A DECADE OF WOMEN'S EMPOWERMENT THROUGH LOCAL GOVERNMENT IN INDIA

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Power to the Women — Innovative Strategies and Approaches Adopted for Empowerment in a Urban Community Development Programme

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Abstract: The paper highlights innovative strategies adopted in a demonstration project on "Participatory poverty reduction and control of diarrhoeal diseases through improved water supply and sanitation", implemented in five slum areas of Chennai city. The project aimed to create an enabling framework to stimulate bottom-up community planning, cooperation and convergence between stakeholders, NGOs and community-based organizations and the community. It helped to create a community structure called Community Development Society and led to the empowerment of women, which has reduced poverty in crucial areas that were hindering the quality of life in various ways.

Introduction

The right to development and the right to a life free from poverty are basic human rights. The UN Charter, the Universal Declaration of Human Rights, the World Summit on Social Development, and many other multilateral declarations and conferences, have recognized and reconfirmed economic, social, political, civil, and cultural rights with the goal of eradicating poverty and its consequences. Some of these rights are an adequate standard of living, food, housing, education, health, work, social security and a share in the benefits of social progress.

The United Nations Development Programme addresses poverty as a denial of human rights, various choices and opportunities basic to human development. UNDP defines poverty from a sustainable human development perspective. These include the ability: to lead a long, creative and healthy life; to acquire knowledge; to have freedom, dignity, self-respect and respect for others; and, to have access to the resources needed for a decent standard of living. In 2000, the UN General Assembly set goals for development, known as the *Millennium Development Goals,* to be achieved by 2015. They are the eradication of extreme poverty and hunger, achieving universal primary education, promoting gender equality and the empowerment of women, and reducing child mortality.

Dimensions of Poverty

The Human Development Report 1997 introduced a measure of human poverty called The Human Poverty Index (HPI). This index measures deprivation by looking at five real-life attributes of poverty, such as illiteracy, malnutrition among children, early death, poor health care and poor access to safe water. The World Development Report 2000 proposed a strategy for attacking poverty in three ways — promoting opportunity, facilitating empowerment and enhancing security.

Strengthening the ability of poor people to shape decisions that affect their lives, and removing discrimination based on gender, race, ethnicity and social status, are key factors. Good governance has a direct bearing on poverty. Often poor people are direct victims of bad governance. Due to their lack of representation, they tend to be left out of public expenditure programmes, especially those related to access to productive assets and the delivery of social services. A general policy framework is required to: reduce the marginalization of women; help them to participate effectively in economic, political and social life; and, increase their involvement in the developmental policies that affect their

lives. The concept of human development has four components — productivity, equity, sustainability and empowerment. Further, this concept emphasizes gender equality. Sustainable human development implies engendering the development paradigm.

Urban Poverty: A Growing Problem

New initiatives and government programmes have arisen more from an increased awareness of the problems of the urban poor, than from any evident changes in the scale of urban poverty. By 2005, more than half of the world's population is expected to live in urban areas. Urban poverty is a multidimensional phenomenon. The poor suffer from various deprivations (e.g., lack of access to employment, adequate housing and services, social protection, health, education and personal security). Urban poverty is often characterized by cumulative deprivations. One dimension of poverty is often the cause of, or contributor to, another dimension (e.g., unhygienic living conditions due to lack of sanitation and water). Children are also sufferers of unhealthy working conditions. The personal security of the urban poor is jeopardized by family breakdown, often caused by drug and alcohol abuse.

Though poverty eradication is a major objective of the Tenth Five-Year Plan, there is no estimation of actual populations living below the poverty line. The Central and State governments have their own set of figures, and there is no plan to resolve the differences.

Understanding the Nature of Women's Poverty

Gender asymmetry is a universal phenomenon. This gender inequality is reflected in the famous formulation of the UN Decade for women: 'women account for half of the world's population, perform two-thirds of its work, receive one-tenth of the world's income and own less than one hundredth of the world's property'. Most of the world's poor are women. According to the Human Development Report 1995, "Poverty has women's face. Of 1.3 billion people in poverty, 70 per cent are women".

Women are substantially overrepresented amongst the poorest (women and children account for 73% of those below the poverty line). It has been asserted that gender differences within the incidence of poverty in urban areas are more intense than those in the rural areas. Increased female labour force participation, particularly among the lowest income households, is the single most important coping strategy. This makes female–headed households and poor women a distinct poverty group.

Women often have particular difficulties in gaining access to income, resources and services. Women from low-income households experience discrimination in finding work, in securing support for income generation programmes or household improvements, and through having to combine the triple role of child-rearing, household (and community) maintenance and income generation.

Slums in Chennai City

Chennai is one of the major metropolitan cities in India. It prides itself on being the oldest Municipal Corporation in India. Yet it has not escaped the fate of other

metropolitan cities of India in facing the problems of mushrooming slums and squatter settlements. There are 1,500 slum areas in Chennai city. One third of the city's population — i.e., approximately 15 lakh — lives in slums. These slums are a hindrance, not only to the municipal authorities in implementing civic and developmental works, but also affecting the quality of life of the total city population in various ways. The slums and their population are part of the development of urban areas, since they are interdependent regarding services and sustenance. Women from this low-income group constitute 38% of the population, and are major contributors in the informal and service sectors.

Women's lack of access to credit, training, shelter, services, education and decision-making positions prevent women from improving their living conditions and participating in development programmes. In many of the poor households, a woman is the head of the household, with the onerous responsibility of being the breadwinner. It is the women who have to turn a shelter into a home, and who must in the first place set up the family's survival system (i.e., basic amenities, education, health care, safe and protected shelter, water and sanitation facilities). Apart from the above, women have to face the consequences due to problems, like illiteracy, large families, alcoholism, child labour, ill health, underemployment, malnutrition, food insecurity, lack of awareness and poor decision-making power.

Development programmes that tend to ignore women's needs and contributions have often failed. Unless and until women are empowered to fully participate in the programmes, by gaining access to and control of both material and information resources, they will not be able to challenge their existing situation and transform the structures and social inequality. The Third World looks at people as the greatest asset, and believes that true development must focus on people on the premise that they have to develop themselves by participating in activities that affect their lives. As the participation of women is integral to development, they must involve themselves in the planning, implementation and evaluation of the programmes in which they have participated.

The urban slum community is heterogeneous in nature. Therefore, forming them into groups and involving them in the process of development of their families, groups and the whole community is a unique experience for any organization working with urban slums. Projects implemented with women's participation through formation of self-help groups have proved to be successful throughout the world. The concepts of women's group formation and community-based efforts to address poverty issues are certainly not new. Many NGOs have attempted and succeeded in improving the lives of the poor in selected small communities. But these welfare programmes have been restricted to thrift and credit, income generation, literacy, health, child labour and so on.

The above programmes are implemented with the assistance of government and international funding organizations in rural areas, and small and medium towns where the communities are mostly homogenous in nature. While much has been written about the experiences of NGOs, particularly with respect to poverty alleviation and women's access to credit and training, this has been largely of a descriptive nature, and has tended to put forward the voice of the people running the NGO, rather than the voice of the women themselves. There are very few successful urban models, which are handled by the people themselves. Hence the success of this case study, in terms of its process of development and sustainability (and possible replication), served as a great impetus for

sharing this initiative with academics and policy-makers working towards poverty reduction.

Existing Empowerment Models

Some of the prominent empowerment models working through formation of self-help groups are the Grameen Bank, Bangladesh Rural Advancement Committee (BRAC), Proshika, SEWA, Working Women's Forum, SPARC, Mahila Samkhya, UBSP, DWCRA, Sri Padmavathy Mahila Abhyudaya Sangam, Pradhan, MYRADA, and so on. The above models are mostly rural-based, and promoted by individuals and NGOs. They have become more like institutions, rather than community-based organizations, with less priority given to self-reliance.

In most of the cases, self-help groups depend on the NGO for their sustenance and guidance, rather than meeting their own needs. NGOs are interested in having a hold over these groups (to maintain their own existence), rather than making self-help groups function independently. Most of the SHGs have been formed for credit and savings, rather than the holistic development of the community. It was revealed that only women SHGs, who have been involved right from the process of planning to the post-project period, can sustain themselves, take up the responsibility and be less dependent on government or NGOs. Hence, the groups should be used only as entry points for community organization, rather than for activity-based programmes.

Project on Control of Diarrhoeal Diseases through Water and Sanitation

Tamil Nadu Slum Clearance Board, a quasi government organization working for the welfare of slum dwellers, has implemented a demonstration project called 'Control of Diarrhoeal Diseases through Water supply and Sanitation' in five slum areas in Chennai city, in association with UNICEF and the financial assistance of British Airways. Functional support from related governmental departments, non-governmental and community-based organizations was also enlisted. A notable feature of this project was the holistic approach it followed, instead of concentrating on only one or two issues. Water and sanitation are not very attractive entry points for urban community development, but complementing this project with women's involvement makes it an ideal model.

The main objective was to control diarrhoeal diseases, adopting the CDD WATSAN strategy, through an organized community structure. The duration of the project was three years. Specific project objectives were:

– To reduce the diarrhoeal incidence among children under 5 by 25%
– To promote key practices to prevent and manage diarrhoeal diseases
– To provide increased access to sanitation facilities
– To create awareness on health, nutrition, water, sanitation and immunization
– To create an organized structure for the sustenance of area-based services.
– To converge different department's resources for the upliftment of the areas.

In this model, even though the main objective was to control diarhoeal diseases through improved water supply and sanitation, there were interrelated issues that required

equal attention and interventions. The overall goal has been poverty reduction. The reality is that poor families need a critical minimum level of resource inputs to come out of the vicious circle of poverty. Hence the strategy was to identify the specific nature and magnitude of resource inputs needed by each poor family with no cost, low cost and high cost solutions.

Poverty — Defined in an Alternative Way

Currently, poverty is defined on the basis of income of households. The poverty line is that minimum level of income in rural or urban situations, which would enable an average family of five members to purchase the minimum, recommended caloric intake. At the macro level, this exercise has tended to depend on expenditure data, which is subject to a lot of limitations. At the field level, income data is difficult to obtain, difficult to verify, and subject to manipulation and under reporting. Also, income does not adequately reflect the overall living conditions of families. Differentials in income status can be stated in very broad categories. For all these reasons the definition of poverty is fraught with problems and adversely affects the implementation of anti-poverty programmes.

As an innovative approach in the CDD WATSAN project, poverty was defined in an alternative way — on the basis of a risk index called the poverty index. The risk index includes the following factors:

- Family belonging to SC or ST
- Family with children under five years old
- Family having one illiterate adult member
- Family with only one adult earning member
- Family living in a kutcha house
- Family without a household latrine
- Family with no access to safe drinking water
- Family consuming only two or less meals a day
- Family with an alcoholic or drug addict
- Family with a child labourer

Construction of High Risk Family Index

The family was selected as the unit, primarily because it is at the family level that the different social, economic, physical and other related factors determine the quality of life. The purpose of this index was to develop a simple measure that would enable the project to identify combinations of high risk factors and related 'basic needs' programmes, to identify those families 'most in need' so that available resources could be distributed on a priority basis. It was assumed that a set of multidimensional variables, reflecting the various aspects of a poverty syndrome, would be a powerful predictor of affected families. The focus of analysis, therefore, was to identify the 'best combination' of variables or 'risk factors' to predict levels of poverty. Animators, selected from the concerned areas, conducted the survey and results were consolidated. High risk households were categorized into the following:

Environment: Water supply and sanitation
Housing: Kutcha house
Economic: One adult earning member; consuming two or less meals a day
Children: Children below five years old
Education: Illiterate member
Social: Schedule Caste, alcoholic member; child labour

A family with a minimum of four and above 'high risk factors' joined a target group for getting benefits from different departments for housing, literacy, sanitation, water, health and income generation activities. The high risk families needed more inputs, namely physical, social and economic, plus skills. The variables used were demonstrable and verifiable, and the scoring system was simple. High risk families were prioritized according to the availability of resources and convergence of activities. The risk index analysis gave a clear picture of the needs of each family and specific interventions required. Planning of activities was made easier by this process. The baseline survey has helped to identify risk families, as seen in Table I below.

TABLE I

Area	Total No. of households	Families with No. of High Risk Factors								
		3	4	5	6	7	8	9	10	Total
Thiruvika Nagar	39	-	147	151	101	79	53	23	2	**556 (33%)**
VOC Nagar	46	-	7	60	98	116	106	55	9	**451 (27%)**
Ambedkar Nagar	76	4	42	60	55	38	20	7	-	**226 (14%)**
Sastri Nagar	78	-	177	108	29	11	3	-	-	**328 (19%)**
Narasimha Nagar	97	-	8	30	39	40	15	5	-	**137 (8%)**
Total	**3,836**	**4**	**381 (22%)**	**409 (24%)**	**322 (19%)**	**284 (17%)**	**197 (12%)**	**90 (5%)**	**11 (1%)**	**1,698 (100%)**

Innovative Approaches

Under the CDD WATSAN project, a four-pronged approach was adopted to reduce the high risk factors:

– bottom-up planning through community structure;
– convergence of services;
– social mobilization and awareness creation; and,
– capacity building.

1. Bottom-up planning through community structure

Under the project, a community structure was formed for implementing and sustaining project activities. The objective of this structure was three fold — community empowerment, transfer of responsibility to the community, and sustenance of the project. The community structure is a four-tier system: NHG (Neighbourhood Groups); SHG (Self-Help Groups); ADS (Area Development Societies); and, CDS (Community Development Society).

Neighbourhood Groups (NHG)
The NHG, which was the bottom-level structure, consisted of 20 families each. A woman representative from each of these families formed the NHG. These families were identified based on the structure or neighbourhood pattern. Each NHG selected a representative known as the Resident Community Volunteer.

Self Help Groups (SHG)
The SHG consists of 20 women, represented by two to three NHG members and Resident Community Volunteers. The SHG was the entry point for formation of credit and thrift groups, to inculcate the habit of savings for economic empowerment and make them financially independent to take care of the assets created.

Area Development Societies (ADS)
The President/Secretaries of all SHG were members of the ADS at the area level.

Community Development Society (CDS)
It was the apex body of ADS, which in turn was a federation of SHGs of high risk households.

2. Convergence of services of different departments

The existing infrastructure of the sectoral departments — like water, sanitation, health, education and income generation — have been used for implementing the CDD WATSAN strategy by integrating services.

3. Social mobilization and awareness creation

A focus on women's empowerment has been brought into the implementation of project activities. Women have played an active role through interpersonal contacts

using multimedia communication channels, such as wall writing, street plays, distribution of stickers, pamphlets and so on.

4. Capacity building

Various training programmes have been organized for animators, SHG, ADS and CDS members, grassroots functionaries of government, non-governmental and community-based organizations, in the fields of water, sanitation, health, education, family welfare, income generation and so on.

Process of Women's Empowerment

Empowerment is a phenomenon of the 1990s and is defined as 'giving power to', 'creating power within' and 'enabling'. It is a multi-dimensional process, which enables individuals and groups to realize their full identity and powers in all spheres of life. The term became popular in the field of development, especially with reference to women.

Keller and Mbewe [1991] define empowerment as ‘a process whereby women become able to organize themselves to increase their own self-reliance to assert their independent right to make choices and to control resources which will assist in challenging and eliminating their own subordination’. Sharma [1991] defines empowerment as 'a process aimed at changing the nature and direction of systematic forces, which marginalize women and other disadvantaged sections in a given context'. According to Marilee Karl [1995]: ‘Empowerment is a process both individual and collective, since it is through involvement in groups that people most often begin to develop their awareness and the ability to organize to take action and bring about change’. Women’s empowerment can be viewed as a continuum of several interrelated and mutually reinforcing components. In short, empowerment is a process of awareness and capacity building leading to greater participation, to a greater decision-making power and control, and to transformative action. For Kiran Devendra [1994], empowerment of women means ‘equipping women to be economically independent, self-reliant, have a positive self-esteem to enable them to face any difficult situation … able to participate in developmental activities and in the process of decision-making’.

Incorporating empowerment in sustainable development means investing in a long-term process. Empowerment seeks to foster local ownership of development processes and allows women to manage and control resources. Empowerment allows women’s groups to influence the systems that affect their lives. Based on the above concepts of empowerment, under the CDD WATSAN project, a series of capacity building programmes were conducted to enhance leadership and awareness levels of women issues.

In Self-Help Group formation and operationalization, women have learnt from each other the felt needs of self, families and the community in which they live. Through exposure visits to similar programmes implemented in neighbouring states, group discussions and case studies, their awareness levels have been enhanced. Women began to identify themselves in Self-Help Groups, became empowered and were able to collectively represent their grievances with government and NGOs. The empowerment process enabled women first to mobilize their own savings and helped groups to build

'money' power. The programme helped to improve quality of life through improved water supply and sanitation facilities provided by government.

Three stages of development were proposed — i.e., family, group and the total community. Due to health education programmes, women from Self-Help Groups treated gastro-intestinal diseases with home remedies, which were otherwise neglected (until they became chronic and in some cases proved fatal). Health education has also equipped them to prevent and manage diseases. Women have continued to learn new skills through group sharing and participating. They have improved problem-solving capabilities, both individually and collectively, so that programmes can become sustainable.

Through involvement of women in the process of development, change in the self, family and community was witnessed. Women not only saved and accumulated money through group savings, but also witnessed attitudinal and motivational changes. The community was able to get infrastructure facilities to improve their quality of life, and awareness and decision-making levels have been enhanced due to capacity building activities.

Interventions

The project has several achievements to its credit. The activities undertaken under the project related specifically to the risk factors identified are intended to eliminate these factors or reduce their impact. The impact assessment study was undertaken on completion of the three-year project. The infrastructure facilities for improving housing, water supply and sanitation have been provided in a phased manner by the concerned departments. Although the whole community benefited from the project, high risk families were priority targets for intervention. Statistics showing the status of risk factors before and after project interventions is given in Table II at the end.

The following intervention strategies have been implemented for the high risk factors:

Family belonging to SC/ST

At the community level, local associations were functioning to cater to the socio-economic needs of the Scheduled Caste community. Under the project, women have been encouraged to form self-help groups. Through these groups, women have been given training in capacity building, total literacy, income generation activities, and maternal and reproductive health. Out of 1,628 families, 1,276 (78%) families belonging to the Scheduled Caste benefited from one activity or other. The women belonging to the Scheduled Caste had taken an active role in the successful functioning of the Community Development Society.

Children under five years old

Giving children access to an integrated package of basic social services of good quality is one of the most effective and efficient steps in combating poverty. Moreover, ensuring access to basic education, primary health care, adequate nutrition, and safe

water and sanitation are human rights. Investment in children today is the best guarantee of equitable and sustainable development tomorrow.

There were 845 high-risk families with children under five years old. Through coordination with IPP V and NGOs, health camps, eye camps, medical check-up camp, health and nutrition exhibitions were conducted. Apart providing water and sanitation facilities for ICDS centres, teachers were taught about the importance of five components of child welfare, and there was regular interaction among the teachers, parents and women group members on increasing the quality of services for the children. Through this project, 679 (80%) families with children under five years benefited from the above interventions.

Illiteracy

Basic education has intrinsic value. The capability to read and write improves the quality of life and directly affects people's security, because illiteracy and lack of knowledge on numeracy are liabilities. Basic education, especially girls' education, is also fundamental to health. The link between poverty, female literacy and the gender gap has been a subject of intense debate for quite some time now. Poverty has a significant impact on the education of girls. The reverse is also true — i.e., that high education levels can have a positive impact on reducing poverty.

Women members decided that there should not be any member in their project using thumb impressions. The first task of the educated members was to regularly teach illiterates in the concerned areas, adopting primers developed under the Total Literacy Campaign. At the end of the project, all the members learned to write their names and were familiar with reading primers. There were 1,005 illiterate adults in the 1,698 high-risk families identified; 467 (46%) of these illiterates were removed from this 'risk factor' within a period of two years.

Unemployment

The proportion of the population engaged in productive work, the quality of employment, and the remuneration received by the working population are important determinants of human development. Lack of adequate opportunity for gainful employment results in a lowering of income levels, which in turn pushes people into poverty. Thus, there is close relationship between employment, income and poverty. The informal sector plays a significant role in urban areas and holds great potential for poverty reduction.

Under the project, employment opportunities were created and upgraded through job oriented, short-term employment training programmes for 200 slum youth and less educated people, in computer, data entry, nurse-aids, laboratory technician, driving and so on. As a part of economic empowerment to women, an Entrepreneurial Development Programme was conducted. This has provided an opportunity for women to start some economic activity and equipped them with managerial skills. Through the training, women were able to get vocational training, loan assistance and market avenues for the products manufactured by them. Women have also taken up group activities by selling rice, pulses and textiles. SHGs were also able to mobilize financial resources for income

generation activities, through government, bank and NGO assistance, and group savings and subsidies from SJSRY and so on. As part of empowerment, various developmental activities have been routed through SHGs. Out of the 946 high risk families having one adult earning member, an additional 461 (49%) family members got an opportunity to earn a living through the above interventions.

Housing and shelter improvement

During the last half century, the right to housing has been increasingly accepted internationally. The first United Nations document that explicitly refers to the right to housing is the Universal Declaration on Human Rights, which states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services".

In the project, 889 high risk households were living in kutcha houses. Under a shelter upgrading programme, 504 (57%) families have been provided with free houses to protect them from fire accidents, under a government grant programme through the Tamil Nadu Slum Clearance Board. Local NGOs also provided financial assistance to change huts to tiled houses.

Lack of access to safe drinking water

The link between water, sanitation and health status is a complicated one. These non-nutritional factors have a significant impact on the ability of individuals and households to attain a good nutritional status. It is estimated that 80% of all diseases and sickness are water-borne and water-related. A growing population means there is mounting pressure to provide water and sanitation facilities on a sustained basis. Provision of these basic facilities is also crucial for achieving the goal of 'Health for all'.

Access to water is not the only problem. Women have the primary responsibility for fetching water. Thus, the development of basic services without doubt benefits women. The development of local water supplies, sanitation and roads can do much to reduce women's burden and improve the health conditions of women and children. Households that have no water source within their premises need to be covered on a priority basis.

Provision of safe drinking water is an activity designed to benefit all families, while ensuring that high risk families have priority access. This was the second in ‘risk factors’ identified in the project areas — 1,302 out of the 1,698 families had no access to safe drinking water. Under the project, 353 (27%) families acquired household water supply connections, through internal loans from group savings and a revolving fund available exclusively for improving water and sanitation (from a British Airways’ fund). New pipelines have been laid and drinking water supplies increased through through the efforts of the Area Development Societies, in coordination with Metro Water. Apart from the above, awareness creation on safe handling and consumption of drinking water using IEC materials, street theatre and songs were organized.

Household sanitation

Lack of sanitation facilities can be responsible for severe health problems, such as cholera, diarrhoea, typhoid, para-typhoid, infectious hepatitis and many diseases caused by worms. Lack of toilets also creates unique problems for women and adolescent girls.

The most serious problem is the practice of open defecation. There were no sewer lines in most of the areas, resulting in dependence on available public convenience units. Lack of maintenance of the existing public convenience units, absence of toilets in primary schools, pre-schools and so on, all create problems. The most affected are women, adolescent girls and children. Women and girls go to the toilet early in the morning. In the absence of adequate toilet facilities, they are forced to wait until dark for privacy. Due to lack of open space and development of neighbourhoods, women are forced to depend on public toilets in most cases. Due to long waits, women are increasingly prone to urinary diseases and other complications.

Out of 1,698 high risk households, 1,543 did not have toilets. With the laying of new sewer lines in three project areas, 1,274 (83%) of the households got their household connections and constructed individual toilets, using loans from group savings, the revolving fund through British Airways, and with NGO assistance.

Household food security

Improved nutrition increases capacity to earn and produce, and the income earned provides the means to buy food. Having access to adequate food affects people's ability to participate in all spheres of economic, political and social life, and to move out of chronic poverty. People's access to food is affected by a number of factors, including inequitable distribution of food, environmental degradation, natural disasters and conflict.

More than two-thirds of the workforce is still dependent on agriculture. The persistence of poverty and food insecurity in rural areas has resulted in distress-induced urbanization. The poor who migrate from villages to towns rarely get absorbed in the organized industrial sector of the towns. Consequently, this has led to a bloated tertiary sector in urban areas, euphemistically referred to as the ‘informal sector’.

A specific consequence of this pattern of urbanization is the development of slums and squatter settlements, characterized by low living standards and unsanitary conditions. T his has led to high levels of unemployment and underemployment in towns. The problem of food security in urban areas is closely linked to the overall development experience of the country. In the project, 746 high-risk families were suffering from household food insecurity (i.e., able to eat only two or less meals a day).

Several interventions have been designed to address this problem, including activities related to income generation for women to improve purchasing power, access to credit, and preparation of low cost nutritious food for children under three years, and for pregnant and nursing mothers. Under the project, 160 (21%) high risk families were able to improve their purchasing power using income generation activities.

Alcoholism and drug addiction

Alcoholism and drug addiction are major social problems in slum areas. About 75% of the slum families suffer from this social evil, which affects their quality of life.

Youth from slum community are the most vulnerable group regarding susceptibility to drinking and drugs. Male expenditure on alcohol has a major impact on women's control over family income.

Without hesitation, women shared the problems caused by the drinking habits of their husbands during the meetings. Most of the women were victims of wife beating, violence and extra-marital relationships. SHG members at one stage decided to tackle this issue through a group approach. SHG members joined together and warned male members about proposed action if the problem persisted. There were reports of a drastic change in behaviour and consumption of alcohol. Of the 1,002 alcoholic members in the 1,698 high risk households; 147 (15%) cases have stopped drinking due to counselling arranged through the project, doctor's advice and continuous persuasion of women members. It was also revealed that a sizeable number have reduced alcohol intake.

Child labour

While income poverty does not automatically lead to child labour, it certainly provides a fertile ground for the economic exploitation of children. When a child's primary caretakers cannot make both ends meet, the child will be pressured to work from an early age to supplement the family's income. Any child who has been deprived of his or her right to a childhood is a child in need of care and protection. Generally it is the family's responsibility to nurture and protect the child. However when the family itself is in crisis due to circumstances such as poverty or marginalization, it becomes difficult to fulfill this role. This leaves the child vulnerable to exploitation. The vicious circle of child illiteracy, cheap child labour and poverty cannot be used to deny a child his/her basic right to develop as a full human being.

Out of 1,698 high risk households, there were 443 child labourers. They were working in a nearby slaughter house, steel polishing units, bottle cleaning, mechanic, tea and meat shops, lorry cleaning and so on. As part of a rehabilitative measure, children working in these hazardous areas were removed and admitted to one-year transit schools run exclusively for child labourers. This programme was implemented by TNSCB, in coordination with local NGOs and CDS members. These schools served as preparatory centres for pursuing formal education, and also served as an innovative model for prevention and rehabilitation of child labourers and school dropouts. Out of the total number of 443 child labourers surveyed, 250 (56%) have been streamed into regular schools through transit schools.

Sustainability

The sustainability of the CDS is ensured in the following ways:

- The CDS, as a formally registered society, has the potential for institutionalizing the empowering process. This will occur through motivation and capacity building received from training and orientation on the process of development.

- The CDS bylaws empower the society to approach and receive funds and resources directly from any source.

- By being women-centred, the CDS has generated a remarkable level of enthusiasm, motivation and initiative that clearly indicates the potential for sustainability. It is fully managed by women themselves who are handling individual, family and community affairs.

- The CDS has an inbuilt strategy for beneficiary contribution to activities.

- CDS members are also serving as resource persons for NGOs implementing similar community development programmes.

- Great emphasis has been placed on training the CDS office bearers and members to develop financial, managerial, technical and leadership skills for sustainability of the programme.

Replicability

One of the important features that enhances the potential for replicability is that the programme is implemented as a women's programme for achieving the objective of control and management of diarrhoeal diseases through improved water supply and sanitation. This is combined with supportive activities to improve nutrition, literacy, health, education, housing, employment, food security, elimination of child labour, reduction of alcoholism and so on. In this project, the family is targeted as a unit, which helps incorporate all the basic concerns of the poor in their day-to-day lives. One of the positive impacts of the project is that NGOs working in slum areas have adopted similar approaches and strategies from the CDD WATSAN project for delivery of their activities.

Lessons Learnt

In spite of the positive aspects of the project, the following lessons have been learned to incorporate in future projects:

- Government departments implementing community development projects will have difficulty in sustaining resources due to dependency on external agencies. Hence there should be financial support from government and technical support from the training centres specially formed for CDS (e.g., Urban Management and Training Centre functioning exclusively for poverty alleviation programmes at Coimbatore).

- Government staff should be made accountable for smooth implementation.

- There should be a module on training of CDS members on the concept, role and responsibilities, so that within a specified period they can achieve certain results.

- Sustainability of the CDS can be monitored by the concerned government departments, with the appointment of a Community Organizer (e.g., patterned after UBSP), who is more accountable as a public servant.

- The Community Organiser appointed should have interest and motivation in community development programmes.

- CDS should be the fulcrum for all government inputs.

Conclusion

Perceiving urban poverty reduction in a wider context and with reference to the various dimensions of poverty and its cumulative impacts would help city planners design their policies and strategies in a more effective way. For any poverty reduction programme, formulated objectives should be specific, measurable, realistic and time bound. One of the main tasks is to monitor progress. Feedback to the stakeholders on progress of action plans should be ensured. The community should be involved in the project preparation and implementation so that sustainability can be ensured. Community-driven development and participatory planning has the potential to increase the power of poor communities to negotiate with public authorities, the private sector and civil society for their share of services.

Although there are various models of urban poverty alleviation and reduction implemented throughout the nation, there is no comprehensive community-based approach to reduce or alleviate poverty in the real sense. Each department should conceive separate action plans for implementation of their activities. In the case of a financial crunch, government cannot afford to implement programmes for the same category repeatedly.

Hence, schemes to improve human resources and inculcate their responsibilities should be implemented through formation of community-based structures, with women self-help groups as the focal points. The available urban initiatives for reducing poverty should be analytically studied from the field level, and suitable models adopted for replication (rather than just duplicating the services). Any poverty reduction scheme should be closely monitored from various dimensions to bring out the shortcomings and improvements needed to achieve the set goals.

TABLE II
High Risk Factors by Household before and after Project Interventions

S. No	Risk factors	Thiruvika Nagar		VOC Nagar		Dr.Ambedkar Nagar		Sastri Nagar		Narasimha Nagar		Total	
		Original High Risk Factors	Reduced High Risk Factors	Original High Risk Factors	Reduced High Risk Factors	Original High Risk Factors	Reduced High Risk Factors	Original High Risk Factors	Reduced High Risk Factors	Original High Risk Factors	Reduced High Risk Factors	Original High Risk Factors	Reduced High Risk Factors
1	Family belonging to SC/ST	270	270	417	417	188	188	271	271	130	130	1,276	1,276 (100%)
2	Family with children under 5 years old	256	206	254	201	108	94	163	129	64	49	845	679 (80%)
3	Family having one illiterate adult member	436	153	280	152	162	131	43	17	84	14	1005	467 (46%)
4	Family with only one adult earning member	432	223	295	179	86	17	43	16	90	26	946	461 (49%)
5	Family living in a kutcha house	225	127	364	201	127	42	99	80	74	54	889	504 (57%)
6	Family without a household toilet	387	40	395	96	138	56	316	112	66	49	1302	353 (27%)
7	Family with no access to drinking water	598	366	381	377	139	130	304	291	121	110	1543	1,274 (83%)
8	Family consuming only two or less meals a day	160	39	307	53	91	12	96	13	92	43	746	160 (21%)
9	Family with an alcoholic or drug addict member	340	21	273	48	135	24	171	33	83	21	1002	147 (15%)
10	Family with a child labourer	49	23	195	107	125	93	17	4	57	23	443	250 56%)
Total		3,153	932	3,161	1,199	1,299	517	1,523	812	861	479	9997	5,571