empowers its members. Since the union and cooperative were formed, through the process of collectivization, the negotiating power, visibility and dignity of waste pickers has increased. Collective action remains a key strategy in our work to create pathways to social inclusion, by educating waste pickers about their entitlements, enabling them to fight for their rights and entitlements, increasing access to existing services, demanding additional services to fill gaps, and by leveraging existing and new mechanisms and strategies to hold government and other service providers accountable.

Conclusion

The proposed recommendations for government and other service providers and the interventions that are being implemented by KKPKP were conceived within a vision of the city as a socially and spatially diverse, inclusive, economically equitable, politically participatory and culturally vibrant ecosystem.

The work described here is based on the recognition that the city comprises different sections of society that contribute to its existence as well as to its vibrancy, and that all its resources belong to all its residents in equal measure. New migrants and transitory populations are more vulnerable to exclusion. However, the length of stay in a city is no measure of inclusion because exclusion takes place on account of a combination of factors. It is as much the responsibility of the residents of the city as it is of the PMC to ensure that all manner of exclusions are identified, addressed and remedied. In this report we have looked at a limited selection of sectoral schemes and services, their provisions, inadequacies and their utility for waste pickers. Kashtakari Pune is visualized as a response that facilitates inclusion of excluded populations into the city, in ways that matter.

On a personal note, I returned to working on government schemes after almost eight years. During that time, I had been involved in formulating the welfare benefits for waste pickers from the PMC and in advocating for social security pensions for informal workers. Much has changed in the interim. New laws have been enacted, including the Right to Services Act, the Adhar Act, Food Security Act, and others. New schemes have come into existence. While at the core the benefits of the schemes were the same, they have largely become dependent on individuals negotiating with private and public service providers to secure their entitlements. The modes of service delivery have also changed, with more online processes that have ostensibly added efficiency, yet have also made services more inaccessible.

The relevance of the methodology that we adopted, of looking at access from the perspective of the

experience of the waste pickers, revealed the myriad ways in which the delivery systems almost conspire to deny services and entitlements and how that shapes the experiences of those who seek those services. The willingness of waste pickers to resist deprivation and to persist in securing what is rightfully theirs was very encouraging. It is important the waste pickers learn to negotiate the systems themselves and fearlessly confront those in power without flinching.

In the final analysis, it is waste pickers themselves who must argue their case. KKPKP is not a service delivery organisation. It has been founded on the premise that waste pickers must understand the political economy of service provision and denial and act to change those. The next stage will be that of waste pickers taking the sum of their experiences and the findings of this report to dialogue with bureaucrats and elected representatives to make things work better for them and for others like them.

Partnerships lie at the heart of the 3D Program.
We are grateful for the support we receive from
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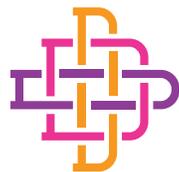
Hosted by United Nations Foundation

Funded by Bill and Melinda Gates Foundation

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