VOLUNTARISM AND DEVELOPMENT: A Social Science Focus On Health

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to
my friend
parthasarathi
who has learnt to speak
the voice of reason even in the
face of insanity;

and
to my friends
dharani, manoranjan
mruthyunjoya and saroj
for their enlightening friendship

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DECLARATION

This is to certify that the dissertation entitled 'VOLUNTARISM AND DEVELOPMENT : A SOCIAL SCIENCE FOCUS ON HEALTH' submitted by Sudhir Kumar Pattnaik for the award of the DEGREE OF MASTER OF PHILOSOPHY (M.PHIL.) is his own work to the best of our knowledge and has not been previously submitted for any other Degree of this or any other University.

We recommend that this dissertation may be placed before the examiners for evaluation.

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C O N T E N T S

A B B R E V I A T I O N S

CRHP	:	Comprehensive Rural Health Project
FRCH	:	Foundation for Research in Community Health
ICMR	:	Indian Council of Medical Research
ICSSR	:	Indian Council of Social Sciences Research
GOI	:	Government of India
SWRC	:	Social Work and Research Centre
UNICEF	:	United Nations International Children's Emergency Fund
VHAI	:	Voluntary Health Association of India
VOLAG	:	Voluntary Agencies
WHO	:	World Health Organisation

AN INTRODUCTION

A look at the recent literature on development both at the national as well as international levels reveals two important trends : (i) a search for alternative developmental approaches to meet the 'basic needs' of the Third World population, specifically, of the poorer sections of the Third World societies, and (ii) a search for alternative institutions operating outside the State development machinery, which by providing 'innovative approaches' can meet the 'basic needs' of the poor. The main assumption is that, these institutions(often identified as non-governmental or voluntary organizations) do not have any 'institutional limitations' in reaching the poverty groups.

Out of a vast and complex group of functionally as well as ideologically diversified voluntary organizations, one or two, mostly of recent origin, are being taken as samples representing the rest and their 'innovativeness' and 'potentiality' to provide alternatives are being highly appreciated. At the same time a look at Indian society would reveal the growth of pluralistic tendencies in its political process. While in Western societies, we see pluralism mainly as a manifestation of extreme liberalism, in India today we see both a 'pluralism of the Left' (which includes

different Leftist political parties, Naxalite groups and radical voluntary action groups who derive their inspiration mainly from Marxism) and a 'pluralism of the Right' (which includes bourgeoise political parties, voluntary and non-radical action groups). These developments together have added a new dimension to the nature of voluntarism which has a long history in India. The voluntary sector seems to have been turned into a battle-ground where conflicting ideologies and counter-ideologies are involved in a proxy war making the 'poor' their common object. Thus voluntarism looks more complex and more ambiguous today, than it was ever before. This development necessiates the examination of the sociology of voluntarism in a historical perspective.

Stepping into history, the present study seeks to reveal in the first chapter the changing nature of voluntarism in India till date and the possible influences it had received from different socio-economic forces operating at the national and international levels, at different stages of its growth. In the second chapter, we shall come to know how the 'lacunae' and 'limitations' existing in the State 'development' machinery (in our case

the health services system) owing mainly to extra-institutional factors, are being treated as normal 'institutional limitations' by the protagonists of the new role adopted by the voluntary organizations today. These 'institutional limitations' mainly provide them an entry-point to establish their positions vis-a-vis the institutions of the State. The third chapter will present a general critique of the 'innovativeness' which voluntary organisations claim to have and the new approaches they claim to have successfully experimented. This would enable us to know where voluntary institutions stand as compared to the institutions of the State. The final chapter, by going through the debate which is going on in and around the voluntary sector, would present the basis of the 'claims' and 'assertions' voluntary organizations are making today. The correlations between various developments taking place at the national and international political levels, so far as their implications for the voluntary sector, could be traced here. Among other things, it would tell us that any study on voluntary organizations should not look at them, as they are, but as they were and as they are becoming.

Secondly, both the institutions of the State, and the voluntary and action groups have their roots in the larger socio-economic structure. They represent and reflect the conflicting socio-economic and political forces operating in a society which is becoming increasingly 'pluralistic'. As 'pluarlism' is the enemy of poverty, the problem of poverty remaining the same, a struggle is going on between approaches to poverty and its ingredients like ill-health. The poor have been virtually put into a dilemma as to which approach they would provide legitimacy.

The study does not have any intention to undermine the importance of voluntary organizations in a society featured by object poverty and gross economic inequalities. Rather it should be treated as a modest attempt at understanding the sociology of voluntarism and its possible implications for the poor. Health has been taken as the main area of focus owing to the reason that ill-health and poverty are the most interdependent phenomena. The approaches to health have so far ignored this fact and these approaches are dominating voluntary action in the field of health. 'Innovative' concepts and approaches

have been developed to deal with symptoms of ill-health, without any effort to reach the roots. As the number of voluntary groups in the field of health is quite significant, and as health is being treated as a lever of development, an understanding of voluntarism will be more fruitful if we confine ourselves to the field of health. The conclusions drawn on the basis of this study should be treated as assumptions mainly, as the present study is just a background work for advanced research.

CHAPTER - 1

VOLUNTARISM : THE HISTORICAL MAZE

A historical analysis of the growth and evolution of voluntarism is necessary for more than one reason. Firstly, it tells us that 'voluntarism' as a concept cannot be defined universally. Secondly, voluntarism is not an individual instinct or an extension of the individual's concern to serve the distressed but that it is the product of an inter-play of social forces. Thirdly, voluntarism being a product itself of the social forces also effect changes in those social forces. A successive chronology in the historical analysis has not been maintained because of the fear that the totality of the analysis might not be fully evident. Thus the study has been divided into phases overlapping in time because it emphasizes more on identifying certain significant trends over time rather than seek the comfort of water-tight time-periods.

VOLUNTARISM : THE GENESIS

Voluntarism in its organizational or institutional form has been a characteristic feature of modern society, mostly of the non-egalitarian type. However, conditions leading to the emergence of voluntary organizations have never been the same, nor do the existing voluntary organizations have similar structures and functions. A

theory based on two assumptions explainstheir origin (Oommen, 1984). (The first assumption traces their origin to the post-Industrial Revoluntary-European society. The dehumanization process of the Industrial Revolution and consequent urbanizations dislocated the traditional social structures such as the extended family, church and community, leading to the disruption of personal and familialties in the society. Voluntary associations emerged as response to the challenge of this dehumanization process and took over the functions of the traditional social institutions. However, in countries like France and Great Britain, where the Industrial Revolution first took place, the number of voluntary organizations is quite less compared to that in the United States. Such a difference is attributed to the varied 'national characters' and 'personality structures' of the peoples of the respective countries. The American propensity to form voluntary associations is attributed to the individual-centred American culture.

According to the second assumption, voluntary organizations have emerged and continue to function as a 'check' on 'authoritarianism' of the State in the West. They are treated as essential instruments of

'political pluralism' as they play a critical role in the democratic system by making possible the citizens' influence on government. Such an assumption treats voluntary organizations as synonymous with 'pressure groups' and 'interest groups' who participate indirectly in the power process of a capitalist state. The major limitation of this theory is that it does not explain the growth of voluntary organizations in the West, who, although are funded by the society of their origin, do not have any functional relevance to their own societies. Their activities are rather scattered over the Third World countries (e.g. CARE, Save the Children Fund, Work On Hunger).

The growth of voluntarism in the form of organizations and associations in the non-Western Third World societies like India is also explained by scholars (Oommen, 1984). The theory propounded by them treat the society under discussion as 'traditional societies' (marching from the pre-capital to capitalistic or pre-modern to modern stages) and explain that voluntary organizations in the society have emerged to perform some 'bridge' or 'link' functions. The main purpose of voluntary organizations to smoothen the course of transition by modernizing the traditional social structure

and in certain cases by getting traditionalized, while performing modern functions. According to the theory, voluntary associations such as caste associations would tend to modernize or secularize the traditional structures, while the youth clubs, women's clubs and cooperative societies which have been created by government enactments will get traditionalized while doing modern functions. Such a 'bridge' or 'link' role of voluntary organizations would lead to the 'structural integration' in a transitional society.

The limitations of such a theory are obvious. Firstly, by treating voluntary organizations as agents of transition, the theory provides legitimacy to the capitalist value system. Secondly, it does not include a large number of voluntary organizations within its scope, although 'pressure groups' having ambiguous functions like caste associations and the government-created social institutions have found a place in it. Thirdly, the social and historical reasons for the emergence and expansion of voluntary organizations in India have not been taken into account.

Voluntarism and voluntary organizations in India have a long and chequered history. Voluntarism did not

originate with the formation of modern institutions. The basic law which governs the registered voluntary organizations today was enacted in 1860.[1]

VOLUNTARISM IN INDIA : THE FIRST PHASE

We shall discuss the growth of voluntarism in India by dividing it mainly into three phases. In the first phase, which begins some years before 1860 and continues till 1920, we see a large number of voluntary organizations in the form of reformist societies coming into existence with the aim of bringing social and cultural reforms in society. The notables among these voluntary societies included the Arya Samaj, the Brahma Samaj, the Prathana Samaj, Ramakirishna Mission and the Decan Educational Society. While most of them were devoted to specific social and cultural reforms such as abolition of child-marriage and promotion of widow/ remarriage, others worked for the educational and cultural development of the natives. The growth of voluntarism in this period is characterized by certain distinct features :

Firstly, voluntarism was promoted and patronized by the British for they catered to the material and social needs of the newly-educated class of Indians, which

the British thought was the best instruments of their rule in India (Seth, 1983). Secondly, these voluntary societies were led by Indian intellectuals trained in the Western tradition of 'liberalism', 'rationalism' and 'humanism'. They wanted to indoctrinate the masses with their ideas. Thirdly, these organizations were centred mostly in cities and towns. The vast majority of the rural masses were literally beyond their influence. This might have prevented the leaders of these organizations from an understanding of the problems of the masses, a phenomenon which continues till date.) The most important feature of the voluntary organizations of this period was that they did not dwell on the 'economic question' or the 'poverty phenomenon'. At a time when they were at the peak of their activities, millions and millions of peasants and artisans were thrown out of employment owing to the oppressive land-lord centred agrarian economy and owing to the collapse of the rural handicrafts industry under the adverse influence of British trade policy.[2] The voluntary organizations led by the Western-educated intellectuals were so obsessed with removing its elements of 'irrationality' in Indian social and cultural systems that they ignored to question the 'rationality' of the colonial system which had

contributed to the misery of the millions of Indians. Thus, in the first phase, voluntarism was based on the ideas of Western 'liberalism', 'rationalism' and 'humanism'. The voluntary organizations were absolutely 'reformist' and 'conformist'. Even the 'charity-orientations' or 'relief appreach' of them could not be found in this phase.[3]

THE SECOND PHASE :

It was after the appearance, it is said, of Dadabhai Naroji's Drain Theory that the conscience of the Indian intellectuals got a shock and they could realize that it was, in fact, the British exploitation of the Indian economy, which had resulted in large-scale poverty (Seth, 1983). However, no such change was visible in the approach and nature of these voluntary organizations, led by the 'intellectuals'. Even, the Indian National Congress which was formed after the publication of 'Poverty and Un-British Rule in India', continued to function as a debating society having no relevance to India's economic situation. The appearance of militant nationalistic elements later made little difference, so far as the understanding of the plight of the masses was concerned.

The second phase of growth of voluntarism and its

organizational fronts took place in the 1920s, with political developments in and around the country influencing its nature and course. By this time the message of the Russian Revolution had already reached the oppressed peasants. A number of peasant struggles erupted in fragmented forms in different parts of the country (Desai, 1979). A number of associations of the oppressed peasants and the oppressive ryots were coming up with a conformist attitude towards each other. At the same time, history shows the emergence of Gandhi in the Indian political scene with the leadership of the Congress passing into him, and the Congress trying to become a man-based party under his leadership.)

Thus in this period, the history shows Gandhi as a "concious strategist, utilizing the peasants for reformist pressure and as a consistent opponent of any class struggle against local exploiters having the support of British arms, laws and the police" (Ranga and Saraswati, 1979). History also shows how the Congress, a party of the Indian bourgeoisie, atte pted to bring the peasantry into the vortex of a large national movement, and took up certain issues and stimulated specific types of

movements, associations and institutions to channelize peasant struggles into specific, limited reformist movements to strengthen the bargaining position of the Indian bourgeoisie. Gardhi, during this period, endeavoured to provide specific direction to the peasant struggles within a conciously-evolved political matrix and did not let them go beyond reformist pressure for economic relief.[4] Thus the Congress evolved a new broader strategy of involving the peasantry in the nationalist movement. Voluntary organizations (both existing and emerging) provided the meeting ground for the conflicting interests of the peasants and their oppressors to fight against the 'common oppressor'. The Non-Cooperation Movement launched by the Congress provided the occassion. Thus, on the eve of the launching of the Non-Cooperation Movement, the Ahmedabad session of the Congress held in 1920 expressed in one of its resolutions that "this Congress trusts that every person of the age of eighteen and over will immediately join the volunteer organizations". The so-called radical elements in the Congress like Nehru also appealed to radical peasants' associations, and most of them joined the Congress and freedom movement (Desai, 1969). After joining the Congress, their radicalization got neutralized at least for some years.

At the withdrawal of the Non-Cooperation Movement, the Congress evolved a strategy of elaborating the institutional devices to help Congress to systematically reach out to the rural masses, give immediate relief to certain sections of the society and train a cadre of constructive workers who could take leadership in rural areas for launching some political movements in non-class lines.[5] Different 'Kisan Sabhas' and 'Seva Dals' such as the Hindustani Seva Dal came into existence in this period. The charity orientation of the voluntary organizations seems to have begun in this period.

The growth of voluntary organizations in this phase is marked by some distinct features. Firstly, the reform orientations of the voluntary organizations declined with a conciously devised political strategy of the Congress gradually prevailing upon them. From a position of political neutrality they transformed themselves into the role of neutralizing the conflicting political and economic interests by conciously bringing them into their fold. These conflicting interests, of course, started unfolding themselves in the later years. So, those who say that the voluntary sector was homogenous and heterogenity is a phenomenon of the 1960s, should take into account these historical factors. Again, the Charity

Approach which inspired the course of voluntarism for more than half a century, was not born out of a concern for the distressed and the poor.) Mostly, the Charity Approach emerged as a consequerce of a political strategy to contain the growing discontentment of the suffering masses by providirg them immediate relief and thus preventirg them from takirg to any revolutiorary pa.th.

One more thing to be seen in this period is the role of ideology or ideological conciousness influencing the course of voluntary action. The Gandhian ideology of Sarvodays as opposed to the ideology of communism could be seen here. Gandhi warned the rich that "violent and bloody revolution is a certainty one day unless there is a voluntary abdication of riches ard the power that riches give, and sharing them for a common good is made - the present owners have to make the choice between class war and voluntarily converting themselves into trustees of their wealth."[6] Here comes the principle of trusteeship as an ingredient of the ideology of Sarvodaya. The study briefly touches Sarvodaya, Bhoodan and Gramdan movements which had influenced the course of voluntary action for a long time.

The philosophy of Sarvodaya which was based on a compromise between poverty and its causes, was accepted by people like J.P. Narayan as the "Socialist Programme in the Indian context". A conference of constructive workers was held in 1948 and out of this Sarva Seva Sangha emerged as the coordinating body of the 'Sarvodaya Movement'. The movement was reportedly at its peak in 1964, with 8620 Lok Sevaks, 8114 Shanti Sainiks, 2000 organizational workers and about 200,000 workers in khadi institutions. The movement by and large had kept pace with the government programmes.' When Panchayati Raj gave way to Block Development, the Sarvodaya agencies matched it with 'Gram Vikas' and other programmes of their own. The movement steadily declined after 1964.

Some of the important revealings about the Sarvodaya movement are worth mentioning. According to a study the leadership of the movement was deominated by the upper caste (10 per cent) and middle class (90 per cent). Again, among the leadership of this movement there was a lack of clarity about the Sarvodaya ideology. The type of voluntary action Sarvodaya preached was external to their mental make-up and contrary to their social position. This is why, with the decline of Sarvodaya in 1964, we see many Sarvodayites joining the 'communists', 'socialists'

and the Rastriya Swayam Sevak Sangh. The rest preferred social work (Roy, 1983).

The Sarvodaya - like tradition of voluntary action continued with the launching of the Bhoodan and then Gramadan movements by Binoba Bhave. Bhoodan began in the year 1952 as a 'Gandhian response' to the Telengana uprising by the communists. Again the same old slogan was repated : 'to choose between class war and voluntary sharing of wealth with others'. With active governmental support and assistance Bhoodan continued till 1957, when it lost its significance and developed into Gramadan, Gramdan also ran into rough weather after some years (Oommen 1972).

Land was donated mainly in Bihar, Rajasthan, Madhya Pradesh and Uttar Pradesh (although it began in Telengana and marched from the South) where feudalism had greater sway than elsewhere in the country. The major response was said to be from the labourers and poor peasants. 99 per cent of the land donated was of poor quality. By 1963, Sampoorna (total Gramdan gave way to Sulabha (easy) Gramdan and by 1975 Gramdan itself tapered off (Roy, 1983).

The continuance of the Bhoodan - Gramdan type of voluntary action for a considerable period of time was said to be possible partly due to the active connivance and acquiescence of the vested interests and forces in the society (Oommen 1972). Most of the land, voluntarily contributed, was unproductive and in most cases it was done to avoid the legal measures against high land-holding. Secondly, government patronage was extended with the aim of fulfilling its commitment to a socialistic pattern of society. In any case, it was prosecuted and presented as an alternative to the radical Left movement. It left an important lesson : that, so far as the distribution or sharing of the means of production is concerned voluntary action cannot be successful. Though the poor were prepared to contribute their labour, the rich were unwilling to part with their wealth, with their productive land.

A new source of influence has already been opened up for the voluntary sector. This was independent India 's 'welfare constitution'. Basically, being a product of the assembly of the upper class intellectuals, the constitution incorporated within it, Gandhian and Socialistic principles (representing two opposite ideologies) to be implemented by the capitalist State at

its will.[7] One kind of guided'voluntary action' was launched by the State with the formation of coordinating voluntary bodies with heavy bureaucratic structures at the national and State levels. The Central Social Welfare Board and the Social Welfare Boards in the States represent such a bureaucratization of voluntary action. Several other bureaucratic organizations also came into existence. Voluntary organizations were entrusted with the responsibility of implementing governmental programmes alongwith the State bureaucracy after the First Five-Year Plan was launched in 1952. Many of the voluntary organizations got involved in the implementation of Five-Year Plan Projects.

Till the late sixties, 80 per cent of the voluntary organizations were charity-oriented and carried out institutional programmes, with official bureaucratic organizations coordinating their activities (Fernandes, 1986). Voluntarism was based mainly on 'humanism' and 'ideology' based on the compromises between the causes and consequences of poverty. It had firm faith in the status quo. In no case did the voluntary organizations question the rationality of a system where

gross inequality and object poverty were the two distinct phenomena. The few voluntary organizations which grew with a difference also believed in the 'myth of socialism' that the Congress and the constitution created.

THE THIRD PHASE :

In the late sixties the voluntary sector began witnessing 'qualitative and quantitative' changes in it. Such a change is being interpreted and explained by scholars, 'activists' and 'ideologues' in their respective languages.[8] This has, in fact, initiated a long debate within the voluntary sector as well as between the voluntary sector and those who are concerned about it.

In the third phase, we see voluntary organizations, working at the macro-level with a long history (e.g. Tuberculo Association of India), continue their relief-and-rehabilitation oriented approach. They also stand outside the 'debate'.[9] Voluntary organizations, who were implementing developmental programmes till recently, reportedly got 'disillusioned' with the 'official development strategy (Fernandes, 1986). While some organizations resorted to 'innovative' or 'alternative' strategies, some other voluntary organizations assumed completely a new role - a role of activizing the people by creating political awareness among the depressed to bargain with the political authority for a better living.

Whether these organizations in particular and voluntary sector in general got 'disillusioned' with the 'official development strategy' or not will be revealed as we go on. The voluntary sector in this place, as we see, has opened up greater avenues for the employment of larger number of qualified and unemployed youth. A 'professional spirit' started dominating this phase. The voluntary sector also sees a high influence of funds into it from various international development agencies and aid-giving agencies.[10]

While the voluntary sector is witnessing changes within it, major changes are taking place around it. A positive correlation between them could not be ruled out. Firstly, one sees a dialogue on development going on at the international level with reference to Third World countries. International development and aid-giving agencies have expressed their dissatisfaction with the 'elitist', 'corrupt' and 'inefficient' bureaucracy of the Third World.[11] The present development plans and programmes also have been criticized, as the phenomenon of poverty is worsening in these countries. The needs of the Third World societies have been devided and a search is going on for evolving alternative strategies to meet the basic needs of the concerned people. A search

is also going on for locating 'alternative institutions' who can implement the strategy without questioning the rationality of it. They are said to have no 'structural constraints' in reaching out to the people.[12] At the same time, we notice a campaigning going on for 'privatization', with international aid-giving agencies and foreign government actively joining it. This period also witnesses a campaign going on for popularizing sophisticated medical and development technology. Voluntary agencies are providing a fertile ground for their testing and transfer.

This is the period in which one also sees the Indian political system unfolding its limitations and revealing the contradictions existing in it. The national 'growth rate' is certainly shooting up but at the cost of distributive justice. Thus the gap between poverty and affluence is widening. The developmental strategy seems to be aiming at managing poverty but not resolving it. Government policies and programmes including the ones relating to the field of health seem to be based on populist rhetorics such as 'garibi-hatao' 'food-for-work', 'people's health in people's hands'.[13] These policies characterized by 'adhocism', 'inconsistency' and 'superficial

commitments' are admittedly ending in failure. Every time, the government is proving its inability to solve the problem of poverty.

On the other hand we see different types of responses to such a situation of crisis. Firstly, we see a culture of violence and bloodshed is gradually replacing the culture of passivity and indifference, so far as the people's response to the failures of the system is concerned. Whether such a change speaks of the influence of radical ideology over the masses or whether it is a spontaneous outcome owing to a prolonged period of suffering and misery, is debatable. In either case it reveals the fact that the system has not come upto the people's expectations.

The second type of response is coming from international development and aid-giving agencies with the idea of privatization (Kothari 1986). The underlying assumption is that the Third World government, elected 'by the people and for the people' have not been able to meet people's expectations, mainly owing to an ailing bureaucracy - a bureaucracy which is 'corrupt', 'inefficient' and 'elitist'. The immediate suggestion, therefore, is the denationalization of services and assigning them to

the private and voluntary sectors which are efficient and committed to 'goal attainment'. This suggestion is primarily based on the Western experience. Here the question arises whether the concept of privatization can be an answer to the present 'crisis' ? In developed societies privatization does not affect any group of the population adversely because though there is inequality, it is of affluence only. To the contrary, in developing countries like India, we have inequality of poverty, where it should be the absolute responsibility of the State to equalize the lesser equals (Pattnaik, 1987).

The third type of response is coming from the voluntary sector itself, who claim to have developed an answer. These organizations - many of whom are working at micro-level developmental projects - claim to have successfully experimented with the concepts of 'people's participation', 'self-reliance', etc. Without relying on the government, the community (the population with whom they are working in different areas) can mobilize its own resources and depend on it.[14] Voluntary agencies and their leaders have successfully put forth their point on the media and intellectual platforms.

The purpose of writing all this is that, the

present strategy of involving the voluntary sector in the path of development and government collaboration with them, should be seen in the light of these developments. The Seventh Plan Papers have a separate chapter dealing with voluntary agencies (GOI, 1986). A code of conduct and a national council of voluntary organizations are to be established.[15] This has made the approach of the government to the voluntary organizations more ambiguous.

Thus, in the later phase of voluntarism we see its nature becoming more and more complex. Several national andinternational forces are acting on the voluntary sector. The diversities in the voluntary sector are getting increasingly manifest with a section of it dominating the show. The voluntary sector in this stage seems to have turned itself into a battle-ground where different 'ideologies' are engaged in a war of supremacy - the common man being the victim in each case.

VOLUNTARISM AND HEALTH :

All these developments had repurcussions on health. It resulted in a similar kind of voluntary action in health. It is said that in modern times, Christain missionaries pioneered the tradition of running charitable

dispensaries and hospitals (Mukhopadhya, 1987). Much later Hindu charitable organizations like the Ramakrishna Mission also opened charitable dispensaries. But the nature of voluntary activities was ambiguous as it was often alleged that the missionary organizations had a vested interest in it. Voluntary action was identified with these activities. For a long time the problems of ill-health and diseases did not catch the attention of the Indian intellectuals involved in socio-cultural reforms. It was only in the first two decades of the present century that isolated cases of voluntary action in the field of health by enlightened individuals was witnessed. Gurudev Tagore evolved a health care service for the Santhal villages around Shantiniketan which included the refreshing concepts of cooperation, low-cost curative services, etc. (Mukhopadhya, 1987).

In the twenties and the thirties voluntary action in the health field was influenced by Gandhian ideology. The first of voluntarism was guided by a humanist concern and an 'anti-colonial and nationalistic spirit. A 'concern' for the victims of ill-health and communicable diseases was created among the intellectuals and medical professionals. Such a concern and conciousness resulted in the formation of voluntary bodies like the Hind Kustha Nivran Sangh and

the Tuberculosis Association of India. The Indian Medical Association was also born out of voluntary efforts by nationalistic-minded doctors like B.C. Roy, A.K. Ansari, Khan Saheb and N.M. Jaisurya. These medical professionals also received influence from abroad. They were inspired by the Welfare State movement going on in the United Kingdom and the Socialized Health Services in the Soviet Union (Banerji, 1986).

Highlighting the deplorable state of health in India in his Presidential Address at the All India Medical Conference at Lahore in 1929, Dr. B.C. Roy had called for an organized voluntary effort by the Indian Medical Association, "it is not necessary for me to mention that the history of government during the past 100 years has been such that we need not look for inspiration or help from the authorities. If we mean to do anything we shall have to do it inspite of the government. We must organize ourselves, voluntary organizations have to be formed for social services, for giving aid during epidemics, for the medical inspection of school children, for raising sanitary conciousness among the masses".[16]

Voluntary efforts in health emerged in this period due to a humanistic concern for the problems of ill-health

and diseases which had engulfed millions and millions of people in rural India. However, the causes of ill-health and the socio-economic factors which influenced its nature and dimensions could not be understood.

In the years following Independence the voluntary health sector has witnessed a rapid growth in its number and activities. In 1974, 1,149 hospitals having 73,686 beds came within the voluntary sector. They accounted for 23 per cent of all hospital beds in the country. There were also 934 dispensaries in this sector catering to 39,06,351 out-patients annually. Out of the 1,149 hospitals in the voluntary sector, 811 were located in the church sector, with a capacity of beds constituting 94 per cent (69,799) of the total (Tong, 1975). According to the government health statistics (as on 1-1-1983) the number of hospitals located in the private and voluntary sector had gone upto 3022. The total number of hospitals and beds available in the country was 6901. Thus, while the private and voluntary sectors together owned 43.8 per cent of the total percentage, 50.7 per cent was government owned and 5.5 per cent were owned by local bodies. The proportion of hospital beds owned by the private sector was even

lower at 27.6 per cent of the total, while the government owned 67.7 per cent. The rural-urban distribution of these facilities is mostly skewed with only 26.9 per cent hospitals and 13.5 per cent of beds being in rural areas (GOI, 1983). The breakdowns by private and public ownership are not available separately for rural-urban facilities. Co ing to the ownership of dispensaries, only 14.4 per cent of them are run by the private and voluntary sectors. Again, while government facilities are distributed all over the country, hospitals run by non-governmental organizations are mainly located in urban areas (Chatterji, 1988).

While the number of voluntary organizations is increasing, we notice a larger inflow of foreign funds into the voluntary sector in the form of different aids and contributions. The number of voluntary organizations is increasing so rapidly that, international aid-giving agencies and foreign governments have found it difficult to finance them directly. A number of 'nodal' agencies have come up in this period, through whom funds are being transferred to the micro-level voluntary organizations. The appearance of 'nodal' agencies at macro-levels might have effected the nature of voluntary activities in

more than one way. Firstly, it might have introduced the element of 'competition' in the voluntary sector at the micro-level. Voluntary organizations have to compete with each other in developing 'innovative' approaches in order to proof before the nodal agencies that they are different from the rest. This will help them to get more and more funds. Secondly, voluntary activities can be better regulated through these 'nodal' agencies. Thus the element of control or supervision is being shifted to the hands of the international agencies.

Apart from this we see changes taking place in the international thinking on health and development in the Third World. Different approaches have been devised by international health agencies such as the WHO and UNICEF to meet the challenges thrown by the Third World societies so far as the high incidence of 'communicable diseases', 'population growth' and 'health status' in general are concerned. The 'major concern' for international health agencies, after the launching of the Communicable Diseases Programme, has been the 'population explosion'. This has led to the emergence of family planning. It is needless to say that almost

all the approaches have been technology-oriented. This has affected the smooth passage of sophisticated medical technology to India. A technology-oriented family planning approach was launched in India in the sixties. The role of voluntary organizations here was to "convert the Family Planning Programme from a routine government programme to a people's movement."[18] Voluntary organizations carrying out family planning activities got 100 per cent financial assistance. However, as history says, even in the case of the Family Planning Association of India (one of the oldest voluntary organizations), the involvement of citizens was not impressive, turning the slogan of people's movement into a myth (Banerji, 1985).

Later, more and more goal-oriented programmes have come to dominate the field of health activities. In 1978, the Alma-Ata Conference held under the joint auspices of the WHO and the UNICEF gave birth to a new approach in health care know as the 'Primary Health Care Approach', which fixed a goal of 'Health For All By 2000 A.D.' (WHO/UNICEF, 1978). This conference was preceded by a joint study by the WHO and the UNICEF for finding out alternative approaches to meet the basic health needs of the Third World people (WHO/UNICEF, 1977). This

study examines some of the isolated voluntary health projects in the Third World like the CRHP, Jamked, in India. The conclusion drawn goes strongly in favour of voluntary organizations. At the same time, some assumptions go against the government health services. The government health sector lacks infrstructural facilities, trained manpower and committed medical and paramedical personnel, and thus cannot be trusted to execute any goal-oriented programme.

The national govern ent has expressed its commitment to the goal of attaining health for all by 2000 A.D.[19] The primary health care approach also got necessary patronage. Such a 'commitment' seems to have made the government look for help from voluntary and private health bodies because the public health sector alone cannot achieve it. At the same time, voluntary organizations have something to do to 'please' the government in the form of implementing the community health worker scheme successfully. Although recommendations for a cadre of village level health workers go back to the Bhore Committee of 1949, and although they were reiterated by the Srivastava Committee, the implementation of the proposal owes much to the experiences of the voluntary health projects at Kasa, Miraj and Jamkhed in

Maharashtra (Chatterji, 1988). The community health workers scheme was introduced at the national level in 1977.

The 'action-demonstrations' of some of the voluntary health projects seem to have affected the government's health policy, though collectively voluntary health programmes have had little impact on aggregate health statistics. Voluntary organizations in the field of health have acquired a considerable importance since the emergence of the 'community health approach'. Voluntary health projects adopting the community health model had got wide support from the government and the WHO by the late seventies. In 1976, in a symposium held under the joint auspices of the Indian Council of Social Science Research and Indian Council of Medical Research, some 'significant' on-going projects in health were reviewed (ICMR-ICSSR, 1976). The number of such projects was doubled by 1980, when the ICMR hosted a conference, this time to evaluate strategies for primary health care. These events signalled a change in the governments perception of the voluntary sector. In recent years, mainly since the Sixth Five-Year Plan, the role of the voluntary

sector in developmental programmes has become a kind of 'official work' (Chatterji, 1988). A recent government document substantiates this role with the words that "achieving active community participation in health and health related programmes should also be a part of the strategy. In particular, active community participation and involvement of NGOs in a massive health education effort is urgently needed... with a view to reducing government expenditure and freely utilizing untapped resources, planned programmes may be devised, related to the local requirements and patients, to encourage the establishment of practices by private medical professionals, increase investment by non-governmental agencies in establishing curative centres and by offering organized logistical, financial and technical support to voluntary agencies active in the health field".[20]

If some of the government documents are read together the picture will appear somewhat confusing. It is difficult to know clearly whether the government wants voluntary organizations to 'supplement' its efforts or 'collaborate' with them. A recent publication of the

Ministry of Health and Family Welfare, stresses the steps that the government has taken, to date, to support the voluntary sector and refer repeatedly to the fact that NGOs 'supplement' governmental efforts.[21] The National Health Policy, on the other hand, suggests that the government is interested in 'collaborating' with the voluntary sector in the health field, the immediate cause being the inability of the public health system to deal effectively with national health problems. A partnership between the government and the voluntary sector is expected to overcome some of the structural weaknesses of the macrolevel system and result in a better utilization of the government's resources. The Approach Paper to the Seventh Plan translated the recommendations of the National Health Policy to involve voluntary organizations into a broad action strategy. It identified the areas of family planning, health education and curative medicine as important, and suggested five ways in which voluntary agencies can participate - in planning, education, service provisions, resources, supplementations and innovations.[22]

Thus a few significant developments could be traced in and around the voluntary sector active in the

field of health. Firstly, on the lines of international development agencies, international health agencies are also advocating a new role for the voluntary and private sector, which would divide the responsibility of the State in looking after the health of the people. Secondly, a positive response is coming from the government to this call. The government is also treating both private and voluntary sectors as synonymous.[23] The approach towards the voluntary organization looks unclear, though the emphasis on their potentiality is increasing. Thirdly, we see a group of micro-level vountary health agencies increasingly claiming their success in reaching out to the community, through successful experimentations of 'innovative concepts'.

The study shall undertake a theoretical critique of these concepts but not before an examination, in the next chapter, of the State health services, whose 'limitations' provide an excellent opportunity to the voluntary organizations to make their mark.

CHAPTER - 2

LIMITATIONS OF THE STATE HEALTH SERVICES: SCOPE FOR VOLUNTARISM

Before trying to locate the voluntary organizations in the health field vis-a-vis the State health services system, a brief analysis of the State health services system itself is needed, mainly because, it is the 'anomalies' or 'limitations' in the health services system which are providing voluntary organizations an entry-point to establish themselves. This is the consequence of widely considering the health services system prima facie and of treating the 'anomalies' or 'limitations' as inevitable. The present study looks at the health services system as a part of the larger socio-economic system with the assumption that the anomalies have their roots in the socio-economic structure itself and not in the institutions originating out of the structure. The voluntary organizations and the State health service system have their roots in the socio-economic system.

In a capitalist system, where health is being commericialized, the health services system functions as a commodity having an "exchange value" but not necessarily a "use value".[24] This does not affect the population adversely because the existing inequality is of affluence merely. Where socialism is building up,

the health services function as a part of a package of food, housing, clothing, safe drinking water, education and employment for all.[25] In India, the health services system presents a paradoxical picture. It stands somewhere between a promise and the realities which are shaping its nature. The dominant ideology of the ruling class, their socio-economic composition, the nexus between different vested interests such as the medical profession and the commercial medical industry, the sub-ordination of the national society to the international system domirated by the developed countries of the West are among the several factors which together have influenced the growth and development of the health services system in Irdia, which, therefore, now reveals certain distinct features: mass-services dichotomy, urban and curative orientation, ad hoc and unscientific planning, lack of understanding of the social realities influencing health status, absence of proper research and analysis to provide support to policy and programme formulation and their evaluation.

THE IRRATIONAL BEGINNING:

The element of 'irrationality' is inherent in the health services'system'. The mass-services dichotomy

is not a recent phenomenon. Ever since its inception, modern health services have become alienated from the masses. Medical services in British India catered overwhelmingly to the needs of the army and European civil population : only a tiny proportion of the native population residing in the cities or urban centres could avail of modern medical services. Among the rest (more than 90 per cent of the population) only a minority could get some form of medical care from the extremely limited number of hospitals and dispensaries run by government institutions and private practioners. Public health services were provided only when there was a massive outbreak of epidemic diseases such as plague, cholera and small-pox (Bannerji, 1974). The public health service infranstructure was ad hoc in nature and the provision of health services depended on the 'will' of the rulers.

With this 'will' getting legitimate expression in Independent India's welfare corstitution, the gap between the mass and the services got further strengthened.[26] The health services system which India inherited on independence continued to have the colonial features such as : class orientation of Indian physicians, their

enculturation in British-modelled Indian medical colleges, and a more thorough and more extensive indoctrination of the key leaders of the Indian medical profession in the Royal Colleges. These physicians, who had been indoctrinated in Western values, acquired dominant leadership position in all facets of health services in India (Banerji, 1975). This factor helped the interests of the medical profession to get precedence over that of the interests of the people. Thus the position that medical elite occupy among the ruling elites, and the influences they receive from commercial and other interests have influenced policy-making in the health field; specifically, it has contributed to the growth of urban and curative orientation in the health services.

ATTEMPTS AT RATIONALIZATION :

It is not exactly that no effort has been made to rationalize the health services and to make them people-oriented. The 1930s marked the growth of a conciousness among the national movement leadership and enlightened medical professionals for the development of a health services infrstructure which would cater to the needs of the masses. Such a conciousness culminated in the formation of special sub-committee on health by

the National Planning Committee of the Indian National Congress in 1935. Popularly known as the Sokhey Committee, the highlighting point of its recommendations was that it had assigned the responsibility of maintaining the health of the people to the State (NPC, 1940). All other recommendations relied on this single suggestion. The committee, for example, suggested the integration of the curative and preventive functions in a single State agency. It also stressed the need for : training large numbers of health workers in practical community and personal hygiene, putting emphasis on the social aspects and implications of medical and public health work; integration of indigenous medical practitioners into the State health services system, giving them scientific training where necessary, etc. In its final report, the committee had clearly mentioned that the corner-stone of the scheme was a community health worker (NPC, 1940).

Such an effort in bridging the gap between man and the services got final recognition with the formation of the first ever official committee on health in 1943. The Bhore Committee echoed the concern of the Sokhey Committee and added some more measures, all of which are

pertinent even today. The Bhore Committee took the people as the objective and assigned the State absolute responsibility for maintaining the health of the people. It suggested that, no individual should be denied adequate medical care because of his inability to pay for it : health services should be located as close to the people as possible to ensure the maximum benefit to the communities served; the active cooperation of the people must be secured in the development the health programme; the physician of tomorrow was vizualized to be scientist and social worker, ready to cooperate in a team work, in close touch with the people he disinterestedly serves, a friend and a leader he directs all his efforts towards the prevention of disease and becomes a therapist where prevention has broken down, the social physician protecting the people and guiding them to a healthier and happier life.[27] The committee was hopeful that a health organization, enriched by the spirit of such a medical profession, will naturally work towards the promotion of the closest cooperation of the people. It will recognize that an irformed public opinion is the only foundation in which the superstructure of national health can safely be built (GOI, 1946).

The purpose of presenting, in brief, some of the

recommendations of the committee is to highlight the point that, as long as in the 1940s, a committee of outstanding medical professionals, had assigned the responsibility of maintaining the health of the people by the State itself. 'People's Participation' and 'People's Involvement in the Health Policy', which are being presented in the form of slogans and 'innovative' ideas, had, in fact, been devised by these committees. Though the Bore Committee recommendations are said to have provided the broad framework for the development of the health services in India, the highlighting points have been left out. Both the long-term and short-term schemes which the committee prescribed for the expansion of the health services infrastructure and manpower development are yet to be worked out fully.[28]

THE CONTEMPORARY REALITY :

(a) MALDISTRIBUTION OF RESOURCES

Today, even after 40 years of Independence, the health services remain alienated from the masses. The urban and curative bias is still pre-dominant. The limited resources, which the planners allocate for the health sector, is mostly consumed by a sophisticated and curative-oriented services system, operating in urban India, which constitutes only 22 per cent of the total population. On the other

hand a financially starved rural health services system with a network PHCs and a non-functional referral system is catering to the needs of about 78 per cent of the population residing in rural India. Out of the total 7369 hospitals in the country 5424 (73 per cent) are located in urban areas while only 1945 (26 per cent) are serving the rural population. Similarly, while urban hospitals own almost 86 per cent (446019) of the total 514989 beds, only 68970 beds (13 per cent) are available for the rural population. Again while 80 per cent of the country's doctors are based in urban India, only 20 per cent of them serve 80 per cent of the total population (GOI, 1983). At a time when we see such an uneven distribution of health resources in favour of the minority urban India, there is an enormous pressure from within the medicare profession as well as from the medical technology industries on the government to establish highly specialized services in Urban centres - services such as coronary care units, cobalt treatment facilities and C.T. Scanners (Zurbrigg, 1984). These services, which are exhorbitantly costly to maintain (let alone establish), are of dubious life-saving capacity and are available to only tiny proportion of the population.

(b) MAL-DISTRIBUTION OF MEDICAL TECHNOLOGY :

The distribution of medical technology has been disproportionately in favour of curative-oriented urban hospitals which deprives the peripheral units even to have elementary facilities like an X-Ray machine, emergency blood supplies, etc. (Qadeer, 1986). So far as availability of drugs is concerned, the emphasis of even the public sector has been more on sales of non-essential items like tonics, vitamins and nutritional supplements. While 25 per cent of the annual drug production in the country is taken up by vitamin tonics and nutrients, only 1.4 per cent is devoted to essential drugs like anti-tuberculosis drugs. As a result, essential drugs such as INH, Streptomycin (for TB) and Dapsone (for leprosy) are in constant critical under-supply. The production INH and Dapsone is only one-third and one-quarter respectively of the minimum requirements.[29] The rise in the price of essential drugs further adds to the burden of the poor man. This makes them more in-accessible to the majority of the peripheral institutions and poorer sections. At the same time, the medical technology industries through the mass media mechanism are successfully creating artificial 'needs' in favour of their tonics or nutritional supplement products.

(c) THE UNSCIENTIFIC VERTICAL PROGRAMMES:

The conventional approach to health problems dominated policy-making in the healthfield, which could not promote a rational development of the health services infrastructure. Policy planners took up specific health problems and the entire health services machinery geared to their eradication and control. The national health programmes were launched to combat communicable diseases like small-pox, malaria and tuberculosis. They were almost exclusively based on what were then considered to be the 'near-miraculous potency of the newly-discovered technology'. The protagonists of this approach were so deeply convinced about its soundness that they emphatically asserted that as the diseases were going to be eradicated from the country once and for all or at least controlled so thoroughly that they would cease to be public health problems; there was little sense in conducting any major research in these areas.[30] These programmes got the patronage of world health bodies like the UNICEF and WHO. As Banerji points out, these vertical programmes were attractive to the political leaders for a number of reasons. They gave spectacular results within a short time; they dealt with health problems which were extensively prevalent; they were assured of support from internal organizations and western countries; and they offered a single alternative to establishing a network

of permanent health services to cover the vast population of the country.[31] Before the health services system could recover from the traumatic effect of the vertical programmes, an even more extensive programme was launched in the form of Family Planning Programme.

These specific vertical programmes along with the Family Planning Programme totally disorganized the health services system. Out of the total resources allocated for the health sector, a large amount was already being consumed by hospital and medical colleges in all the big cities. Of the limited resources earmarked for attending to the needs of the masses, the bulk was allocated for running vertical programmes. Hence, the development of a health services infrastructure got neglected.

(d) WRONG PRIORITIES:

The health services system has been based on wrong priorities. This gets reflected in the investment pattern. Medical expenditures have been consistently high as compared to public health expenditures which cover water supply sewerage, control of communicable diseases, health education, health statistics and research. From 1950 to 1979, while the expenditure on public health varied between 27 to 42 per cent of the total expenditure on health services, the range

varied from 61 to 73 per cent on the medical and family planning fields. Investment in family planning itself has risen from one-third of the total medical expenditure in 1966-69 to nearly one-half in 1979. The Minimum Needs Programme whose share in the health budget rose from 17 per cent in Fifth Plan to 31 per cent in the Sixth Plan also reflects a misplaced priority. It is true that it was an effort to invest additionally into infrastructural facilities but it happended at the cost of the preventive programmes. The much-needed rural infrastructural facilities are being developed but they will continue to have vertical orientations only.[32]

The actual investment in health, when calculated at current prices, comes to 0.23 per cent and 1.24 per cent of the total national expenditure over the years from 1950 to 1979. This is against the minimum 5 per cent as prescribed by the expert committees. However, unless the increase in the investment is preceded by a change in the priorities, it will not help the masses in real terms.

(e) PEOPLE'S PARTICIPATION : THE MYTH :

The schemes that were introduced in order to ensure 'People's Participation' in health care services

(concepts earlier experimented by some voluntary agencies) led to further alienation of services from the masses, turning the concept of 'People's Participation into a 'myth'. Qadeer, in one of her studies in a tribal district of Madhya Pradesh, finds that, the introduction of the community health workers scheme, has created another divide in the health services system.[33] The poorer sections who were earlier using the local healers for the lack of accessibility to the PHC were now using the CHW in the hope of better treatment. In the absence of a proper link, between the CHW's work and the PHC network, the PHC remains alienated from the people. Without even questioning the selection procedures and background of the community health workers, it can safely be said that, without improving the economic conditions of the people in general, if one of them is selected to educate the rest, with necessary information or medical knowledge transmitted into him by the higher authorities, he might become an elite among the masses. His desire for maintenance or improvement of his newly-achieved status will lead him to move towards the already more privileged sections of the community than the masses. This will further compound the mass-services dichotomy .

The top-down approach rules out the participatory element in health planning. In health services, two

kinds of participatory activities are possible: one, where the recipients of the services are involved in the planning and evaluating processes and can thus influence the services, and the other, where various categories of health workers have similar role to play in running the services which they provide.[34] People's participation remains a myth in India, as in the presence of stratifications in Indian villages, it does not encourage people's accessibility to health services or health policy-making. The participation of health workers in planning and evaluation of their work is unheard of in the Indian setting. Decision-making in the health-field has been the exclusive domain of the medical experts only(Zurbrigg, 1984).

The health services system instead of promoting participation in rural areas is contributing to alientation as the medical and para-medical personnel remain as 'Sahib' or 'mem-Sahib' in the perception of the rural people.[35] The staff of the PHC often identify themselves with the rich and privileged few of the villages, which gives them status and money. Thus, as the structure of the PHC becomes subservient to the social structure of the people, it remains

alienated from the common masses. Another factor contributing to the alienation or mass-services dichotomy is the working hours of a PHC. The PHC, like a banking establishment remains open for all practical purposes for six to eight hours on week days. This is happening when the country has a record number of unemployed doctors. The people who need health services (mostly belonging to the working class) go to work before the PHC opens and come back after it closes down. This factor not only leads to under-utilization of whatever medical services are available but adds to the poor man's burden as he has to look for a private practitioner.

The concept of 'social physician' which the Bhore Committee had visualized remains a myth. Considering the social background of physicians and the health workers, their training set-up and the type of medical education they receive makes them oriented more towards the profession than the people - medical graduates become more ambitious to be trained in super-specialities and serve urban populations which can give them both money and status. This is why the internship programmes of the medical colleges do not

serve any purpose. The intern is given 15 to 30 days to get acquainted with the social realities of a village. He becomes so busy dealing with out-patients that he hardly gets time to think of their personal life. Moreover, even if the intern or doctor understands the social realities of the village(which prevents the PHC from getting closer to the people or leads to the failure of the government's health programme) he cannot do much because there is no feedback system.

UNSCIENTIFIC UNDERSTANDING OF PEOPLES''FELT NEEDS'

Another reason why the health services have not come upto expectations of the people is its lack of understanding of the unmet felt needs of the people (the unmet felt needs were discovered for the first time in a scientific study which preceded the formulation of the national Tuberculosis programme). In the absence of scientific research and a proper feed-back mechanism the health programmes are heading towards failure and health services system has remained far from being a need-based system. When the people's feltneed is for food, a package of nutrition supplement programme is being provided as a solution(a programme which covers a particular age group of children). On the other hand, people have been blamed for their ignorance and lack of willingness to utilize the health services.

The ICMR-ICSSR study group(which was formed to facilitate the adaptation and implementation of WHO strategy of 'health for all by 2000 AD') brought out some of the major limitations of the present health services system (ICMR-ICSSR, 1980). There was a realization that due to a complex of socio-economic, political and environmental factors, the health services system has not been able to meet the needs of the people. However, such a realization is not reflected in their recommendations and so any strategy which they evolve is least likely to yield any desirable result. The collection of vital statistics still ignores the class differentials, which would otherwise have given us a clear picture of the health status of the downtrodden and the underprivileged classes. The National Sample Survey's Sample Registration Schemes only shows the rural urban disparities in death and morbidity patterns. We come to know aboutthe differences in mortality and morbidity rates between classes through micro-level studies(Tyalor, et. al. 1968, Sahu, 1980). In the absence of an understanding of the social realities existing in Indian villages, the needs and expectations of the people, health services are not only getting alienated from the people, the inequality in the health status is further widening.

This rather brief analysis acquaints us with the problems of the present health services system and its possible consequences on the health status of the people. Health policies have been based on unscientific approaches, wrong priorities, inappropriate technologies, have conformed to the interests of the medical profession, medical industries and the privileged sector of society. As a result of all this, a national health services infrastructure catering to the needs of the masses is yet to develop, inspite of the fact that as back as in the 1940s, expert committees had prescribed a somewhat reasonable framework for it.[37] One of the main reasons being attributed to the phenomenon is, the common class background of the medical elites and policy-makers who together contribute to policy-making in the health-field and their vulnerability to vested interests in the society as well as abroad. The governing elites have the interests of the profession vividly in mind when shaping health policy. The practical reasons are said to have reinforced this class affinity.

Firstly, national health planners and government officials primarily belong to the urbam-educated elite of Indian society. With numerous private clinics to choose from and with incomes which make such services

easily affordable, all their health needs are amply catered to. And, conveniently, the large public institutions provide the highly specialized medical technology which is too costly for private clinics. There is therefore no direct stimulus from political leaders and parties for distributive changes in the system(Urbrigg, 1984). Secondly, to give priority to the needs of the common people in a field such as health care would potentially bring into question all national policies and hence the privileged position of the elites themselves in society. This would include issues such as the continual maldistribution of land, industrial resources and professional services such as education and law. Thus a reordering of medical priorities poses a comprehensive threat to existing interests and powers throughout society(ibid).[36]

As is evident by now, the factors contributing to the growth and development of health services have their roots not in the health institutions or health services system but in the larger socio-economic structures. Notwithstanding this fact, the limitations of the health services system are being interpreted as normal 'instiutional limitations'; this only provides voluntary agencies (the alternative institutions) an entry point to establish their position vis-avis the institutions of the state. Keeping

this in view, we shall switch over, in the next chapter, to see where the voluntary health institutions stand as compared to the state health services. In what way are they closer to the people? How different are they from the state health services system?[37]

CHAPTER - 3

PERSPECTIVES AND INNOVATIVENESS IN VOLUNTARISM

The craze for 'alternatives' or 'innovative' approaches found its expression in voluntary health activities mostly in the early 1970s. Many changes were taking place in and around this time. The health services system at home was revealing its limitations in reaching the people. A change also became evident at the international level in the approach to the Third World problems of poverty and ill health.[38] Everywhere a search was going on for finding alternative approaches to these problems. At this time, a number of voluntary model projects were launched with the active support of national and international agencies and governments. These projects started experimenting with 'innovative' ideas, the reported success of which provided them the media and the platform to present them as alternatives. Before making a theoretical examination of the functioning and relevance of their 'innovative' ideas and concepts, we shall present the distinct features characterising these model projects and the evaluation studies based on them.

VOLUNTARY DEVELOPMENT AGENCIES : THE BASIC APPROACHES

They start basically with a local approach to the problems of ill health in the area of their activities

mostly with "no replication or national change in mind". This start itself can be questioned because a project which cannot be replicated or which is not intended to be replicated has almost no value for the nation. They devise their own concept of 'community' and apply it to the villages of their respective project areas. These 'communities' are treated as independent units having no relationship with each other or with the external world, and which can thus be easily made a target for 'desirable changes'. This displays a lack of understanding of the intensity and complexity of the local problems. It is assumed that they are independent of the larger socio-economic structure which could be resolved with efficient and sincere technological and developmental interventions. What is to be done, they say, is to get the legitimacy of the 'community' through the techniques of 'community participation', 'community self-reliance', 'community involvement'. If we do not take the project leaders as independent entities, their approach reflects the approach which is followed at the international level to the Third World problems of poverty and ill-health. Their approach is basically an approach to the'poverty and ill-health of the nations' (which could be measured

in terms of GNP, PCI, IMR, etc) but not 'poverty or ill-health in the nation' (which will question the basis of existing social relationship and gross-socio-economic inequality).[39] Such an approach encourages the localization of problems and providing local solutions, as the main purpose is to increase the overall national output. These projects usually start with the local approach and later on claim to have developed a model for the nation. On the basis of their evaluation studies, even international organizations recognise such a claim of theirs, and they are given the status of a 'Brahmin' among the voluntary sector. Newell writes :

"They are much wider than the conventional ones and range from that of health as a political and social right to that of health as an expression or spin off, of a quietly functioning informed community ... They do not question the fact that infants need food, pregnant mothers need to be delivered, immunization are useful and prevent illness, or that sick people need treatment. On the contrary, they emphasize that these are some expressions of community action and that they will inevitably follow, if you proceed in a reasonable way, and take the wider issues into account,

the wider issues include : productivity and sufficient resources to eat and be educated; a sense of community organizational self-sufficiency in all important matters and a reliance on outside resources only for emergencies; an understanding of the uniqueness of each community coupled with individual and group pride and the dignity associated with it, " (Newell, 1975).

With a local approach which treats units of population as independent entities, wider issues of rights and national change could not be touched. As Newell himself observes : "One of the ingredients in the success of these local solutions may have been the intimacy and intensity of the efforts by the founders and the leaders, and the fact that they were not designed with replication or national change in mind. A different kind of impetus and a different power base are required to change countries".

Though the projects are presented as local solutions to local problems, they are also being presented as alternative solutions to the national problems by the same people, through their evaluation studies.[40]

The evaluation studies, ranging from individual scholars to the world bodies like WHO and UNICEF, display some general trends worth recognizing. Most of these studies, in fact, have been prematurely done. The evaluation study by WHO/UNICEF, for example, has highly appreciated the performance of the projects which are hardly 3 to 5 years old. Is not this, too short a period to assess even the local significance of a project? Secondly, evaluative uniformity is seldom observed in the assessment of these projects. Thirdly these evaluative studies precede the formulation of international health strategies and thus can not be free of related intentions. The joint study of WHO/ UNICEF was followed by the Alma-Ata Conference which fixed a target of health for all by 2000 A.D., which (they believe) could not be achieved without the involvement of private and voluntary sectors. Again, the ICMR/ICSSR workshops on 'alternative health care approaches' preceded the formulation of national health policy.

VOLUNTARY DEVELOPMENT AGENCIES : THE BASIC FEATURES AND CHARACTERISTICS

The distinct features which have been hitherto

neglected or ignored by the evaluation studies, are more than one. First, these projects have individuals with very special backgrounds as their leaders. The personality of the project leaders becomes a factor in the functioning of the projects. Where they are not centered around charismatic individuals, they are launched by big medical institutions with the active collaboration of government and non-governmental organizations with more than one purpose (and not necessarily addressing themselves to the problems of the poor). Secondly, as they are mostly launched with huge external investments which are not easily forthcoming, these projects have a lesser chance of being replicated elsewhere. There increasing dependence on foreign funds is overlooked by most of the evaluation studies. Thirdly, the achievements of the projects are highlited by comparing it with a government primary health centre, which barely gets an annual grant of 30,000 rupees. Again, a PHC is not an independent agency but a small unit of the health services systems which is a sub-system of the larger socio-political system. The variables taken for comparison sometimes are highly inappropriate. The doctor-patient relationship in the health projects, for exaple, is being compared with the

doctor-patient relationship in PHC. Why is a doctor in a PHC not as dedicated as the Aroles or how many Aroles can be produced :- These questions are seldom asked.[41] Fourthly, their claim to have improved the health status of the population is questionable and can be contested. Infant mortality rate or mortality rate is taken as indicators of such an improvement, but no importance is attached to the morbidity rate which continues to be the same. Health services are not treated to be the single factor contributing to the IMR decline. Such a claim can also be contested by other health agencies and private practitioners operating in the same area or in close proximity. Fifthly, they operate areas where health services infrstructure is mostly absent, resulting in them being treated as substitute services. In other cases they act as an extension of the government sector, as they have in their objectives the implementation of governmental programmes.

The scope of the present study would not permit us to present any critical analysis of the programmes of these projects individually or to observe the functioning of the project in relation to socio-economic realities of the villages. Quite unlike an evaluation

study, where the programmes and their contribution to changes in mortality rate, infant mortality rate and birth rate are highlighted, we have made an attempt to analyse the basic approaches and concepts they have adopted, their feasibility and relevance. In course of our discussion, we shall refer to a few of the highly popularized projects such as Comprehensive Rural Health Project, Jamkhed and Social Work and Research Centre, Tilonia. So far as Jamkhed is concerned, it represents the group of innovative projects whose basic approach seems to treat health as an agent of social change. SWRC represents the voluntary organizations who claim to be treating health as a major component in its broad strategy of social change. While the basic emphasis of projects like Jamkhed is on a basic health need approach, Tilonia puts emphasisis on the professionalization of rural development which will effect a new community based health strategy.[42] However, both the projects adopt more or less the same concepts to achieve their goal : the concepts, community, community-self-reliance, community participation, internal generation of resources, community involvement, development through nutrition, development through health education and village health worker. The folling passages of the study will present

a general critique of these concepts so far as their 'innovativeness', 'replicability', 'feasibility' and 'relevance' are concerned.

These projects treat the population of the areas they are covering as a 'coherent community' which could be cut off from the rest of the society for achieving 'significant changes' in it. Mostly, their understanding of the community is based on the perception of their project leaders who receive influences from a host of conflicting sources.[43] Thus, though they emphasize in the beginning on very different approaches, in the end they result in the same thing. Their approach is basically based on a concern for change but it displays a lack of understanding of the forces which effect change. In the beginning, they emphasize on an approach to meet the total needs of the community but at the end they end up with a basic 'health need approach'. The following words from the Aroles will testify this : "Since a traditional-curative-oriented hospital system does not penerate the communities and does not see patients as a part of a community in relation to the environment they live in, it fails to meet the total need of the community."[44] But at best they realisation manifests in a basic health need approach with focusses on both curative and preventive

aspects of the diseases. Even the emphasis on a preventive approach makes little difference, as it does not touch the roots of the disease, nor can it respond to the total needs of even the artificially demareated community; at best it can seek to bring change through medical-technological interventions or through popularization of modern medical knowledge among the 'ignorant' or 'illiterate' masses. Thus they mainly emphasize on a participatory health care delivery system and a good health education mechanism. Their concern for the social forces which influence the community from within or without do not become manifest.

Their definition of community self-reliance is equally ambiguous. Their objective is to make the community self-reliant on its own resources for promoting its health and development. As the community is 'ignorant' and does not know how to mobilize its own resources, it is 'taught' by these projects how to generate resources internally. What is surprising is that although most of the projects have emphasized clearly in their objectives on internal generation of resources for 'community-self reliance' their dependence on external resources is continuing as usual and in certain cases increasing. The following table illustrates this :

SWRC - TILONIA

Year	Total resources	Share of external resources	Share of internal resources	Percentage of external support of the total resources
1st Year	593238	593238	-	100%
1983	267030	206731	60299	77.4%
1984	280074	231295	56779	82.88%

CRHP JAMKHED

1st Year	255000	130000	125000	50.98%
1983	3083000	1883000	120000	61.07%
1984	3625000	2455000	1170000	67.72%

Source : National Institute of Rural Development, 1986.

The SWRC, Tilonia began with full external support which included aids from national and international agencies and governments. Though by the year 1983, it had come down to 77.4%, it again showed a rise to 82.88% in the year 1984. Similarly, the CRHP, Jamkhed, was launched with more than 50% of its total resources coming in the form of aids from agencies and governments, national as well as international. In the subsequent year, the percentage instead of coming down has gone higher. In 1984, 69.72% per cent of total resources of the project was drawn from external sources. In the case of both the

projects, the internal generation of resources shows a decline. Thus for all practical purposes the projects make the community dependent on anonymous external sources whose continuity is always a question-mark; what is presented as self-reliance, in fact, promotes mass-dependence.

Their dependence on external funds further creats problems as they are not given without obligations attached to them. Even the freedom of the project leaders to use the fund according to their own plan is curtailed. In its own words, SWRC says that from the "outset the SWRC has had to piece together its annual budget and programmes pattern largely from grants received from a variety of private and government agencies. Since most of these grants have been tied to specific projects and purposes of special interest to the donors, this has left the SWRC with very limited and 'uncommitted' funds with which to cover general organization and administrative costs, or to expand ongoing programmes, or to initiate new ones in line with its own priorities".[45]

Though projects such as SWRC make it an objective to bring self reliance through economic change', through a process of supplying agricultural materials, health

technology and knowledge, the existing economic reality within the 'community' is totally untouched. It is firmly assumed that without disturbing the existing status-quo, change could be effected with medical-technological input to the community. The method of distributing the input is also not clear. The project leaders identify themselves with 'com unity leaders'. Again, the concerned community is not the exclusive zone of activities for the project: certain other governmental non-governmental and private services are also available to the community. As the people continue to receive the services from other agencies the claim of success by the projects can be easily be disputed.

PERSPECTIVES AND INNOVATIVENESS IN VOLUNTARY SECTOR : THE CONCEPT OF COMMUNITY PARTICIPATION

Examining the concepts of 'community participation and involvement', we find that by taking the villages of the project area as independent and special entities having no interaction with each other, the projects intend to initiate a new social relationship. But as the idea of the new social relationship is not based on the understanding of the complexity of the existing social relationships or their history, it is more likely to reinforce the existing

pattern of social-intercourse. In both Jamkhed and Tilonia, the emphasis has been on 'community leaders' whose participation, as they themselves say, accelerate the process of community participation. The following words from the Aroles will supplement it :

"Various communites in three needy and realatively underdeveloped districts of South-east Maharashtra were appreached. It was explained to the community leaders that we were interested in meeting the basic health needs of the people ... . Provided they participated actively in making a building available for health activities in each village, participated in active health promotional and preventive activities such as the mass immunization of children, and provided volunteers to help the health personnel in their work."[46]

"The community leaders were enlightened and influential. Some of them knew us. These leaders understood our plans and invited us to work in the area. They took us around to the various villages and introduced us and the programmes to the communities. They helped to remove suspicious and doubts from the minds of the villagers."[47]

"We had a series of meetings with the community leaders and explained our programmes to them. I doubt whether many really understood the programme at that time. Most of them were very happy to welcome us and to have curative facilities so close to them."[48]

Then obviously the question arises as regards the identity and background of the community leaders and the motivation behind their participation. Right from the selection of areas till the carrying out of the programme, the community leaders have been their pillars. These community leaders were not created by the project; rather they belong to the higher strata of the existing social hierarchy, who have traditionally influenced the social intercourse in the villages. By giving the community leaders a major role in the project activities, two processes are activated : (i) The project leader by interning over the sources of influence in the community can effectively implement predesigned strategies and then get the legitimacy from the so called community; (ii) By listening to the will of the community leaders who represent none but themselves or their interests, the project conforms itself to the existing social structure of the villages. The main motivation behind the community leaders is, as the project leaders themselves say, "to have curative facilities so close to them."

One more important point worth mentioning is that the facilities of modern medicine for which there is a tremedous felt need, is either inadequate or not available. The projects thus make the entry point through curative services. It is but natural for the people to welcome any such entry and participate in its activities if that means the continuity of the services in their own area. Thus participation for the people often becomes a weapon for retaining such services without which they face much suffering, than it being a spontaneous identification, on one's one, with the project and its activities. The project leaders are also not clear about what do they mean by 'community participation'. The participation, encouraged by the community leaders and a modern medical facility often end up in the implementation of project programme only.

The Aroles write : "From the start, community participation has been an essential part of the project. The community in Jamkhed is poor and lacks good housing, electricity and running water. However, it provided simple accommodation for the project and staff and donated land and buildings for the work, not only in the main centre but also in the villages. In all the villages, the community assists voluntarily in the preparation of food

for nutrition programme. In addition, it contributes to the building of roads to give health team workers better access to the villages. A youth organization collects blood for the health centre and is particularly active in mass mobilization for immunization and in other public health services."[49]

So far as decision-making is concerned, it is the 'community leaders' who become a party to it and not the people (who do not have any real leader). The leaders often represents their own interests and certain programmes of the project help them in perpetuating them. In certain cases the project, through the concept of participation, promotes not only the interests of the local leaders but also of certain other interests, inherited along with them. By participation, SWRC, for example, means "joint efforts of the professional and the farmer in a move towards professionalization of rural development".[50] It serves more than one purpose. In the words of SWRC itself, "the Centre aims at generating employment among (urban) specialists by bringing them closer to the problems and life styles of the rural areas : The Centre provides them facilities,

equipment and the conditions to enable them to contribute their best". The former is supposed to participate as a man "who can provide the urban specialist a better understanding of rural life and development from a human angle."[51]

First of all, such a participation enables the specialist participants to earn their bread. Though the project leaders visualise changes in village economic life, it actually helps the economic life of the 'outsiders'. Whether farmers need specialist input or not, it is another matter; but it serves the interests of the 'specialists'.[52] Secondly, when it comes to the use of specialist knowledge, the big farmers are most likely to benefit from it, considering their intimacy with the project leaders. These specialists, because of their urban background, because their main concern is their job are bound to identify with the higher strata of the village farmers. The top specialists receive salaries in line with or somewhat above corresponding scales the government sector; the wages of the professional and field workers are commensurate with these prevailing in the local market. The specialists range in age from 22 to 28.

The point of focussing on their concept of community

participation or involvement which they claim to be an innovative idea, is that, first, it is based on wrong premises; secondly, it promotes specific vested interests; thridly, it restrengthens the existing social structure so that those who are dominating are most likely to approximate the maximum benefits out of the projects; fourthly, it provides legitimacy to internal as well as external sources of influence. People in general and the concerned health and development workers in particular participate only in delivery of services; without having much say in the decision making process.

PERSPECTIVES AND INNOVATIVENESS IN VOLUNTARY SECTOR : EDUCATING THE 'IGNORANTS'

Coming to 'village health workers' and 'health education, we notice that in the basic approach to health education, although these health organizations speak of nothing but 'innovation', it is all rather a repitition of the same old patemalistic approach of chaning the attitudes of the ignorants through the input of modern medical knowledge. Such an approach is based on a belief in the cultural uniqueness of a community and a faith in modern Western medical knowledge and its power of bringing a positive transformation of that culture.

The community should be educated to give up the irrational practices, it has developed owing to years of ignorance, and to adopt a new rational one imported from the West. The health culture is not seen as a part of the overall culture which in term is influenced by a host of socio-economic-ecological, factors.[53] They take the existing health behaviour on its face value and seek to make interventions in it through developed technological and educational inputs. Thus they rely on the same techniques which manipulate behaviour rather than facilitate individuals'/groups ' abilities to influence and control their physical, social and economic environments. Thus health education diverts people from chaning the social context of behaviour to changing the individual context of behaviour .[54]

If these projects really had come close to the people (as they claim) they would have understood why people behave as they do, but all these projects do is to change the people's behaviour. The pattern of diseases prevalent in the area, and the type of problem that according to the perception of the project leader needs serious attention, decides the type of education that has to be imparted to the community. Such an approach had been

condemned by the Director General of WHO in his address to the 11th International Conference on Health Education in 1982: "I sincerely hope this conference will write an obituary to that type of health education which is concerned with telling people how to act and that instead it will emphasise on taking due consideration of the social forces that bring them to act as they do".[55]

Quite contrary to the observation of Dr. Mahler one of the WHOs best - appreciated project says "The problems result from a lack of health education, an unhealthy environment, ways of living, scarcity of resources, and the community's culture. Undoubtedly, modern medical technology is necessary to solve of the problems. However, to a large extent the community has to find the solutions. People selected by the community can be used to impart health education, change the community's attitude to health, and give simple medical care".[56]

What looks innovative with the Project's approach is its selection of the health educators (VHWs) from the people, who have cultural affinity with the people they will be serving and who can thus effectively convince them to give up the old practices and embrace the new

knowledge.

These health educators constitute one of the most important components of the project's health care delivery system. These village health workers are selected from among the people, who happen to have a little general education. On their selection, Jamkhed writes : "city trained health workers talk differently, dress differently and have a different way of life from the village folk. This produces barriers between the health worker and the villagers, and results in poor communication between the villager and the workers ... On the other hand, a person chosen from the community and trained is accepted health promotion can easily be achieved. .. Having once convinced herself of various health needs she is able to bring about change much faster than a professional... Since her incentive is not money but job satisfaction, her services are not expensive and are within the reach of the community".[57] The main emphasis of V.H.W. is on population control and MCH, but the delivery of the entire health strategy depends on them.

A "VHW begins her day by organising a feeding and nutrition programme in the village. Here, she pays

special attention to underweight and malnourished children. She helps the mother to cook and to feed the child and gives group health education, using audio-visual aids. Children are screened for single ailments such as sore eyes, skin infections diawrhoeas, and fevers and simple medical care is given. Children are weighed and immunization schedules arranged in consultation with the mobile health team.

Pregnant mothers are seen and appropriate advice and simple iron and vitamin pills are given. Immunization against tetanus is arranged with the nurse. ... In house to house visiting the VHW identifies women of child bearing age. She distributes oral contraceptives and condoms. Similarly, women are motivated to undergo sterilization. In addition to motivating the patient, the VHW has to convince the mother-in-law, as she exerts great influence over the daughter-in-law. The VHW collects vital statistics (birth and death) in the village for each week ... Health education is VHW's most important function -- Every week, she takes a bus or walks 6-7 miles to the main centre to receive here training ... A health promotion stall is constructed and it is taken to various market places and fairs, where the VHW arranges puppet shows, etc. and mobilises the masses for health education.

Each village health worker receives an honorarium of Rs.30.00 p.m."[58]

This overburdened health worker who puts all his efforts in bringing clients for population central, providing health education, and other curative services is considered to be doing so for the sake of job satisfaction only. She is also treated as the representative of the 'community' who can effectively convince the masses and make them accept the project programmes. The selection of VHWs might lead to more than one consequence. Firstly, no rural man or woman who lives on daily wages or working in the field may be happy with a monthly salary of Rs.30/- for the sake of serving the people only. He or she might become a mini-doctor and earn money by selling whatever medicines he/she has or by selling his or her services or he might get dis-interested in his/her work after a very short period, as he/she has tremendous work load but no monetary incentive. This is especially so when at the same time, the specialists or other professionals in the project continue to draw salaries higher than or atleast commensurate with the salaries of the government employees.[59] Secondly, as the purpose is to make the selection of VHW less

expensive, no uniformity is observed in their selection. sometimes, village councils are asked to nominate them, and thus, it is very difficult to say whether they really identify with the masses or with the leaders who select them. Again, in certain cases they are selected on the spot, amidst excitement, while the project leaders visit the places.

"After a fairly open and can-did discussion of pros and cons, the local groups decided to collect 25 paise from each household each month, and selected 17 year old Lakhpat Singh from the local Kajput family, who had completed eight years of schooling, to be the village health worker. The young man's father agreed to this and Lakpat Singh was greeted by the crowd as the new doctorsaib".[60]

"The meeting (which selected the VHW), which lasted nearly two hours, was one of many such village gatherings."

Though these village health workers become a part of the health team and are treated as the representative of the communities, they takeonly predesigned programmes to the community. The relationship with the community becomes a one way traffic as they do not study the health

needs of the people. Their little education does not enable them to recognise the unmet felt needs of the people. The feed back system is almost absent, so far as informing the decision-makers about the needs of the villages are concerned. Thus, here the VHW does not represent the people, rather it represents the project and on its direction tries to make the people adjust to and adopt the programmes of the project.

Inspite of these facts, certain projects compare their VHW with the Chinese "barefoot doctors".

"This new strategy (the community based health strategy), devised by the resident campus doctor, the medical social worker, and a newly arrived lady doctor, adopted the Chinese concept of the 'barefoot doctor' to the conditions of rural Rajasthan".[61]

Often they use the Chinese concept of barefoot doctor without even properly understanding their real functions and their background. The following sentences will say, how different the concept of barefoot doctor is; how different they are from the VHW and how improbable it is to immitate the Chinese concept in our present socio-economic system.

"China's countryside is divided into communes; these are divided into production brigades, which in turn are divided into production teams. The barefoot doctors usually work in health stations at the production brigade level, but do much of their work, both medical and agricultural with their fellow members of the production teams. The barefoot doctors income is generally determined the same way as that of the other peasants in his commune; each peasant's earnings depend on the total income of his brigade and the number 'work points' that he collects. The barefoot doctor earns just as he would for agricultural work. The barefoot doctors are selected by their fellow peasants for training, and these co-workers often choose the most capable barefoot doctor for education as physicians."[62]

This speaks of the mystification of the concept of the barefoot doctor at the hands of the project leaders; the concept which cannot be limited in any other social set up. The concept of VHW is not at all comparable with the Chinese barefoot doctors. Thus, it is difficult to trace any innovativeness about the concepts of health education as well as the VHW.

Their approach to the problem of malnutrition is also conventional. Research studies have shown that the problem of calorie deficiency is by for the most crucial factor in malnutrition.[63] As calorie consumption is directly linked to individuals purchasing capacity, the problem of nutrition is closely linked with problems of poverty. Thus the problem of malnutrition could not be solved without changing the poverty situation, which will necessitate wide socio-economic transformation. Such a change cannot be achieved through micro-level projects. "It is largely the socio-economic under-privileged homes were malnutrition is most prevalent. Under such conditions, there can only be lasting results if a more constant supply of the right kind of food is assured, and this can be extremely difficult to achieve."[64]

As a constant supply of the right kind of food depends on the right kind of socio-economic system, these projects can go nowhere near the problems of malnutrition even within their 'communities'. Though they start with a realisation that the priorities of the people are food and water and not health, their approach do not reflect such a realization. They often

land up with nutrition supplement or rehabilitation programmes, which never fulfills the food requirement of the people. The Aroles' observations testifies this:

"We would visit a village late in the evening and over a cup of tea just talk to the village council members and other leaders. These intimate contracts soon made us realize that their priorities were not health but food and water".[65] This realisation seems to be new, as most of the voluntary organisations seldom take food as priority. What do the Aroles say after this realization ?

"We began with food. We focussed the people's attention on the most vulnerable groups underfives and mothers. Since there was not enough food in the area, it had to be acquired. We took on the responsibility for finding the source of food. People organised a community kitchen. They found fire wood, large cooking vessels, and volunteers to cook food every morning and to keep records. Thus, the felt need for food was translated into the development of a nutrition programme".[66]

How does a nutrition supplementation programme focussing on children under age group of five, can meet

the felt need for food of the community is seldom questioned. Food and nutrition becomes one of the main objectives of some projects like SWRC, Tilonia, but such an objective finds expression in nutrition programmes focussed on under fives. In certain other cases, a nutrition education programme is launched to educate ignorant mothers how to prepare nutritious food.

The question of poverty underlying the problem of food and malnutrition is not touched but an attempt is being made to solve it through nutrution supplementation programme which covers only children under five. Secondly, whether a nutrition supplementation programme helps children grow it also debatable considering the borrowed standard of measurement we follow. By focussing on children under five, the future of the children is ignored. The children who had been dependent on nutrition supplement till they attain the age of five, have to go back to their house of poverty bringing fresh problems for the household. As, according to their own observations, food is the real felt need of the people, dependence on any temporary source will aggravate the situation in the later stage. This betrays their own understanding of the problem of malnutrition.[67] Nutrition

supplement can never become a substitute for food.

VOLUNTARY DEVELOPMENT AGENCY : THE CONTRADICTIONS AND LIMITATIONS

These 'innovative' projects have been launched to initiate a process of social change through, either a 'broad strategy of development' or a 'comprehensive basic health need' approach. Thus, if we are to assess them, then we must do so on the basis of their individual contribution to the changes in the socio-economic life of a given population and their "collective" impact on macro-level social change. As no such collectivity exists in the voluntary secotr (which is featured by divergent ideologies or principles), their impact on micro-level social change cannot be effectively assessed.[68] As regards the impact on their respective 'communities', by treating the 'communities' as independent units having no relationship with each other, by thinking that individually they can bring a change in the 'communities' with the mobilization of the potentiality and resources of these 'communities', the projects fail to understand the social structure of the villages and the nature of the interaction between its constituents, and thus, in effect,

they result in service-flows and resource-flows in favour of the dominant interests. Moreover, instead of being dependent on an internal generation of resources, the 'community' becomes increasingly dependent on external resources. Further, almost all the approaches of the projects are based on borrowed perceptions and on incomplete understandings of village realities.[69]

In certain cases, in the name of 'innovation', which these projects, with a clever use of words (such as 'professionalization of rural development' and 'community participation'), often serve the interests of outsiders (to the village common-folk) who come as 'professionals' to teach the 'ignorant' farmers. When we examine these projects in relation to the government and the people, another picture blossoms : these projects often mediate between the people, and the government and other interests. They implement governmental programmes and seek the active support of the government machinery in the implementation of their 'own' programmes as is evident in agriculture, water supply, communication, etc.[70] As their achievements are touted as being singular to them, they emerge as a force in between the people and the government. As such, the presure on the government gets eased as more and more people look upto the projects as

viable alternatives, while being quite in the dark as to the forces governing these projects. The government, in turn, evades its responsibility towards the people and often relies heavily on the information (on Indian social realities) given by these projects. This new space carved out by these projects is further facilitated by the unmet felt needs (of the people) for health services owing to the absence, for a number of reasons, of an adequate or popular State health services infrastructure. An effective curative system not only enhances the popularity of the project leaders but also of the project through a moulded public opinion.[71]

Shifting to the aspect of funding, we again face difficulties and contradittions. As these projects often admit, that most of their funds which they receive are 'committed', how can they use the funds to meet the felt needs of the community?[72] As funds are given with intentions which do not necessarily coincide with genuine community intentions, these projects channel vested interests into the villages. Moreover the quantum of funds which are injected into the project areas is not quite forthcoming to 'communities' which are outside the purview of these projects. And yet, with much input of

resources, there is no indication of the improvement of the economic status of individuals or of their self-sufficiency; where the health status is presented to have improved the claims and the indicators are disputable.

Thus, our analysis of the main approaches of these representative projects, lead us to the conclusion that they cannot be replicated any and everywhere in India, that their 'innovationess' is nothing but old wine in a new bottle, and that they merely reinforce the existent Indian social structure with all its gross inequalities.[73] There are certain other factors (such as the background of the project leaders and the forces which help them in the launching of their ambitious projects) to be sure, which also make these projects quite special with lessened relevance to the needs and aspirations of the poor on an all-India basis. But it is beyond the scope of this study to examine, in depth, these factors; nevertheless, we shall try to arrive at some probable answer in the next chapter.

CHAPTER - 4

DEVELOPMENT AND VOLUNTARISM : THE COMPETING FORCES AND UNCERTAIN ALTERNATIVES

The first question that strikes our mind now is why these 'development' oriented voluntary agencies, their model projects and model schemes get so much publicity and appreciation, which they do not seem to deserve? Who are these voluntary agencies delivering development? Who are the people supporting their activities and why do they support?

The basic problem which concerns the Third World Societies today, is the two interdependent phenomena of 'poverty and ill health'. The intensity and dimension of these two problems betray any standard of measurement. Any discussion on these two great problems brings into focus several competing forces operating within the society as well as outside, who claim to be working with 'great concern' to bring a change in the situation which is worsening day by day. The developmental voluntary agencies and their model projects represent one of such competing forces who by confining themselves to a particular area (comprising a certain population) are making interventions in the status of poverty and ill health; the nature of

intervention depending on their perception of the social reality. As they owe their existence mainly to the aid giving and funding agencies(who often advance funds with a purpose), their perception is most likely to be influenced by the 'perception' of these forces who are operating at the international level.

We shall be briefly touching the forces at the international level who not only finance these agencies but provide an 'ideological framework' within which they operate. The ideological framework remaining the same, their approaches notice changes with changes in their perception of world poverty and ill health. Voluntary agencies provide them the laboratory for experimenting the 'new' or 'alternative' approaches to the problem of poverty and ill-health. In the second part of the present chapter, we shall come across the nature of their relationship with the policy-making fabric at home. In the third part, we shall present a brief critique of the other competing forces, who seem to be equally concerned about the 'problems' and also 'claim' to have alternatives to the 'establishment'. This leads to conflicts among ideologies and approaches, and further shapes the

nature of voluntary action. While discussing, we shall keep in mind that, each of them present itself as an 'alternative' to the 'establishment' or to its policies and programmes.

VOLUNTARY ACTION AND THE DEVELOPMENT ESTABLISHMENTS : THE MANIFOLD INFLUENCES

The international 'Development Establishment' - "the body of internationally minded individuals who are active in major Western development aid agencies or who are their champion within Western political circles" provide funds and the operational framework to these development oriented projects and agencies.[74] These funds are given for specific purposes and are a a part of their overall strategy towards the Third World problem of hunger and ill-health. Their strategy keeps on changing with changes in the perception about these twin problems. The present emphasis on the potentiality of voluntary agencies as an 'alternative' reflects such a change in their 'perception'.

If we go historically, in the sixties and seventies population growth was considered to be either the cause or major contributing factor to world poverty; thus the emphasis was placed on population control (Navarro, 1984). A strategy was evolved looking at the GNP rate per capita. It was assumed

that the fewer the 'capitas' the more GNP for the existing ones. To reduce the 'capitas' poorer countries were suggested(or forced) to control the size of their population. Western aid agencies allocated most of their funds for population control. In 1976, two thirds of all U.S. health foreign assistance was allocated to population programmes. In 1977, approximately half of Britains' multi-lateral health aid contributions were devoted to population control (Doyal, 1979). Voluntary agencies were among the major recipients of these funds, who received it directly or through the national government. Voluntary agencies carrying out family planning activities got 100 per cent central aid in India. A bias for population control activities still dominates the approach towards voluntary organisation. Making a critique of it, Zurbrigg writes, "More recently it has become common and tacitly accepted, the use health projects to popularize family planning. Even today, official support for voluntary projects is conditional to the results in the field. One of the most blatant examples of such manipulation is the distribution of (CARE) food shortly after child birth to poor women, who accept sterilization. It is evident that the ultimate goal of this development effort may

not be in the long term interest of the individual women and families making food handouts a stock manipulation of human hunger".[75] Their approach witnessed further change, with the 'oil and natural gas crisis' of the West in the early seventies revealing the resources potentiality of Third World nations, which were being exploited by the 'developed west' to their own advantage. This led to the development of yet another approach complementary to population control which emphasized in the transfer of technological knowhow to make use of their resources for their own development. Later on a realization took place owing mainly to the anti-technology stand taken by Illich and others that, such a process will lead to a stage whereby a dependency on technology would be created which would hinder the possibility for individual and community development; thus the alternative emerged was the development of autonomous spaces outside formal institutions, placing great emphasis on self-care and self-reliance - terms that have been used almost interchangebly. 'Self reliance' was supposed to be for the community what 'self care' was for individual.[76] The term 'community' gained popularity with emphasis on the concept of self-reliance. Obviously,

the groups directly working with the 'community' were given great importance and priority in the latest strategy of development. These groups are none but the micro-level voluntary agencies or projects, who, it is assumed work, at the 'community levels'.

These communities, (rural communities only) were already receiving development services in the form of informational , technical and material inputs. But it was assumed that a mere input of services would not change the poverty and ill health syndrome, unless the victims participate in the delivery of these services. The victims of poverty and ill-health were assumed to be living in rural communities only; the communities are characterised by extremely limited resources, poor communications, vast distances, individual and community poverty and lack of education - leading the communities to a perpetual state of poverty. Thus , as the problems of poverty and ill health are concentrated in these communities, it is thought it would be convenient to divide them as separate units and mobilize the existing resources within, and with sufficient external inputs, in order to make them self-reliant.[77] Some needs are identified as 'basic' and the emphasis is put on meeting them. However, as resources are assumed to be limited,

self-sufficiency could not be achieved unless the community participates in the process. Voluntary agencies (which are assumed to be working close to the communities and which are said to have understood the social realities within) provide the laboratory for experimentation of these ideas and concepts, which will lead to formulation of macro-level plans.

Emphasising on rural 'communities' and treating them as harmonious units having no conflictual relationship with each other, the strategy of the development establishment, provides for 'community participation' and 'community involvement' to ensure development. One is bound to be sceptical about the genuineness of the understanding of the community. The WHO which shares the perception of the development establishment understands a community as an aggregate of individuals having common interests and aspirations including health (WHO, 1978). Thus, community participation is defined as "the process by which individuals (and families) assume responsibility for their own health and welfare and for those in the community who develop the capacity to their and community's development".[78] Community is thus seen as an aggregate of individuals. As N. A Gray writes,

"such a thinking assumes that there is some straight forward simple entity identified as pertaining to the common good, which can always be stripped naked by discussion and acclaimed by all. I would argue that there can be common interests in equalitarian communities which Indian villages are not. It seems to me that such stifling of the conflict of interests and opinions, serve not the emergence of synthesis from thesis and anti-thesis, but the interest of the powerful individuals and groups. The consequence which emerges is always the views of the rulers, not the ruled".[79] The concept of community participation is not based on an honest understanding of community. "A community is a set of power relations in which individuals are grouped into different categories, of which classes are the key ones. And power is distributed according to those categories. A physician, for example, is not merely an individual, he/she is a member of class(as well as a race and gender) whose power comes not only from his/her medical position but also from the position he/she occupies within the class, gender, and race relations in that society. It is primarily one's class position that determines one's interests. The primary commitment of those in the medical profession is to the optimization of the interests of their class"(Navarro, 1982).

Notwithstanding, the realities that affect and determine community life in Third World rural societies, the process of involving people in the development process continues with an accelerating speed. This strategy of the Development Establishment finds expression in the policies of World health bodies such as WHO and UNICEF, "who for many years have functioned as "transmission belts" of positions and ideologies generated for the most part in those development establishments.[80] In every sphere of development including health today, the emphasis is on 'community participation and 'community self-reliance', with voluntary agencies providing data support to the wider use of these concepts.

Such a situation has given rise to two major interpretations;the first interpretation treats the present strategy as a result of the deliberate effort of international capitalism to sustain itshold over Third World countries, while the other looks at the phenomenon as a consequence of biased understanding of the realities owing to the adherence of a certain ideology.[81] The first interpretation is widely heared from voluntary groups who are mainly involved

in 'activising' the victims of poverty and ill-health. These groups believe that, the political stability of national society, which is subserving the international capitalist regime, is under threat: as, in response to the failures of the governmental programmes in meeting the minimum needs of the people, different radical organisations of the people are coming up with a threat to the existing political and social border. The present attempt at involving the people in the path of development through voluntary projects is perceived as a strategy to neutralize such radicalization.[82]

The policy statements of world bodies such as the World Bank, which reflects their lack of trust in institutions bringing reforms provides logic to their apprehension. Based on the Indian experience, Robert McNamara, the then World Bank president pontificated in his warning to all Third World Societies: "No one can pretend that genuine land and tenancy reform is easy. It is hardly surprising that numbers of the political power structure , who own large holdings, should resist reforms. But the real issue is whether indefinite procrastination is politically prudent. An increasingly inequitable

situation, will pose a growing threat to politically prudent. An increasingly inequitable situation, will pose a growing threat to political stability". Thus he prescribes new forms of rural institutions and organizations which will give as much attention to promoting the inherent potential and productivity of the poor as is generally given to protecting the power of the privileged.[83] Kothari and others find a link between this realization and the concept of privatisation which international development bodies propogate. The rural institutions (Volags) are given preference to the State development machinery.[84] It is contended that as they lack accountability, the shifting of responsibility from the State to their shoulder, will facilitate the entry of vested interests. The whole scene is seen as a conspiracy of the development establishments in order to suppress peoples' movements for its own survivial and continuity.

On the contrary, Navarro, who presents the other interpretation feels that "it does not represent a conspiracy by those establishments to keep the poor poor. Nor are the lies put forward to obfuscate the truth. We have to remember that to toll a lie, one needs to know the truth. And those establishments do not know it. These positions respond to a vision

of reality (or ideology) that makes sense for the class which holds it... As Marx indicated, every class has its own ideology... vision of reality - that serves consciously or unconsciously to reproduce its own interests. It is also characteristic of every dominant class to see its own specific class interests as universal interests. This point bears repeating in view of the obverburdance of references that see history as an outcome not of structures but of personalities, conspiracies, and individual motivations. Individuals may be unconscious bearers of ideologies and practices that serve quite different purp oses from the ones individually and sonsciously designed. The international health field is croded with such contradictions between intentions and eff ects."[85]

Whether it is a deliberate conspiracy against the poor or a lack of understanding of the social realities due to ideological-class positions, the fact remains that the structural question which any honest analysis of causes of poverty and ill-health throws upon havebeen avoided. Rather the emphasis has been on 'alternative' institutions which believe in the charisma and honesty of the individuals

leading them. A brief analysis of the politics of aid which constitutes the life-line for these alternative institutions will take us more towards the first interpretation.

If the strategies of the development establishments analysed along with the large amount of aid they provide to the implementation agencies, the motive looks somewhat ambiguous. As regards the motive behind providing aid to the development projects and programmes of Third World Governments, an official U.S. documents says, "our basic, broadest goal is a political one. It is not development for the sake of development - an important objective is to open up the maximum opportunity for domestic private initiative and to ensure that foreign private investment particularly from the U.S. is welcomed and well-treated. The problem is to evaluate the manner in which the programme can make the greatest contribution to the totality of U.S. interests".[86]

These motives will become somewhat clear, if we look into the aids coming into the health sector. Aids in the health-field ensure a market for international health and medical technology industries. "Since the post war period, the provision of aid has become an important mechanism for the expansion of international markets, both in health sector and elsewhere. Most medical aid either takes a technological form or it is tied to technological inputs.

Hence it encourages a form of health care which will ultimately be of little value to the mass of the Third World inhabitants but which is extremely profitable to the donor countries and the multinational corporations".[87]

While aid forms only a small proportion of health expenditure in most Third World countries, it nevertheless exercises a strong influence over the services provided, reinforcing a pattern of health and care which is increasingly recognised as inappropriate to Third World needs. In the British case, aid is important in promoting the export of British goods and services, in fostering dependence on British scientific expertise and in reinforcing the general dominants of the western medical paradigm over potentially more effective alternatives".[88]

Thus, the claim of the voluntary agencies that they are politically or ideologically neutral and have genuine concern for the poor or poverty groups, care be challenged. As Lappe and Collonis write with regard to U.S. aid for the voluntary sector, "most impressive is the difficulty that even the best voluntary agencies have in avoiding.... reinforcement of oppressive elite-controlled economic and plitical structures....(indeed) the majority of voluntary agencies especially the largest, seem to opt to

colloborate directly with foreign governments, including some of the worlds most repressive ones".[89] Much of the activities of the voluntary development agencies unwittingly or otherwise, serve the political ideological and economic interests of the industrialised western countries. The scope of our study would not permit us to go beyond and present a more detailed picture of the motives surrounding voluntary projects in the development field.

If such arethe realities, which govern voluntary action in the field of health and development, no wonder how and why model projects of voluntary sector get publicity and appreciation by the same forces who are responsible for their origin and existence. Voluntary action is thus guided by the interests and motives of their funding agencies, no matter, whatever concern they individually have for the poor and how much they have understood poverty. In any case, they come between the people and the government as a midle sector. They make the hungry and diseased dependent upon them,but as they themselves are dependent on external resources, the dependency of the people is being shifted from a 'responsible government' to anonymous sources who are not within the reach of the people or the government. The irony is that, through their plans and policies, Third

WOR
world governments(including that of ours) are providing legitimacy to the existence of such a sector. In the subsequent part of the study, we shall present in brief how the government creates an alternative to its own institutions and its rationality.

THE NATIONAL GOVERNMENT AND VOLUNTARY ACTION : THE LEGITIMIZATION OF A MIDDLE SECTOR

It isnot that the international development establishments are the only forces who influence voluntary action at home; the national government is also promoting a particular type of voluntary action by patronizing a particular group of voluntary agencies. This is however not to say that, the sources of influence are independent of each other. The advantage with the national government is that, it can legitimize the type of voluntary action it wants, by legislative enactments. The plans and programmes of the government reflects such a tendency. It began in the Fifth Plan period, when the government started encouraging the voluntary agencies to take over on a contractual basis the programmes of the government in the social services sector.[90] In the health sector, the government began giving its PHCs to NGOs to run them; also certain national programmes(e.g. leprosy) in a specifiedd area would be given to NGOs to implement. The Sixth Five Year Plan period witnessed the acceleration of such

a process . Lobby groups constituting voluntary organisations were formed. The representatives of these agencies were made official advisors or nominated as expertsiin government committees and bodies, including the planning commission, indicating that the NGO business was official business. By the time, the seventh five year plan draft was prepared, the lobby groups of NGO had become quite active. The approach paper of Seventh Five Year Plans states, "voluntary organisations will have to be associated more closely and actively than hitherto with the programmes for reduction of poverty, and with the efforts to make minimum needs available to the population for improving their quality of life. This will be incorporated as part of the overall strategy for augmenting such programmes meant for the poor, as also an alternative feed back mechanism for ascertaining whether the target groups have received the benefits meant for them", (GOI, 1984). The National Health Policy of 1983, reflects such a faith in voluntary sector, when it emphasizes the need for greater reliance on the voluntary and private sectors for achieving the goals of "Health for all by the year 2000 AD". The policy envisages a very 'constructive' and 'supportive' relationship between the public and private sector in

the area of health by providing a corrective to be re-establish the position of the private health sector. The government does not seem to make any distinction between 'voluntary action' and the profit oriented private sector; thus the scene becomes somewhat more confusing and more complex. In any case it provides legitimacy to a middle sector.

Why is the government providing legitimacy to a middle sector? More than one reason can be attributed to it. First, the national government is also dependent on the international aid and development agencies for its developmental programmes and the transfer of technological know how. Thus the approach that international development establishment follows towards voluntary sector is bound to influence the policies of national government. The ruling elites and the development establishment also have a similar worldview. Secondly, it might be true that the state bureaucracy is inefficient, corrupt and demoralized ; thus cannot carry the developmental programmes to the people. But why is the bureaucracy in such a state as it is today - a question seldom asked. As the bureaucracy is an integral part of the political system, it reflects only the contradictions and limitations in the system itself. Any such analysis will bring into question the very basis of the system; thus, the easy way out is to blame the bureaucracy for every failure and seek alternatives to it.

Thirdly, the successive failures of the government development programmes and the worsening of the poverty and ill-health situations, are generating reactions from the people. Whether under the influence of radical ideologies or otherwise, passive indifference is gradually giving place to violent protests and movements so far as peoples response to the failure of the system to meet their food and health needs is concerned. An organised response in any case will contain a potential threat to the existing'social order '. Different action groups are busy organising the people under their respective banners to demand their rights. The more radicals of them, rather go a step forward and demand a radical transformation of the system. Thus, the government by favouring a group of non-radical and status-quoist voluntary agencies, can leave the rest to choose between cooperation and state repression. It is politically prudent for the government to look for a "voluntary-non party sector" which accepts the ideology, spirit, and content of the official programmes andcarries them out in the desired manner. When perceived as collaborative the voluntary sectorcan expect existance, recognition, and rewards. Otherwise it faces a financial squeeze (as in the case of groups in the Rajasthan referred to earlier) or face a judicial enquiry.

(a-la-the Kudal commission), or direct repression. This pattern does not change irrespective of which party is in command of the government(Sethi, 1985).

Again, promoting a process of mobilizing and organizing the rural poor(an activity stressed in the government's new documents) on non-political lines. the government can simultaneously gain legitimacy for itself while de-legitimizing other efforts to mobilize and unite the people with long term political objectives. Thus the criteria for the voluntary agencies working intthe field of rural development have been prescribed as below:

a. It must be a registered society under the Registration of Societies Act 1860 or equivalent enactment of states;

b. It must be based in rural areas and must have worked there for atleast 4 to 5 years;

c. It must have professional and managerial expertise to produce regular audit statements and reports for funds received from government.

d. It must not belinked directly or indirectly to any political party and any one holding public office through a process of election is not qualified to represent voluntary agencies;

e. It is explicitly connected to secularism, socialism and democracy; it must declare it will adopt only legal and non-violent means for rural development purposes;

f. It must implement anti-poverty, minimum needs and socio economic development programmes designed to raise awareness levels of families living below the poverty-line and leading to an improvement in the quality of their lives".[91]

Thus, through legislative enactments the responsibility of the state to look after the health and development of the people is being shifted to this politically neutral middle sector, which would not question the rationality of the ill-conceived development plans and policies. The government's perception(rather the ruling elites, perception) of the voluntary sector is influenced by a host of political factors, some of which have been discussed above. The experiments of innovative ideas by some model projects further strengthens their perception. But as we discussed in the preceding chapter, these projects can at best have local significance. Even their local success can be contested by other agencies operating within the same project area. Moreover, even there has not been any study which can substantiate the role of voluntary agencies in 'delivering development'.[92]

As it is revealed in the different phases of our discussions, the voluntary development agencies cannot provide an alternative to the established order, nor do they have alternative solutions. These voluntary development agencies can at best operate as an extension of the government sector, sharing the ruling elitos' perception of the social realities or favourably contributing to it. Thus, the twin problems of poverty and ill-health remain as they were. As Zurbrigg writes, "development projects and model schemes, then are irrelevant to the ultimate proble ms of ill-health, no matter what their technical innovation and expertise, unless they clearly lead to empowering the poor and healthless to confront their dependency not only with regard to existing health system but more importantly within the entire social order. Unless they clearly lead to confronting the reality of present gross-mal distribution of health and economic resources and the powers that continue to legitimate and tolerate such injustices. Development efforts which do not start at this basic level of analysis and action are irrelevant to the national struggle".[93] A change in the status of ill health cannot be achieved by these voluntary action, unless the wider issues concerning poverty are resolved. The voluntary agencies under discussion do not seem to be capable of doing so.

VOLUNTARY ACTION AND THE CONFLICTING SOCIAL FORCES: THE UNCERTAIN ALTERNATIVES

So far, our focus has been on a group of voluntary agencies(who of course constitute the majority) who believe, that by delivering development services and making the people participate in its delivery. They can provide solutions to the problems of poverty and ill health. We had mentionedin the beginning of this chapter that there are other competing forces who claim to have understood the phenomena of poverty and ill health and are said to be following alternative strategies for their eradication or improvement. Some of these forces can be identified as gross-root action groups who are active within the voluntary sector and claim to have no political affiliations.[94] As Sethi writes, they represent the 'institutional mechanism' through which attempts have been made to articulate the needs of the marginalized to empower them, so that the mainstream society is forced to respond. In the vaccum created by development failures of the state, and the inability of the existing political parties(of all shades) to recognize articulate and mobilize the resultant discontent, it has been the social action groups which have thrown into forefront. Many of us have looked these attempts weak/sporadic /fragmented but with hope".[95]

Unlike the development oriented voluntary agencies, these action groups are working among the oppressed masses in order to create an awareness among them about their rights to revolt against the injustice and to demand their basic rights. In a nutshell, on a non-party line these groups mobilize people to provide an alternativeto the party political process, which as they believe is catering to the needs of a few at present. However, their 'alternative' also has severe limitations and they also do not look very different from the others.

First , they do not constitute a coherrent group sharing a common ideology or perception. They derive their inspiration from diverse ideologies and thus develop conflicting approaches. A collectivity of voluntary action groups is very difficult to find. Secondly, they are not much different from the developmental voluntary agencies so far as the 'dependence' on external sources is concerned. Foreign monetary assistance constitutes the life line for these social action groups. They need fund for two inter-related reasons; (i) sustain their own activities and (ii) to provide service to the community without which they cannot get an entry point. As one theorist for social action group writes, "the best situation would be

for the groups to have their own funds generated either out of their economic activity, or from contributions from their middle class sympathisers and base groups. But since the base population is itself fighting for survival, expecting it to support others is hardly possible. Similarly, the members of middle class sympathises is strictly stretched to their limits - .. In such a situation characterised by a low and insecure financial base most groups are forced to seek institutional financial support... Government assistance is neither easily available (not withstanding claims that the funds for Volags have been increased manifold) nor is it worthwhile expecting it for programmes that are directly supportive of the state. As for the corporate sector - its funding bias is very clear... The only institutional sources that remain are the foreign funding agencies, and linking up with them involves an entirely new set of dilemas including moral. Nevertheless, it is a reality (no matter how unwelcome), that access to foreign funding sources represents the life line for many of the social action groups".[96]

Thirdly, these voluntary action groups lack a clear vision of the realty and a clear approach.

Though they claim to have 'alternatives', they are not clear what alternatives they have in mind. Like the voluntary development agencies, voluntary social action group are also willing to extent official programmes to the community, thus supplementing the efforts of the government. As Sethi writes, "the struggle is not for or against an official programme, but a search for Truth and justice... the challenge is thus how to extend the official programme, while maintaining criticality".[97] It becomes really a difficult task to locate, if there is any significant difference between the two groups (voluntary development agencies and voluntary action groups). As they themselves admit, foreign financial assistance constitute their life line, they make the people of their area dependent again on anonymous sources, whose interests as we have discussed earlier are not clear. Inspite of all these limitations, they are consistently putting their voice for a non-party political alternative to political party process in order to bring a 'complete transformation' of social realities.

Thus, the social action groups operating within the voluntary sector, though seem to follow a different approach, their inspiration and framework of operation remain much the same. There cannot be alternative approaches to the problems of poverty and ill health

which will rather distort the reality and create confession. Again, the claim that gross-root action groups have, that they have understood poverty and are developing approaches (mainly based on their field experiences) to resolve it sounds peculiar. There cannot be poverty groups; poverty concerns the community in general and is a consequence of the exploitative relationship between the classes. To confine it to an artifically created community or group and developing an approach based on 'experiences' with it will betray the concept of poverty itself.

In the recent years the number of these voluntary developmental agencies and voluntary action groups has multiplied. This coincides with (1) the failure of the system to meet the food and health needs of the population and (2) the failure of political parties to come upto the expectation of the people. Even the left political parties and left oriented radical action groups have not been able to create confidence in the people. As one study reveals, out of the 48 millions agricultural labourers and 18 million share croppers only 3 millions have been unionised(Alexander, 1981): the rest remain literally untouched by political parties including the left parties. On the other hand, as the radical action

group's violent and fragmented activities(which are confined to small geographical areas), devoids them of any macro-political significance. The state can easily suppress such activities by using its coercive powers; thus the scene of poverty and ill-health remaining the same, will lead further to the victimization of the poor.

Again it is not easy to motivate people for a popular revolution just by feeding them with ideas and ideologies, when they are already starving and suffering from ill-health. The first thing they need is the minimum food and health needs; which any group or fraction within the voluntary sector is capable of providing independently (without external support). It will be equally fruitless for the people to depend on anonymous sources whose sincerity and motives raise always a question mark.

Thus, we can end up by saying that there are several political forces (known within the voluntary sector as voluntary development agencies/radical and non-radical action groups/grass-root groups); who are competing with each other for providing alternatives' to the present problems fof poverty and ill-health. The development oriented voluntary agencies(such as CRHP Jankhed and SWRC Tilonia) who get wide publicity and appreciation

from the national government and the international development establishments represent one of such forces. Considering their limitations and the anomalies in their basic approach to the 'social realities'(surrounding poverty and ill-health), they are least likely to contribute to the process of social change. The other competing forces have more or less the same limitations . Though they look different from each other, they are really not. Most of them lack macro-political perspectives and significance owing to the local and fragmented approaches they follow. The presence of all these conflicting forces makes voluntary action more complex and more ambiguous. Instead of contributing anything significantly to the phenomena of poverty and ill-health, voluntary action is reflecting the forces of 'pluralism ' in Indian Society today.

CONCLUSION : THE MAIN ISSUES

(Voluntarism, as we see through the chapters cannot be universally defined.) If voluntary action is to be judged by the spontaneous participation of the people in the management of their own affairs, we may not find a single voluntary agency which can satisfy our definition. As it is the socio-economic structures which determine peoples participation in the process of their own development, the genuine participation of the people is very difficult to trace in the Indian context. "A Feudal or a totally capitalistic state" writes S.K. Dey, "can afford no voluntary action except for its furtherance. (Voluntary action arises and meaningfully only where power to the people rules in an honest and refined democracy".)[98] (In a society characterised by object poverty and gross economic-inequalities, (Where the power of the people rests in the hands of the more equals), voluntarism seems to be more a prodduct of interaction between conflicting social forces, than an extension of individual or groups concern for the victims of poverty and ill health.)(As we saw in the beginning , the nature of voluntary activities change with a change in the nature of social forces(who interact with each other in order to produce some changes in their own favour). Individuals and groups in the voluntary sector, unwittingly or otherwise, serve one or the other political interests

stretching from the national society to the international development establishments. Those who subscribe to the ideology of the ruling elites and their collaborators are being given paramount importance. Their achievements are being reromanticised (as we saw in the second chapter) to such an extent, that it rather leads to the rationalisation of the failure of the systems to meet even the basic needs of the poor. The failure of the system and its 'subsdiary forces' to solve the problem of poverty and ill health gives rise to a number of competing forces within the society in general and the voluntary sector in particular. But as each of them has problems of conceptualizing the social realities and as each of them is dependent on anonymous sources for sustaining its activities; they are least likely to come anywhere near the roots of the problems.

The real development can be achieved not by simply providing services to a class divided community not it can be achieved by posing questions about the motives and interests behind them; the real development rather depends on the understanding of the exploitative social structures and a necessary will to change the social relationships in order to make it free of exploitations. Such a change is least likely to be achieved even with the help of the 'collectivity' of forces active

within the voluntary sector. It is also equally irrational to ask the poor and the diseased to wait for a radical change in the social order; which stands as a distant reality today. To organise the victims of poverty and ill health(who are already starved and disease-ridden) for any political or social movement for bringing desirable changes,makes the task even more difficult. The first thing they need is food and health care; but at the same time any dependence on "vested interests" for providing them food and medicines will defeat the whole purpose.

Thus, the limitations of the existing alternatives (mainly presented by the voluntary institutions and action groups) brings into focus the concept of Health Worker as an agent of social change" : a concept being discussed by some social scientists active in the field of health. The 'health worker' as it is believed, works closer to the people and has rapport over them. He has also a more clear vision of social realities. The assumption is to mobilise the people, making health as a central issue and then put pressure on the system at least to concede to them the basic minimum needs; the process that the health worker can initiate. Thus, the health worker is conceived as an activist within the system, who can, take advantage of the 'constitutional obligations' of the state, in order to make the system people oriented.

However, the concept needs a more detailed examination, considering the number and nature of questions it involves, with regard to its feasibility and real significance. The scope of the present study would not let us examine the issues at present; as the purpose of the present study is only to present voluntary sector as it was and as it is becoming and thus in the process to analyse the trends and influences, dominating and determining voluntary action. Some questions which need further examination can be categorised as:(1) how do voluntary agencies operate in relation to micro social realities (ii) Where do voluntary agencies stand in peoples' perception ? (iii) Do the people themselves provide legitimacy to the existence of a middle sector ? (iv) How do people perceive a health worker and how voluntary institutions/action groups/health workers operate in a given social structure?

NOTES

CHAPTER - 1

1. (a) Almost all the voluntary agencies in India have been registered under the Society Registration Act of 1860. The Societies registered under this act are entitled to government funds and other benefits.

(b) Here we take the opportunity of explaining in brief the concept 'pluralism', we have used in the introduction. By 'pluralism' we mean political pluralism which stands as the enemy of economic poverty. Pluralism has been a feature of affluent democracies, where it operates mainly as an extension of 'liberalism' - the guiding spirit of capitalist state. Different groups and parties struggle with another for retaining or capturing political power for perpetuating or advancing their own economic and political interests. It seldom affects the people, as the inequalities existing there is of affluence only. In a system like that of ours, which is characterised by inequalities of poverty, appearance of divergent ideologies in the political

process will lead to conflict of approaches and ideologies only; which will rather distort the social realities. The pluralism we see in India at present is not only an extension of liberalism but also an extension of marxism(or it is degeneration of Marxism !).

2. For a detailed understanding of the economic causes of Indian Nationalism, See A.R. Desai, Social Background of Indian Nationalism, Popular, Bombay, 1969.

3. Though religious missionaries were providing charity oriented services, it was alleged that they were motivated by religious interests. Charity often preceded religious conversion.

4. A.R. Desai(ed) Peasant Struggle in India, OXFORD, New Delhi, 1979, pp. 4-9.

5. See A.R. Desai, Social Background of Indian Nationalism, op.cit.,

6. Quoted by Dunu Roy, Between Dogma and Debate in Harsh Sethi and Smitu Kothari(ed), The Non-Party Political Process: Uncertain Alternatives, UNRISD/ Lokayan, New Delhi, 1983, pp. 48-49.

7. The Gandhian and socialistic principles have been incorporated in the 'Directive Principles of State Policy' of the constitution. The implementation of these principles depends on the 'will' or convenience of the rulers. These principles are not enforceable in the court of law. See Constitution of India, Eastern , Lucknow, 1087.

8. The increase in the number of Volags and the change in the nature of their activities particularly in the late sixties has led to several interpretation of the phenomena. However, the debate on it became lively only when the government disclosed its plan to put Volags under a council and a code of conduct.

9. The emphasis has been on delivering development to the rural community; thus the emphasis is on micro-level developmental activities.

10. See Shiela Zurbrigg, Structure of Ill-health and the Source of Change, Joseph, Madras, 1984, pp. 214-31.

11. The believe that bureaucracy is inefficient is even propagated with the help of the bureaucrafts themselves, See Bunker Roy, We Would Not Need Them if Government Could Do the 'job', Yojana, Vol. 28, no. 21-22, Nov. 1984, p.21.

12. By 'Structural Constraints' they mean institutional limitations only. These two phrases are being used inter-changebly, though structure and institution are not the same.

13. Rajni Kothari has made a critique of these populist rhetorics. See Rajni Kothari, The NGOs, The State and World Capitalism in ISI Manograph, n.28.

14. These 'concepts' are being popularised by international development establishments and the world bodies like WHO/UNICEF in their latest approach to the problems of rural poverty and ill-health. K.Newell(ed) Health by the people', WHO, Geneva, 1975(Alternative Approaches of Health Care, WHO/UNICEF, 1978).

15. Harsh Sethi and Smitu Kothari, 'On Anti-Voluntarism', Vol. 4, n.314, Lokayan Bulletin, Lokayan, New Delhi 1986, p.2.

16. Quoted in D. Bannerji , Health and Family Planning Services in India, Lokpaksh, New Delhi, 1987, p.15.

17. A number of 'nodal' agencies are operating in India today such as Oxfam, Action Aid, CARITAS, EZE, Ford Foundation, AVARD, Jamestji Tata Trustee etc. See Jesani, Gupta and Dugal, NGOs in Health Care, Vol. I, FRCH, Bombay, 1986, p.2.

18. Quoted by Bannerji, op.cit., p.207.

19. National Health Policy, GOI, New Delhi, 1983.

20. See "Colloborating with NGO in implementing national strategy of Health for All, GOI, New Delhi, 1985.

21. The document on voluntary agencies, Ministry of Health and Family Welfare, GOI, New Delhi, 1985.

22. Planning Commission, the Approach Paper to the Seventh Five Year Plan 1985-90, GOI, New Delhi, 1984.

23. The government does not differentiate between private and voluntary sector. This is reflected in almost all government documents, see for example, Health Statistics of India, GOI, 1983.

CHAPTER - 2

24. For a better understandingread, V.Navarro, Medicine under capitalism - Prodist, N.Y. 1978.

25. By socialistic countries we mean, USSR, China, Cuba and the East European Socialist countries, where 'socialism' is building up.

26. Health has been included in the 'Directive Principles of State Policy' of the constitution; then its implementation depends on the Will of the State, pp. 80, op.cit.,

27. Read Bhore Committee Report on Health Survey and Develcpment GOI, 1964, V.VI.

28. The Bhore committee had presented two type schemes; one covers two planning period while the other was a longterm plan. This was expanded the medical institutions and man power to the rural areas (GOI, 1946). However, due to lack of Political Will, these schemes have not been implemented.

29. Shila Surbrigg, op.cit., p.107.

30. D. Bannerji, op.cit., pp. 131-36.

31. Bannerji, ibid.

32. I Qadeer, Health Services System an expression of socio economic inequalities - Vol. 35, Social Action July-Sept, 1985.

33. I Qadeer, Peoples Participation in Health Services, Medico Friends Circle, 1977.

34. Qadeer, Health Services System - An expression of Socio-economic inequalities, op.cit.

35. D. Banerji, 'Poverty Class and Health Culture; Prachi Prakashan, New Delhi-1982, Appendix V.

36. Zurbrigg, Chapter IV, 'Special Interest', op.cit

37. The main purpose of writing the limitations of state health services is that, these limitations only provide scope for voluntarism. However, as these limitations are rooted in the socio-economic structures, the Volags are also likely to reflect similar limitations.

CHAPTER - 3

38. See Navarro, op.cit., pp. 159-71.

39. This approach facilitates inputs of money and materials to the Fragmented groups and communities; as the target is to increase the overall national output. Thus the distribution pattern is ignored.

40. See the Evaluation Studies, Newell, op.cit., and Alternatives WHO/UNICEF, op.cit.,

41. Drs. R.K. Arole and Mabelle Arole, are the couple, directing the CRHP, Project Jamkhed. Almost all evaluation studies have appreciated the special personalities of the doctors.

42. See Mabelle Arole and Rajnikant Arole Newell(ed)., Health by the People, op.cit., pp. 70-71. Also see, VHAI files on SWRC, Tilonia.

43 The Project Directors might have individual concern for the problem but they receive influences from the International Development Establishments, the national policy making fabric and from one dominant interests of the areas, thus are least likely to function independently.

44. Mabelle Arole and Rajnikant Arole, op.cit., p.70.

45. Collected from evaluation Study on SWRC, the Background and overview" - VHAI, file on SWRC, VHAI, New Delhi, p.7.

46. Aroles, op.cit., p.71.

47. Ibid., p.74.

48. Ibid., pp. 74-75.

49. R.K. Arole on 'Community Participation' collected from VHAI File on CRHP Jamkhed, VHAI, New Delhi.

50. See objectives of SWRC, in VHAI Files on Social Work and Research Centre Tilonia, VHAI, N.Delhi.

51. See 'The Profile of concept in Practice', SWRC, October, 1976.

52. In one of the objects of SWRC has been to provide employment to technically qualified educated youth in the rural development sector. It is difficult to know with what concern a job oriented youth help the starved peasant to make the latter self-sufficient.

53. For a detailed understanding of the concept, 'Health Culture' read S.K. Sahu, 'Health Culture of the Oraon's of Rourkela, Unpublished P.hd thesis, CSMCH/ SSS J.N.U. 1980. And also D. Bannerji, Poverty Class and Health Culture Prachi Prakashan , New Delhi, 1982.

54. It is related to the concept of victim blaming, which has been widely condemned by Bannerji in most of his studies. The fault is always found with individual's irrational behaviour: He is treated as independent of his Social setting.

55. Quoted by Bannerji in Health and Family Planning, Services in India, op.cit., pp. 392-93.

56. Aroles, in Health by the People, op.cit., p.80.

57. Ibid., pp. 78-79.

58. Ibid.,

59. Evaluation study on SWRC, op.cit., p.7.

60. Community Health Programme, SWRC collected from VHAI File, op.cit., p.19.

61. Ibid., p.18.

62. Vicsor. W. Sidel and Rusth Sidel, in the health care delivery system of the People's Republic of China K.W. New Delhi(ed)., Health by the People, op.cit., p.9.

63. C. Gopalan and B.S. Narsingarao Nutritional Constraints on Growth and Development in current Indian Dietaries, Indian Journal of Medical Research, Vol. 57, n.6, p.14.

64. Quoted in an Evaluation study on nutritional Rehablitation Programme of Rusha, VHAI File on Rural unit for social and Health Affairs, VHAI, New Delhi.

65. Mabella and R.K. Aroles, op.cit., pp. 75-76.

66. Ibid.

67. They start with this realizations but their programmes contradict their own understanding. See Aroles, op.cit., pp. 75-76.

68. Voluntary sector is so divided (ideologically and functionally) the concept of 'collectivity' can not be applied to it.

69. These project leaders, (as it is vident in the discussion) approach the communites with a pre-conceived notion and pre-designed framework.

70. Evaluation study on SWRC, op.cit.,

71. The evaluation studies show it that, these health projects have impressive creative services, which is most likely to influence public opinion with regard to the reaction to other programmes.

72. This is the major contradiction we see in the objectives and functioning of the projects.

73. (i) CRHP Jamkhed is located in Jamkhed village, Ahmednagar district, some 400 k.m. South-east of Bombay.

(ii) The Social Work and Research Centre (SWRC) is an indigenous voluntary organization that got its start in 1972 in a backward rural subdivision of Ajmer District in Rajasthan State in India.

CHAPTER - 4

74. Vicente Navarro : A critique of the ideological and political position ofthe Brandt Report and the Alma Ata' decoration' V.14, n.2, International Journal of Health Services, 1984, p.161.

75. Op.cit., p.228.

76. Navarro, op.cit.,

77. For a better understanding of the use of these concepts , read in Newell, op.cit.

78. Quoted by Navarro, op.cit., p.168.

79. H. Gray, 'The Problem' From Rural Sociology in India, ed., A.R. Desai, Popular, 1978, p.539.

80. Navarro, op.cit., p.165.

81. The first interpretation is being presented mainly by Action groups and action group theorists ,, Read Kothari, op.cit.,

82. Ibid.

83. Robert McNamara, Address to World Bank, 1975.

84. Op.cit.

85. Navarro, op.cit., 168.

86. Quoted by S.George in How the other Half Dies?. The Reasons for World Hunger, Penguin Books, 1976, p.70.

87. L.Doyal, The Political Economy of Health, Pluto Press, 1979, pp. 280-81.

88. Ibid., p.273.

89. F. Lappe, J. Collin, D.Kirley, Aid As Obstacle, Institute for Food and Development Policy, San Francisco, 1980, p.137.

90. Previously the government used to sanction grants to voluntary agencies but there was no specific policy towards them. See Ravi Duggal, NGOs, Government and Private Sector in Health, Economy and Political Weekly, Vol. XXIII, n.13, March 26,1988.

91. Bunker Roy, op.cit., p.22.

92. This was admitted by CH Hanumantha Rao, Member, Planning Commission in his interview to Yojana, op.cit., p.151.

93. Zurbrigg, op.cit., p.151.

94. They represent non-radical gross root groups. Some of them were human rights campaigns in the seventies.

95. Harsh Sethi, Wither Voluntary Action? Seminar, 309, May 1985.

96. Harsh Sethi, ibid.

97. Ibid.

98. S.K. Dey. Why don't we learn from the past? Yojana, op.cit. p.9.

BIBLIOGRAPHY

Adhikari, R ; Transnationals and Environment , Mainstream, March 1,1986.

Adiseshiah, Malcom ; 'No Good For The Big Task" - On Testing Voluntary Organisations, Yojana , vol. 28, n. 20/21, November, 1984.

Alexander, K.C. ; The Dynamics of Peasant Organisations in South India, Social Action, Vol. 31, Jan-March, 1981.

Baig, Tara Ali ; Voluntary Action; Retrospect and Prospect Mainstream - Jan 12,1985.

_____ ; The Welfare Triangle - Sunday Magazine The Hindustan Times, New Delhi, May 18,1986.

Banerji, D. ; Voluntary Agencies and India's National Tuberculosis Programme, A Background Document for the GBM of VHAI, held at Ootacamund i on April 26,1984.

_____ ; Health and Family Planning Servics in India - An Epidemiological; Socio - Cultural and Political Analysis and a Perspective , Lok Paksh, New Delhi 1985.

Banerji, D. ; Social and cultural Foundations of Health Services System, Economic and Politically Weekly (EPW) IX, Special Number, 1335-43, 1974.

_____ ; Poverty, Class and Health Culture, Prachi Prakashan , New Delhi, 1982.

Baig, T.A. ; The Welfare Triangle, Sunday Magazine, The Hindustan Times, May 18, 1986, New Delhi.

Bandopadhaya, D : An Escape or a Commitment ? Yojana, Vol. 28, n. 20/21,Nov. 1984.

Baxi, Upendra ; Activism at Cross Roads with Signposts, in ISI Monograph n.28, Indian Social Institute, New Delhi, 1986

_____ ; Two Threats to Democratic Social Action, Mainstream , August 2,1986.

_____ ; For Bunker, A Word of Advice, Mainstream, April 6, 1986.

_____ ; Power Broker, Beware Bunker Cometh, Mainstream, July 5, 1986.

Bang Abhay ; Learning from the Savar Project in K.S. Jaya Roy(ed) Under the Lens Medico Friends Circle(MFC/VHAI), Pune/ New Delhi, 1986.

Bang Abhay ; Myths in Community Health, Peoples Participation and Economic Self-reliance in K.S. Jaya Roy (ed), Ibid.

Benjamin, J. ; Voluntary Bodies and Rural Development Mainstream , July 19,1986.

Bhatacharya , A. ; Voluntary Agencies - Identity Crisis, Mainstream , July 27,1985.

C. Gopalan and B.S. Narsingarao ; Nutritional Constraints on Growth and Development in current Indian Dietaries, Indian Journal of Medical Research, Vol. 57, n.6

C.H. Hanumanth Rao ; An Interview, Yojana , Vol. 28, n.20/21, Nov. 1984.

Chad, S. ; Limitaticns of Voluntarism, Mainstream, May 15,1985.

Chatterjee, Mera ; Implementing Health Policy, Manhor, New Delhi, 1988.

Clerk, Andrew. ; What Developmental Workers Expect from Health Planners in K.S. Jaya Rao(ed), op.cit.

De, Nitish ; They do Fill the Slot, Yojana, op.cit.

Desai, A.R ; Social Background of Indian Nationalism, Popular Bombay, 1967.

_____ ; Peasant Struggle in India(ed) Oxford , New Delhi, 1979.

Desmukh, Nana. ; A Very Welcome Move Indeed on Volags, Yojana, op.cit.

Devi, Mahasweta ; You just cannot do without them, Yojana, Ibid...

Diwan, Krishnadev ; Shall we not be running a risk - Yojana, Ibid..

Doogra, Bharat ; Hopes may remain just hopes, Yojana, Ibid..

Doyal, L ; The Political Economy of Health , Pluto Press, 1979.

Dey, S.K. ; Why don't we learn from the past? Yojana, op.cit.

Duggal, R. ; NGOs, Government and Private Sector in Health, EPW, V. XXIII, n.13, March 26,1988.

Eldridge, P. ; Political Role of Community Action Groups in India and Indonesia, Alternatives, V. X, 1984.

Fernandese, W. ; Post Concilar Social Awareness in the Indian Chruch, Vidyajyoti, 47, n.6, July 1983.

_____ ; Some Dilemas Facing Action Groups, Reflections from Activists, Social Action, V.34, n.2, April-June,1984.

_____ ; Social Action Groups and Search for Alternatives , Dr. Alfred de Souza Memorial Essays, Indian Social Institute, New Delhi, 1986.

_____ ; Threats to Voluntary Sector - An Introduction, ISI Monograph,n.28, op.cit.

George, Susan ; How the other Half Dies; The Real Reasons for World Hunger , Penguin, London, 1976.

Government of India , ; Report of the Health Survey and Development Committee(Bhore Committee) (Delhi, Manager of Publications,Division), 1946.

_____ ; Report of the Committee on Multipurpose Workers(Kartar Singh Committee) (New Delhi, Ministry of Health and Family Planning), 1973.

Government of India ; Draft National Health Policy (New Delhi, Ministry of Health and Family Welfare), 1977.

_____ ; Sixth Five Year Plan 1980-85 (New Delhi, Planning Commission, 1980.

_____ ; Recommendations of the Seventh Joint Conference of the Central Council of Health and the Central Family Welfare Council (New Delhi, Ministry of Health and Family Welfare), 1981.

_____ ; Statement of National Health Policy, (New Delhi, Ministry of Health and Family Welfare), 1982.

_____ ; Health Statistics , Central Health Investigation Bureau, 1983.

Gray , H. ; From Rural Sociology in India, ed., A.R. Desai, Popular, 1978.

Illich, Ivan ; Medical Nemesis: The Expropriation of Health, Caldar and Boyars, London, 1975.

Government of India ; Draft National Health Policy (New Delhi, Ministry of Health and Family Welfare), 1977.

_____ ; Sixth Five Year Plan 1980-85 (New Delhi, Planning Commission, 1980.

_____ ; Recommendations of the Seventh Joint Conference of the Central Council of Health and the Central Family Welfare Council (New Delhi, Ministry of Health and Family Welfare), 1981.

_____ ; Statement of National Health Policy, (New Delhi, Ministry of Health and Family Welfare), 1982.

_____ ; Health Statistics , Central Health Investigation Bureau, 1983.

Gray , H. ; From Rural Sociology in India, ed., A.R. Desai, Popular, 1978.

Illich, Ivan ; Medical Nemesis: The Expropriation of Health, Caldar and Boyars, London, 1975.

Indian Council of Medical Research ; Evaluation of Primary Health Care Programme, Proceedings of the National Conference, held in April, 1980, ICMR, New Delhi, 1980.

ICMR-ICSR ; Alternative Approaches to Health Care, ICMR, New Delhi, 1977.

_____ ; Health for All: An Alternative Strategy, Indian Institute of Education, Pune, 1981.

Jaju, Vlhas ; Role of Village Health Workers - A glorified Image - K.S. Jaya Roy (ed), op.cit.

_____ ; Community Participation in PHC, Ibid.

Jain, L.C. ; Gross without Roots; Rural Development Under Government Auspices, Mainstream, October, 13, 1984.

_____ ; Debates in the Voluntary Sector - Some Reflections in ISI Monograph, op.cit.

Jhon, J. ; A critique of action groups : The Marxist Review, V. XVI, n.2, August, 1982.

Kabra, K.N. ; Why go for a false alternative, Yojana , op.cit.

Karrat, Prakash ; Action Groups/Volags : A Factor in Imperialist Strategy, The Marxist, V. 2,n.2, April-June 1984.

Kothari Rajni ; Masses, Classes and the State, Alternatives, V.XI, 1986.

_____ ; Grass Roots, Seminar, January, 1984.

_____ ; The NGOs, The State and World Capitalism, ISI Monograph,op.cit .

Kulkarni, M ; Bunker, Baxi and Voluntary Sector, Mainstream, June 5, 1985.

Kulkarni, P.D : Voluntary Action Myth and Reality, J.B.M. Lecture, (NIPCID,N.Delhi,1983.

Kulkarni, S ; Volags and the New Policy, Lokayan Bulletin, V.4, n.3/4, Lokayan, New Delhi, 1986.

Lappe, Collin & Kirley ; Aid as Obstacle, Institute for Food and Development Policy, San Francisco, 1980.

Mukhapadhya, Amol : 'Health for the Millions' VHAI Bulletin, vol XIII no 5/6 1967 148

Mendha Purkar, S. ; National Council Some Thoughts - A Discussion, Mainstream, August 2,19

Muricken , Ajit ; Again on Action Groups - Agents of Change for Revolution, The Marxist Review, V. XVI,n.4, October, 1982).

Babarro, David ; Health for all by 2000 AD - A great polemic dissolves into platitudes, K.S. Jaya Rao(ed), op.cit.

Navrro, Vicente ; A critque of the ideological and political position of the brandt report and the Alma-Ata Declaration,IJHS , V.14,n.2,1984.

Oomen T.K ; Stability and change : An analysis of Bhoodan and Gramdan, Movement in India, Thomson, N.Delhi, 1972.

_____ ; Social Structure and Politics- Studies in Independent India, Hindustan, New Delhi, 1984.

Pardesi, G. For Roy, Boxi - A word of caution , Mainstream , April 27,1985.

Patnaik , S. ; Political economy of involving voluntary sector in the path of development (unpublished) , A Paper presented at Indian Social Science Congress, Mysore (July 14,1987.

Qadeer, I ; Health Services System an expression of socio economic inequalities - Vol. 35, Social Action, July-Sept. 1985

_____ ; Peoples participations in health services, Medico friends circle,1977.

Rajkrishna ; It would just be a futile exercise, Yojana , op.cit.

Rajgopal Arvind ; And the poor get gassed; MNC's aided development and the State the Case of Bhopal, Berkerly Journal of Sociology, V.XXXII,1987.

Roy Bunker ; We would not need them, if government can Yojana, op.cit.

_____ ; For PM - a word of advice, Mainstream March 9,1985.

_____ ; Power brokers in voluntary sector, Mainstream, June 14,1986.

Roy Bunker ; Raw deal for rural poor, Mainstream, February 15,1986.

_____ ; Discipline and accountability, A discussion , Mainstream, Sept. 20,1986.

Roy Dunu ; Between Dogma and Debate(ed), Kothari and Sethi, Non party political process - Uncertain alternatives, Lokayan, N.Delhi, 1984.

Redy Rama ; The Co-operative Sector and government control, ISI Monograph, op.cit.

Ritu Priya ; Voluntary action for an alternative health system, Lokayan bulletin, op.cit.

Sarkar, B ; They do have a role to play : Yojana , op.cit.

Sahyamurty T.V. ; Political Economy of Poverty and Aid; Case of Indiain Mainstream , A series of Articles , Nov 20,27, Dec. 4 & Dec 11, 1982.

Valkin, Henry ; Action groups - Beginning or End of a Dream, social action, v. 34, n.2, April-June, 1984.

Vishwanathan , L.S. ; Peoples Organisations for rural development Mainstream, Jul 27,1985.

LIST OF DOCUMENTS

1. VHAI files on CRHP, Jamkhed; SWRC, Tilonia and Rusa,Tamil Nadu, Voluntary health institution of India , New Delhi.

2. VHAI on Evaluation studies on voluntary projects, VHAI, New Delhi.

3.