ROLE OF NGOs IN HEALTH AND DEVELOPMENT PROGRAMMES IN INDIA SINCE INDEPENDENCE : A POLICY ANALYSIS

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CERTIFICATE

This is to certify that the dissertation entitled **"ROLE OF NGOs IN HELATH AND DEVELOPMENT PROGRAMMES IN INDIA SINCE INDEPENDENCE : A POLICY ANALYSIS"** submitted by **Manoj Kumar Kar** 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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CONTENTS

ACKNOWLEDGEMENT

Today in India Community Health needs urgent attention from all scholars working in the field of developmental sector. Being a student of Public Administration I made a serious effort to understand the multi-dimensional linkages in Health and Development. After scanning the different lierature with social sciences in health I focussed my attention to carry out analysis on the **"Role of NGOs in Community Health"**. Because of the sea change which is going to take place in India due to Liberalisation, Privatisation and Globalisation of Indian economy to bring out overall development of the country in the context of global market.

This dissertation has been worked out mostly on the secondary literature and data contributed by eminent scholars working in the field of Non-governmental Organisations. Also it is the culmination of several years of work of different NGOs involved in Health and related development sectors in India.

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ABBREVIATIONS

ACHAN	Asian Community Health Action Network
AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
AVARD	Association of Voluntary Agencies for Rural Developent
AWARE	Action for Welfare and Awakening in Rural Environment
BIMARU	Bihar, Madhy Pradesh, Rajasthan & Uttar Pradesh
BSA	Banwasi Sewa Ashram
CAPART	Council for Advancement of People's Action & Rural Technology
CBD	Community-based Contraceptive Distribution
CBO	Community Based Organisation
CDP	Community Development Programme
CHDP	Comprehensive Health and Development Project
CHG	Community Health Guide
CHV	Community Heatlh Volunteer
CHW	Community Health Worker
CINI	Child In Need Institute
CPR	Centre for Policy Research
CSWB	Central Social Welfare Board
DRDA	District Rural Development Agency
DWCRA	Development of Women and children in Rural Areas

EC	European Communtiy
EGS	Employment Generation Scheme
FCRA	Foreign Contributions Regulations Act
FPAI	Family Planning Association of India
FRCH	Foundation for Research in Community Health
GOI	Government of India
GONGO	Government Oriented NGO
ICDS	Integrated Child Development Scheme
ICMR	Indian Council of Medical Research
ICSSR	Indian Council of Social Science Research
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IRDP	Integrated Rural Development Programme
KEM	King Edward Memorial Hospital
KSSP	Kerala Sastra Sahitya Parisad
MCH	Maternal and Child Health
MH & FW	Ministry of Heatlh & Family Welfare
MHC	Mini Health Centres
MPW	Multi Purpose Worker
NGO	Non-Governmental Organisation
NIH & FW	National Institute of Health & Family Welfare
PHC	Primary Health Centre
PRIA	Participatory Research In Asia

PSS	Parivar Seva Sanstha
PVOH	Private Voluntary Organisation for Heath
RCO	Rural Community Organisers
RUHSA	Rural Unit for Health and Social Affairs
S&T	Science and Technology
SEWA - Rural	Society for Education Welfare and Action-Rural
SSWAB	State Social Welfare Advisory Board
SWRC	Social Work Research Centre
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
UPASI	United Planters' Association of Southern India
USAID	United States Agency for International Development
VHAI	Voluntary Health Assocation of India
VHS	Voluntary Health Services
VHW	Village Health Worker
VOLAG	Voluntary Agency
WHO	World Health Organisation

CHAPTER - I

INTRODUCTION

Voluntarism has a long history in India. It was the main source of welfare and development since Vedic times except for the Maurya and Gupta periods which had substantial public welfare systems (Sen, 1993, p.3)[1]. The colonial period witnessed the large impact of Gandhi on the Growth of voluntarism. He believed that voluntary action was the only development path for India. In addition rural reconstruction, the goal of Gandhian volags (voluntary agencies) was the political independence of the country.

Gandhian and religious volags dominated the scene after Independence. The former aimed at agricultural and livestock programmes, Khadi, (hand woven clothe) and village industries, cooperatives and education. Religious volags aims at relief for refugees and victims of natural disaster as well as education.

Consensus on development strategy began to break down during the 1960s and 1970s. This mood of disillusionment influenced the evolution of the voluntary sector. The Sarvodaya Movement, involving the voluntary distribution of land to the poor, reached its zenith and then lost its appeal during this period. (Panadikar 1987)[2].

The 1980s and early 1990s saw a large expansion of Non-Governmental Organizations (NGOs) both because people were loosing faith in government and because there was a very rapid rise in the availability of funds from domestic and foreign sources. A distinctive feature of this period was the proliferation of organizations with separatist and fundamentalist aims. (Gulhati, et al. 1995)[3]

NGO-a term increasingly used by government and International Funding agencies stresses the Non Governmental nature of the activity.[4]

NGOs over the years have become an important segment of the development and welfare sectors. A large number of NGOs working all over the country, each with its own approach, methodology and objective.[5]

NGOs popularly called 'Voluntary organisations' in the field of Health care have acquired a considerable importance since the emergence of the 'Community Health Approach'.[6]

NGOs generally speaking would include the entire private sector but in its popular uses the term NGO is not the equivalent of the popular notion of the private sector.[7]

NGOs and Voluntary organisations are most often used as interchangeable terms. But such usage is considered to be incorrect because strictly speaking such organisations are neither voluntary in character nor individuals working in them are volunteers.[8]

NGOs are private organisations with a difference. Firstly, an overwhelming majority of NGOs are registered as public trusts or societies. The adjoint of this is that they can receive donations and donors of various tax deductions. Secondly, NGOs are run as non-profit making ventures. Thirdly, the areas of work they are involved in, is what is popularly known as the Development sector. This includes welfare programmes such as health, education, nutrition, family planning, water supply and housing; and agriculture related development programmes (IRDP etc.) and employment programmes (EGS, FFW etc.). And fourthly, NGOs as a rule do not generate their own funds completely but rely on external financial assistance from

governmental as well as Non-Government (Funding) agencies, both national and International. Finally, to a large extent the programmes adopted by NGOs, especially in rural areas, are programmes of the governments rural development and social services sector and quite often the implementation of these programmes are considered a collaborative effort.[9]

NGOs are a very heterogenous group with their own thinking and motives which can range from proselytization, charity or development to political activism. By their very nature they are highly individualistic and non-conformist, zealous in guarding their autonomy and hence action. Never the less because of their selfless commitment they have high credibility with the people with whom they work as well as in society as a whole.[10]

The strength of the NGOs (Voluntary organisations) was not only in their motivation and credibility but also in the freedom of action which they enjoy as compared with the government or even the organised private sector. They are free to choose their area as well as the type of work, can enjoy readily adapt to changing circumstances and enjoy remarkable latitude for social experimentation and research. On the other hand a major constraint of voluntary organisations is their inability to support themselves and having to depend on external funding from International or national funding agencies; whether it be governmental or private organisations or trusts from public contribution. The nature and extent of the activities of NGOs are therefore to a considerable extent dictated by the source of their funds. This also results in lack of security for planning of large scale long term activities as also in the securing and retention of personnel, most of whom are highly professionalised.

In India, the health and development sector has a long tradition of voluntarism. For centuries, the tradition healer family in a their community pioneered the tradition of running charitable dispensaries and hospitals. Gurudev Ravindranath Tagore went much further in his effort by evolving health care service for the Santhal villages around Shantiniketan; which included the refreshing concepts of cooperation, low-cost curative services etc. Mahatma Gandhi throughout his life propagated naturopathy, better sanitation, simple and wholesome food through the constructive organisations that his followers set up through the country.[11]

From the mid-sixties onwards, the western curative model of health care went through a lot of questioning in the development circles all over the world, out of this process grew various models in the voluntary sector, which emphasised more on the health workers played a significant role and more importance was placed on preventive aspects including health education. A lot more effort was made to involve the community in their own health- care. Unfortunately, this trend of thought somehow missed the important role of traditional systems of medicine, particularly involvement of traditional health practitioners in health-care delivery systems.

Existing Voluntary health services through different Non-Governmental organisations can be mainly divided under the following categories:[12]

i) Specialised Community Health Programmes

These groups are primarily running decentralised, low-cost, community health programmes. In these efforts, stress is on training of local levels village health-workers, doing preventive work, health education and on community involvement.

Many of them go a little beyond health by running income-generation schemes for the poorer community so that they can meet their basic nutritional needs. Examples of this approach are the health programmes run by the Society for Comprehensive Health Project at Jamkhed, Maharashtra, Ashis Gram Rachna Trust at Pachod, Maharashtra, RUHSA campus and child Need Institute in West Bengal. These programmes have done innovative work in primary Health care which is worth replicating.

ii) Integrated Development Programmes

In these programmes, health is a part of the overall development activity. Consequently their thrust in health care may not be as systematic or as effective as the early type but the overall long-term effect of their work in health and development is very significant. The examples of this type are : The Self Employed Women's Association - Ahmedabad, Social Work Research Centre - Tilonia, Gram Vikas - Berhampur (Ganjam) and the Maharogi Sewa Samiti - Maharashtra etc.

iii) Health Care for Special Groups of People

This includes education, rehabilitation, care of handicapped people like spastics, the mentally retarded and treatment and care of leprosy patients etc. These specialised agencies are doing pioneering services keeping in view of the fact hardly any government infrastructure exists in this sector of health care. The examples under this type include; Viklang Kendra in Allahabad, Spastic Society centres in New Delhi, Bombay, Calcutta etc. Some NGOs like (FPAI) Family Planing Association of India just take on specialised family planing activity.

Despite the remarkable voluntary effort all over the country; the reasonable 'National Health Policy' formulated at a the Government level during the mid-seventies; the present state of India's Health is a fact for major concern. Since till date India is categorised with the poorest and most underdeveloped nations of the world like Mauritania and Nepal as far as health state is concerned. Also there is an extraordinary difference between the health status of the people of states of Kerala and Punjab on the one hand and the people of Uttar Pradesh and Bihar on the other. The health status in Kerala and Punjab can be compared with some of the developed countries and U.P., Bihar, Madhya Pradesh and Rajasthan can be termed as among the worst anywhere in the world. The following chart gives a glimpse of the grim picture of the country's health status[13]:

i) 85% of our children are malnourished, one lakh die due to it each year.

ii) Our Infant Mortality Rate (IMR) is 105 per 1000. The Rural IMR is 140-30% of all deaths in our country.

iii) Children under 5 years form 10% of rural population. 50% of rural deaths are in that age group.

iv) Mortality rate of rural population on an average is twice as high as that of the urban population.

v) Haemoglobin percentage of the average Indian women is far below the normal requirements.

vi) Half of the world's 20 million TB patients are in India.

vii) One-third of the 10 million leprosy patients in the world are Indians.

viii) 13.5 millions or 2% of the total population suffers from pulmonary TB.

ix) 14 million suffer from filariasis.

x) Our water borne diseases, Cholera, Typhoid and Gastroenteritis, affect innumerable millions, killing at least 1.5 million people every year.

xi) 24% of deaths are due to diseases of non-immunisation.

xii) Every year we have 3 million new cases of Malaria and 1.2 millions of them die.

xiii We have 9 millions blind Indians : 5 million are curable, 25,000 children blind because of vitamin-A deficiency, 3 millions suffer from other forms of this deficiency - night blindness, dry eyes, rough skin.

xiv) There is one doctor to every 3000 population. 80% of the Indian doctors work in urban areas while 80% of them live in rural areas.

xv) Drugs cover only 20% of the population.

xvi) 56% of the deaths are preventable.

xvii) Diseases of pregnancy, childbirth and early infancy account for 14% of all deaths.

xviii) 3/4th of the Health budget is poured into expensive specialist services benefitting less than 1/4th of the population.

There are some fundamental problems in the health care delivery system exist in India. In general some of the basic causes of this situation can be identified as follows:[14]

i) There has been little or no participation of the people in health care, particularly in the government sector.

ii) Although there has been some restrictive of the colonial health system after Independence, it has not been radically altered to meet the needs of the rural community.

iii) The gross disparity of health budgets between big city based hospitals and the rural primary health care needs to be revived. Also, for the last few five year plans, budgetary allocation to the health sector has gone through substantial reduction.

iv) The present government health plan model did not try to build on the existing strengths of traditional health care system.

v) There has been very little effort and evenness success in improving the sanitation and safe drinking water supply situation, which is the major cause of ailment in this country.

vi) Primary education is not spread throughout the country adequately and even in the areas where it has spread, it has failed to build a rational and scientific attitude among the people. The drug companies and related marketing forces have propped up " Pill, injection and tonic" oriented health care among the majority of the people.

vii) There has been hardly any inter-sectoral coordination within and outside the health sector, consequently, there have been too many vital gaps, overlapping and confusion.

viii) Too much emphasis on the family planing target has kept primary health care professionals totally engrossed on this activity.

Therefore, in the present context, the most relevant role or stand the NGOs can take in the field of health - development sector which can affect both the implementor as well as policy planner of the Health and Development Programmes can be discussed through the following heads:[15]

a) To develop a rational and scientific attitude for health care among the people so that they do not succumb to the publicity of vested interests but promote a kind of health care which generates most benefit for them.

b) It is of primary importance to build up a health movement in the country. Creating popular pressure at the grass-root level for better utilisation of existing government health facilities and at the policy level to restructured the health plan and for reorientation of the health budget is important.

c) Remote areas where government health structure does not exist can be reached by NGOs with primary health care approach; by which the existing gap can be bridged in the government health system.

In our country after four decades of Independence and planned development almost half the population lives below the poverty line, where lack of employment facilities, inaccessibility of minimum wage, complete absence of basic amenities of life and working under hazardous conditions are routine matter, for the majority of this half, Health for All by the year 2000 is a distant mirage. Thus this dissertation tries to analyse the major initiatives taken by NGOs so far the social-economic and political structure of the drastic social-change required in the health development programmes for the meaningful policy-sensitive issues in response to the vogue of 'Health for All' by 2000 A.D.

The last decade could well be called the decade of Non-Governmental Organisations (NGOs), Voluntary Development organisations, Voluntary Agencies etc. In the broader context of the development debate, the experiences of NGOs have received particularly visibility during the last decade whether it is Adult Education

and Literacy or Primary Health Care, NGOs seem to have made their mark. Issues of women's rights, themes of women and development of oppression against women and gender discrimination are today at the centre stage of development debate and on the agenda of planning of programmes because of different institutional supports in the concerned field like, women's organisations, voluntary organisations etc.

The visibility has been possible, on the one hand, because of the claims and public postures taken by the NGOs, consortiums and Networks of NGOs themselves. The internationalisation of those networks and linkages across NGOs has, on the other hand, only helped to increase that visibility. Bringing hither to neglected sectors and clusters of population into development planning-women, tribals, the landless, working children etc. in general and their Health in particular is being claimed as one of the major contributions of Non governmental development organisations during the last few decades.[16] Raising issues has been ignored in development dialogue, debate and planning-issues of legal rights, women's oppression, deterioration, sustainable development, indigenous system of health practices etc; has also been claimed to be possible because of the continuous working of NGOs in these areas.

The growing visibility of NGOs provoked a series of associated responses. Major international and theoreticians had to deal with NGOs, their roles, positions, behaviours and dynamics - a phenomenon largely missing a decade ago. Most bilateral agencies engaged in providing development aid have started including NGOs in their framework. The same can be said for multi-lateral institutions and in recent years by such bodies categorised by the world bank as follows:[17]

1. National governments throughout the length and breadth of the world, have had to deal with the growing visibility of NGOs, in varying degrees. Of course, this has also resulted in counter-claims, largely innovating from official machinery, on the one hand, and political power centres, on the other. These counter-claiming decry the work of NGOs as a temporary aberration in societies, as a part of a 'global conspiracy' to weakens the state and the political system. The most profound counter-claim questions the vary contribution of NGOs during the last decade by printing out that they have very little to show as an alternative and that they are mere 'professional-dissenters' of all that national and international agencies propose to implement (Tandon).[18]

2. While the underlying motivations for such counter-claims may be worth pursuing, it is now evident that NGOs occupy a historic and visible presence on the development arena, nationally and internationally.

Another trend which has become increasingly visible in recent years is the growing harassment of those working with the NGOs and the NGOs themselves, by the state, its agencies, law and order machinery as well as vested interests. Physical attacks, malicious campaigns, manipulative undermining and divisive interference are various forms in which this harassment of NGOs and their staff is going on the different parts of the world and more intensively in the countries of the south.

3. Partially in response to the growing international presence and partially in response to the increasing national voice created by NGOs and their networks,

national government have begun to feel the need for measures intended to silence the voice of NGOs. In a country like India this has been much more widespread and intense in recent years. It certainly raises questions about the effect of the work of the NGOs which is threatening the status-quo in some way or the other. If local and regional vested interests and ruling elites react, if government officials, agents of the local and national government react, if the law-and-order machinery is used to suppress the freedom of speech and association and the work of NGOs, then it certainly indicates that NGOs are having some effect somewhere.

4. India is one of the major countries involved in the debate around issues of development and is also a witness to these trends. They have been able to establish a significant presence from the local to the national and now also at the international level. Also many of these NGOs have pioneered in the process of national development planning. The entire range of issues related to women, their rights and voice against gender discrimination, the rights of the girl child, education of women, leadership and empowerment of the poor, health-developments of the underprivileged sections etc. can be articulated, debated and proposed by NGOs as their performance. Popularising science and technology, repropagating indigenous and appropriate technology, on the one hand, and promotion of people's culture and folk forms for education, health and empowerment of the poor on the other are also the areas where NGOs have contributed some pioneering work. Thus in a country like India, no aspect of the development discourse can be carried forward today without paying attention to the work and the voice of the NGOs.

And yet we know that voluntary initiatives, voluntary action, voluntary work and voluntary organisations have a long chequered and glorious history in this country, Social-reform movements, political movements, movements for liberation of the country-all have derived strength from voluntary initiative and voluntary action. Historically, all types and forms of voluntary organisations and development promoting institutions have existed and continued to exist, in India. We have excellent relief and rehabilitation organisations, we have efficient educational and health institutions; we have 'new development-agenda' organisations, specialised technical assistance organisations, social-action groups in the field of non-governmental development sectors.

But what has been history of NGOs? What have been their contributions in the past? What historical factors have facilitated or constrained their growth? What is their contemporary character? What range of roles and initiatives do they encompass? What kinds of innovations made by them have found their way in larger development policies? What is their future? and what is the potential for their future contribution? These become the issues and questions raised in the present dissertation in order to understand the context in which NGOs have grown and evolved in health and development sectors in India.

The above questions have been analysed on the basis of different scholars view points and findings. To arrive at a broad conclusion on the topic a theoretical approach is necessary to understand the evolution of NGO/voluntarism; several scholars have contributed to develop a common understanding on the evolution of NGO out of the concept of welfare state.

Evolution Of The Welfare State

Rise of capitalism is associated with the establishment of modern states. As these were built up and internal feudal restrictions of trade, transit of production activities were done away with; the rational economy of modern time emerged and it provided condition for the gradual establishment of what we presently know as the systems of health care services.[19]

Welfare State

According to Asa Briggs(1966:10-12)[20], "a welfare state is a state in which organised power is deliberately used (through Politics and Administration) at least in three directions-first by guaranteeing individuals and families a minimum income irrespective of the market value of their work or their property; second by narrowing the extent of insecurity by enabling individuals and families to meet certain 'social contingencies'(for example, sickness, old age and unemployment) which lead otherwise to individual and citizens without distinction of status or class are offered the best standards available in relation to a certain agreed range of social services"[21]. According to Briggs, the first and second of these objects may be called a 'social service state' because it brings in the idea of 'optimism' rather than the older idea of the 'minimum'. Thus, as Desai (1966:163) points out, the welfare state "wants to positively intervene and reshape the economy in such a manner, what a floor of social living is created for all citizens, by providing a certain range of facilities and provisions irrespective of the Status and class position of citizens in society.[22]

This definition clears that welfare state cannot exist without the state massively increasing its expenditure for the essential services. This goes well with Dobb's

(1978:387) contention that the 1940s is regarded as the period of a qualitative change in the economic functions of the state, a period marked by the state undertaking production, but more importantly, massively increasing its expenditure[23]. Further, in the developed countries, the establishment of welfare status was preceded by four centuries of economic growth aided by intense colonial exploitation and also by over one hundred years of states minimum services to certain was started there, it was essentially a question of reorganising the existing services in such a way that the direct play of market forces was consciously restricted or contained at the time of exchange (delivery of services) by the state.[24]

Underdeveloped Countries

For various reasons, the underdeveloped countries were late entrants in the historic process of industrialisation and modernisation. In the developed countries, the state intervention had evolved from the four centuries of economic growth. But the underdeveloped countries had no time to allow for such organic growth of their economies. Further, the economies of most of them even after political independence, continued to remain highly dependent, and even under control, of the developed countries. Thus, their development if highly conditioned by the role played by the state in their economies as well as services. The earliest example is that of Japan, where in the late 19th century and later, the state itself undertook the task of industrialisation. The modern industry was set up by the state at its own expense, and the same was later privatised or transferred to the private sector which ultimately took over state enterprises, was nurtured and promoted through state contracts, and so on (Mandel 1971:499)[25].

Modern Welfare State

In the Western Europe, the transition from the 'social service state' to the 'welfare state' took place in the second quarter of 20th century[26]. This a period of the 'great economic depression', rise of fascism, Second World War and the rising activity of masses. This situation brought about a change in the thinking of economists. Keynes (1967) showed in his book published in 1936 that the 'outstanding faults of our economic society in which we live are its failure to provide for full employment and its arbitrary and inequitable distribution of wealth and incomes' and that for the growth of capital, full employment is highly conductive and actually necessary. And further, 'the central controls are necessary to ensure full employment will of course, involve a large extension of the traditional functions of government's (Keynes, 1967:372-84)[27]. The state intervention therefore, was no longer regarded as an evil, but as "simultaneously a feature of the welfare society as well as a stabilising device for the economy as a whole". (Winch 1969:21)[28], (Doyal and Pennell, 1981:141-76).[29]

Health care was also taken as a part of the welfare package, for it is traditionally associated with charity and welfare; and also under increasing demand and full employment, the productivity of labour power and thus health of workers because important for the economic development as such. The working class, on the other hand, had made great sacrifices during the second World War and after the war got over, put unbearable pressure on the governments to go for the National Insurance and complete coverage. The actual implementation including the relative scope for the operation of private sector in health care, were politically determined depending on

the relative strength strongly of the workers and rulers in each country (Navarro 1978).[30]

Indian Welfare State

While examining the welfare functions of the Indian State, the first aspect to catch our attention is the constitution. V.Jagannadham (1966:250)[31] says that 'India has written into her constitution the ideology of the welfare state'. Also 'the Preamble declares India as a Sovereign, Socialist, Secular, Democratic Republic' (Constitution, 1977:1)[32]. The directive principles of state policy, lay down in details various function of the state in various welfare activities such as provision of adequate income, employment (right to work), prevention of concentration of wealth, redistribution of wealth, free legal aid, free education, improvement of public health and so on[33].

In order to help people to effectively exercise their fundamental rights and to progressively realise the directive principles, the Government of India set up in March 1950 the Planning Commission (1952:3) Thus from the very beginning, planning was made, in Myrdal's (1982 : 711) words; "The intellectual matrix of the entire modernisation idealogy". Instead the planning by the state has become a growing concern for the economic development and welfare in the last four decades.[34]

Is India a welfare state? According to Asa Briggs definition; India is far away from fulfilling conditions to make claim of having welfare state[35]. The state policies are still talking about providing 'minimum' to selected deprived strata. This is, a far cry from the objective of providing 'optimum' to all. M.Venkatarangaiya (1966:221) believes that in the post second world war epoch, the "states in underdeveloped areas

have no other alternative than to function as welfare states", and he argues that "in western countries economic development took place before the welfare state was born. This was only an accident and it does not follow from it that such a state is out of place in an underdeveloped economy".[36] Although we agree with Venkatarangaiya that even within capitalist economy the ideas of welfare state are worth arguing for and fighting for. We should not, even for a moment, deter from critically evaluating the actual performance of the state in India in making those ideals a reality.

How far have the state's polices in India furthered the realisation of ideals of welfare statism in the field of health care? Many scholars have examined state policies and their actual implementation [Banerji,(1985), ICMR/ICSSR (1981), Jeffery (1988)][37]. But in brief, it can be stated that what V.Jagannadham (1966:253) desired as three fold policy hazards seem to hold true even today. Jagannadham formulated these hazards as "(1) The confusing dichotomy between the social objectives of policies and legislation, and the traditional commercial cost benefit analysis of the private market; (2) The frustrating lag between idealism and pragmatism in policy formulation and (3) The depressing deficiencies in the follow-up of the polices".[38]

A complex inter-relationship exists between health and development; it is certainly not a one-way relationship, and there are surely reciprocal and synergistic elements to it. It has long been acknowledged that the health status of the population in any particular place a country influences development. It can be a limiting factor, as generally poor individual health can lower work capacity and productivity, in an aggregate in a population, this can severely restrict the growth of economies. On the other hand, economic development can make it possible to finance good

environmental health, sanitation, screening and health promotion and to provide broad-based social care for needy groups. General social development, particularly education and literacy, has almost invariably been associated with improved health status via-improved nutrition, hygiene and reproductive health. Socio-economic development, particularly if equitably spread through the population-although this is rarely the case-also enables housing and related services to improve. The classical cycle of poverty can be broken by development[39].

However, it is notoriously difficult to provide generalisations about the relationships between development and a population's health status. But, many examples on this literature show how economic development has contributed to improve quality of life and health status, via indicators such as increased life expectancy, falling infant, child and maternal mortality and enhanced access to services. In contrast, there are examples in which economic development, infrastructure expansion and agricultural intensification do not always coincide with improved human well-being. There is in fact growing realisation that macroeconomic changes not always filter down to benefit all of the population and many perhaps soundly based policies in economic terms, notably structural adjustment policies can have devastating human effects in increasing poverty and maldistribution of resources. In the face of these policies, the health sector above cannot overcome concomitant Health and Development problems.

Recently, the WHO has recognised three major groups of problems which have contributed to a growing health crisis in many countries, or which have hindered a clear improvement of health with development (weil et al. 1990). These three major

problems are: firstly, the very magnitude and diversity of health hazards associated with development; Secondly, the cost of diseases caused by industrialisation and urbanisation and also by medicine itself, the oestrogenic diseases, and thirdly, the need for, or imposition of, macroeconomic adjustment which has resulted in major cuts in the health and social welfare budgets of many developing and some developed countries.[40]

The present study has been to understand the role of NGOs and future perspectives considering the above theoretical understanding on the growth of voluntary sector in India. This study is based entirely on secondary resources and has designed its analysis in following chapters.

In chapter two 'Non-Governmental Organisation In India: A Historical Perspective' the growth of NGOs covering from different stages i.e. (a) the mid to late colonial period (b) the early post Independence period (c) post Independence period (1947 to 1960) (d) and the period between 1960 to the present years is discussed. This chapter provides ample data to build up the body of knowledge in the growth and genesis of NGO sector in India in broad developmental paradigm of Indian history.

In chapter three 'Growth of NGOs Through Policy Planning in India' is discussed. This chapter provides ample data on the different governmental policies in various developmental sectors including health. In periods of planned development the NGOs have received fillip to face responsibility to meet the needs of the underprivileged sections.

In chapter fourth 'NGOs Role in Health Sector: Issues and Perspectives' have been analysed on the basis of available literature and data therein. This chapter brings out clearly the past and present perspectives of the role of NGOs in health sector and a critical appraisal of their role was worked out.

In chapter fifth 'NGOs in Health Sector: Future Perspective'; an attempt was made to bring out an analysis highlighting the current problems experienced by the NGOs in collaborating the governmental policies in achieving 'Health for All'by 2000 AD in the context of SAP (Structural Adjustment Policy).

CHAPTER - II

NON-GOVERNMENTAL ORGANISATION IN INDIA : A HISTORICAL PERSPECTIVE

India's complexity as a country lies in its religious, political, ethnic, social and cultural diversity as well as in its long history of civilization[1]. Therefore defining the Non-Governmental sector in India is a different task because no single underlying theme or pattern can characterise the development of the Non-Governmental sector. Hence this chapter uses a historical perspective as an analytical tool to describe definitions-both conceptual and legal, that are then related to the structural/operational definition of the 'non governmental sector' suggested by Salamon and Anheier (1992)[2]. This sector and the various terms used to describe it are analyzed in the context of the broader political economy at various periods of history to uncover underlying themes that are useful to understand its present and past role

It is important to divide the development of modern voluntarism[3] and the Indian non-governmental sector after the 'Earlier period' and 'Early British period; into four different periods; the Mid to Late colonial period (1810s & to 1947); the Early post independence period (1947 to the Late 1950s); the period between 1960s and 1980s and the more recent past since then. Each period is characterised by a number of distinct themes or patterns that are vital to understand the development of the non-governmental sector in India.

Historical Development

Voluntarism has long been an integral part of the Indian Society, dating back to 1,500 BC when it was mentioned in the 'Rig Vedas'[4]. Voluntarism was the main source of welfare and development except for those few empires with a well developed public welfare system[5]. The role of political regimes was mainly restricted to promoting moral, aesthetic, and spiritual progress of the civilization, in addition

to enduring exploitation by the monarch, the aristocracy ,and Government officials: Naturally, voluntarism played an important role in social and economic development of the Civilization. It operated in the fields of health, education, cultural promotion and in crises such as droughts, floods, and epidemics, and the poor were taken care of by social mechanisms outside the state - through the joint-family, caste, solidarity of colleagues, guilds, and individual religious philanthropy. The relationship between individual philanthropy and religion is explained by the mandates regarding charity laid down by predominant religions - Hinduism and Islam, as well as other religions: Buddhism, Jainism, Zoroastrianism (Dadrawala, 1991)[6], and Sikhism.

The Mid To Late Colonial Period (1810s-1947): The Era Of Church, National Bourgeoisie, Gandhian Philanthropy And Separatist Movements

The first voluntary efforts in social development were initiated by Christian missionaries in the early 1810s (Pande, 1967; Terry, 1983; Baig,1985; Bhattacharya, 1987; Inamder, 1987; Tandon, 1988)[7]. Although their principal objective was propagating Christianity, they started to build schools, colleges, dispensaries and orphanages around the 1810s and 1820s (Natarajan, 1962; Singh, 1968)[8]. Parallel to their efforts in the urban areas; Christian missionaries formed rural colonies from the 1860s until the 1940s with an emphasis on modernisation efforts focused on self-help, and the establishment of cooperative credit societies, health care, and training facilities, whereas the empowerment component consisted of adult literacy classes and the establishment of Panchayats (Local village councils) to solve local problems while dealing with a chain of events during this era culminating into the contemporary voluntary action, It would be pertinent to mention a number of socio-religious movements that emerged to grapple with various issues afflicting the society. Notable

among those movements were Brahmo Samaj (1818 AD); Prarthana Samaj (1867 AD) Arya samaj (1875 AD) and Ramakrishna Mission, Satyahodhak Samaj and Indian National Social Conference began to emerge from these social movements (PRIA - 1991)[9]. Even though each of these had its own thrust and concerns with various points of difference, they together covered a wide variety of social and religious issues such as opposing caste system, Sati system, child- marriage superstition, idolatry, polytheism, rituals, hereditary, priesthood and hegemony of priests and social and legal inequalities, propagating modern education, equal right to women window remarriage, prohibition, freedom of individuals social integration and regeneration reinterpretation of scriptures and above all nationalism.

Alongside the above socio religious movements, there were various other protests and movements against colonial rulers such as uprisings of peasantry in many areas against the unjust settlement practices and exploitative and oppressive revenue fixation and collection; protests and movements by forest dwellers against restricting their access to forests; protests against commercial plantations and mono culture and protests against restrictions of fishing and navigation rights.[10] Evidently, many such protests and movements became an integral part of the national freedom movement and made vital contribution to accelerate the process to win freedom.

The most important organisational offshoot of the nineteenth century reform movement and subsequent national consciousness was the establishment of the Indian National Congress in 1885. Liberal Minded British officials and businessmen assisted the modern Indian elite in establishing the congress which became the official platform for expressing growing national consciousness (Kochavek, 1947; D' Cruz, 1988; PRIA, 1991)[11].

There have been some other strands of voluntary action visible in Indian society. Charity, relief and welfare by religious bodies and other socially concerned institutions and groups have all along been visible there in it ; Like in most other societies. Such a self-less voluntary action which even though informal and unorganised, Covers the entire grant of rural life and keeps the communities going; thus greatly facilitates organised NGO actions.

The voluntary movement received the maximum impetus and incentive from Gandhi, who believed that voluntary action was the only path to India's development. Gandhi's concept of development included all aspects of Life; social, political, economic, cultural, and spiritual, (Chaturvedi, 1987)[12]. His notion of rural development was constructing self-supporting, self-governing and self-reliant village communities where everyone's needs were satisfied and everyone lived in harmony and cooperation. To achieve this goal, Gandhi introduced a 'constructive programme' to achieve egalitarianism in Indian society by introducing basic education and sanitation, and by eradicating 'untouchability'.

Thus the emphasis was on empowerment and transformation of the society and acquired a political context, instead of issue- based voluntarism of the nineteenth century. Also the demands made by various classes to further their social, political or economic interests as exhibited by the formation of business and caste associations.

The Early Post - Independence Period (1947s To The Late 1950s): The Era Of Religion - Based And Gandhian NGOs

Two types of NGOs were predominant in this period of history; Gandhian NGOs and religion-based NGOs (Including both Christian and non-christian NGOs). Concurrent with these trends, older types of NGOs continued to exist in the sector.

The primary activities of the Gandhian NGOs in this period were development and empowerment, while those of religion based NGOs were welfare and empowerment. For Gandhi, the constructive programme was the truthful and non-violent way of winning complete Independence It was designed to build up the Nation from the very bottom upward. Apart from being deeply transformative it was a strategic instrument for mass mobilisation for the National freedom movement, as envisaged it eventually became mass scale voluntary action. The out standing significance of this effort, however lies in the fact that it gave birth, space and substance to a socially conscious and participatory, politically aware, change and active , and ideologically secular and transformative voluntary action movement in India.

During this period. Gandhian NGOs were also requested to train government officials employed in development projects, for example, the ministry of Community Development involved Gandhian NGOs to organise and conduct training programmes for its extension workers. Another example is the training of health workers undertaken by Gandhian-NGOs at the request of the Ministry of Health (Muttalib, 1987; Tandon, 1988)[13]. In the process of the mentioned constructive programme, there was considerable institution building, giving birth to a number of specialised All India Voluntary Organisation spread across the country, such as All India Spinners

Association(1925); upliftment of the untouchables; Later 'Bharatiya Adimayati Sevak Sangh' (1948) for the upliftment of the tribals and similar bodies to promote prohibition, languages, eradication of leprosy, cattle etc. These constructive work organisation provided a solid base to the freedom struggle.

Some other voluntary organisations such as Servants of India Society(1905) and Servants of People Society(1921) emerged during or around the same period[14]. Yet another notable aspect of Non-Governmental development action during the late pre-Independence period was some innovative initiatives and experiments by eminent socially concerned persons such as Rabindranath Tagore in Sriniketan and Jagatram and Dave in Vedchi.[15]

The welfare component of most religions based NGOs in this period is reflected in their effort to provide relief for refugees and flood and famine victims; and provision of health and nutrition services for the poor. The empowerment component is located in their educational activities.

The primary motive of the religion-based NGOs was religious philanthropy, while those of the post-Independence Gandhians that formed NGOs was to ensure a secure financial future (Sethi, 1988)[16] Kothari writes that Gandhi's constructive programme was continued by NGOs headed by Gandhians with financial assistance from the state. He suggested that Gandhians who did not or could not join the ruling party or the government worked closely with the government to set up handicrafts and village industries, rural development agencies, credit cooperatives and educational institutions.

The emergence of a large number of NGOs is perhaps, attributable to the initiative taken by the newly independent Indian state in promoting NGOs in development work, for example, the government took the initiative to form the Central Social Welfare Board (CSWB) in 1953 to promote and fund NGOs, setting aside 30 million rupees (approximate 1990 value = 410 million rupees or US$22 million) for funding them (Paul Chowdhury, 1987; Inamder, 1987)[17]. Paul Chowdhury states that planners under the leadership of Jawaharlal Nehru and voluntary social worker Durgabai Deshmukh felt that social work should be left to the voluntary sector with the state providing technical and financial support[18]. In the following year, the CSWB created the State Social Welfare Advisory Boards (SSWAB) for the purpose of strengthening existing NGOs and establishing new ones in the project areas that did not yet have them (Jagganadham, 1987)[19]. According to Chaturvedi(1987), the creation of CSWB and the SSWABs gave a new lease on life to the stagnating Gandhian NGOs. Seth and Sethi (1991) view the close relationship and dependence of the Gandhian NGOs on the state as a devise of vibrant sector of Gandhian organisations[20].

The Post Independence Period - The 1960s and 1970s:

The types of NGOs that existed in this period include welfare oriented NGOs, indigenous NGOs formed by international NGOs and Welfare Wings of Churches (WCO), NGOs formed by the middle class professionals; NGOs known as non-party political formations or action groups, Community Based Organisations (CBO) formed by the poor with help of other types of NGOs or the local Government. Concurrent with these newer trends, the older types of NGOs continued to exist in the sector.

The welfare-oriented NGOs that emerged in the 1960s and to a certain extent in the early 1970s were mainly involved in providing relief to victims of disasters such as famines, floods, cyclones. Indigenous NGOs formed in the mid-1960s by International NGOs were primarily development-oriented with an element of empowerment. The NGOs formed by the middle class professionals in the late 1960s and early 1970s were capable of a high degree of specialisation in development work while including empowerment. The NGOs known as action groups or non-party political formations began to emerge in late 1960s and their numbers began to grow after mid 1970s. The primary emphasis of these NGOs was empowerment, although some of them mixed empowerment with development. CBOs that were formed in the early and mid-1970s undertook various developmental and empowerment oriented projects. Corporate philanthropy consisted of development programmes in rural areas (Franda, 1983; Terry, 1983)[21]. The NGOs formed by the Government were also development oriented (Franda, 1983; Kothari, 1986)[22].

The founders of NGOs in 1960s and 1970s had different motivations. The welfare-oriented NGOs, formed by the middle class and action-groups were most likely products of the socio- economic and political conditions of this period. These are discussed in detail in the next sub section International NGOs formed Indian NGOs out of a compassion for the poor in the developing world CBOs were formed by the poor who felt a need to serve their community often with outside intervention from the local state or NGOs assistance. Corporate philanthropy emerged because of tax incentives provided by the state, while the state sponsored NGOs were formed to develop appropriate technology.

The emergence of a large number of the welfare-oriented NGOs in the 1960s in the 1960s and to a certain extent the early 1970s is attributable to two factors (Franda, 1983; Terry, 1983; Fernandes, 1986)[23]. First, there was a need for relief work because of the regular occurrence of disasters such as famines, floods and cyclones in this period of Indian history. The need for relief work was exacerbated by the Bangladesh war in 1971, which led to a massive influx of refugees into India. Second, western funding for relief work increased considerably during this period of history.

Emergence of NGOs in the late 1960s and early 1970s was conceivably due to the lack of jobs among the educated youth (Kaul, 1972; Sharma and Apte, 1976), as well as growing dissatisfaction with the existing institutional arrangements in India.[24]

The 1980s And 1990s : The Predominance Of NGOs

Major factors which deeply influenced the characteristics and growth of voluntary action in India during the post Independence period are discussed as follows[25]:

1. After Independence the National Government initiated a process of planned development on the Western model. Most of the unjust oppressive and exploitative socio-economic institutions and legal framework inherited from the colonial rulers continued. Many restrictive laws were enacted and policies proclaimed, of course, with exception of legislation for Zamindari abolition, land reforms etc. Big projects such as irrigation, dams, power plants and industries displaced a large number of people, mostly the tribals, creating a

new sizable category of ecological refugees[26]. A small minority of affluent benefited at the expense of a large majority of the poor. And all these activities were performed in the name of development and in 'public interest' for national reconstruction. Massive Community Development Programme launched for rural development could hardly create much impact for want of popular participation. There were also sporadic organised protests against such types of development. Public debate against 'trickle down' theory of development and 'rich becoming richer, poor poorer' had started well within the first development decade by late 1950s. However, craze for 'nation building' and catching up with the West marked by hope and promise was so fascinating and charisma of the freedom movement graduated national leadership in power was initially so overwhelming that it took almost two decades for the basic issues of people centred development to surface and start gaining momentum on a sustainable basis, notwithstanding its strand being present all through since pre-Independence and national freedom movement days. During this phase, the state and the Government, thus assumed the principal responsibility and role of development and social change severely circumscribing the scope of voluntary action . In this situation, NGOs continued with conventional charity and welfare work and had only peripheral involvement in Government's development action.

2. After Independence a large number of freedom fighters inspired by Gandhi renounced power politics and joined non-Governmental Gandhian constructive work stream. This stream continuing as one of the largest, made notable contribution to the growth of NGOs sector during the post-Independence

period. Apart from various constructive programmes, Bhoodan/Gramdan (Land gift/village gift), movements launched by this stream under the leadership Vinoba Bhave as a part of the Sarvodaya Movement during first phase[27]. Conceptually these movements together represented an attempt towards non-violent rural reconstruction and social transformation, basically different from the prevailing charity/welfare approach during that phase with the achievement or failure, it has been one of the most significant Non-Governmental interventions in rural reconstruction for development during the post independence period.

3. As the public critique of centralised growth - centred development pursued by the Government became sharper from late sixties onwards, the Government responded with a number of 'target-group' and 'problem-area' focused programmes. By late seventies and through eighties the process culminated into a plethora of antipoverty programmes in which considerably increased involvement of NGOs was also sought. It implied increased funding of NGOs by the Government. In the process, it was but natural that a large number of new NGOs emerged and they along with most of the existing ones started implementing various Government programmes; generally in a more cost-effective, efficient and participatory manner, It is believed that weakening bureaucratic development delivery mechanism of the Government also contributed to and facilitated the expansion of NGO-sector during this period.

4. The issues relating to popular participation, equity and sustainability, linked with those of environment, Dalits and gender, arose from the persisting social,

economic and political situation and came into focus, particularly during late seventies through eighties. Expansion of communication system for rising awareness, locally as well as globally, stimulated and accelerated the process. The issues and NGO strategies in response to them contributed a great deal to qualitative change in voluntary action; which sharpened and strengthened its transformative strand and activism. This has also been the period of deeper social concern especially among the youth and intellectuals. Increasing impact, visibility and credibility of NGOs coupled with increasing attention and assistance to them by the donor agencies during this very period has also made significant contribution to the growth of NGO sector.

Finally, in between various other factors have influenced the NGO sector one way or the other. Natural disasters and recognition of the need of poverty alleviation programmes for development action to minimise them, emphasis on professionalisation of NGOs and assistance needed for the purpose, initiatives taken by business and industry as a part of their social responsibility ; networking needs, and clashing sectarian interests may be mentioned in this regard[28].

The above description seems to suggest that voluntary action in different parts of India was rooted in a specific socio political context and was inspired by the emergence and continuity of social reforms, social change and political movements in different parts of the country.

All these facts contributed to the growth process of NGO sector in India bringing it to its present stage .

Conceptual Approach of NGO

According to Literature (Seth; 1982; Franda, 1983, Sethi, 1984; Sethi and Kothari, 1984; Frenandes and Lobo, 1986; Jain 1986; Kothari, 1986; PRIA, 1987; Seth and Sethi 1991)[29], the terms used to refer to the NGOs in India are: voluntary associations; voluntary organisations; voluntary agencies; philanthropic organisations; welfare organisations; action groups; women's organisations; non-governmental organisations, Government organised NOGs; church organisations; religious groups; and Community Based Organisations (CBOs). The most commonly used acronym in India is VOLAG (voluntary Agency), which is unique to India. This sector is generally referred to as the voluntary sector or the non-governmental sector.[30] Voluntary associations and related terms are traditional 'Indian English' terms. In Hindi language, NGOs are referred to as Seshcha Sevi Sangathans/sanghatans.[31] With the exception of the term Government organised NGOs for example National Dairy Development Board and CAPART, all the above terms refer to empowerment oriented NGOs that emerged from the 1960 onwards.

The term NGO is a catchy phrase which fails to capture the wide array of institutions which share common features with such organisations (Salamon and Anheier, 1992)[32]. NGOs are generally formed by professionals from the middle class to serve the poor and have salaried employees (Pardon, 1987; May, 1989)[33]. Today NGOs are defined as humanitarian organisations and are recognised as having 'NGO status' by intergovernmental organisations such as the United Nations (UN) or European Community (EC) by NGOs in developed countries or by national governments (Borghese, 1987; May, 1989). It is however, difficult to single out

Indian NGOs because there is no accepted method for recognising wheather or not a particular organisation has NGO status. Generally large and medium sized developmental and empowerment-oriented non-profit organisations which receive foreign funds are categorized as NGOs in India. According to a popular NGO-Society for Participatory Research In Asia the term 'NGO' is a negative and non-explanatory label because it includes private sector formations, development corporations, welfare boards etc.

According to PRIA, the terms 'Voluntary Development Organisations' should be used rather than NGO to define developmental organisations. There is no general consensus about the time of emergence of the term in India.[34]

Typology

The experience of voluntary development organisations through NGOs in India has became so diverse and multifaceted that there is a need to systematise and classify this vast range.

The purpose of evolving a typology is to attempt a classification of the range of Development NGOs India today. It is an attempt to describe through certain categories what exists in this field and differentiating between one type of NGO with another to understand their implications. Thus it follows with the classification of NGOs in India on certain dimensions which have both a descriptive as well as an analytical value in enhancing the understanding of their nature and functions. These typologies are as based on the following discussed parameters:

1. Inspiration

One of me most important sources of differentiation in NGOs the nature of the inspiration of the Founder or Founders. This inspiration provides the philosophical perspective as well as analytical framework in viewing the social reality and thereby becomes the basis for evolving a set of actions by a given NGO. The inspiration takes various forms -it may be philosophical, intellectual, religious or ideological inspiration. Different types have quite different implications for the manner in which these organisations get established and the manner in which they function. Some of these types are discussed below.

Historically, one of the most significant inspirations has been the Gandhian school built on the experience of the freedom Straggle and Mahatma Gandhi's call for constructive social work, to help rural mass to achieve their own economic-social regeneration. The keystone of such organisations has been village reconstruction to reestablish traditional handicraft industries and create pride in 'Swadeshi' or 'Indianness' e.g. Sewapuri case[35].

A second school, also historically quite active which could be called as Socialist School. This inspiration can be best typified in the leadership of Purushottam Das Tandon, Ram Manohar Lohia and Jaya Prakash Narayan. Chattra Yuva Sanghars Vahini as an outcome of the J.P. movement in Bihar and other parts of North India during mid-70s is a typical example of this inspiration[36].

A third type of inspiration is the Marxist and neo-Marxist perspective. Several organisations inspired by this left ideologies were from the outcome of the left political parties. Some people who were involved in ultra-left movements, like the

Naxalite Struggle, after some time changed their course and also set-up voluntary organisations.

Historically, the church has been a major source of inspiration and the teachings of Christianity have been used to inspire whole generations of missionaries to serve the poor and the needy. Likewise the influence of Islamic, Buddhist and other traditions has also been quite viable. Also the Ramakrishna Mission through its countrywide network of missionary development initiatives is a case in point. Its contemporary version is a voluntary development NGO - the Lok Shiksha Parishad. (Tandon, 1991)[37].

2. Rationale

The second parameter could be called the rationale for initiating voluntary action through NGOs. It is almost like an universal-view. The literature available for examining the range of NGOs in the country under the category could be of four distinct types as emerged till date[38]; which are as follows:

The first type is based on the rational that people need help that poor, down-trodden, weak need assistance and help. Most NGOs operating on a charity and welfare perspective carry this rationale. They provide relief and rehabilitation during events of disaster, droughts, cyclone, floods, earth-quake etc; which also operate under this underlying assumption.

The second type comprises an universal view that could be called as developmentalist. Here the focus is on people who could do the work on their own but with 'NGO' support particularly in the form of programmes, resources, ideas and

skills. Under this category the programmes of health, agriculture, irrigation, economic activities, appropriate technology etc. is included.

The third type is based on the theme of empowerment. It assumes that the poor need to get organised and struggle in order for appropriate change to occur. The focus of intervention, therefore because on the conscientisation and organisation of certain sections, poor tribals, dalits, landless, women etc. The ultimate purpose of the strategy is empowerment. The struggle of the poor may be catalysed through a variety of such activities which may focus on acquisition of assets, wages, implementation of certain progressive legislations, education, etc.

And the fourth type is the need for support and influence at different levels not merely struggle by the poor directly and their organisations but struggle at the level of influencing policy, struggle at the level of ideas, struggle at the local, district, state, national and international levels. This perspective assumes that with growing modernisation of our societies and economical, forces of oppression and marginalisation operate from different levels and need to be countered and confronted at those levels. Therefore the support and influence will take different forms at different levels. It is here that institutions engaged in advocacy research networking documentation, training federating etc. came into the picture (support organisation)[39].

These four types tend to describe a wide variety of programmes and activities that NGOs undertaken. Therefore, it is observed that a health programme carried out with the first rationale of help tends to provide medicines and treatments, while another are carried out with the rationale of development tends to educate people and solve other non-health related problems in an integrated manner. Thus these

distinctions are important not merely in their underlying belief but in the outcome as reflected in the manner in which programmes and activities are carried out by such NGOs . Further differentiation does occur on the basis of the strategy of intervention. For example some organisations focus on one sector, like health, education, income generation etc. some organisations are multi-sectoral or integrated in their approach. Some NGOs focus on one constituency e.g. tribals or landless in a given geographical area. Some NGOs focus on multiple constituencies. These variations of sector and constituency also get further amplified within the rationale and the universal view described above. Thus it is possible to find different types of NGOs, carrying out the same sectoral work with similar constituencies but having totally different orientation, approach and activities.

3. *Size*

In the present context, size has become one of the main parameters which explains the differences among NGOs[40]. Size can be classified in various ways such as; one dimension is the area of coverage. Many NGOs are covering one or two villages or slums; some are national in their coverage. Another dimension of size in terms of full-time and part time staff and the over all budgets and resources. Thus it is possible to develop various categories within these parameters of size of NGOs.

The first category of small organisations is the most predominant are in the Indian context. These are the organisations (NGOs) which work in a few villages within a block of a district or in a few slums in one part of the city. Most of their funds are based in local resources, some contributed by members of the NGOs

themselves, though they may occasionally receive some funds from outside on an informal or intermittent basis.

The second category of medium size NGOs tends to cover a block or two in rural areas or several slums in a city and could also cover larger cluster if the nature of their work is at other levels than grassroots. Their fund arrangements are from national or international donor agencies.

The third category of big NGOs would be those who have project budgets varying from 5 to 20 lakhs of rupees per annum. They cover wider area, several districts or cities and they operate on a regular programme basis.

The last category could be called larger size NGOs which are fewer in number in India at present. They would have a budget around or above fifty lakhs per annum based on project grants from several sources.

Implications Of Typologies Of NGOs

A classification would be helpful to describe and understand the nature of NGOs in India today. This fact further can be analyzed by considering the following issues:

The first implication of this classification is that when 'universal view' rationales are mixed with a single organisation it creates confusion about identity. Thus when a NGO based on the rationale of help and charity also takes on a developmental perspective different segments and people within the organisation

behave and react differently, thereby causing internal tensions and confusion externally.

The second implication is that the nature of the 'universal view' and rationale for setting up an organisation may end up defining its reflections with others in society. This fact tend to provide a definite space to NGOs in the socio political arena of the country. For example, those set up with the rational of help may find no conflict with the Government or the political parties, while those set up with the rationale of empowerment may find themselves in conflict with both.

A third implication is that growth in size implies several institutional demands and forces which are different from other parameters. And that independent of inspiration and rationale for setting-up of an organisation, growth in size brings similar pressures and demands.

Thus the present section on elaborating the history and evolution of NGOs has clearly highlighted the significance of understanding regional variations in a country like India. Regional variations have affected evolution of types of non-governmental organisations as well. Certain inspirations are more available in certain parts of the country as was discussed early in this section. The classification of the above type would help us to explore greater depth, the kinds of roles, functions and potentiality (fund available), scope of NGOs in India.

Roles

Based on the roles played by NGOs as the literature shows[41] the three distinct types are: (a) Field level (implementing) NGOs; (b) Support level (Service -provider)

NGOs; (c) Associations/ Networks NGOs. As obvious, the first type includes micro-level NGOs, whereas the last two types are macro level NGOs.

Earlier, the NGOs associations/networks combined both 'association functions' and 'service functions' and they were the ones which provided need-based services to NGOs affiliated to them and also to non-affiliated NGOs, as far as possible. Most of the associations are old as well as new ones, continuing with the above two pronged functions. However during the 1970s and 80s number of support organisations have emerged to provide various kinds of services to NGOs. Examples are PRIA, PRADAN, AFFORD, and ACORD in New Delhi, AFARM in Pune, CHETNA in Ahmedabad XISS in Ranchi, ADITHI in Patna, AIRD and SEARCH in Bangalore, RDAS in Hyderabad, SPIAD and LSP in West Bengal, GNK in Ghaziabad (UP) are only a few many of such support NGOs, filling in wide gaps left by the associations/networks[42].

There are support NGOs also in many other fields such as technology, communication skills and materials, and marketing promotion. Action research, building up knowledge-base relevant to NGOs' development action and clearing house and documentation are among very vital areas in which a number of support NGOs and networks have been active.

Quite a few of the networks and support NGOs also undertake their own experimental field projects to test and /or evolve innovative approaches and learn from direct experience. Some of the support NGOs eventually seek affiliation of NGOs served by them and thus try to acquire networking character for contacts, convenience in serving and legitimacy. Some of the support NGOs and apex bodies

assist foreign funding agencies in identifying grassroots NGO partners, formulation and appraisal of project proposals channelling of funds, monitoring and evaluation of implementation and training in a much more cost effective manner.

On the other hand, quite a few of the competent field level NGOs, apart from implementing their own projects, have been performing the functions of support NGOs and networks. This is due to pressure from the needy NGOs as well as to gain leadership and influence. However this is a very cost effective and essential way to multiply need-based support to grassroot-level NGOs spread across the country.

Objectively, the above trends have their roots in the situation prevailing in the NGO sector. However, lately, Finding agencies, particularly foreign ones have been trying to promote certain networks and support NGOs with noble as well as ignoble intentions, more often simply to have amenable NGOs. On the whole, there is a wide variety of NGOs reflecting manifestation of diversities in the country.

Popular Participation

NGOs in India are generally committed to popular participation. It is a very positive aspect of their development initiatives. It is well recognised that popular participation in decision making is essential not merely for the success and sustainability of development programmes but basically because people have a right to shape their destinies according to their own needs , aspirations, priorities and perceptions.

NGOs have been devising and adopting appropriate strategies of popular participation in diverse situations. They have been trying to involve people actively

in planning, implementing, monitoring and evaluation of people centred projects and programmes. However, apart from variations in strategies and approaches, popular participation in practice varies in degree from NGO to NGO and from project to project[43].

Activist NGOs have been far more successful in generating effective popular participation especially of the poor and disadvantaged sections. They usually do it through a sustained process of awareness. raising organisation and peaceful struggle on people centred issues , focus in their work is on structural change. However, NGOs work with the people in the unorganised sectors where there is no regular organised institutional base to enable people to participate through it . So exceptions apart, popular participation generated by NGOs is generally through improvised adhoc peoples' organisations such as all inclusive Gram Sabhas (village assemblies) and Lok Samities (peoples committees) or sectoral interest groups, especially of the poor and disadvantaged sections with appropriate networking at higher levels[44]. However there are also a few successful NGO initiatives of organising trade unions and cooperatives of workers in the unorganised sector. Panchayati Raj Bodies were conceived as peoples' own institutions at the village/primary community level, intermediate level and district level, to harness people's creative energies for their self-development . But for want of genuine democratic decentralisation, these institutions hardly have any powers, functions and resources and have therefore remained crippled, ineffective and defunct in most of the states in the country. In some of the states such as Karnataka and West Bengal experience of involving these institutions in development even it to a limited extent has been happy. Even where Panchayati Raj bodies exist and function, NGOs reach out further down to small cohesive groups of the poor at the

hamlet level, living together, and endeavouring together to facilitate more effective direct participation of the disadvantaged sections[45].

Repeated failures of centralised planning and development in India have created a situation where Government is now more receptive to the rationale of democratic decentralisation and popular participation. Numerous successful examples set and tremendous pressure generated by NGOs have also considerably contributed to improvement in the policy environment for popular participation. Thus NGOs' rich and varied experience, despite its limitations and handicaps, offers valuable insights, into strategies to generate and sustain popular participation.

Associations / Networks

Associations / networks of NGOs in India are as old and diverse as NGOs themselves although the term network is comparatively recent in origin[46]. Associations such as All India Spinners Association, All India Village Industries Association, and All India Women's Conference were formed during the pre-Independence period; 1920s and 30s. Christian missionaries also and had their own networks. This process continued through the early post-independence period. 'Sarv Seva Sangh' and 'Association of Voluntary Agencies for Rural Development' (AVARD) were formed in 1948 and 1958 respectively[47]. 'Bharatiya Adimjati Sevak Sangh' and 'Harijan Sevak Sangh' also belong to early period. Based on territorial jurisdiction, sectoral concerns, and persuasions, associations networks NGOs in India can be categorised as follows;

i) Territorial Jurisdiction : National (all-India), Zonal (inter-state), State, Sub-state district.

ii) Sectoral concerns : sectoral, multisectoral

iii) Persuasion : persuasion wise, open/secular.

Considering the size of the country, inter state diversities, convergence of various development functions and activities at the state level, and the need of a forum to promote friendship, cooperation and interaction among the NGOs at that level, a number of state networks have emerged during late seventies through eighties. Some of the national networks took initiative to promote such state networks. AVARD's planned efforts to promote state networks in AP, Bihar. Gujarat, Madhaya Pradesh, Rajasthan, UP and West Bengal and Zonal network in North East deserve special mention in this regard[48]. Some of the national networks, especially sectoral ones such as Voluntary Health Association of India (VHAI) have their state level branches or networks in most or some other states. In larger states such as Bihar, UP, Sub-state networks have emerged to cope with interstate diversities. Networking has gone further down to the district level; such networks, one each of Howrah district in West Bengal and Phulbani district in Orissa are cases in point[49].

NGOs in science and technology have their own networks: All India Peoples Science Congress at the national level and state level bodies in most of the states. Kerala Sastra Sahitya Parishad (KSSP) is an example of state level network[50]. Thus the networks/associations role in stimulating and strengthening the NGO sector has however been notable.

As mentioned earlier, there are cases of implementing NGOs and support NGOs performing networking function; this is on the increase especially because existing networks are unable to cope with the vast needs of the NGOs but to a

considerable extent also due to unhealthy competition for leadership, There are a number of self appointed leaders of NGOs vying with one another. Bottom-up democratic and top-down not so democratic both the processes are seen as regards formation of networks. To some extent Governmental foreign funding agencies have been instrumental in promoting their own amenable NGO networks/ nodal agencies and leaders as well as unhealthy competition among them.

However, formal networks at various levels need to strengthen their institutional capabilities a great deal to improve their performance in 'networking' as well as support functions. In coming years, as obvious trend visible is for an increasing number of forceful informal strategic, networks coming up to spearhead various movements and campaigns for people centred development and against anti-people Governmental polices.

Activities And Scopes Of NGOs

NGOs in India are engaged in all conceivable activities for cultural, educational, health, economic and social development in their respective areas of operation. While planning and undertaking such activities they try to respond to local situations, needs, perceptions and priorities. Well planned, systematic and strategic interventions by NGOs have been increasing over the years particularly during the past two decades[51]. Impact and visibility of NGOs has also been increasing. Activism and professionalisation of NGOs have greatly contributed to their impact, visibility, media accessible. NGO sector also has its share of elitism; since for the last two decades, more articulate and sophisticated NGOs and NGO leaders have been emerging; they have greater access to existing information system, powers that be and

resources. This is no doubt a positive development, some of its weaknesses notwithstanding . On the other hand less articulate, less visible and less known grassroots NGOs remain the backbone of NGO sector.

However there is still a long way to go in this regard, Most of the NGO interventions are adhoc, haphazard and often determined by availability of resources and therefore donor driven. Nature of activities and interventions also depends on level of awareness capability, perception, priority, persuasion, and approach of the NGOs concerned. However NGOs have shown tremendous potential to learn and grow with the work. NGO community in India can be compared with a tree having all round prolific growth while casting off its yellow leaves in the growth process.

As indicated earlier, NGOS of different hues perceive, determine, and play their roles differently. However, there is consensus of the following scopes over the roles of NGOs[52]:

i) Facilitating Participatory Process

This is a multi-faceted scope. It involves a sustained process of animation, organisation, motivation, facilitation action and progress. In practice only a small number of NGOS are able to play their role in this scientific manner. Various awareness raising, training, and development education initiatives form a part of this role.

ii) Generating Alternatives

It involves continuous experimentation and action research with innovative ideas and approaches in people centred and people led development; especially at the

micro-level. Flexibility, freedom of action, openness, and intimate contact and intensive interaction with local people and situations help NGOs a great deal in generating better replicable development alternatives. NGOs in India have made notable contribution in this regard, set examples and shown the way.

iii) Monitoring the Effects of Development Actions and Highlighting Their contributions:

It includes monitoring of development actions by Government and private sector (business and industry) as well as by NGOs themselves. This kind of monitoring and constructive criticism is essential for corrective and transformative steps. It is in this way that NGOs have been able to bring to the fore issues relating to environment, women , Dalits (downtrodden) etc.

iv) Advocating causes

Policy advocacy in favour of the disadvantaged sections of the society and for structural changes is vital, especially in a democratic set up. This kind of advocacy by NGOs has been increasing and becoming more forceful over the years.

v) Supporting peaceful struggles of people for their Empowerment and against Injustice, Exploitation and Oppression

It is becoming very common with social activist groups. This role also has been assuming greater importance in the situation prevailing in India and with the growing awareness among the masses.

vi) Protection, upholding and Nourishing values

It calls for deeper thought and understanding, but is important for NGOs, particularly in a miliu reolete with betrayals and conspiratorial tactics in society and

governance and power-politics. Moral regeneration is considered extremely vital. While playing this role, NGOs themselves practise what they preach.

vii) Strengthening Democratic Institutions

The stronger the democratic institutions, the greater the possibility of people-centred development. Hence it is vital for NGOs to strengthen these institutions.

These scopes of NGOs together capture various roles perceived and played including training and development education, professional assistance, constructive work , action-research, monitoring, activism and structural transformation. In democratic set-up in India where public opinion plays an important role over the Governmental policies and programmes; the focus has been shifting towards generating from bottom enlightened and forceful people's opinion and peaceful action to bring about the desired changes.

Support Needs

The needs of NGOs in India with regard to capacity building have been identified as follows[53]:

i) Strategic Needs

Fostering a favourable social environment and a supportive policy environment, knowledge building , Expanding the NGO sector , Leadership development, Human resource development; and Networking.

ii) Operational Needs

Skills, training, professional and management inputs, networking for collaborative problem- solving and grassroot research.

iii Maintenance Needs

Accounting and Administrative systems ; and infrastructure and social security. The needs of NGOs, in short, are development of education, training, professional assistance in planning and implementing programmes, assistance in resource-raising, information collection and dissemination, advocacy and joint action and cooperation on issues of common concern. Currently, only a fraction of them are being met. Wide gaps left in meeting them have attracted a number of consultants to step in, especially in the last two decades. Ultimately, however, NGO networks and support groups will have to build their own initiatives and capacities to answer those needs, whether directly or through networking across the country.

Funding Pattern Of NGOs

Historically, NGOs have been funded by different Governmental, non-institutional charity organisation at both the national and international level. In the Post-Independence Period, the non-institutional funding is the form of donation from the community, richer section of the society or from philanthropists etc. The most dominant sources of funding for NGOs in India till date have been international sources and the Government funding[54]. These sources are discussed funding as follows:

International Sources of Funding

The International contribution or foreign contributions in India is denoted as the donation, delivery or transfer made by any foreign source of any article, currency or foreign security, This is divided into the following categories;

i) Bilateral Institutional Funding

Bilateral funding includes aid from agencies, department and ministries of the developed countries such as U.S.A., U.K., Japan, Sweden, Denmark, Norway, Canada and Australia etc. However, the substantial portion of this aid is made available to the Governmental sponsored programmes, while a very small proportion is made available to NGOs under the approval of the Government for the specific programme and largely regulated by the Government.

ii) Multilateral Institutional Funding

The multilateral funding includes funds from various agencies of United Nations system like WHO, UNESCO, UNICEF, FAO, UNFPA, UNDP, ILO, UNEP etc. The other multilateral institutions like World Bank, IMF also provide funding to the NGOs in India under the overall supervision and regulation of the Government. It is mainly project based or scheme based. This type of funding is very limited and is confined largely to the major NGOs in India.

iii) International NGOs

Private and NGOs of the developed nations primarily the European and American institutions, foundations like Ford Foundation, Rockfeller Foundation etc. provide support to the NGOs in India. Also a major source of funding comes to Indian NGOs from International Non-governmental sector. This funding is restricted to specialised institutions or available by the approval of the Government of India.

The major thrust areas of the international funding have been in the sectors like health, environment, family welfare, women and children, educdation, rural development and science and technology coming under the overall development

programmes. The limitation in this type of funding is being temporary in nature and for short duration, action-oriented[55].

A Governmental legislation was passed in 1976, to regulate the flow of foreign contribution to the Non-governmental sector in India. For receiving any kind of assistance from the International Donors, the NGOs are required to register under the Foreign Contribution and Regulation Act (FCRA), 1976, under the Ministry of Home Affairs, Government of India[56].

Governmental Funding in India

For supporting the policy initiative of encouragement of NGOs in Development sector the Government of India provided different programmes of financial assistance to the NGOs through grants-in-aid. Limited funding is available with the State Government and at the local institutional level. Many Government agencies like National Children's Fund, Central Social Welfare Board, Family Associations of India, CAPART etc. provide funding for NGOs. They are for specific purpose and in a limited scale[57].

At the local level, funds are provided largely through the District Rural Development Agencies (DRDAS), Zilla Parishads, Panchayati Raj Institutions etc. At the Central Government level, grants-in-aid are given to NGOs by various departments and ministries such as Ministry of Human Resources Development, Department of Education, Department of Women and Child Development, Ministry of Welfare, Rural Development, Environment and Forest and Science and Technology etc. The basic motto behind grants-in-aid is to encourage and promote NGOs in India

and particularly in the areas where governmental action is rather limited. The rules of administration of grants-in-aid flow largely from the General Financial Rules, 1963 of Government of India[58].

NGOs In Health Sector

The present section discusses the NGOs experience and approach to the health sector as a part of the development paradigm in India. In development terms, NGOs have provided an alternative and in many cases, a supplement to Government programmes. In several instances, NGOs have addressed the needs of the poor who are not served by Government programmes further, a vigorous non-Government sector as is present in India, is indicative on the part of Government, that some social functions are outside its legitimate control, thus reinforcing the role of NGOs for the pluralization of society. With this backdrop the present analysis proceeds for a better understanding of NGOs performance in the Health sector in a historical set up.

Although the state accepted responsibility for public-health in the mid 19th century, early efforts were almost entirely urban oriented with a strong emphasis on curative services; rural areas received attention mostly in times of epidemics. Only in 1946 was the concept of community based primary health care for both rural and urban areas brought to the forefront of Government attention by the Bhore Committee on public health[59]. Among other things, it recommended the provision of primary health care through a three tiered system with a primary health unit for a population of 20, 000, emphasis on preventive health care through health education, immunisation programmes and environmental public health measures; training of

support health personnel to guide people and reoriented medical education to cater to rural needs.

After Independence, the state took on the primary role in initiating and implementing development activities including the provision of health care and the recommendations of the Bhore Committee as well as those of the several other Committees subsequently appointed by Government on various aspects of community health were incorporated in the Five Year Plans and implemented through different Government programmes. Though the health situation improved considerably a result of these efforts, it was still far from satisfactory as late as 80s[60].

The Health and Development field has been aided particularly by Non-governmental sector inspite of government's remaining as a major partron, especially since Independence. What is noteworthy is that the NGO sector was in contrast to the government, able to demostrate significant reductions in mortality and fertility amonst its client groups, largely because many of the successful non-governmental organisations addressed themselves directly to the problems outlined earliers. Through trial and error and conscious innovations over a period, they (NGOs) evolved an approach to community health which worked altogether. It was an aproach combining commitment and close involvement with the community at the grassroots, specific trageting of the poor and disadvataged and organisational innovations. As a result, the NGO sector has built up a body of knowledge and practices how to identify the poorest in a community and how to involve them in the process of development which can be considered as an alternative approach to development. Because of this, there is a growing interest among governments, academics, social activists and donors

(domestic or international) in the development initiatives of the NGO sector in Health, the objective being to learn from the diverse experiences of NGOs[61].

In India, NGOs working for community welfare were the result of a desire for social service associated with charity. The revival of Hinduism in the early Nineteenth century associated with the Christian missionaries and their activity were responsible for much of the early community welfare work. A large number of organisations came into existence between 1920 and 1947 as part of India's freedom struggle, as Indian patriots, enlightened officials and quasi missionary (YMCA) realised the need to up-lift the poor if self-government was to have any meaning[62]. Most of these NGOs were engaged in ameliorative work ot relieve distress rather than developmental work to bring about long-term changes. An important part of this welfare way to offer medical aid, the approach being to set-up a hospsital or dispensary at the taluka (district/sub-district) level or in a densely populated village on an accessible route; with major emphasis on curative than the preventive or promotive aspects of health care[63].

However, there were three important exceptions to this pattern which were to provide alternate models to non-Governmental grassroots work in later years. These were the Martandam Rural Demonstration centre in Trivandrum set up by the Christian missionary organisation, the YMCA and the various projects for rural regeneration set up by Gandhiji and his followers such as the Sewagram project and Anand Niketan Ashram and Rabindranath Tagore's Sriniketan Institute of Rural Reconstruction, they all believed in long term development rather than temporary poverty alleviation[64]. They emphasised self-help to develop self -reliance in

communities changing attitudes and social consciousness through education to make a long term impact and integrated development of the community by simultaneous efforts on many fronts[65].

In post Independence India, there was a phenomenal growth in the number of NGOs. Many were started as charities for relief work in the wake of droughts and floods but later turned to developmental work for long-term solutions to the problem of poverty. others came about due to a disenchantment with official development efforts which they felt were too slow or too corrupt or unable to reach the most needy. In this first phase (1947- 1960) most of the NGOs were conformist in their approach working within the established social framework and containing and resolving the conflicts within the existing socio-political structure[66].

In the mid- 60s, many realized that charity was not enough. Development, whereby local resources were to be used for the community's development, has to replace welfare; their emphasis therefore shifted from charity to promoting self-reliance[67]. This phase marked the growth of social & consciousness among the educated, for many professionals, economists, sociologists, doctors, graduated to the NGO sector. It also reflected a growing impatience not only with the Government's slow functioning its inefficiency, corruption, and its development strategies which had failed to bridge the gap between the rich and poor, but also with the apathy and the dependent mentality of the masses who waited for the Government to solve all their problems rather than take any initiative themselves.

It was in the field of health that this new orientations first emerged. Experiments at Narangwal in the late 1960s. showed the way but its consolidation

took place in Maharashtra with the Jamkhed, Mandwa, Miraj and Kara projects taking the lead[68]. The new approach had three main characteristics:

It was against giving anything free of charge, because if given free it ceases to have value for the people,creates a feudal relationship and paternalistic attitude to development along with a sense dependency among the beneficiaries;

- It was characterised by a project -based involvement
- It was professional in character.

Following the WHO-UNICEF Alma Ata declaration on primary health care, which advocates Health for All by the year. 2000 A.D; there was also a switch in emphasis from the purely curative to a balanced mix of preventive and curative services[69]. However, curative services remained and continue to remain an important component of health care offered by NGOs because they establish an organisations credibility in the community and lend it high visibility, facilitating later work in preventive health or other developmental areas.

Public recognition of the effectiveness of NGOs in grassroots development, including community health care, and the post 1977 official support extended to it by the Governmental and international agencies- bilateral, multilateral and private led to the rapid multiplication and involvement of NGOs in rural regeneration. The post 1970 years were characterised as being change or people oriented. Poverty was regarded not merely as a question of income generation but of attitudinal and value changes and of reorienting the social and political structure. The catchwords thus become conscientization, participatory development, peoples organisation etc and many NGOs were established to protest against socio-political abuses.

Thus NGO health projects were characterised by:

i) an increasing involvement of the community in all aspects of programming.,

ii) adaptation of local health service personnel to primary health care,

ii) closer links between health and general development so that many way NGO focusing on health alone diversified into another development activities such as agricultural development and employment projects for women,

iv) a greater demand for rational resources and political will to support primary health care

v) after 1975, when the women's movement had led to a recognition of the role of women in development, a greater concern with the health of women with a greater recognition of their potential as agents of change for health and development in the community.

Within this historical perspective of NGOs in Health and development the discussion further continue to understand their growth through different policy planning existed in India since Independence to exploit the early mentioned objectives to the maximum extent.

CHAPTER - III

GROWTH OF HEALTH SECTOR NGOs THROUGH POLICY PLANNING

The growth and development of various NGOs in India provided a good amount of insights how the NGOs have sholdered the responsibility in various developmental sectors to make available fruits of development to the underprivileged, exploited and marginalised communities in different stages of Indian developmental history. But questions arise how the different policy decisions have given importance from time to time to the various NGOs to come forward to share responsibility in developmental measures. Unless an attempt is made to analyse how various developmental policy provided sufficient scope to play significant role to the NGOs, the direction of their future role in developmental as well as health sector can not be accused properly.

There are several alternatives to the present mode of development, but those who bear the onus of influencing developmental policies do not seem to pay sufficient attention to the models already developed by scores of NGOs, based on their grassroot experiences. To a certain extent, the NGOs themselves are responsible for their own neglect, for most are so involved in their day-to-day efforts, as to become isolated from their Socio-political environment and to let their experiences, however unique, remain largely unrecorded and unheard[1].

Thus the contribution of the NGO sector is often unrecognised in evolving Policy, whereas it could provide a most useful basis for evolving more effective alternatives. NGO experiences are at times devalued because they are evaluated against a present criterion of development and not in terms intrinsic to their existence[2]. However, for our Policy makers who have fixed paradigms of development often not in tune with realities faced by the majority of our countrymen;

NGO experiences can provide valuable ground level facts. NGOs can no longer be dismissed as mere experiments considering the long period of tried and tested interventions. This does not imply a blind faith in NGO assertions but an acknowledgement of their contributions when defining developmental issues.

Policy Relating To Community Development And Rural Reconstruction

NGOs in India function in both rural and urban areas, in one or more development sectors like health, education and employment, with activities ranging from providing services to advocacy and having charity, welfare, religious, political or corporate affiliations. Most of these NGOs are registered as non-profit-private trusts or societies funded from private, government, corporate or international agencies. Above 8,000 NGOs received government funding in the 80s[3].

An estimated 5,000 organisations received International funding[4]. More than 100 field projects in rural areas concerned with health programmes have been identified in Maharashtra alone, where NGOs have a higher concentration in the least developed ones. The NGO culture is also more marked in the developed states like Maharashtra, Gujarat, Kerala etc., compared to the less developed states in northern India. Activist groups are also largely concentrated in Southern India - Maharashtra, Karnataka, Tamil Nadu and Andhra Pradesh with a few in Bengal and Bihar[5]. The work of missionarters is also concentrated in these Southern States[6]. The Gandhian/Sarvodaya organisations made maximum impact after Independence till the mid-sixties, when voluntary action and NGOs joined together with government for

nation building[7]. This resulted in both co-option and also formalisation of NGO work mainly in education, health and economic activities.

After Independence many NGO experiments and models became replicas that government used for formulating its own development strategy. Thus, the Community Development Programme-Projects of the government that began in Etawah, U.P. and the YMCA in Martandam, T.N. Successful experiments with the community health approach by NGOs in the first half of the 1970s led to their being assigned an important role by the government in development planning and implementation and marked the culmination of an interaction which had begun with the First Five year plan. The plan had stated[8]; "Any plan for social and economic regeneration should take into account the services rendered by these agencies and the state should give them maximum cooperation in strengthening their efforts. Public cooperation through volutary service organisations is capable of yielding valuable results in channelling private efforts for the promotion of social welfare".

The result was that the government began to provide grants to NGOs to enable them to carry out their new development tasks, but the quantum of funding till the mid-60s was not very significant, and NGOs were not accorded any official status in the implementation of development programmes. Further development was the setting up of institutions for training young people in social work. The next phase between the 60s and early 70s was when a critique of the development model followed by the govt. began to emerge. In this period, the students' and Naxalite movements also gained momentum. There was simultaneously a change in strategy to area development programmes involving peoples participation in government schemes.

Many NGOs which had started only with health interventions, went on to enter other areas like employment, agriculture and education to evolve as comprehensive development projects. Some of these NGOs took up government schemes for implementation. Other developments were the World Bank's support of anti-poverty programmes; and the corporate sector also became involved in altruism, of which House of Tata's was an example. However, growing disenchantment with the Government's development strategy in contrast to NGOs' success in reaching the poorest, and the government's own realisation that it could not handle the enormous task of alleviating poverty single handedly, NGOs were given an increasingly important role from the Third Five Year Plan onwards. Each plan provided a growing amount to be channelled through NGOs for development programmes.

NGOs Growth In Fourth and Fifth Five Year Plans

The 1970s saw a great mushrooming of NGOs for various reasons. Firstly, the government was encouraging them by giving grants or permitting them to receive foreign funds directly. Secondly, the corporate sector in partnership with the government was encouraging and supporting NGOs, especially in the rural areas. Thirdly, new tax deductions to donors for providing funds for rural development and social services to NGOs were introduced in the Income Tax Act, therefore, increasing willingness to donate funds to NGOs. And finally, the professionalisation of the NGO sector provided opportunities to committed and motivated individuals to take up careers in 'development'[9].

Further, in the Fifth Five Year Plan period the government began encouraging NGOs to take over, on a contractual basis, the programmes of the government in the

social services sector. This was certainly a major policy shift from being earlier only a grant-giver. In the health sector the government began giving its Primary Health Centres to the NGOs to run them; also, certain national programmes (eg. leprosy) in a specified area would be given to NGOs to implement. Under the Sixth Five Year Plan this process was accelerated. In addition NGO representatives were made official advisors or nominated as experts in government committees and bodies, including the Planning Commission, indicating that NGO business was also official business. From the late 70s, ideas of conscientization and people's participation began to emerge. The next phase in the 80s witnessed involvement with issues like environment and women's concerns. It has also seen the emergence of support organisations specializing in training, research, advocacy, documentation etc.

In health, the charity orientation gave way to emphasis on self-reliance and people's involvement in their own development. While the early initiatives were in setting up hospitals, giving fire service, or distributing free medicines, the emphasis, particularly from early seventies, was on health care at the doorsteps of the rural workers. The new approach made several innovative experiments in primary health care.

In rural field projects, village health workers, locally selected and field trained, were employed for health services, reducing the almost total dependency on the professionals. Preventive and promotive health services involving community involvement like antenatal care, care of pre-school children, early detection and follow-up of commicable diseases, were given importance besides including oral rehydration, immunization and the concept of essential medicine. An epidemiological

basis to the analysis of health and a community orientation to the resolution of health problems was adopted[10]. Health education was given due importance. Experiments at Banwasi Sewa Ashram set up in the 50s in U.P., Narangwal(Punjab) in the late 60s were forerunners; later many rural, field oriented health projects were set up around the early 70s like the Jamkhed, Mandwa, Miraj and Kasa projects which consolidated this health approach. Also during this period attempts have been made to find alternate source of financing health care particularly through commity financing, which has also evoked strong opposition from some sections of health activists.

In Urban areas also, there were a few NGOs working with health care in the slums. A number of research and documentation centres, advocacy groups and movements and health related publications, ranging from newsletters to medical journals began functioning. Support organisations for NGOs in health were also set up. In the 80s there have been many efforts to relate health to the macro-system. Health related issues like health policy, health expenditure, medical education, privatisation, rational drug and essential drugs, amniocentesis, have been taken up in a number of forms. Health culture, health economics and politics have been studied, including health in Panchayati Raj. A section of NGOs have been involved revitalising the indigeneous systems of medicine and folk medicine traditions.

NGOs During Sixth Five Year Plan And After

During the Sixth Five Year Plan period NGO representatives lobbied the government with all its might and its impact can be seen in the 'National Health Policy' statement and the Seventh Five Year Plan. The 80s saw a consolidation of the NGO strengths, with their representatives getting place in government policy making

bodies effectively asserting their position, both in government bodies and through public platforms. The health section in the Sixth Five Year Plan document was heavily influenced by NGO methodology and the rural infrastructure prescribed was founded on recommendations, based on NGO experiences, as stated in ICSSR/ICMR report, "Health for All : An Alternate strategy". For the first time the government declaration of the 'National Health Policy' acknowledged the importance of NGOs. The Seventh Five Year Plan asserted the incrasing reliance on the NGO sector to achieve the goal of 'Health for All'. The policy statement in the National Development Council was approved the role of NGOs which could play in planning and implementation of their own schemes since they had developed expertise to do so, particularly in the health sector. The active participation of rural agencies had been encouraged in a number of areas like improvement of primary health care, control of communicable diseases, MCH services, Sanitation, Rehabilitation of handicapped, reduction of infant mortality and family welfare. The Prime Minister's Technology Mission on drinking water, literacy and immunization envisaged a more effective role of NGOs. A Mission Director (Volutary Agencies) on Technology Mission had been appointed by the 'Office of the Adviser' to the Prime Minister, for better co-ordination and effective implementation[11].

The Approach papers of the Seventh Five Year Plan calling for greater participation from NGOs, stated; "Non-governmental organisation will have to be associated more closely and actively than hitherto with the programmes for reduction of poverty and with the efforts to make the 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)"[12]. It further adds that, 'Achieving active community participation and involvement in health and health related development programmes should also be 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 fully utilizing untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encourage establishment of practice by private medical professionals, increased investment by NGOs in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field.'

The Ministry of Health and Family Welfare (MH & FW) is in full agreement with the Planning Commission on the issue of greater involvement of NGOs in the field of health care. In a government of India published (1985) document it was stated that, "The government has envisaged a very prominent role of NGOs in the implementation of these (health, family welfare and 20 point) programmes. In october 1982, directives were issued that NGOs be involved in the implementation of anti-poverty and minimum needs programmes which contain all the important health programmes like MCH, Family Planning, Health Education, Drinking Water Facilities, Immunization etc. and consultative groups be formed in all the states headed by a senior officer of the state.... Also NGOs involved in running hospitals and dispensaries outside the government health sectors"[13].

Even the 'National Health Policy' of 1983 recognised the need for greater reliance on the NGO and private sectors for achieving the goals of "Health for All by the year 2000 A.D." - Thus the statement therein is[14] - " The policy envisages a very constructive and supportive relationship between the public and private sectors in the area of health by providing a corrective to re-establish the position of the private health sector."

The above statements make it appear that:

a) The government has accepted its inability to provide adequate health care.

b) The active participation of the NGOs is most necessary for achieving goals of the health sector and

c) Privatisation of the health sector will result in better provision of health services.

This perspective suits both the government and the private health sector. The government succumbs to historical evidence of the failure of all its anti-poverty programmes including those of the health sector and invites the private sector to take charge the fight against poverty and disease. The private sector which is mainly responsible for the poverty, ill-health, malnutrition, poor-housing and sanitation etc. has over the years demonstrated to the government; through 'NGO-efforts', that it can do a better job even if 'development'! that is to be assessed in further analysis of the fact.

The government has thus been increasingly acknowledging the expertise and the innovative nature of NGO-intervention, and shown keenness to replicate innovative schemes already tried and tested in the field as well as readiness to

reformulate old schemes, just as the NGO sector has sought to influence government policies on the basis of its expertise and experiences. The meeting of these two efforts however has not always been too happy. Whenever the government has tried to incorporate NGO initiatives within its rigid policies and infrastructure, the original innovation has been largely coopted, only to become part of the traditional government machinery. Thus village health workers, the very basis of NGOs' rural health projects, were reduced to the undervalued lowest rung in the health hierarchy of the rural public health system. The original Community Health Centre, which was to be the centre of comprehensive health for 100,000 population, was reduced to yet another curative hospital rather than the centre for comprehensive health activities at 100,000 level[15]. The government was accused of following the NGO experiments twisted out of context.

The Rural Health Project of the King Edward Memorial Hospital (KEM - Project) was consciously structured as a partnership between the government and an NGO to innovate and experiment within existing public health policies so that the government could test its own health tenets and, if successful, introduce them on a wider scale[16]. The KEM - Project was given the responsibility of managing the health care of Vadu block in Pune district of Maharashtra, using the government's own health staff for that block. But here, the government surrended only technical control and retained administrative control over the staff. However, the government went further in one instance, transfering the entire managerial responsibility - technical and administrative to an NGO. The complete responsibility for the health care of Jhagadia block in Bharuch district of Gujarat state, has been transferred to the society for Education Welfare and Action - Rural (SEWA - Rural); another of the Anubhav

projects (financed by Ford Foundation) - by the Government of India, the Government of Gujarat and the district panchayat (village unit) , the three agencies virtually involved in the various health programmes for the block[17].

Thus a self-fulfilling prophecy is generated regarding NGOs involvement in Government health-development programmes that:

a) the government is inefficient, complacent and too bureaucratised and therefore cannot reach the people with its development programmes howsoever well planned; and

b) the private sector is efficient, cost-effective, flexible and non-formal and therefore it can successfully execute the programmes of development taking it to population groups for whom they are really meant.

All this is clearly indicative of the close nexus between the private sector, NGOs and government policy making. The role played by the private sector in building up its socially more acceptable image through the NGO sector emerges clearly, how the government is used by the private sector for strengthening itself has also been established.

Policy Analysis

Today, in the health and development sector we see a great boom in privatisation both independently as well as through the NGO sector. For which diagnostic centres, corporate hospitals, health insurance and the like are on the uptrend, egged by the present government's policies to 're-establish the private sector'. What is meant by it? What are the aims of such a strategy? Whom and what

does it involve? How is it to be set about? What criteria may be used to judge whether it has been 'operationalised' or results achieved? Although 'National Health Policy' statement (GOI, 1982)[18] invokes the private sector on several counts, there are no readily available answers to these questions. Thus the present section intends to review the basis of such a stretegy which would enquire the desirability in connection with possibilities thereto in the context of development.

Besides joining hands with the private sector for primary health care, the government also wishes to increase investment by private agencies in curative medical centres, particularly in 'speciality' and'super-speciality' facilities, to ensure that they are adequately available within the country. The objective is to reduce government spending on these, so that more money become available for basic health services and existing government curative facilities are eventually used to treat the needy, underprevileged. To achieve this, it is proposed in the government policy-statements that the government has to offer logistic, financial and technical support to the private health sector. Thus in a spirit of 'privatisation', the government is devolving on the private sector same responsibilities which have been its preview to date. The several modalities enunciated pay due heed to the plurality of the private health sector: the private-NGOs in the health sector is to participate in the extension of primary health care while private commercial intersts invest in curative and special facilities[19]. In this way, a more focused role seems to be envisioned for the government in the provision of health services. If the health sector is viewed as a conventional pyramidal structure, government services would be limited to the intermediate levels, while private agencies occupy the top and bottom of the pyramid. Their situation implies that both community-based voluntary agencies and sophisticated urban medical

organisations will have 'interfaces' with the government health system. It is the nature of these interfaces; 'private-public' or 'government-NGO' collaboration that is of immidiate interest in the policy of privatisation.

However, the proposal for 'privatisation' can be viewed in a number of ways. At its most straight forward, it can signify the government's desire to expand private enterprise in all spheres of health in order to inrease proples' access to health care. By the absorption of private agencies and personnel in state policy and programmes, the joint health sector may recieve a fillip so that it becomes bigger, more varied and more effective. The inclusion of indigenous practitioners in the strategy suggests that no systems are barred in the effort to expand health coverage, although the exclusion of private allopatic practitioners is puzzling in this regard. In any case, the scenario is one of "a hundred flowers blooming", albeit at the periphery of government health services.

At this level, ' privatisation' may be part of a strategy for decentralisation, necessary to achieve better results in health, just as in other development sectors such as education or agriculture. Within the standard of governmental approach of policy making and planning at the centre and service delivery at the 'grass-roots', with privatisation the implementation of programmes at the local-level would simply be entrusted to NGOs. This may help to circumvent a major problem, encountered in governmental efforts to decentralise the reluctance of state-level leaders to devolve power on the district, block and village levels. The locus of conflict is shifted from centre-state or state-district etc. to NGOs-state relations.

In the view of 'privatisation' the desire of government to involve NGOs in National Health Development can be seen to stem from its admitted inability to meet policy and planning objectives and targets and to the implement programmes with the desired characteristics (e.g. community participation) or coverage (e.g.in remote areas where government doctors will not go). The decentralised and socially committed nature of NGOs and its superior ability to organise poeple composed with bureacuratic structures are given as reasons for 'privatisations'[20]. In this context, the government perhaps views itself as providing 'legal sanctions' and 'back up' to the NGOs to fulfil its mandate to spearhead social change. Another less-favourable interpretation of privatisation which finds currency in radical analysis of the government's courtship of NGOs (e.g.Sethi, 1984)[21]; is that privatisation is a strategy to coopt the NGOs in order to quell shouts about bureaucratic inefficiency, corruption etc. and to dilute threats to existing power structures.

In this concern, the provision of funds and technical assistance to NGOs, the placement of private sector leaders on governmental committees or giving consultancies to them, are considered tacties of defusion. Although the government appears to be 'decentralising' the cooperation view holds that the devolution of responsibilities on the NGOs is nominal rather than real. It becomes real in another possible interpretation for privatisation in which the term is taken to be akin to 'denationalisation'[22]. This fact may stem from the realisation that, despite the immense resources the state has sunk into health services over the past forty eight years of Independence, it still fails to reach the majority of population. In contrast, the 'success' of the private sector is invoked. The corollary of 'denationalisation' is greater 'privatisation of the state', that is increasing reservation of government health

services for 'the few', so that ultimately public services are made private[23]. Which of these interpretations of the strategy of privatisation is desirable? as well as possible? For understanding these facts the strengths and weaknesses of NGOs in health - development sectors must be examined.

Strengths And Weaknesses Of NGOs In Health And Development Ssectors

The potential for 'privatisation' or for collobration between the government and the NGOs will be delimited by the strengths and weakness of both. NGOs in health sector are considered to have succeeded where government strutures have failed. What have been the ingredients of the success? What have been the 'stress points'? The following facts very well discuss the above querries.

NGOs have at one certain advantages and constraints to government programmes and their contributions and failures have to be seen in this context. The advantages are more clearly known: the motivation, dedication and commitment of the leadership and staff; the greater good will and receptiveness of the community in response to the close and intimate contact developed by NGOs, and the flexibility in operations, including an ability to experiment with new ideas and discard old ones that is afforded by their small size and non-bureaucratic structuring. Some NGOs have the advantage of the backup and support of large organisations or institutions such as medical college or hospital, a business organisation or a professional association, which undoubtedly contributes to their success. The disadvantages are many and more complex but rooted primarily in smaller and more uncertain resources in terms of both money and skills, though there are other problems which need

elaboration. Both government and NGOs face some challenges because the problems of poverty, illiteracy and unemployment are so pervasive[24]. A streehitakarini found to its dismay, its biggest problem is the environment itself. The congestion and overcrowding, the lack of sanitation and clean drinking water and the lack of homogeniety in an urban slum composed of many castes, religions and languages make it difficult to plan for and spread health education. Migration in and out of the slum makes continuous monitoring impossible and the high levels of unemployed ensure that despite acceptance of health messages, and there is neither money nor facility to practice them, with far fewer resources NGOs can easily get overwhelmed by these problems.

A weak financial base is one of the major hurdles faced by NGOs which have to depend heavily on funds from government or foreign agencies[25]. Even the Anubhav NGOs which are larger and more affluent than the average ones are dependent heavily on these sources; for some almost half their budget comes from foreign donor agencies (as in case of CINI, the pachod project, AWARE) or from the government (SEWA - Rural). This severely restricts their freedom and independence though it may not be openly admitted.

Because of uncertainly in funding, NGOs often have to compromise either in the activities they take on or in the manner of implementing them in order to conform to the funding agency's requirements. On the other hand, a good NGO is often under pressure to accept funds from several sources and ends up bitting off more than it can chew comfortably, or loses programme cohesiveness by having to relay on too many disparate sources. Without continuous assured funding, long term perspective

planning becomes difficult. The low income of the client groups also mean that self-supporting projects remain a distant mirage. The question of funding is thus one of the knottiest problems faced by an NGO.

There are other difficulties created by the NGO Government interface. Red-tapism and administrative bottlenecks have led to delayed receipt of grants and supplier of drugs from the government. Some NGOs implementing government programmes in a particular area have faced difficulties in meeting the recruting requirements laid down by the government. In some cases, duplication of health services has also been experienced, as in the VHS programme, since the bureaucracy has been slow to withdraw its own personnel from the areas where MHCs are operating in spite of government instructions to do so[26].

In both the RUHSA and KEM projects, where the government has surrendered only technical and not administrative control over the staff which placed under the NGO for health programme implementation, dual control has posed problems of coordination in administrative, management and supervisory issues[27]. Recruitment and training of staff have also proved more difficult because of consequent divided loyalties. Even where total managerial control, administrative and technical, has been invested in the NGO, as in the case of SEWA-Rural, there have been problems. A lot of reporting, record keeping and follow up is required for the government can be a distraction and a strain. Further much less fiexibility is evident or forthcoming in respect of individual budgeted heads of expenditure, hampering innovation and a pragmatic approach to spending.

Despite the considerable effort, sensitivity and patience on the part of both the government and the NGO that required to achieve a harmonious relationship most desiring to cooperate with the government believe it can be done. Even as agency like AWARE, whose prime function is to conscientize the largest population to make demands on the government system to secure what's their due, and which can therefore be expected to come into conflict with the establishment frequently, has managed to keep such occasions to the minimum and has been able to cooperate closely with government functionaries[28]. Once an NGO establishes its credentials with the government and the people, there is less likelyhood of the government being heavy-handed and strictly regulatory.

Sociological barriers are another constraints faced by NGOs. By and large, the traditionally conservative attitudes about women's roles and their illiteracy, itself a result of those attitudes, has meant that projects, especially in north India, have found it very difficult to hire women as community health workers or as higher functionaries. And without them it has been twice as difficult to reach poor women with health or other developmental programmes. Additionally, programmew directed at raising the status of women such as those undertaken by RUHSA, have met with resistance from the community because of deep-seated fears that they will change the established men-women relatonship within the family and the community. In RUSHA's experience husbands did not like even the midwives to talk much to their wives for fear that it could trigger irreversible thought processes[29]. The solution adopted by RUSHA to remove such traditional attitudes was to educate men, especially in women's issues.

The personnel problem faced by these NGOs has not been confined to recruiting women alone, but applies to the recruitment of doctors, other health functionaries and professional staff because of difficult rural living conditions, the major gap between urban and rural opportunities for earning high incomes and for professional advancement and the lack of personnel in rural areas. While the sociological barriers and recruitment problems are common to both government and NGO programmes, staff recruitment problems faced by NGOs have been compounded by their inability to pay high salaries to offer job security due to uncertain founding or upward mobility because of the relatively small size of their operations.

The limits to NGOs' success have come not only from constraints internal to NGOs but also from their external environment which includes conditions which have already been discussed earlier, and the nature of the non-governmental voluntory sector itself. Indian voluntarism is fragmented and there are internal dissensions and factions. Thus it is not always possible to support, over a sufficient period of time, a common cause which would improve impact. To this extent, these grassroot level experiments do not constitute a monolithic movement of people's participaiton and self-reliance. Also, as the VHS experience has highlighted, there are the difficulties created by lack of horizontal coordination within the health sector, leading to duplication and overlapping.

First, there is the lack of coordination between the various units of the health department in the state government which deal separately with public health, family welfare, medical services, medical education and so on, thus effecting policies towards NGOs. Second, there is lack of coordination between the state government

and NGOs, especially as it related to information on government schemes and funds for NGOs, and accountability and auditing the operations of NGOs and the release of funds. Finally, there is lack of coordination between NGOs who could benefit by sharing their experiences. Often, they live isolated lives, cut off from other similar agencies and from the larger Socio-political environment. The situation is made worse by the lack of umbrella organisation which could coordinate, represent and service the NGOs[30].

Collaboration Between Government And NGOs

The issue of privatisation or collabaration between government and NGOs must be viewed in the light of the common features, differences and problems and possibilities of NGOs for which it is necessary to analyse the present policy on the subject concerned.

As already discussed, the 'National Health Policy' statement suggests that government interest in collaborating immediate cause, the inability of the public health system to deal effectively with national health problems. A partnership between government and NGOs is expected to overecome some of the structural weaknesses of the macro-health system and to result in better utilisation of the government resources.

However, close security of some other government documents reveal a somewhat confused view of the relationship between government and NGOs. A publication of the Ministry of Health and Family Welfare (MOH&FW, 1985)[31] stresses the steps the government has taken to date to support the NGOs and refers repeatedly to the fact that non-governmental agencies 'supplement' government

efforts. This view is expanded some what in the following statement of the National Institute of Health and Family Welfare (1977)[32] : "These agencies (NGOs) are mainly engaged to supplement the work of official organisations to explore ways and means of doing new things, such as the spearheading of Family- Planning movement in India and putting up demonstration and experimental projects ...(P.11)

Recently, the Approach paper to the Seventh Five Year Plan (1984) translated the recomendaitons of the 'National Health Policy' to involve NGOs 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 NGOs can participate in planning, education, service provision, resource supplementation and innovation.

Thus, the government view of collaboration with the NGOs is largely one of encouraging the latter to fill the cracks between government health programmes, to undertake experimentation, and to provide resources. This is accompanied by the belief that government support and reinforcement will serve to give the NGOs the additional momentum it requires.

A somewhat complementary attitude exists in some quarters of the NGOs. For example, an editorial in a newsletter of the Asian Community Health Action Network (ACHAN), which includes some Indian Voluntary health groups, proclaims; .... cooperation between governments and NGOs is unlikely to be very effective unless a significant portion of the initiative and the creativity in this relationship comes from the government (ACHAN, 1982)[33]. Another instance of this perception is provided by a national networking agency. At a seminar conducted by the VHAI (NEW

DELHI) to discuss the 'National Health Policy' statement, the main objectives set were the "dissemination of the policy and identification of modalities for collaboration with the government in its implementation at every level". Although the associations has recently been concerned with issues relating to the demedicalisation of health care (such as low cost drugs, health education and the integration of health and development programmes), it does not seem to see a role for itself as a pressure group on the government to adopt favourable strategies, norms or policies in this regard.

Thus, it appears that NGOs are perceived both by themselves and the government as playing a supportive and not a lead or 'forceful' role. Not only can they not 'push or instruct government,' (ACHAN, 1982)[34], but their creative instinct have apparently to give way to government ones. Along these lines an extreme suggestion has been provided by Roy (1985) who states that because the voluntary sector is 'demoralised and splintered' and suspicious of its fellow members on account of 'irregularities' and politicisation within it, the government is the only agency capable of bringing factions together"[35].

There is another more complex perception emanates from the gap that existed between the 'GO-NGO' collaboration that the governments avowed recognition the NGOs should be involved in the national health effort and its positive action in this direction. While higher echelons of government, believe that the earlier attitude of government as 'patron' and NGOs as 'clients' has changed into one of equal partnership (MOH&FW, 1985)[36]; NGOs allege that this change has not permeated lower level of government with which they deal more frequently (Roy, 1983)[37]. This

attitude arises in part from governmental perceptions of NGOs as 'competitors' or as redundant entities.

Government Assistance To NGOs In Health Sector

According to the Ministry of Health and Family Welfare (MOH&FW, 1985)[38], the government has taken several steps to date to 'collaborate' with NGOs in Health Sector. In the 1950s, a Board of Inspection was establish in the Ministry of Health to visit voluntary medical organisations and encourage them to 'supplement' government effort. The Board was instrumental in recomending financial assistance to these agancies, and indeed the grant of funds has been the premier mode of collaboration between government and NGOs. Also NGOs are assisted specifically to promote voluntary blood donation, organise eye camps and promote family planning.

But, how does the NGOs view this modality? The issue of taking funds from government has perhaps been divisive. On the one hand, there is the feeling that government funds are public funds and so the government should make more funds available to the organisations who are in touch with the people (Roy, 1983)[39]. In turn, some NGOs feel that taking government funds ensures credibility with the government and the people, and accountability to them. While reporting that his experience with government funding has been encouraging, Roy (1983)[40] laments that a NGO becomes committed to "a straight, tangibly-oriented programmes that has no room for improvisation or initiative" if it takes funds from government. In general, Roy perceives the 'attitudes and approaches' of government officials towards NGOs may cause problems for voluntary groups; thus driving them to seek. Their funding

elsewhere; "A foreign donor agency comes with a human face; the government in many cases think they are doing us a favour. The favour comes as an equal and is prepared to consider the agency efficient unless proved otherwise; the latter does not believe in equal partnership and in eighty per cent of the cases considers NGOs guilty of corruption, of irregularities, of inefficiency ....." (Roy, 1983)[41]. By the ammendment of the Foreign Contributions Act (1985)[42] now requires (NGOs) organisations receiving foreign donations to obtain prior clearance from the Home Ministry.

Despite the contractual nature of funding agreements, 'misunderstanding'- either genuine or 'engineered'- can lead to the application of adhoc decision; which lead many NGOs to stay away from government grants, which perhaps explains why funds meant for private programmes often go unutilised. Thus the 'communication and credibility gap' remains a major constraint to the 'GO-NGO'collaboration.

It seems clear that the criticality of the NGOs to national health programmes lies not in its size, which is small in terms of its coverage of the nation's population, but in the nature of its experience with primary health care, which however has been only faintly 'evaluated'. Despite the government's dependence in private sector experimentation, the lessons of NGOs' experience have had a limited applicability to the macro health system[43]. This constrained reality contrasts markedly with the policy presription for 'privatisation' which implies large scale difference on the part of the public health system to the private health sector.

Another attribute of the NGOs in health sector that puts pay to the possibility of 'privatisation' is its considerable heterogeneity, 'charity-oriented', 'developmental'

and 'political-activities' agencies make different contributions and would require different approaches on the part of government[44]. In the absence of a 'particular-standard' but effective approach, the government may find its interactions with NGOs in health sector too costly. Indeed, despite the changed orientation of NGOs' activity from 'social welfare to development', a look at its interaction with government reveals no new modalities.

Thus, any governmental attempt to decentralise health services through the NGOs in health sector (using micro-level projects to deliver macro-programmes) would be severely limited by its small size and heterogeneity. The government's hope to increase people's access to primary health care through the 'private sector' therefore, will have to take the form either of increasing size of the voluntary health sector several fold, or of markedly improving the capacity of government health services to 'absorb' its significant lessons. The first of these options clearly has limited potential, given the very special needs (besides finances and technical know-how) of Voluntary health-action; (e.g. dedicated leaders, community rapport) which cannot be 'produced' on demand by the government or anyone else. The second option, therefore, is for more important if collaboration between the government and NGOs is to have any meaning to the national health effort. Although this fact leads to the fact that NGOs must help the government to gain 'know-how' with regard to delivering primary health care and to improve the functioning of its health services, thereby enhancing its efforts and maximising the effectiveness of its resources, the tendency to date has been to concentrate on how the government must help the NGOs. Specifically, the following activities can be envisioned which would be fruitful but not detrimental to the 'National Health Policy' effort:

- Continued 'experimentation' by NGOs to develop approach and methods relevant to the macro-health system in the country.
- Pressure from the NGOs in Health Sector on the government (i) to improve its services so that more people enjoy access to them and;

  (ii) to develop structures capable of 'replicating' proven approaches on a larger scale.
- Funds from government to NGOs for specific project inputs and relevent research.
- The collection and dissemination of information on both private and public health programmes, and networking of 'actors' in both fields, undertaken by both public and private institutions.
- Interaction between the two sets of actors to foster a greater effort to educate the public, particularly by government institutions and large 'national' NGOs.

Finally, some modalities that are rejected by the present analysis must be of important facts to be mentioned. First, the attraction of private-sector resources into public programmes (except through health insurance schemes in the organised sector) would seem to be barking up the wrong tree. Second, the establishment of any 'code of conduct' (Roy,1985)[45] by government for the NGOs in health-sector would likely to restrict voluntary action and may become an instrument of repression, as Baxi has argued (1985)[46]. If government's objective is to foster NGOs' activity, they are administrative or legal procedure which centralises authority is a fundamental contradiction. Dialouge between government and NGOs must concentrate on creating space for Voluntary health action, rather than circumscribing it. Third, the creation of a 'semi-autonomous government department for social-service' (suggested by

Chandra, 1985) would make NGOs extensions of the government machinery and destroy their dynamism[47]. The government should concentrate on planning for its own health service system to take into account the lessons of the private sector. Fourth, while government should encourage the private Voluntary sector, 'denationatisation' would work against the interests of national health. Although bids may be made by the private sector to take over government programmes, there are many reasons why health care cannot be left to the private sector alone, whether one considers 'commercial' or 'Voluntary' organisations, together or separately. These reasons are as follows:

- The private sector cannot spread widely and densely enough over the country to adequately meet the rural health needs.
- It lacks steady resource base and widespread infrastructure that the government has.
- Its Voluntary component depends on the funds from external agencies and other uncertain sources.

- Its profit-making segment will not perform well in rural areas, even given Robin Hood methods.
- Nor will it provide the public health, preventive and promotive services required, as these are perceived to take away from its livelyhood.

Majority of Indian in need of health care, need free services because they cannot afford even highly-subsidised ones. In this concern health care remains a social and community service and cannot become fully commercial enterprise (Basu)[48].

The inadequacies of the private-sector are clearly demonstrated by the situation in urban areas where, despite a glut of private practitioners, clinics, hospitals. The poor flock to government hospitals and charitable clinics. The heavy demands on these urban facilities may suggest that they should be expanded, but perhaps more important, is the need to reserve these free public services for those who need them most, keeping out the affluent who can well afford to patronise the private sector. At best, the private sector can contribute to the national health effort by providing special services, generating knowledge, mobilising people and exerting pressure on government through its Voluntary effort by NGOs to fulfill its objective as well as responsibility.

CHAPTER - IV

NGOs ROLE IN HEALTH SECTOR : ISSUES AND PERSPECTIVES

Significant improvements in health status and control of communicable disease through strengthening of infrastructure have been made in India in the last four decades[1]. The thrust during the Eighth Five Year plan is to consolidate and strengthen the infrastructure in remote areas, particularly tribal, and urban slums.

'Health for All', stressed in the 'Alma Ata Declaration' of 1977, is one of the most momentous undertake of all mankind, seeking to touch the life of every human being on earth, irrespective of the circumstances. The 'National Health Policy' of 1983, to achieve the goal of Primary Health Care of all Indian citizens, has emphasized the need to devise innovative strategies for imparting new dynamism to the Health and Development Programmes[2].

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The voluntary sector, throughout the world, has played an important role in the delivery of primary health care in the face of most adverse situations. The Seventh Five Year Plan and the 'National Health Policy' recommended that one of the five strategies to achieve the health care goals should be through involvement of NGOs.

The voluntary sector has a rich heritage of contributions in socio-economic development. The Central and State Governments have initiated several programmes of strengthening the voluntary sector including financial assistance and infrastructural support. The voluntary sector is being actively involved in effective implementation of the Area Projects. Under a special scheme of PVOH-I and II, the Government of India with USAID financial and technical assistance, is strengthening nearly fifty NGOs[4].

The NGO sector has emerged today the Third Force to work with the Government and Private Sectors - to deliver primary health care to isolated, inaccessible, scattered communities in hilly, rural or tribal areas; dacoit infested villages, urban slums, poverty-stricken, alcoholic, and untouchable communities. The innovations in comprehensive health care and development of the people have demonstrated the leadership with vision and dynamism, a firm commitment and organizational flexibility for community participation as a process for health and development of the community and enabling the people to discover their true potentials.

It is well recognized that NGOs are closer to people, flexible, innovative, cost effective and more successful in facilitating popular participation and implementing health and its related programmes. The Governments Approach to the Eighth Five Year Plan (1990-95) promise to reorient the national development policy 'towards social transformation' and recognizes that meaningful development consists in mobilizing the skills, strengths and creative capabilities of the masses and securing their active

participation[5]. Who will mobilize and facilitate active participation of the masses better than the NGOs?

Moreover it is recognised that the task of formulating a 'model' or an appropriate system of health care becomes a highly challenging, managerial, sociological, technological, epidemiological fact which if simplified the current level of health policy 'Planning, will produce imperfect results. After all, the difference between the NGOs and the government sector are very subtle in this regard, they have preconceived ideals.

Need For Greater Involvement Of NGOs

With the above context the present issues regarding involvement of NGOs health and development sectors concerning the government programme implementation can be grouped into three categories[6]:

1. Decentralization, so that local organisers are given flexibility to operate the programmes as per needs of the local people and the area. Their own efforts (rather than instructions from the above) will bring great sense of responsibility and answerability among them.
2. Greater collaboration between government and the local NGOs so that credibility and comprehensive approach of welfare of NGOs could be fully harnessed for increasing acceptance of the programme.
3. Strengthening the monitoring system so that all components of the programme are continuously monitored and corrective measures are taken to rectify the problems. For this purpose, it may be necessary to associate NGOs with the states with poor

performance. These NGOs can work closely with the state government to monitor the programme and identify the corrective measures.

The increased collaboration between the government NGOs will be able to give correct image to the programme that it is for the overall welfare of the people. The potential of NGOs in health and development sector has been well recognised. The government has shown increasing commitment in their involvement, the decision on their extensive involvement has been taken at the highest level. This determination is clearly reflected in the 'National Health Policy'[7], the seventh Five-year Plan (1984), revised family welfare policy[8] and a recently developed Action Plan[9]. The clear objective in all the four documents as to broad-base programme outreach by maximising involvement of non-government structure which could ultimately sustain and further the development programmes. The effort is to make developmental activity as people's programme with support of government, from its present status where it is a government programme with same support of people. This is a basic change in the policy and approach to the programme.

Different Kinds Of NGOs Involved In Health Sector

The non-governmental effort in the health sector as it exists today can be broadly classified as following[10]:

Specialized Community Health Programmes

Many of them go a little beyond health by running income generation schemes for the poorer communities so that they can meet their basic criteria and needs

Integrated Development Programmes

In these programmes, health is a part of integrated development activities. Consequently, their emphasis on health care may not be as systematic or as effective as that of the previous group but the long-term impact of their work on health and the development of the community of significant.

Health Care For Special Groups Of People

This includes education, rehabilitation and care of the handicapped. These specialized agencies are playing an important role, keeping in view the fact that hardly any government infrastructure exists in this sector of health care.

Government NGOs

These groups are NGOs which play the role of implementing government programmes like family planning and integrated child development services. These bodies are usually more efficient than the government system but their overall approach is the same.

Health Work Sponsored By Rotary Clubs, Lions Clubs And Chambers Of Commerce

They usually concentrate on eye camps, conducting cataract operations in the rural areas on a large scale with the help of various specialists.

Health Researchers And Activities

The efforts of these groups are usually directed towards writing occasional papers, organizing meetings on conceptual aspects of health care and critiquing government policy through their journal which usually have limited circulation.

Campaign Groups

These groups are working on specific health issues, such as a rational drug policy and AIDS policy among others.

According to an estimate, more than seven thousand NGOs are working in the above areas of health care throughout the country[11]. NGOs have showed a significant performance in developing alternative 'models' as well as providing low-cost and effective health services in many parts of the country. Also they have been able to develop village-based health cadres, educational materials and appropriate technology. However, NGOs help in filling the critical gaps that exist in government health services.

NGOs Contributions In The Health Sector

A generalized feeling among the community is the developmental programmes are of the government and for the government that are not seen as their programme for their own development. This is a major fact that the motivation to accept programme services has been laking despite all efforts made by the programme's government machinery[12]. Besides this basic change in the orientation to the programme for which NGOs are very much adept because of their good image and credibility. They can also:

i) Made advice and services easily accessible, particularly for the underserved areas and population groups.

ii) Coordinate with the programme workers, traditional birth attendants and Health Guides.

iii) Train the functionaries, particularly low-level functionaries in their field based activities.

iv) Help in continuous supply of spacing methods like oral contraceptive pills to the acceptors.

v) Provide follow up services to the acceptors, perticularly to terminal method acceptors and

vi) Provide support to make family welfare educational activities more effective, to make it meaningful.

NGO field projects working in the area of health have different orientations such as Gandhian, Radical, Feminist, Religious, Corporate, scientific and Welfare catering to overall development sector, as discussed in the previous chapters.

NGO Experiences For Community Health Services

An important lesson from most of these NGO experiences is that contrary to common belief many, if not most, of the health problems of the community can be tackled by members of the community itself, if provided with the necessary knowledge encouragement, training of local workers and support[13]. This includes preventive, promotive as well as curative care, not only for minor illness but also for most of the major diseases covered by the national disease control programme, e.g. Malaria, Taberculosis, Leprosy and Immunization as well as Family Planning. This is because the knowledge and technology for the prevention, cure and control of these diseases which are of a communicable nature are remarkably simple, effective, cheap as well as safe and

hence can be best utilized by the people themselves. While the skills are simple, teaching and making them available to the community requires a high degree of cultural affinity with the people as well as constant availability and accountability to them[14].

Four decades of appropriating these health functions by the health services has demonstrated their inability to achieve the results. This has also prevented the people from solving those problems within thir own ability and created as sense of dependency and helplessness. It has also diverted the resources and attention of the health personnel from those problems for which they are trained and their services most needed[15].

Immunization, Nutrition, Pre-natal and Post-natal care, safe deliveries, detection of foetal abnormality, Health Education, Health and Nutrition of pre-school children, spraying for malaria, chlorination of wells, hygiene and sanitation, rehabilitation, are some of the promotive, preventive measures requiring sustained effort and cultural affinity rather than a high level of technical inputs[16]. These have been successfully implemented with involvement of local people as non-medical community health and paramedical workers, by practically all these NGOs. These locally selected health workers have been able to spread health awareness, information and education, in a manner in which no outsider could have made the same impact. It must be noted that there is an intensive coverage of the population by village workers trained by NGOs. Practically all the experiences demonstrate that trained village health workers and the supportive ANMs have been able to take over much of the curative load including diagnosis, treatment, injections, followup, etc., to the extent that professionals who

initiated the programmes were later only needed for the far fewer diagnostic and referral problems. This cadre of trained workers has been accepted by the community as useful health personnel over a period of time. Maintenance of records, co-ordination of health activities in an area, preparing health eduction and training material, imparting training, acting as community organizers, advocating cause, building and maintaining the infrastructure such as wells, roads and health centres, are some of the activities best handled by local people, as demonstrated to a varying degree in those projects. Given the opportunity, semi-literate and even illiterate workers have proved to be articulate, practical and efficient health functionaries. The NGOs, depending on their input, have been able to achieve control over many of the serious national health problems like communicable diseases, high mortality, high birth rate. Family Planning coverage and even serious local health issues like alcoholism (AWARE, SEARCH)[17].

In the case of Family Planning they have demonstrated that health and population control cannot be mutually exclusive. A high couple protection rate and a low birth rate and infant mortality rate are possible only when accompanied by an overall enhancement in health inputs and health status. That the best family Planning measure is development, is not just a cliche but is demonstrated by NGO experiences[18]. Education, employment, income generation, infrastructure and improved living conditions have been implemented in the projects which have seen a lowered birth rate, despite having no largest pressures. People's rapport, faith and trust in their own health workers, together with provision of other non-Family Planning health services, particularly curative, have proved to be crucial to acceptance of Family Planning measures (eg. Streehitakarini, SEWA Rural,

Munnar, RUHSA, Jamkhed)[19]. This approach to health has also resulted in re-orientation from a predominantly curative emphasis to granting preventive and promotive health its due place in the health programmes.

Sensitivity to cultural and social factors seems to be the key to effective health care[20]. Openness and communication with the community is vital. This includes granting due respect to traditional health practices, and attempting to incorporate folk remedies as also the traditional systems, The experiences of Banwasi Seva Ashram, for example, demonstrate that this is possible to a considerable extent. Only a person familiar with members of the community, their language, life styles, health beliefs and practices, is able to influence health behavior. Modern medicine has provided simple, safe and effective technology, which nevertheless requires a high degree of social and cultural affinity in its application. Hence a locally selected and trained person is best suited, being familiar with local conditions and familiarity with the community.

The NGO projects demonstrate that an effective Village Health Worker (VHW) needs[21]:

- appropriate selection;
- continuous on-the-job training;
- adequate resources;
- back-up of an effective, supportive and referral system;
- intensive coverage by a small population to health worker ration;
- due respect and faith in the ability of the village health workers;

The reason why the Government 'Community Health Worker' Scheme has failed is because these prerequisites have been ignored[22]. Today the over-burdened and inappropriately trained ANM, a young alien, coming from outside to the community, and the grossly devalued village health worker, are travesties of their counterparts as seen in NGOs. However, given the above conditions, local health workers can deliver results which no amount of techno-managerial or enhanced infrastructural inputs can achieve. This is not to decry the importance of more highly trained medical personnel, but to limit their role to more specialized curative and preventive functions as well as for training, support and technical advice to the community.

These NGO experiences also teach that village level health services require adequae back-up and a referral system. In all cases where village health workers have been effective, they have been backed by a well-operated base hospital having pathology facilities, doctors, nurses, beds, adequate drugs, transport and diet facilities. These hospitals are simple structures with dedicated doctors and nurses. rational prescription practices are responsible for their low expenditure on drugs and hence on overall expenses. Doctors are crucial at this level, to provide the services they are best equipped for, eg. curative support and technical inputs for training and planning health programmes. The Munnar hospital, though equipped with some of the latest high-tech equipment, and doctors of several specialties, has a systematic two way referral system of a very high order[23]. Patients to the hospitals are mostly referred cases who are sent back to locally based health centres for convalescence, thus avoiding a longer period of occupation of expensive hospital beds. The Jamkhed hospital has facilities for

accommodation for the relatives of patients with facilities for their stay and cooking, thus allaying the fears of rural people in an alien hospital setting[24]. These hospitals also served as the centre for training, record keeping, planning of services, including the preventive and promotive programmes and administration, in the manner the Community Health Centre was originally envisaged in the ICSSR/ICMR report.

The backbone of effective referral is transport and communication facilities. Most field projects may have just a jeep (the use of which is often politicised in the government PHCs) making regular rounds of the designated areas for training, monitoring and support. AWARE innovatively uses boats to reach inaccessible areas[25]. Regular visits of village health workers to the base, for for training, supplies or reporting, generally using local transport also helps maintain contact. Except for emergencies, such simple channels of referral should suffice. It is the linkage between the village worker or ANM and the base hospital, which is important as it gives confidence to the community and its village health workers, who do not feel isolated, and has given credibility by her power to refer patients. This is in turn helps her gain respect of the people and enhances her self-confidence.

All these projects demonstrate that decentralization of health is not only desirable, but possible. It enables empowerment and enhancement of the people's capabilities, leading to a shift from the 'delivery' of health services to self-reliance of people. CINI gives a sensitive account of the process[26]. This could also result in the eventual phasing

out of the NGO (AWARE, CINI), but this phasing out is a relatively rare phenomena among NGOs and can have an adverse fall-out (Mandwa)[27].

In the process of decentralization, technical guidance, support in planning, training inputs and curative referral were the major interventions from outside the community, and had been attempted in different ways by these NGOs. RUHSA, apart from Munnar and Jamkhed, have reiterated that the block (about 100,000 population level) seems to be the most effective unit for health coverage with the majority of the functions being undertaken at the village level itself[28]. Decentralization includes optimum encouragement of local talents and resources to undertake local health related functions like simple pathology, purchase and dispersion of medicines, cooking supplementary meals from locally available foodstuff, manufacture of furniture/ artificial limbs or other requirements, etc. SEWA-Rural demonstrates that decentralized health services at the 1000,000 population level, as proposed by the ICSSR/ICMR report and adopted by the government's health policy from Sixth Plan onwards, can be implemented effectively[29].

These NGOs have demonstrated in a variety of settings, the ability of community members to take up successively complex health responsibilities, with the passage of time. Community members have contributed their unique insights in planning and developing health programmes which are relevant to their needs. Two of these ten NGOs have health workers who are members of the community, on their governing board. (Streehitkarini, Banwasi)[30]. In many of them, senior workers participate in programme

planning. Involving local leaders like Panchayats to gain entry in the community, the NGOs have succeeded in later involving their population.

The importance of health education and information is reiterated in every NGO experience. The most powerful tool for people to gain control over their own health is health education and information. Simple knowledge of nutrition, coupled with immunization and supervised delivery, could save lakhs of infant and neonatal deaths. Health education and information can also be a powerful catalyst for people to demand their rights and accountability from the health services and personnel. It is hence no surprise that education and information have been used to great effect and are integral to the strategy of all NGOs, even those as diverse AWARE and Streehitkarini. This again is chiefly a non-medical intervention requiring high social and cultural skills and affinity, hence best designed and imparted by local people, with technical guidance from the professionals[31].

By far, the most important lesson is that priorities in health goals must start from the people. Identification of health needs must be an ongoing process which is not easy, as it must start with the people, giving vital health education and information until they are equipped to identify, articulate and participate in meeting their own felt needs. The process is uphill but effective, because it is the only way to ensure the relevance of health interventions. The planning, implementing and monitoring must all come from the people for whom the interventions are meant. The extent of success in intervention will depend directly upon the extent of sensitivity to the local conditions and the involvement

of the local people, SEARCH documents this. All NGOs use this methodology to varying degrees of success in activities ranging from programme implementation to advocacy. Health goals, methodology, implementation, monitoring and any changes in these, must involve people, otherwise mere lip-service to people's participation results in unrealistic targetisation, with under-usage and mismanagement of health resources and services, devaluation of local health workers and poor impact on health, as amply demonstrated in the public health services[32].

The importance of human relations cannot be over emphasized. The most valuable asset of the NGOs are the 'health personnel'. The impersonal attitude prevailing at all levels of the public health system, the authoritarian management style and particularly the terror of targets and transfers are all responsible for incalculable harm to the quality of health services. While the inter-personal relationships and motivation of NGOs may not be replicable elsewhere, some hard facts are worth noting. Correct selection of workers is half the battle won. This applies not only at the village level, but also for other personnel. Continued training is vital for success - a short period of training in the beginning, with constant and repetitive inputs, seems to work best. This work along the line for doctors and nurses as well, who must be updated and also given refresher courses. The location of training is most important - it must be as close to the actual field and conditions of work as possible, not at the district level. The content of training must be flexible, close to ground level realities, and made interesting, not theoretical. The next level of workers, at all levels, prove to be the most effective trainers, and senior personnel of PHC as developers of training must have respect and empathy for the less

educated trainees as well as for their native intelligence. Discussion and practical demonstration are preferable to theoretical lectures, as shown in all experiences[33].

The importance of accountability and of appropriate documentation are seen in NGO experiences. Accountability should be qualitative, and measured in terms of actual results not merely quantitative achievements. Effective channels of two way communication and information must be developed, to prevent tragedies like unreported morbidity or deaths, due to fear, as seen in the public system of today. Accountability should be an ongoing participative function, not a mere reporting exercise. An analytical, research-oriented thinking should be developed along the line, including simple but comprehensive record keeping[34]. Some NGOs have been remiss in records and documenting which may have cast doubt on their achievements. Management, record keeping, account keeping, communication, training abilities, are some of the skills which are as important as medical knowledge.

It is also recognised that the task of formulating a model's an appropriate sysem of health care becomes a highly challenging managerial, sociological, technological, epidemiological and political task which, if simplified to the current level of health planning, will produce imperfect results[35]. After all, the difference between the NGO and the government sectors is very subtle in this regard; they have preconceived ideas, a lot of money and little knowledge of the dynamics of community health. Genuine 'models' of community based health care are hard to find.

The concept of 'participation', currently in vogue, is another problem. In the case of the establishment, for whom anything referring to empowerment of the people is hard to accept, the term has come to mean compliance, contribution or collaboration. In its true sense, participation leading to empowerment stands as a challenge to the interests of the establishment.

The effect of community health experiments in shaping government policy with regard to health care has been limited, although a few of the concepts have been incorporated in government programmes. Some representatives of NGOs have been absorbed in the government's policy-making bodies. This is a critical area totally neglected by NGOs. All the NGO-initiatives are not necessarily in the area of extreme needs. One finds very limited NGO-initiatives in the BIMARU staes (Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Andhra Pradesh) as compared to the better-off states like Kerala or Maharashtra. Even in Kerala, they are not necessarily in the least developed parts of the Malabar coast or the highlands[36].

Hardly any effort has been made to form public opinion or mass organizations like trade unions[37], people's movements or political bodies to generate a demand for more appropriate and effective health services. In spite of these limitations, however, the contributions of the health sector NGOs in providing appropriate health services in needy areas is highly appreciable.

The Kerala Sastra Sahitya Parishad (KSSP) is one of the few NGOs which has attempted to demystify medicine. Special campaigns on the drug policy, anti-smoking and

amniocentesis have had some limited impact, both at the policy level as well as in educating the consumers[38]. The KSSP emphasizes that the greatest health problem is poverty and that the majority of aliments arise from the inadequacy of proper food and an unhealthy living environment. The KSSP has organized numerous health camps, published several documents on people's health, and are in constant touch with various organizations like the Voluntary Health Association of India and Medico Friends Circle. The KSSP believes that health care is a basic right of every citizen and an effective health care delivery system should work towards keeping the entire population physically and mentally healthy. It warns people against the modern health. It warns people against the modern health care systems controlled by multinational drug companies, stressing instead the wealth of knowledge that exists in traditional systems of medicine[39].

Linkages between health and other areas of development, like education, environment, economic and political factors have been integral in NGO experiences[40]. It is interesting that NGOs starting with purely health interventions have spread to these areas of development and NGOs having other developmental goals have found that inclusion of health activities is almost inevitable. The most effective intervention is a package including, at the very least, health, nutrition and education. Witness the merging of conventional ICDS and health services in all field projects. Such integration has also been contemplated by policy makers. In 1989, the Planning Commission met several NGOs to discuss the convergence of health, nutrition and education at the village level at a meeting organized by FRCH in Pune[41]. Health related NGOs have also taken up various economic and political issues. Infrastructure, employment and income generation,

environment, agriculture, and their linkages with health are emphasized by these NGO experience. Indeed the struggle for health is part of the larger struggle for equitable distribution of the nation's and the earth's resources.

A Hard Look At NGOs

There is a danger, however, in suggesting that all NGO activities are admirable and worth replicating. A subsequent article by Michael Cernea makes a strong plea for increasing the role of NGOs, as well as for a recognition and demonstration of their gereat potential as a development resource[42]. He does, however, vividly point out that it is all-advised to glamorize NGOs and their achievements. They have many weaknesses which to quote Cernea, include:

a) **Limited replicability:** Many NGO-sponsored activities are too small and localized to have important regional or national impact. NGO activities depend on a highly motivated and culturally sensitive staff, and where staff intensity and motivation cannot be replicated, the activities themselves cannot be replicated.

b) **Limited self-sustainability:** Many NGO sponsored projects are not designed so that in the future they can sustain themselves with little or no outside aid to the beneficiary communities; this is particularly true when it comes to the long-term maintenance requirements of water and sanitation systems and other small-scale local infrastructure projects.

c) **Limited technical analysis:** Initiation of local NGO projects often occurs with limited technical feasibility analysis and weak data bases. This is often the result of a lack ofsufficient technical, managerial or economic staff/skills, which is

understandable given the circumstances of many NGOs, yet affects overall results.

d) **Lack of broad programming context:** Although it may vary by region or sector, NGO projects often are implemented individually, not as part of a broader programming strategy. Often NGOs carry out their initiatives and projects individually and relatively or completely unconnected with other NGOs or programmes, a tendency that hinders the establishment of country-wide or region-wide programmes.

Critical Appraisal : From Community Health Angle

While recognising the creative contribution of the NGOs in the health sector in the country and to the health policy as well, the 1994-95 should become a period of serious reflection within the NGO sector constituency about its own role. This is necessary particularly in the context of the many negative developments and critical issues that are observed in the evolving health core situation in present condition. Some of the querries that are addressed in this concern are as follows:

- Is the government consciously trying to blur the difference between the profit sector and the non-profit sector by using the term NGOs for both ?
- Has the government purposely focused on the NGO sector as alternative service providers and overlooked the increasing role they are beginning to play as trainers, issue raisers, researchers and policy generators ?
- Is the motivations for increasing partnership with non-governmental health agencies because of a recognition in planning circles of their potential or is at the

behest or compulsion of bilateral or multilateral International aid agencies?

- Is the availability of increased funding and pressures of scaling up that are common today, affecting the creative contribution of this sector and comprising it value systems?
- Is the increasing professionalisation of voluntary health effort improving their efficiency but causing a loss of vision and commitment because of the entry of market economy values ?
- Finally, there is an increasing tendency in both government and non-governmental health circles to romanticise the 'Voluntary Health Agency' and to denigrate government health efforts.

This leads to unrealistic expectations from the non-governmental sector and at the same time reduces efforts to reform the government system. Both these strategies will prove counter-productive in the long run[43].

CHAPTER - V

NGOs IN HEALTH SECTOR: FUTURE PERSPECTIVE

It is important, and not belittling, to analyse the weakness of NGOs, precisely because altogether they are going through a period of impressive organizational growth which could be steered towards overcoming them[1]. Insightful observers have noted that NGOs are so frequently lost in self admiration that they fail to see, that even the strengths for which they the acclaimed can also be serious weaknesses; for instance in the face of pervasive poverty, "small-scale" can merely mean "insignificant"; "politically independent" can mean "powerless" or "disconnected"; "low cost" can mean "under financed" or "poor quality"; "innovative" can mean simply "temporary" or "unsustainable"[2] and then comes to the worthwhile conclusion: "The essential fact is the recognition of the key, growing, contribution that NGOs can and do make should not be accompanied by the mistake of idealizing them. NGOs have a great capacity, but they are not the ultimate panacea to the contradictions and difficulties of planned change and induced development. An objective approach to the limitations and weaknesses of NGOs is required for strengthening their own structures and performance, as well as for making their activities technically and economically sounder, and more replicable"[3].

The health groups (NGOs) are also divided on ideological grounds - foreign or locally funded, those following traditional or modern medicine, etc. Most of these groups are dominated by a group of elite who meet nationally or internationally to express concern and share information, however, they do not have any mechanism by which to transfer this information to either the common people or social activist who might be able to use this in their struggle. To this elite, even paramedics and village health workers are mere functionaries and not agents of change[4].

Given this situation, health organizations in the NGO sector need to focus on the following issues, apart from their current activities, these are[5] :

- They must join in the broader struggle for social justice with other progressive forces;
- They should work on critical issues of socio-economic justice in the areas where they operate;
- They must understand the macro level health plan and work towards a viable alternative health strategy.

Present Problems

Developments in health must be closely tried to a concern for 'total human development' which encompasses the physical, mental, social and spiritual well being of the individual[6]. Human development requires an approach which integrates and and harmonites the various factors which contribute to the health and well being of individual, families and communities. A fragmented approach will not yield the sought after results. As noted in the NGO report to 'Alma-Ata'[7]; "It is not enough, for example, to disseminate health and nutrition, education of land tenure and utilization preclude the production of adequate food for local consumption. It is futile to promote a health insurance scheme if employment opportunities are so limited that participation is beyond the reach of many. Provision of source of clean water to a community will have impact on water borne disease only in so far as the community is educated and in its use and management".

It follows that an acceptable level of health for all by the year 2000 cannot be achieve by the health sector alone. It can only be attained through an intersectoral approach, coordinating efforts in health with relevant activities of other social and economic development sectors.

The World-wide debate in health care has by now established a number of fundamental principles for health development[8]. These are : the responsibility of governments for the health of their people; the right and duty of people individually and collectively to participate in the promotion of their health; the duty of governments and the health professions to provide the public with relevant information on health matters so that people can assure greater responsibility for their own health; individual, community and national self-determination and self-reliance in health matters; the interdependence of individuals, communities and countries based on their common concern for health, more equitable distribution of health resources within and among countries, including their preferential allocation to those in greatest social need so that the health system adequately covers all the population; emphasis on preventive measures well integrated with curative, rehabilitative and environmental measures; the pursuit of relevant biomedical and health services research and the sppedy application of research findings; the search for forms of technology appropriate for each level of care and for each country; and appropriate training and orientation of all health workers to server the community and fill their social as well as technical roles.

A principle deserving special stress is that which focuses on women and health. Their health and nutritional needs are crucial, especially during the child-bearing years. They play a central role in food production and family nutrition which must be supported. They are important as providers of health care in the family and in the health professions. In the promotion of 'Health for All', women need to be drawn more in participation in planning and formulating health care plans[9].

Primary health care forms an integral part of the country's health system, of which it is the central function and brain agent for delivering health care. It is also an integral part of the overall social and economic development of the community. For primary health care to succeed, it will require the support of the rest of the health system and of other social and economic sectors concerned. Health system support includes facilities for consultation on health on problems, referral of patients to local and more specialized health institutions, provision of supportive supervision and guidance, logistic support and supplies[10].

A community with self-reliance is consonant with an integrated approach to human development[11]. The aim is to provide individuals and communities with the means to promote their own well-being and to participate in their own health care. Through increased awareness in the possibility for development, local motivation is enhanced along with the will to pursue the changes called for[12]. Developments in health care provide a valid and practical means for promoting the confidence within the community

for further involvement in development activities. Initiation of health care services can thereby provide an opening wedge for a broader approach to community development.

A Future Look

A policy review survey completed (1992) brought together forecasts of important economic, social and political trends that would have a bearing on health, and a framework of the health scenario in India by 2005 A.D.[13] While these trends and findings forecast about the challenges that would face the NGOs in health sector, in the next fifteen years is very thought provoking. The following listed are the components of a new philosophical framework that is urgently needed[14]:

- Preferential treatment for the poor, particularly those marginalised by the new economic policies.
- Upholding the justice dimension of health work and acting as an opposing power to the pharmaceutical industry and to vested interests.
- Focus on enabling/empowering people in health work. This would avoid dependance, non-participation, promote community responsibility and a people's health movement.
- Greater commitment to a holistic approach to health and to an integration of various systems of medicine.
- Ensuring a shift to a community based, non-institutional approach to health including the demystifyication and deprofessionalisation of medical knowledge.
- Increasing access of the poor and underprivileged to medical and health care.

- Developing a sense of understanding, earing and community belonging among health workers.
- Promoting spiritual dimensions of health and well-being.
- Promoting gender related issues - especially women's health status, their access to health care and impact of technology on women.
- Getting involved in environmental/ ecological issues that relate to health.
- Strengthening self-reliance at all levels by promoting herbal and home remedies, non-drug therapies, low-cost care and appropriate health technology.

In conclusion, the nineties are going to be a watershed decade in the growth and contribution of the health sector NGOs.

The critical questions outlined obviously focus on negative developments that can increasingly subvert the NGOs role in health care. The challenges of the future outlined above, focus on the emerging needs that could be a positive inspiration to new directions and new priorities. Which of these will finally decide the role of the voluntary health sector in 2000 A.D. will depend on an increasing self-reflection and collective effort. Whether the NGOs in health sector gearing up for this reflective task that draws from and leads to further health action is to be seen in holistic context.

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