

**The Role of Voluntary Organizations in Rural Development:
A Study in Selected Sectors in West Bengal**

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BY

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DECLARATION

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ABSTRACT

Introduction

Development is a subject of intense interest for social scientists in all the countries, developed or developing. Development has been one of the most important concepts of our time, raising various questions about values, techniques and choices. The formation and implementation of national policies revolves round this central aspect of development of any country.

In spite of the fact that the state is the prime mover of development in the developing countries and the development efforts are mostly state initiated, the administration in these countries are suffering from their own contradictions and the development process is largely thwarted. In a self-development participatory process of development the role of non-bureaucratic organization has consequently assume rising importance especially in creating awareness and developing real participation among the deprived sections of the rural population. In a changed (market economy) economic environment the state has also come forward to encourage voluntarism that makes development endogenous and springs from the heart of the people. Struggles for organizing the poor, conscientization and people's empowerment have become the key words for voluntary actions.

Theoretical Framework

The concept of development is perceived not only as a condition of life but also as a goal to be attained, as the capacity to grow and change and develop.

These three ideas of development are bound together in efforts to understand and deal with the phenomenon of development. With the process of decolonization, development became the most dominant issue in newly emerging societies. During 1950s–1990s the conceptual meaning of development has been changed drastically and new meaning and strategies of development have developed. The major strategies of development like the modernization paradigm, developmentalism, dependency theory, articulation of modes of production, new political economy approach or political autonomy approach, another development, basic needs, sustainable development are the product of this period. (decolonization period).

In countries which have development as a major national goal, bureaucracy is supposed to function as an agent of change then as an instrument of stability and continuity. In the context of development administration the Weberian model of bureaucracy may not be conducive to the fulfillment of development objectives. A development bureaucracy must be more functionally oriented, achievement centered, action-oriented, streamlined and result oriented.

The problem of bureaucracy is somewhat complex in developing countries where social and political institutions are relatively less developed and the state has mainly to depend upon the administrative structure for the accomplishment of its goal. So, all development programmes require considerable direct involvement and participation by the bureaucracy at all stages of their formulation and implementation. Indian bureaucracy was considered as capable of bringing about speedy socio-economic development in the country. But the characteristics of development bureaucracy are lacking in the Indian bureaucracy. It is centralized, rule-bound, authoritarian, lack initiative, change resistant.

The process of economic liberalization in its basic conceptual framework seeks a reduced governmental intervention in the economic sector. The newer approach is to cut back the scope of government activities through privatization, deregulation, decentralization and similar efforts which may be subsumed as debureaucratization. In debureaucratization downsizing of bureaucracy and the reduction of its scope have resulted in taking over its functions and activities by other groups or organizations.

A society's progress is determined by its social development which is both the cause and effect of economic growth. In a developing country social development depends on the proper and adequate human development particularly in rural sector where majority of the people are very poor, illiterate and lack the necessary knowledge, skills, initiative. India's track record in human development is dismal. In the 1990s reform process the new thinking regarding state's role is that state should retreat in the economic sector but concentrate on social sector. The new thinking regarding the role of the state raises some fundamental questions. Administrative culture and morality remain problematic and improvement within the administrative infrastructure in programmes, project management is very much dissatisfactory. The Eighth Five Year Plan had identified human development as the main focus of development in social sector. After the introduction of New Economic Policy and despite fiscal austerity, the government committed itself to increase outlay for clearly targeted social sector expenditures and for rural development during the plan period. But constraints on budgetary resources forced the government to postpone the provision for extra funds and on the contrary, to curtail them along with all other public expenditure. This expenditure cuts in social sector affect the development of social sector. With all these problems it is doubtful whether the state will be able to render service effectively to the social sector. In this

context, the voluntary organizations or non-governmental organizations may play a crucial role in developing the rural area and rural man power.

In India, in the past, various activities and functions were performed by a variety of local organizations which were essentially philanthropic and societal in nature. With the passage of time, because of their proximity to grassroots, flexibility of approach, ability for experimentation and people-centred, people-oriented model of development, the NGOs have emerged as one of the most viable alternatives in the search of development planners to bring about sustainable development and effective structural change from centralized to decentralized delivery system. The NGOs have a crucial role to play in development particularly in developing nations like India. Participation is the most key component of development process. Participation in the process of development requires conscientizations, education and training of the rural people. NGOs can play a very active role in mobilizing the rural people through proper motivation, education and training in participatory decision making process. They have challenging role to play as catalysts of social change, as educators as conscientizers as innovators and as awareness builders. In the context of market economy NGOs may perform their specific functions ensuring distributive justice, abolishing inequalities and judging every issue in terms of human rights.

In the context of the possibility of dynamic role that NGOs can play in the development process (particularly in rural development) the present study is a modest attempt to explore the ground realities of the role played by NGOs in rural development in West Bengal in some selected sectors – health, women welfare and women empowerment.

Methodology

Method of Data Collection

The study was done in two parts. For the first part of the study, which was mainly exploratory in nature, reliance was made primarily on books, journals, government reports, and annual reports, other published and unpublished source-materials. The data collected from these sources are supplemented by way of adopting the empirical survey method of personal interview based on structured as well as unstructured questionnaires.

For the second part of the study, the data were collected solely and completely by using the personal interview method of survey research. A structured questionnaire was administered among the sampled respondents for information relevant for the present study.

In the second part of the study interview method was adopted at two stages one at the organizational level and the other at the beneficiary level. As the organizations are working at the community level to empower the rural people socially and economically the study was shifted from the organizational level to beneficiary level of inquiry to see how far rural people are getting empowered and developed assessing the changes in their perceptions and attitudes. Consequently a survey research method of personal interview with a structured and unstructured questionnaire was chosen as the principal source of data collection for this part of the study.

Data Processing and Analysis

The two sets of questionnaire prepared for interviewing the two groups of respondents included both open-ended and close-ended questions. The data gathered from the close-ended questions were readily amenable to statistical analysis. Hence, the data that were obtained from the structured questions were first classified into categories and arranged in the form of

tables. Finally the data were analysed and measured in percentage to find out the relationship between the dependent variables and a set of independent variables.

Locale of the Proposed Study

The field work of the proposed study was conducted in two districts of West Bengal – one in Darjeeling and the other in Birbhum. The districts were selected from the 18 districts of West Bengal ranked on the basis of human development index.ⁱ

The motto of the study was to choose one district from upper rank and one from the lower rank. The nine districts from the upper rank and the rest nine from the lower rank formed two parts. By random sampling Darjeeling district from the first part and Birbhum district from the second part were selected for the field study.

Findings

The study finds that barring a few organizations, majority of the NGOs concentrate on dissemination of health information, awareness creation, providing health services and related advices which are all communication based, while delivery of medicinal materials was done by two third of the organizations.

The techniques used by the NGOs like group meeting, health camps, cultural shows, practical training for awareness creation on health matters are very effective. The relation between the organizations and the community is positive. The relation between the NGOs and the Government agencies is a sort of cooperative relation.

The study finds that in delivering rural development efforts the role of the NGOs may be mediators between government agencies and rural people; co-partners of government and supplementary to government agencies but never alternative or substitute to government. Non-governmental organizations can speed up the vast activities of the state. They can only meet the challenge of making the beneficiaries get all the health inputs in selected pockets of rural, tribal and urban fringes but can raise resources – human material and monetary sparsely. Non-governmental organizations through their limited dedicated workers can motivate, create field for self-sustaining activity, where their voice can be receptive.

The role played by the NGO in its effort towards economic empowerment of women through microfinance is impressive. The formation of self help groups as a basis for the social and economic empowerment of the rural deprived and disadvantaged women has yielded positive contribution in the mobilization and self development of women. Women who have participated in self-help groups have developed strong sense of self confidence and faith in their ability to interact with power structures and increase their contribution to the household. The disadvantaged women are capable of bringing about their economic upliftment given sufficient and necessary support. Women being the members of the SHGs enjoy better standard of living, awareness to children concerned and above all a sense of belongingness to the witness of social development.

Social Mobilization has increased considerable control over physical mobility of women. Mobility within and outside village, reduced men's resistance, the acceptance of this mobility in family and community at large has resulted in breaking up geographical isolation and creating social network. Group activity has led to a greater cohesion, serving as a social safety net and reduced the feeling of vulnerability. Greater decision making

power of women within the household does not only improve gender justice but create a more equal dispersion of power in a household.

The savings by the poor women facilitated greater control over financial resources and access to cash in need and the women feel secured during emergencies. The savings facilities in the SHG programmes have created an opportunity for women to have savings in their names. But there is no information about how these savings are used and whether women really can decide as to how they want to spend the savings. Because women continue to depend on men for support from loan repayment to spending their savings.

Empowerment has taken place but primarily in case of group leader and office bearers whose mobility and skills are enhanced due to their leading roles in the groups and capacity building training programmes of group given to them rather each member of the groups.

Local banks are reluctant to give enough time to this bank linkage programme which creates an obstacle to the quick bank linkage of the SHGs. It is a harassment to the SHG members and at the same time the denial of Govt. policy of inclusive growth. However the free and flexible characteristics of the NGO in the execution of their programmes make it more dynamic to reach to the population irrespective of age, education, income, caste, class etc.

Therefore the NGOs concerned have done some justice albeit to a limited extend to the rural poor in general and rural women in particular with their limited resources where the state fails to do with huge resources at its disposal, both administrative and functional. The state has now recognized the role of the NGOs as supplementary agencies to assist the state in its development efforts.

PREFACE

The developing countries like India have some common characteristics like wide spread illiteracy, unequal distribution of wealth, rural poverty, unemployment, agriculture based economy. In the wake of political independence there has been pressing demands upon the state to provide speedy socio-economic and cultural transformation and people's welfare. But with increasing volumes of functions of the state no effective and comprehensive development plan and programmes can be carried out by the government alone. Bureaucracy the main instrument of Government has failed to implement effectively the development programmes due to their traditional characteristics. Again, with the advent of market economy specially in 1990s the role of the state in social sector has been reduced. But market cannot solve the social problems and rectify social handicaps.

In this context the growth and the role of voluntary organizations or non-governmental organizations (NGOs) are crucial in the process of social development. The NGOs are very dynamic and flexible in bringing about socio-economic transformation in rural India. Realising the potential and effective role of the NGOs in soliciting people's participation in the process of development, the government is inviting the NGOs in executing its programmes and projects. The process of development becomes incomplete and inequitable if women are excluded from the benefit of this process. Empowerment of women must be an integral part of sustainable human development. Non- governmental organizations are successfully working on women empowerment. In the process of women empowerment women's health and women's economic empowerment is most important. In West Bengal the development in these two sectors is less satisfactory from the part of government. Therefore, the proposed study is a modest attempt to

empirically explore the role of the NGOs on women's empowerment in West Bengal.

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APPENDICES

Appendix-A

QUESTIONNAIRE (for officials)

1. Name of the Organization :
2. Office Address :
3. Is this a registered organization: Yes/No. _____
- 3.1 If yes, under which Act? :

- 3.2 In which year the organization
Was registered? : _____
4. What is the territorial base of the operation of the organization?
 - a) Urban
 - b) Rural
 - c) Tribal
 - d) a + b
 - e) All the above
5. What type of service does this organization provide?
6. Who are the target groups of the organization?
 - a) Children
 - b) Women
 - c) Youth
 - d) Tribal
 - e) Rural poor
 - f) Any other specify
 - g) Urban Slum
7. What is the total number of members of the organization?

8. Who take the major policy decisions for the organization?

- a) General body of the permanent members
 - b) Executive body elected by the permanent members
 - c) Administration
9. What is the staff strength of the organization?
- a) Full time
 - b) Part time
 - c) Honorary
10. What is mode of function of the organization?
- a) Project based
 - b) Routine works
 - c) Both
 - d) any other specify
11. What are the sources of funding?
- a) Foreign aid (govt.) _____, (non-govt.) _____
 - b) Government aid (central) _____
 - c) Government aid (state) _____
 - d) Membership subscription _____
 - e) Indian funding agencies _____
 - f) Revenue earned from delivery of services _____
 - g) Any other specify
12. What is the mode of operation of your organization?
- a) Disseminating information
 - b) Creating awareness
 - c) Providing health services
 - d) Giving health related advices
 - e) Persuading people to adopt the practices advised
 - f) Delivering free treatment & medicines
13. What are the techniques you use for disseminating information & creating awareness on health matters?
- a) Group meeting
 - b) Involving local clubs
 - c) Involving organized women groups

- d) Involving local youth
 - e) Involving panchayats
 - f) Organizing health camps
 - g) Involving opponent leaders within the community
14. What methods do you adopt to aware the people about the project?
- a) Holding group meeting with the people
 - b) Arranging cultural programme like puppet show, street theatre
 - c) Giving practical training to the people
 - d) Exposure of the organization's project (i.e. showing the people the organization's practical field of ongoing project)
 - e) Any other specify
15. How is the relation between the community and the organization?
- a) Authoritative
 - b) Consultative
 - c) Collegiate
 - d) Participatory
 - e) Any other specify
16. What are the reasons for limited health access of the people?
- a) Low social status
 - b) Poverty
 - c) Distance
 - d) Ignorance
 - e) Lack of awareness
 - f) All of them
17. What is the relation between the organization, the government agencies and panchayats.
- a) Muturally supportive
 - b) Smooth
 - c) Obstructive
 - d) Adversarial
 - e) Cooperative
 - f) Any other specify

18. Do you think that NGOs should totally substitute the government health care system or should act for extending support government actions?

Yes

No.

Appendix-B
QUESTIONNAIRE (for officials)

General Profile of the Respondent :

1. Name of Respondent:
- 1.a) Designation
2. Sex : a) Male _____ b) Female _____
3. Age :
 - a) 20 – 30 years _____
 - b) 31 – 40 years _____
 - c) 41 – 50 years _____
 - d) 51 – 60 years _____
 - e) 61 – above _____
4. Education:
 - 1) Illiterate
 - 2) Literate
 - 3) Primary
 - 4) High school
 - 5) High school completed
 - 6) Graduate
 - 7) Post graduate degree holder
5. Occupation :
6. Religion :

- a) Hindu _____
- b) Muslim _____
- c) Others _____

7. Caste :

- a) General _____
- b) SC _____
- c) ST _____
- d) OBC _____

8. What is the percentage of pregnant women who have been identified in the last 5 years?

- a) 21% - 30%
- b) 31% - 40%
- c) 41% - 50%
- d) 51% - 60%
- e) 61% - 70%
- f) Above 70%

9. What is the percentage of pregnant women registered by the organization in the last 5 years?

- a) 21% - 30%
- b) 31% - 40%
- c) 41% - 50%
- d) 51% - 60%
- e) 61% - 70%
- f) 71% - 80%
- g) Above 80%

10. Percentage of pregnant women

- 1) Identified
- 2) Registered
- 3) Access to maternity care

Organisation Wise

11. Do you have trained medical staff?

Yes _____ No _____

11.1. If yes, what is the percentage of women who receive prenatal care from trained medical staff during the last 5 years?

12. How many pregnant women were counseled on prenatal self-care including nutrition, hygiene and danger signs during pregnancy in the last 5 years?

13. How many pregnant women received tetanus-toxoid immunization in the last 5 years as recorded by your organization?

14. How many pregnant women took iron and folate tablets in the last 5 years as recorded by your organization?

15. How many mothers received postnatal check-ups from trained medical staff during the last five years?

Appendix -C

QUESTIONNAIRE (for beneficiaries)

Name of the Group –

No. of Members –

1. Name of the person :
2. Name of guardian :
3. Sex : Male Female
- 3.1 Religion: a) Hindu b) Muslim c) Christian
4. Address:
5. Educational Qualification:
6. Caste:
 - a) SC b) ST c) OBC
 - d) Minority e) General f) Others
7. Age : Less than 20
 21 – 30
 31 – 45
 46 – 60
 Above 60
8. Family members : a) Adult Male
 b) Adult Female
 c) Male Child
 d) Female Child
9. What was your monthly income before joining SHG?
 - a) No income
 - b) Upto Rs.500/-
 - c) Rs.501/- – Rs.800/-

d) Rs.801/- – Rs.1000/-

e) Above Rs.1000/-

9.1 What is your monthly income after joining SHG? (Post SHG)

a) No income

b) Upto Rs.500/-

c) Rs.501/- – Rs.800/-

d) Rs.801/- – Rs.1000/-

e) Above Rs.1000/-

10. From whom did you get the information about SHG-bank linkage programme?

a) NGO Members

b) Panchayat members

c) Community leaders

d) Friends

e) Any other

11. Why have you joined the SHG?

a) For getting Subsidy

b) For bank loan

c) For meeting your household requirements

d) To become economically self-reliant through income generation

e) Any other

12. Does your group hold regular meeting?

12.1 If yes, how many times you meet in a (a) Week _____(b)

12.2 Do you attend the group meeting regularly? Yes/No

13. Do you take part in the decision making of your group?

Yes No NA

14. Do you know the amount of loan your group received from the bank?

Yes No NA

14.1 How many numbers of your group received loan from the group?

15. Who take the decision regarding loan disbursement and loan repayment of your group?

a) Members collectively

b) Group leaders only

c) NGO

d) Any other

16. Does your group maintain ledger books of savings and credit, registrar book, minute's book etc?

Yes No NA

17. Have you received any loan from your group?

Yes No NA

17.1 If yes, what is the amount of loan you received?

17.2 How many times have you received loan from your group?

- 17.3 Which of the following was the purpose of your loan?
- a) Business
 - b) Cultivation
 - c) Animal husbandry
 - d) Small Scale industry
 - e) Household consumption
18. Who took the decision of taking loan?
- a) Myself independently
 - b) Husband
 - c) Jointly
 - d) Any other
- 18.1 Who took the decision as to how to use the loan?
- a) Myself independently
 - b) Husband
 - c) Jointly
 - d) Any other
- 18.2 Who took the decision as to what to do with the income generated by the loan?
- a) My self independently
 - b) Husband
 - c) Jointly
 - d) Any other
19. Do you think that joining microfinance programme through SHG increased your financial capacity?

Yes No NA

20. Do you take part in any social activity of your village?

Yes No NA

20.1 If yes, in which of the following programme do you take part?

- a) Child education
- b) Pulse-polio programme
- c) Movement against social discrimination on women
- d) Any other

21. Do you participate in your village development programme?

Yes No NA

21.1 If yes, which type of programme do you take part?

- a) Attending gram sansad meeting
- b) Participating village development programmes organized by NGO's and other groups
- c) Participating in panchayat programmes
- d) Participating in public affairs

22. Do you think/believe that your status in the family and community has been increased being a member of SHG?

Yes No NA

23. Do you think that within the household you get more respect than before?

Yes No NA

24. Do you think that access to microfinance programme through SHG has helped access to health and education of your family?

Yes No NA

24.1 Do you feel that you are now more aware about your children's health and education after joining SHG?

Yes No NA

24.2 Are you part of decisions regarding your children's health and education before joining SHG and after?

Before : Yes / No

After : Yes / No

25. Do you have freedom to take decision on family planning?

Yes No NA

26. Which changes do you feel in yourself after joining micro-finance programme through SHG?

a) Mobility outside home

b) Interactive capacity with people

c) Knowledge about literacy, health care, gender equality and social awareness.

d) Political awareness

27. Do you know the name of the MP and MLA of your district?

Yes No NA

Chapter-I

Significance of the Proposed Study

The developing countries have some common characteristics in terms of widespread illiteracy, unequal distribution of wealth, predominantly agriculture based economy, unabated rural poverty and unemployment. The governments in these countries are faced with challenge of improving the poor masses living in villages through a number of developmental programmes and projects. In the wake of political independence and plans for development in India, the expectations of the people about the ability of the government are very high. There has been pressing demands upon the state to provide leadership and to act as the change agent providing the necessary stimulus in bringing about socio-economic and cultural transformation in the country. With increasing volumes of functions of the state it is true that no effective and comprehensive developmental plan and programmes can be carried out by the government alone. With the advent of market economy the role of the state in social sector has been reduced. But market cannot solve the social problems or rectify the social handicaps. State can play a regulatory role in market economy so that the society cannot be shattered by the negative effects of the market. The growth and the role of voluntary organizations are crucial in the process of social development as they can relieve the government of some of its burdens and responsibilities and at the same time help to provide a mechanism of social change. The changed role of voluntary organizations in bringing about socio-economic transformation in rural India by way of developing the innate qualities of human beings, filling up the communication gap between the planners and implementers, and initiating a participatory model of development, is well recognized by the government and the planners of development. It highlights

the importance of voluntary organizations as the eyes and ears of the beneficiaries, the weaker sections of the society who have been left out of the mainstream development activities. Thus non-governmental voluntary organizations as the institutions of civil society can play a very important role in caring the disadvantaged-weaker sections of the rural poor of the society. Nevertheless, the role of the government, often aided by the voluntary organizations, in planning and implementation of anti-poverty and minimum needs programmes in the field of rural development, simply cannot be overlooked.

Objective of the Proposed Study

The state in developing countries like India is primarily responsible for planned socio-economic development and welfare. The intention of the Constitution makers was that an activist state through positive action could promote the quality of life of the underprivileged, deprived and vulnerable strata of society. In the process of development, bureaucracy was conceived as capable of, implementing and enhancing speedy socio-economic development in the country. Bureaucracy has become an integral part of the development process. However, the decade of 1990s shows a growing concern over the state's ability to function as an instrument of liberation of the poor and deprived. Bureaucracy has failed to perform effectively in meeting the basic needs of the millions of rural poor and providing a better life to them. It has been argued by some development theorists that in certain spheres of activity that requires high motivation and commitment, non-bureaucratic voluntary organizations may be more suitable in accomplishing self-reliance in a participatory process of development. Voluntarism is, thus, increasingly getting importance as an approach as well as a technique in the development process. Therefore, one of the primary objectives of the

proposed study is to explore the role of the state vis-a-vis voluntary organizations in the process of development.

The non-governmental voluntary organizations are of different types depending on their structures, functions, sources of funding and targets of beneficiaries. Basically there are two types of NGOs – one is big-structured, bureaucratic, getting aid from government and international agencies and is in close liaison with state administration. Others are the small-structured, committed, people-centred organizations developed from the heart of the people and are working with the people, at the grassroots level. They are funded by the people themselves. The role of this latter type of voluntary organizations is more crucial in the process of self-reliant, participatory development. Another primary objective of the proposed study is to evaluate the role of these NGOs among the target groups of disadvantageous and deprived sections of the rural poor in West Bengal in generating awareness and empowering them.

In a developing country like India where majority of the people live in rural areas, any effort at development should start with the rural people. NGOs may play the most important role interalia in the fields of health and women's development. One of the objectives of the proposed study is, therefore, to analyse and evaluate the role of the NGOs among targeted beneficiaries in West Bengal in selected sectors of health and women's economic development and welfare.

Both the government and the voluntary organizations are working in different fields of development. Voluntary organizations are successfully gaining importance and attention of the government. Realising the potential and effective role of the voluntary organizations in soliciting people's participation in the process of development without which all the developmental efforts tend to become counter-productive, government is

inviting the voluntary organizations as mediator and co-partner in executing developmental programmes and projects. Voluntary organizations are also taking help from the government in financial and other related matters. Thus, a close liaison is maintained between the voluntary organizations and the administration. Another objective of the study is therefore to explore the different dimensions of relationship between the government and voluntary organizations.

Research Questions

Keeping in view the objectives, the proposed study seeks to answer the following :-

- What are the forces and circumstances that contributed to the growth of non-governmental voluntary organizations in India?
- The various types of non-governmental voluntary organizations based on their differences in their organizational structures, style of functioning and the sources of funding.
- The extent to which voluntary organizations have been successful in conscientizing and empowering people of target groups in West Bengal?
- The extent to which the voluntary organizations are working successfully in selected fields of development – viz. health, women’s development and welfare and their economic empowerment?
- What are the broad perceptions of the government and administration in West Bengal about the functioning of the voluntary organizations and the relationship between administration and voluntary organizations?

Research Design

Method of Data Collection

The study was done in two parts. For the first part of the study, which was mainly exploratory in nature, reliance was made primarily on books, journals, government reports, and annual reports, other published and unpublished source-materials. The data collected from these sources are supplemented by way of adopting the empirical survey method of personal interview based on structured as well as unstructured questionnaires.

For the second part of the study, the data were collected solely and completely by using the personal interview method of survey research. A structured questionnaire was administered among the sampled respondents for information relevant for the present study.

In the second part of the study interview method was adopted at two stages one at the organizational level and the other at the beneficiary level. As the organizations are working at the community level to empower the rural people socially and economically the study was shifted from the organizational level to beneficiary level of inquiry to see how far rural people are getting empowered and developed assessing the changes in their perceptions and attitudes. Consequently a survey research method of personal interview with a structured and unstructured questionnaire was chosen as the principal source of data collection for this part of the study.

Content of Interview Schedule

In all there were two groups of respondents. The first group of respondents consisted of the officials of the organizations and the second group of respondents included the beneficiaries. Consequently, two sets of questionnaire were framed and administered. The first set of questionnaire

included both structured and unstructured questions that were framed for interviewing the officials of the organizations. The first part dealt with some general questions for all the officials of the organizations for obtaining information regarding the style and mode of functioning of the organizations as well as their target groups, the administrative set-up and their area of work. In the second part some structured questions were included to get information about the process and method of work in their respective field, impact and feedback of their work.

For the purpose of interviewing the beneficiaries who constituted the second group of respondents a set of questionnaire was framed which is related to microfinance, formation of self-help group (SHG) women's economic empowerment, social awareness etc. The questionnaire included, apart from questions of general profile of the respondents, those for getting information in specific areas of query. The objectives were to make assessment of the services provided by the organizations in their respective fields and the benefits received by the respondents.

Data Processing and Analysis

The two sets of questionnaire prepared for interviewing the two groups of respondents included both open-ended and close-ended questions. The data gathered from the close-ended questions were readily amenable to statistical analysis. Hence, the data that were obtained from the structured questions were first classified into categories and arranged in the form of tables. Finally the data were analysed and measured in percentage to find out the relationship between the dependent variables and a set of independent variables.

Locale of the Proposed Study

The field work of the proposed study was conducted in two districts of West Bengal – one in Darjeeling and the other in Birbhum. The districts were selected from the 18 districts of West Bengal ranked on the basis of human development index.¹

The motto of the study was to choose one district from upper rank and one from the lower rank. The nine districts from the upper rank and the rest nine from the lower rank formed two parts. By random sampling Darjeeling district from the first part and Birbhum district from the second part were selected for the field study.

The objective of selecting NGOs for the study was to select those NGOs which were working with the community at micro level for at least 10 years or more. For the field study at Birbhum district the list of NGOs which were working on health was collected from the DM office and Family Welfare Office at Suri, the head office of Birbhum district and from some renowned NGOs. But most of the NGOs in the list either extinguished, or not working properly, or not viable to be studied or some were newly established and some could not be traced. Therefore, only 12 NGOs out of 40 were selected which seemed to fulfil the objective of the field study. For the field study at Darjeeling district a list of NGOs working on microfinance programme for women's economic empowerment and welfare under the NABARD sponsored bank-linkage scheme, was collected from the Regional Head Office of NABARD at 6, Royd Street, Kolkata-700016. In Darjeeling district only three such NGOs were working on bank-linkage microfinance

programme. Out of these three NGOs, two NGOs were working at Kalimpong block and one at Naxalbari block. Due to language barrier, lack of communication and the recent political unrest caused by Gorkha Jana Mukti Morcha Movement at Darjeeling hill area, the field survey on Kalimpong based NGOs could not be undertaken. The one NGO at Naxalbari was selected. The beneficiaries were the members of the self-help groups (SHGs) which were formed and nurtured by the NGO at Naxalbari block. Those SHGs were selected for interview which had already been linked with the bank by the NGO. Six members from each group were selected for interview by random sampling method.

Overview of Literature

The literature under review may be clustered into the following context – development, economy, bureaucracy, NGO, micro-finance, women empowerment.

Marcus Franda in his book “India’s Rural Development: An Assessment of Alternatives” (1979) has made a modest attempt to understand the broad contours of India’s rural development and assessed the myriad options open to Indian leadership.² S. P. Srivastava in “The Development Debate: Critical Perspectives” (ed.) (1998) analyses and evaluates the development debate and its various models, dimensions and challenges.³ David C. Korten (ed.) (1992) in his “Getting to the 21st Century Voluntary Action and the Global Agenda” has examined the development experience in 1980s describing the decade as one of crisis, denial and has explored the newly emergent opportunities for 1990s with a new development vision of just, sustainable and inclusive improvements in human well being.⁴ The essays in the volume “Choice, Welfare and

Development” (ed) (1995) by K. Basu, P. Pattanaik and K. Suzumura discuss welfare economics in two related strands – one develops the more theoretical aspects of social choice theory, while the other concerned with the application of welfare economics in the context of developing economics.⁵ Jean Dreze and A. Sen (ed) (1996) in “Indian Development – Selected Regional Perspective” focused on the importance of positive public initiatives in promoting social opportunities and laying the basis for participatory growth.⁶ Ashok Chakraborty in his book “Aid, Institutions and Development – New Approaches to Growth, Governance and Poverty” (2005) argues that there should be more recognition of the role of economic and political governance in achieving positive and sustainable development outcomes. He explains that aid programmes can play a more forceful role in political and institutional reforms, and can truly be made an effective instrument for development.⁷ Mahendra S. Dev in “Inclusive Growth in India – Agriculture, Poverty, and Human Development” (2008) emphasizes the need for economic reforms focusing on key interrelated elements of inclusive growth: agriculture, poverty, food security and employment, social sector, regional disparities, performance, practical issues and challenges.⁸ In the volume consisting of three outstanding works “Poverty and Famines; Hunger and Public Action; India : Economic Development and Social Opportunity” omnibus (1999) by A. Sen and J. Dreze, the authors explored the economic, social and political roots of deprivation in the modern world, and the role of public action in addressing this problem.⁹ Terence J. Byres in his book “The State, Development Planning and Liberalization in India” (1997) provides a comprehensive treatment of the nature, achievements and limitations of Indian development planning between 1950s and the late 1980s addressing issues which continue to be relevant in India’s present liberalized environment. The author critically analyses liberalization in relation to the pre-1991 experience.¹⁰ The book “India, some Aspects of

Economic and Social Development : The CESS Silver Jubilee Lectures” (2008) edited by Mahendra S. Dev has dealt with issues of social development e.g. education, human development, politics of governance, comparative analysis of India–China development path, challenges in Indian fiscal federalism, social dimensions of globalization and trends in employment and some issues on agriculture.¹¹

The book “State, Markets and Inequalities : Human Development in Rural India” (2007) edited by Shariff Abusaleh addresses the role of social sector planning in alleviating deprivation highlighting the extent of deprivation across states and among social groups and points out the responses of households and their ability to have access to services and exploit opportunities in the contemporary competitive world.¹² The contributors, in “Economic Reforms and Social Transformation” (2008) edited by S. R. Ahlawat examined social transformation in India in three dominant spheres, viz. agrarian and rural transformations of excluded and the population, gender employment and transformation.¹³ Sunanda Sen in his book “Globalization and Development” (2007) examines the benefits of globalization that have reached the masses beyond the selected few and also attempts to highlight the contours of the present order of globalization and development.¹⁴ Smita Mishra in “Engendering Governance Institutions: State, Market and Civil Society” (2008) examines different aspects of governance in development from the point of view of gender perspectives.¹⁵ S. N. Pawar and R. B. Patil in the volume “Problems and Prospects of Development, Cooperation, Voluntarism, Communication, Social Tensions and Weaker Sections in Rural India” (1994) have discussed all the issues pertaining to rural development thoroughly to see if the rural development policies that have been pursuing need further rethinking and reformulation and whether the organizational structures that have been erected in rural

India need further revitalization.¹⁶ V. A. Pai Panandiker, in his book “Bureaucracy and Development Administration” (1978), focuses on whether the bureaucracy has the essential values and attitudes necessary to perform the task of transforming traditional societies into modern ones.¹⁷ John Riley, in his book “Stake holders in Rural Development – Critical Collaboration in State–NGO Partnership” (2002) describes and elaborates on a form of collaborative effort between governments and voluntary agencies which works in practice, despite a widespread atmosphere of mutual distrust and antagonism.¹⁸ S. N. Ray, in his book “Communication in Rural Development A Public Policy Perspective” (1995) presented a comprehensive conceptualization of communication and development in Indian context since the years of the modernization paradigm right up to the 1990s and the state of communication research in India based on appropriate methodologies in terms of the alternative and emerging paradigms and reconceptualization.¹⁹ S. K. Das, B. P. Nanda and J. Rath in their edited book “Microfinance and Rural Development in India” (2008) investigated the role of microfinance institutions in the socio-economic development of rural poor of the state of Orissa.²⁰ Satya Sundaram, in his book “Microfinance in India” (2006) analyses microfinance in India in a comprehensive way encompassing the problems of banking sector, innovative schemes of the banks to help the poor, role of self-help groups in empowering rural poor through institutional credit and their positive results.²¹ K. G. Karmakar in his book “Microfinance in India” (2008) provides an informative and holistic status of microfinance in India and suggests a road map for the future. He makes an overview on microfinance institutions and focuses upon the challenges faced by the dominant credit delivery models, i.e. SHG-Bank Linkage Programme and issues related to the emerging microfinance institutions.²² N. Lalitha, in “Rural Women Empowerment and Development Banking” (1997) investigates how far the social and development banking

endeavours to benefit rural women. The author also presents a vivid and penetrating analysis of factors which promote or hinder women access to credit, participation of women borrowers in the management of credit at grassroots level.²³ Asha Mukherjee and K. Bhattacharjee in the volume “Conditioning and Empowerment of Women : A Multidimensional Approach” (2003) analysed the status of women in India and the alternative modes of their empowerment. They deal with the theoretical issues relating to empowerment as well as issues involved in practice.²⁴ Mally Joseph, in the book “Women Participation and Development Strategies” (1997) enquires and tries to identify empirically the actual level of women participation in the development programmes of governmental and non-governmental organizations.²⁵ David H. Smith and Frederick Elkin in their book “Volunteers, Voluntary Associations and Development” (ed) (1981) pointed out a number of issues in voluntary action in less developing countries.²⁶ John Clark, in his “Democratizing Development : The Role of Voluntary Organizations.” (1991) focuses on the need for strengthening the democratic traditions of the organizations and thus making them the means through which the poor can take control of their own resources and livelihood.²⁷ The Economic Research and Training Foundation, Indian Merchants’ Chamber in “Round Table Discussion on Rural Development : Role of Voluntary Agencies and Business Houses” (1977) focuses on the problems that the voluntary organizations have to face like eliciting cooperation of the local community, their relations with the administrative apparatus and financial institutions.²⁸ A. K. Kapoor and Dharamvir Sing, in the book “Rural Development through Non-Governmental Organizations” (1997) represent the story of the NGOs movement in rural development in Himachal Pradesh, starting from its inception still its present state.²⁹ Shivani Dharmarajan, in her “Non-governmental Development Initiative and Public Policy” (1997), focuses on several significant aspects of participatory

development and the role and initiative of voluntary organizations.³⁰ Noorjahan Bava, in her “Non-Governmental Organizations in Development : Theory and Practice” (ed) (1997), emphasizes on important issues of the NGOs like their autonomy, accountability and effectiveness as catalyst of social change or harbingers of silent revolution.³¹ B. T. Lawani, in “Non-Governmental Organizations in Development, Case Study in Solapur District” (1999) has made an attempt to examine the history of voluntary action and structure and management of the voluntary welfare organizations in India and their role in social change and development.³² Rekha Wazir, in her “The Gender Gap in Basic Education : NGOs as Change Agents” (ed) (2000) focuses on both the potentialities and limitations of the NGO in reducing the gender gap, in producing basic education and in bringing about incremental changes at the national level.³³ M. L. Dantwala, Harsh Sethi, Pravin Visaria, in the volume “Social Change through Voluntary Action” (ed) (1998) maintain that voluntary action can be a potent instrument for bringing about social transformation, for eliminating poverty, and for building an egalitarian and human society. They have present convincing examples of successful socio-economic transformation brought about by a determined application of these ideals through six case studies.³⁴

David Hirschmann, in “Development Management versus Third World Bureaucracies : A Brief History of Conflicting Interest” (1999, Development and Change), focuses on the responses of Third World bureaucracies’ to changing demands of development management.³⁵ Satya Deva, in “Bureaucracy and Development” (1986, EPW), deals with the contradictions that the theory of bureaucracy suffers from and the resultant impasse.³⁶ M. A. Muttalib, in “Voluntarism and Development – Theoretical Perspective” (1987, IJPA), focuses on the need in India to entrust the task of rural

development to voluntary Organizations.³⁷ Sanjit (Bunker) Roy, in “Voluntary Agencies in Development : Their Role, Policy and Programmes” (1987, IJPA), focuses on the shift in government thinking regarding involvement of voluntary organizations in development since the Sixth Plan Period.³⁸ V. G. Nandeker, in “Voluntary Associations : A Strategy in Development” (1987, IJPA), emphasizes the importance of the voluntary organizations in development process as a strategy.³⁹ J. S. Mehta, in “Challenge and Opportunity for Voluntarism in Rural Development” (1987, IJPA), focuses on the fact that in rural development efforts voluntary bodies have to face various internal challenges like factionalism and authoritarianism and that they have to guard against these challenges.⁴⁰ H. R. Chaturvedi, in “Role of Voluntary Organizations in Rural Development” (1987, IJPA), examines the role of voluntary organizations in rural development in a historical perspective from Gandhian era to the present day.⁴¹ Udaya Bhaskara Reddy, in “Role of Voluntary Agencies in Rural Development” (1987, IJPA) discusses the role of voluntary organizations in rural development while focusing on different eminent bodies in the field according to their area of specialization.⁴² S. R. Maheshwari, in “Voluntary Action in Rural Development in India” (1987, IJPA), has pointed out that the voluntary organizations’ involvement in rural development is sporadic and intermittent. He opines that there is need of proper planning in voluntary action. He emphasizes that the lack of fund is a major problem to voluntary organizations.⁴³ Nurul Islam and Niaz Ahmed Khan, in “Non-Governmental Organizations in Bangladesh : A Commentary” (1996, Journal of Rural Development), has offered NGO-model, as an alternative to state sponsored development.⁴⁴ Robert T. Anderson, in “Voluntary Associations in History”(1971, American Anthropologist), explains the history of voluntary organizations from neolith to modern period and focuses on their contribution to social stability.⁴⁵ Snehalata Panda, in “Social Transformation

and Voluntary Agencies : A Model” (1987, IJPA), emphasizes on the transformational role of voluntary Organizations as change agents.⁴⁶ Anil Bhat, in “Voluntary Action in India: Role, Trends and Challenges” (1995, EPW), focuses on the point that the voluntary sector needs to play a more overt political role.⁴⁷ George Mathew, in “Decentralized Institutions: Government and Voluntary Sector” (1999, EPW), focuses on the crucial and important role of both panchayats and voluntary agencies in the process of decentralization and development.⁴⁸ Jyotsna Rajvanshi, in “Health Delivery System : Pre-condition for effective Role of NGOs” (1997, The Administrator), focuses on the effective role of NGOs in health delivery system.⁴⁹ Vimala Ramchandran, in “Equality among Unequal Parties : Relationship between NGOs and Government” (1995, The Administrator), focuses on the nature of relationship between NGOs and Government and argues that the relationship is one of unequal partners.⁵⁰ Mahesh Chander, in “Farmers Participation in Rural Development Programmes : Case Studies of some local NGOs in Central Himalayan Region” (1996, Journal of Rural Development), has tried, through the case study, to understand the modus-operandi of three locally active NGOs from the point of view of people’s participation.⁵¹ S. Galab, in “Rural Employment Programmes : Case Study for involving Voluntary Organisations” (1993, EPW), examines the effective role of voluntary agencies in rural employment generation programmes in the Anantapur district in Andhra Pradesh.⁵² K. K. Tripathy and Sudhir K. Jain, in “Micro-Finance and Rural Self-help Employment through self-help groups : A Study of Select District in Orissa and Haryana” (2010, Journal of Rural Development) assess through a primary research in two districts of Haryana and Orissa States the governance issues in the operations of SHGs in rural India.⁵³ D. Nagasya and D. Koleswara Rao, in “Micro Finance and Support Organizations in the Southern States of India” (2009 , Journal of Rural Development) reviewed the recent trends in the SHG-Bank linkage

programme at national and state level, with special reference to Andhra Pradesh in detail and certain aspects of the other three States – Tamil Nadu, Karnataka and Kerala.⁵⁴ C. Krishnan in “Role of Microfinance in Women Empowerment : A Study of Selected Experiments in Kerala” (2009, The Micro Finance Review) tries to assess the experiments of the Shreyas and the Kudumbashree in the process of women empowerment in Kerala.⁵⁵ Gopa Samanta in “Microfinance and Women : Gender Issues of Poverty Alleviation and Empowerment” (2009, The Microfinance Review) examines the success and failure of micro-finance to ameliorate poverty, to generate livelihoods and to empower women by organizing them under self-help groups.⁵⁶

The overview of literature suggests that most of the studies have dealt with the general issues in voluntary actions and the prospective role of the voluntary organizations as an alternative to state initiated efforts for development. The literature is conspicuously marked by the absence of any study on the role of small voluntary organizations which work at the grassroots level for ensuring actual participation of the rural poor in the process of decision-making in different fields of development, in India particularly in West Bengal. The present study is a serious attempt to fill up this research gap in planning and management of development in West Bengal.

Plan of the Study

The first chapter, introductory in nature, delineates the problem, the objectives of the proposed study, the research questions, the methodology followed, and the plan of the study.

The second chapter deals with the meaning of the term 'development', its various changing models, concept, and the changing meaning of rural development and various programmes undertaken by the Government of India, the aspect of development administration, the changing role of the Indian state and the emerging importance of the civil society and its organizations in the development process.

The third chapter analyses the concept and functions of voluntary organizations as well as Non-Governmental Organizations (NGOs), a brief history of NGO with changing approach, strategy and types of NGO. This chapter also includes an evolutionary analysis of Indian NGOs and their necessity in the participatory development.

The fourth chapter examines the concept of health, public health followed by a situational analysis of health status of South Asia. A brief analysis about India's performance on health sector and various Government policies during plan period has been presented in this chapter. As the proposed study primarily concerned with women's health in West Bengal, a brief overview of women's health condition in West Bengal has been analysed.

The fifth chapter deals with the field study on health and the primary data analysis.

The sixth chapter focuses on women's development, various programmes and policies undertaken by the Government of India for women and their economic empowerment through micro-finance.

The seventh chapter focuses on the field study on women's development and microfinance and primary data analysis.

The eighth chapter concludes with research findings and suggests some corrective measures to be undertaken by our policy-makers and political leadership.

REFERENCES

1. Government of West Bengal (GOWB), 2004, Human Development Report 2004, Kolkata, Development and Planning Department, p. 219
2. Franda, M. (1979), India's Rural Development, An Assessment of Alternatives, London, Indian University Press.
3. Srivastava, S. P. (1998), The Development Debate, Critical Perspectives, New Delhi, Rawat Publications.
4. Korten, David C. (1992), Getting to the 21st Century, Voluntary Action and the Global Agenda, New Delhi, Vijay Primalni for Oxford and IBH Publishing Co. Pvt. Ltd.
5. Basu, K., Pattanaik, P. et. al (ed.), (1995), Choice, Welfare and Development, New Delhi, Oxford University Press.
6. Dreze, J. (1996), Indian Development, Selected Regional Perspectives, Oxford, Oxford University Press.
7. Chakraborty, A. (2005), Aid, Institutions and Development, New Approaches to Growth, Governance and Poverty, New Delhi, Oxford University Press.
8. Dev, S. Mahendra (2008), Inclusive Growth in Indian Agriculture, Poverty and Human Development, New Delhi, Oxford University Press.
9. Sen, A. and Dreze, J. (1999), Poverty and Famines, Hunger, Public Action, India: Economic Development and Social Opportunity, Oxford, Oxford University Press.
10. Byres, Terence J. (ed.), (1997), The State Development Planning and Liberalization in India, Delhi, Oxford University Press.

11. Dev, S. Mahendra (2008), India, Some Aspects of Economic and Social Development, The CESS Silver Jubilee Lectures, New Delhi, Academic Foundation.
12. Abusalesh, S. and Krishnaraj, M. (ed.), (2007), States, Markets and Inequalities, Human Development in Rural India, Hyderabad, Orient Longman.
13. Ahlawat, S.R. (ed.), (2008), Economic Reforms and Social Transformation, Jaipur, Rawat Publication.
14. Sen, Sunanda (2007), Globalization and Development, New Delhi, National Book Trust.
15. Misra, S. (ed.), (2008), Engendering Governance Institutions, State Market and Civil Society, Delhi, Sage.
16. Power, S.N. and Patil, R.B. (ed.), (1994), Problems and Prospects of Development, Co-operation, Voluntarism, Communication, Social Tensions and Weaker Sections in Rural India, New Delhi, Mitttal Publications.
17. Pai Panandikar, V.A. (1978), Bureaucracy and Development Administration, New Delhi, Centre for Policy Research.
18. Riley, J.M. (2002), Stakeholder in Rural Development, Critical Collaboration in State -NGO Partnerships, New Delhi, Sage.
19. Ray, S.N. (1995), Communication in Rural Development, A Public Policy Perspective, Simla, Indian Institute of Advanced Study.
20. Das, S.K., Nanda B.P. et.al (ed.), (2008), Microfinance and Rural Development in India, New Delhi, New Century Publications.
21. Sundaram, Satya (2006), Microfinance in India, Delhi, B.R. Publishing Corporation.

22. Karmakar, K.G. (2008), *Microfinance in India*, New Delhi, Sage.
23. Lalitha, N. (1997), *Rural Women Empowerment and Development Banking*, New Delhi, Kanishka Publishers.
24. Mukherjee, Asha, Bhattacharya, K. (ed.), (2003), *Conditioning and Empowerment of Women, A Multidimensional Approach*, New Delhi, Gyan Publishing House.
25. Mally, J.(1997), *Women Participation and Development Strategies*, New Delhi, Kanishka Publishers.
26. Smith, D.M. and Elkin, F. (ed.), (1981), *Volunteers, Voluntary Associations and Development*, The Netherlands, E.J. Brill, Leiden.
27. Clark, John (1991), *Democratizing Development, The Role of Voluntary Organizations*, London, Earthscan Publication.
28. Indian Marchants' Chamber, Economic and Training Foundation, Bombay, (1977), *Rural Development, Role of Voluntary Agencies and Business Houses, Round Table Discussions*. Bombay, IMCERTF.
29. Kapoor, A.K. and Singh, D. (1997), *Rural Development through NGOs*, Jaipur and New Delhi, Rawat Publications.
30. Dharmaranjan, Shivani (1997), *Non-Governmental Development Initiative and Public Policy*, New Delhi, Kanishka Publishers and Distributors.
31. Bava, Noorjahan (ed.), (1997), *Non-Governmental Organisations in Development, Theory and Practice*, New Delhi, Kanishka Publishers.
32. Lawani, B.T. (1999), *Non-Governmental Organisations in Development, Case Study in Solapur District*, New Delhi, Rawat Publications.

33. Wazir, Rekha (2000), *The Gender Gap in Basic Education, NGOs as Change Agents*, New Delhi, Sage.
34. Dantwala, Sethi and Visaria (1998), *Social Change through Voluntary Action*, New Delhi, Sage.
35. Hirschmann, David (1999), "Development Management vs. Third World Bureaucracy, A Brief History of Conflicting Interests", *Development and Change*, Vol. 30, No. 2, April.
36. Deva, Satya (1986), "Bureaucracy and Development, Theoretical Perspective", *IJPA*, Vol.33, No. 3, July – September.
37. Muttalib, M.A. (1987), "Voluntarism and Development, Theoretical Perspectives", *IJPA*, Vol.33, July – September.
38. Roy, S.Bunker (1987), "Voluntary Agencies in Development, Their Role, Policy and Programmes", *IJPA*, Vol.33, No. 3, July – September.
39. Nandeker, V.G. (1987), "Voluntary Associations, A Strategy in Development", *IJPA*, Vol.33, No. 3, July – September.
40. Mehta, J.S. (1987), "Challenge and Opportunity for Voluntarism in Rural Development", *IJPA*, Vol.33, No. 3, July – September.
41. Chaturvedi, H.R. (1987), "Role of Voluntary Organisations in Rural Development", *IJPA*, Vol.33, No. 16, July – September.
42. Reddy, Udaya Bhaskara (1987), "Role of Voluntary Agencies in Rural Development", *IJPA*, Vol.33, No. 3, July – September.
43. Maheswari, S.R. (1978), "Voluntary Action in Organisations in Rural Development in India", *IJPA*, Vol.33, No. 3, July - September.
44. Islam, N. and Khan, N. Ahmed (1996), "NGOs in Bangladesh, A Commentary", *Journal of Rural Development*, Vol. 15, No. 4.

45. Adderson, Robert T. (1971), "Voluntary Associations in History", *American Anthropologist*.
46. Panda, S. (1987), "Social Transformation and Voluntary Agencies, A Model", *IJPA*, Vol.33, No. 3, July – September.
47. Bhat, A. (1955), "Voluntary Action in India", *EPW*, Vol.30, No. 16.
48. Mathew, G. (1999), "Decentralized Institutions, Government and Voluntary Sector", *EPW*, Vol. 34, No. 9, Feb – March.
49. Rajvanshi, J. (1997), "Health Delivery System, Precondition for Effective Role of NGOs", *The Administrator*, Vol. 62, No. 3, July – Sept.
50. Ramachandran, V. (1995), "Equality Among Unequal Parties, Relationship between NGOs and Government", *The Administrator*.
51. Chander M. (1996), "Farmers Participation in Rural Development Programmes, Case Studies of Some Local NGOs in Central Himalayan Region", *Journal of Rural Development*.
52. Galab, S. (1993), "Rural Employment Programmes, Case Study for Involving Voluntary Organisations". *EPW*.
53. Tripathy, K.K. and Jain S.K. (2010), "Micro-Finance and Rural Self-Help Empowerment through Self-Help Groups, A Study of Selected District in Orissa and Haryana", *Journal of Rural Development*", Vol.29, No. 2, April – June.
54. Nagasya, D. and Rao, D.K. (2009), "Microfinance and Supported Organisations in the Southern States of India", *Journal of Rural Development*, Vol. 28, No. 3, July - September.

55. Krishnan, C. (2009), "Role of Microfinance in Women Empowerment, A Study of Selected Experiments in Kerala", The Micro finance Review, Vol. 1, No. 0, Jan-June.
56. Samanta, Gopa (2009), "Microfinance and Women, Gender Issues of Poverty Alleviation and Empowerment", The Microfinance Review Vol. 1, No. 0, Jan-June.

Chapter-II

Development –Its Changing Nature

Development in its varied dimensions is a subject of intense and absorbing interest for social scientists in all the countries, developing and developed. Development has only been, one of the most compelling concepts, provoking painful questions about values, techniques and choices. The formulation and implementation of national policies revolves round this central aspect of development of any country. In our country, the Five Year Plans have been the principal means of coordinating national policies in the service of development. But, despite all efforts, development has proved to be a rather elusive goal for most nations of the developing world. Despite a voluminous literature on development, there is much disagreement and a great deal of ambiguity about its meaning. The term sometimes is used as a concept for change, urbanization, westernization or growth. Apart from contrasting perceptions, there have been many development fashions over the years. As empirical evidence has developed old approaches have been revised and new approaches emerged in an attempt to explain, interpret and advise on what is to be done. From each of the competing perspectives on development, a sharpened, broadened, holistic concept has emerged.¹ The major strategies of development like the modernization paradigm, developmentalism, dependency theory, articulation of modes of production, new political economy approach or political autonomy approach, Another Development, basic needs, sustainable development – have all failed to diagnose properly the causes of underdevelopment and establish the bases for rapid, stable and equitable growth path.²

The concept of development is rather elusive. It is perceived not only as a condition of life but also as a goal to be attained, and as the capacity to grow and change and develop. These three ideas of development are bound

together in efforts to understand and deal with the phenomenon of development. Development is not an absolute condition; there is not a fixed point at which a people, region, or country passes from a state of underdevelopment to a state of development. The relative condition of development, rather, is comparative and ever changing. It fluctuates according to what is needed, possible and desired. It is also relative in terms of what is feasible at any point of time. Development is relative in terms of the aspirations of the people, time, and availability of timely resources / inputs.³

The phenomenal growth of development theory is mainly a post Second World War phenomenon. During the last five decades (1950-1990) the conceptual meaning of development has been changed drastically and new meaning and strategies of development have developed. In the 1950s the emphasis was on economic dimension of development which focuses specially on economic growth of the poor countries. The basic idea was to make calculated input to ensure capital formation as well as raising of the output. It was assumed that, once the growth process gained momentum the growth process itself would take care of the distributional dimension. The development paradigm has stressed economic growth through industrialisation as the key to development. Technology and capital were at the central point of industrialisation.

In the 1960s a relationship between economic development and social change was more keenly realized. It was felt that economic development and technological change are hindered by institutional factors. So, modification in the institutional framework of society and alterations in the attitudes and values were contemplated to facilitate and accelerate the process of economic development. Thus, in this phase a new approach, modernization paradigm was developed. It was assumed that accelerated economic growth

could take place with emphasis on industrialization and modernization. The cumulative benefits of this kind of economic growth were expected to 'trickle down' eventually to the larger number who lived in the rural areas in the underdeveloped or developing countries. 1970s was of the decade of pessimism. It was highly reactive to the inadequate paradigms of development and modernization. The transfer of western capitalist models, concepts and methods are not wholly appropriate to the situation of developing countries. These developmental approaches could not accelerate the economic growth. Rather the reality is the conditions in which developing countries had to function in a state of dependency under neo-colonial or neo-imperial powers. The gap between the rich and poor widened. The disenchantment with growth-centered development was due to the emergence of the new concepts of human-centered development which called for greater access for the common man to development processes and strategies geared to meet basic needs, human resource mobilization, and human capital formation. The powerful currents of rethinking development were generated. "The United Nations Committee on Development Planning called for a rethinking about the priorities of development process along two lines. It called for a New International Economic Order (NIEO) for a restructuring of between North and South; secondly, it emphasized equity and participation, self-reliance and structural reform, poverty removal and employment generation, and renewed efforts for rural development and attention to distressed regions and disadvantaged groups."⁴ The emphasis, therefore, clearly shifted, to a total process involving economic, social, political and cultural spheres. Its principal aim was to improve not only economic, but the social, cultural and environmental welfare of the nation. Local needs and values would determine the direction of development and local institutions would carry it out. This development is endogenous, and springs from the heart of each society. Decentralized, participatory

development process came to be recognized as the need of the hour in developing nations. The current strategies are those of egalitarian development with primary emphasis on redistribution of income in favour of the poor.

From the mid-sixties the developing countries began to articulate their dissatisfaction about the feasibility and viability of the prevailing development approaches for attaining the social objectives. Undifferentiated growth was not raising the levels of employment and not improving the living standards for all in the society. In many countries, despite decades of development efforts, the absolute poverty was growing. Therefore, a search for alternatives started in development thinking. The alternative is to be endogenous and indigenous. It was recognized that the greatest hindrance to the path of development is the absence of real structural change. Michael Todaro observes that development is a multidimensional process involving major changes in social structures, popular attitudes and national institutions as well as the acceleration of economic growth, the reduction of inequality and the eradication of absolute poverty. Development, in his opinion, implies three core values: life sustenance, the ability to provide basic necessities like food, shelter, health and protection; self-esteem, the ability to be a person, a sense of worth and self-respect; and freedom from servitude, the ability to choose, emancipation from alienating material conditions of life and from the social servitude to nature, ignorance, other men, misery, institutions, and dynamic beliefs.⁵ Thus, from all these competing perspectives on development, a broadened conception of development emerges. This holistic conception encompasses not only growth, but capacity, equity and empowerment as well. A self-reliant approach to economic development with central focus on meeting the basic needs of the majority of the population of the developing nations provides a fresh orientation in

development strategy. The basic-needs approach to development policy became current in the mid-to-late 1970s. According to Paul Streeten, “the objective of a basic human needs approach to development is to ensure that all human beings should have the opportunity to live full lives.”⁶

The decade of the 1980s introduced greater focus on participatory decision-making, grassroots participation, and use of pluralistic, open-ended and culture-sensitive models of development. A new approach ‘Another Development’ has been proposed by several scholars which focuses on human and economic concerns and the analysis of social aspects of development began to take place. In 1990s the emphasis was on social development. The subject has been discussed at length in the World Summit on Social Development held at Copenhagen in March, 1995. The UNESCO’s Position Paper for the World Summit on Social Development (1995) raises the argument that development is first and foremost social.⁷ The aim of social development is to effect social wellbeing- the ability of every human being to satisfy his/her basic needs and achieve a satisfactory quality of life within the environment of quality, social justice and human dignity. Social development calls for strategic investment in health, education and social service, and necessitates access of the underprivileged to means of economic wellbeing.⁸

The main achievement of the development decade of 1990s has been to put people at the centre of the development discourse, economic policies and social programmes. The Earth Summit (1992) and the World Summit for Social Development (1995) expressed the core impulse of development in terms of the enlargement and enrichment of the range of choices at the disposal of the people. The critical development issue for the 1990s is not growth. It is transformation, the transformation of institutions, technology, values, behaviour consistent with the social realities. The transformation

must address three basic needs— justice, sustainability and inclusiveness of the society. The current development practice supports an extreme gap between poor and rich, imbalance between over and under consumers of the world resources. This imbalance is simply unacceptable by any standard of human values. Justice does not require equality of income; it requires that all people have the means and the opportunity to have a minimum decent livelihood for themselves and their families. Justice rejects the right of one’s self-enrichment based on the appropriation of the resources on which other’s survival depends. The transformed society must give priority in the use of global resources to assuring all people the opportunity for a decent human existence. Current development practice supports increases in economic output that depend on the unsustainable depletion of the global resources— natural and other. The transformed society must use the earth’s resources in a calculated way that assures sustainable benefits for future generations. The development practice in today’s world systematically deprives substantial segments of the population of the opportunity to make recognized contributions to the improved well being of society. This practice breeds alienation and social conflict. Therefore development must be inclusive. It means that everyone who chooses to be a productive, contributing community member has a right to the opportunity to do so and to be recognized and respected for these contributions. ⁹

Development is sustainable only when human beings are increasingly capable of taking charge of their own. A UNDP Report (1994) says “the essence of human development is to place development at the service of people’s well-being rather than people at the service of development.”¹⁰ In this perspective, human development implies empowering people to make their own choices. It also emphasizes the relevance of local values and knowledge as guidelines and tools for making these choices. Human

development implies people-centered development, a development that is focused on people, their needs and aspirations. A UNDP Report (1994) says “sustainable development is development that not only regenerates economic growth but distributes its benefits equitably. It is development that is pro-poor, pro-nature, pro-jobs, pro-women and pro-children.¹¹ The concept of sustainable human development seeks to re-strengthen the human decision of development by focusing development strategies and policies on people, putting people first and at the center of the development process.

It is now fully acknowledged that sustainable human development entails not only income and employment but also participation in decision-making, equal opportunity, equal access to resources and adherence to international human rights, empowerment and inclusive development. Development is a characteristic feature of modern times especially in developing countries. It is often observed to be the inconclusive term and is being like a rubber concept moulded for the purpose that time demands. But in its totality as a process it starts out of dissatisfaction, gets momentum resulting change and tries to end up with the attainment of a really unattainable goal.

Rural Development – Concept and Strategies

The ultimate purpose of development is to provide everyone with ever-increasing opportunities for a better life. Development, therefore, emphasizes on equitable distribution of income and other social resources in order to promote justice and efficient production, to raise levels of employment, sustainability, to expand and improve facilities for education, health, nutrition, shelter, social and cultural wellbeing. The crisis of development is universal. It exists in the poverty of the masses of the developing countries as well as of others, whose basic human needs like food, shelter, health and education are not met. Any solution to this crisis of development has to be

endogenous one. Development should spring from the heart of each society. In this context, self reliance becomes a basic concept of development especially in the developing countries.

A society's progress in all walks of life is also determined by its social development which is both the cause and effect of economic growth. In a developing country social development depends on the proper and adequate human development particularly in the rural sector, where majority of the people are very poor, illiterate, and lack the necessary knowledge, skills, initiative. With the independence from colonial rule most of the leaders, planners and administrators of these newly independent nations became concerned with developing the rural areas, because majority of the population live in rural areas in a condition of abject poverty, malnutrition, and insanitary living conditions. These factors not only affect the quality of life of people in the rural areas but also reduce their capacity, productivity. The immediate goal of these newly independent countries was, therefore, socio-economic reconstruction. But any strategy of socio-economic development that neglects rural people and rural areas cannot be successful. Rural development, therefore, became an absolute and urgent necessity in the developing countries. And accordingly various rural development programmes and projects were brought to the rural people. But these were, in many cases, piecemeal programmes and not consistent with their need structure. These specialized rural development programmes and projects have not shown positive results and instead of bringing down the gap between the poor and rich, these have accentuated the disparities between the two groups. This raises the fundamental questions of treating the rural development not only as a specialized programme or programme dealing with certain specifics but to perceive it as an integral part of the total social and economic development of a nation. The adhocism in the planning of

these programmes and strategies raised the basic issue of what is required to be developed in these areas. This brings in the problems of conceptualizing rural development. In most developing countries rural development has emerged as a distinct field of policy, practice and research with focus on distributional issues.

The term rural development is of focal interest and is widely acclaimed in both developed and developing countries of the world. There is, however, no universally acceptable definition of rural development and the term is used in different ways and in vastly divergent contexts. As a concept, it connotes overall development of rural areas with a view to improve the quality of life of rural people. In this sense it is a comprehensive and multidimensional concept and encompasses the development of agriculture and allied activities – village and cottage industries crafts, socioeconomic infrastructure, community services and facilities, and above all the human resources in rural areas. As a phenomenon it is the result of interactions between various physical, technological, economic, socio-cultural, and institutional forces and factors. As a strategy, it is designed to improve the economic and social well-being of a specific group of people – the rural poor. As a discipline, it is multidisciplinary in nature representing an intersection of agricultural, social, behavioural, engineering and management sciences.¹²

The World Bank, in its Rural Development Sector Policy Paper of 1975, had defined rural development as a strategy designed to improve the social and economic life of a specific group of people, the rural poor. It involves extending the benefits of development to the poorest among those who seek a livelihood in the rural areas. The group includes small farmers, tenants and landless. The World Bank strategy emphasized growth and the direct alleviation of poverty by government guarantee of the distribution of

benefits of growth. On the contrary, the ILO approach focuses on satisfying also non material needs such as human rights, participation and autonomy. It stresses the redistribution of assets, income and power, and changes in income-distribution and in the structure of production.¹³

Rural development has been conceptualized in a different way with economic growth, with modernization, with increased agricultural production, with socialist forms of organizations, and with services for basic needs such as health, education, transport etc. Development thinking has shifted from the view that growth and modernization would be enough, with benefits trickling down to the poor to the more realistic, even if depressing view that mostly growth and modernization make the poor poorer. The main benefits of development go to the better-off sections of the society than to the poor and the weak. The World Bank strategy suffers from some limitations and exclusions, like the women, the children and the poorest of the poor. A completely, and more inclusive definition has been offered by Robert Chambers that it is a strategy to enable a specific group of people, poor rural women and men, to know, to have access to and to gain for themselves and for their children more of what they want and need. It involves helping the poorest among those who seek a livelihood in the rural areas to demand and control more of the benefits of development.¹⁴

As the current centrepiece of the new development strategy, the concept of rural development has also been undergoing reinterpretation in the same way as the holistic concept of development. In the decades of fifties and sixties, rural development strategy in the context of national approach to development objectives and processes laid the main emphasis on rural economic development, implying largely agricultural growth in a broad sense. As this began to result in social and economic polarization with rising agrarian discontent and even some local conflicts, reformulation of

development strategies and restructuring of programmes began to take place so as to induct the social equity concept as concomitant to than complementary to rural economic growth. Employment expansion, income transfers and extension of social services and social welfare facilities have begun to be given an increased emphasis in strategies and policies.¹⁵

It is now widely recognized that rural development is by no means an agricultural or productivity problem alone, nor is it mainly a technical problem. Poverty is spreading, while constraints seem to multiply and continue to halt progress. It is on the removal of these constraints and the identification of gaps in rural development policy, process and research that there is a real need to focus attention. Rural development must be looked upon as a process of change in societies whereby poverty will be reduced, if not totally eliminated, and the creativity and the existing knowledge of the poor fully utilized. The poor must be enabled access to the resources of the society and the environment and encouraged to achieve control of resources in order to make available resources more productive of amenities, services and goods required and wanted by the poor and their governments.

The integrated approach to rural development has assumed great significance as a means of achieving a balanced development of rural communities. The word 'integrated' indicates a new multipurpose thrust of rural planning. Thus, rural development has to be symbiotically related to national development plans and programmes. The integrated approach to rural development envisages a direct and frontal attack on rural poverty by providing viable income generating assets to the target groups and to enable them through training, extension and other supportive services and infrastructural facilities to maintain the assets. It is a synergic approach aiming at total development of the area and the people by bringing about the necessary institutional and attitudinal changes. It delivers a package of

services through extension methods to encompass not only the economic field, i.e., agricultural and rural industries, but also the establishment of special infrastructure and services in the areas of health and nutrition, education and literacy, basic civic amenities, family planning and so on, with the ultimate objective of improving the quality of life in the vast rural areas. The realisation that poverty eradication is the objective of rural development must mean that all dimensions of poverty must be considered.

There emerged some new concepts and methods which sought to make rural development a meaningful enterprise. These are: development as human enterprise, community resource management at the local level, development as a learning process, decentralization and participation, and local action involving local actors and organizations, local beneficiary groups, local service organizations, local governments, and so on.¹⁶ Community-based resource management, with its emphasis on rural development, decentralization in the sense of delegation or devolution or privatisation, development of non-bureaucratic organizational forms, and community control of productive resources and technologies, has come as an emphatic refutation and denial of the rational and effectiveness of the conventional image of development. The transition from ‘delivered development’, which is planned from the top, with people as objects and beneficiaries to ‘participatory development’ which is planned from the bottom, with the people, particularly the poor, as the subjects of the development process, symbolises the emergence of a new model of development for most of the developing countries.¹⁷ Rural development like Lincoln’s Democracy is to cater to the ‘of’, ‘by’ and ‘for’ the rural population.

In the context of decentralized, people-oriented, participatory and self-reliant rural development with an accent on distributive justice and

egalitarian social order, it is very disappointing that a distinctly Indian comprehensive public policy can not be yet evolved; and whatever research has been or is being carried out at the level of professionals, academics and other social scientists, it seems, has not found its way into the policy process.

At the time of independence, the debate over the direction of Indian society and the economy centered on three vision of the country's future – a Gandhian view of a return to a largely rural, self-sufficient and decentralized polity and economic system based on India's villages; a socialist ideal, promoted by Nehru, in which the government would take a leading hand in planning and controlling the creation of a centralized, industrial state that would bring India into the modern world; and a liberal, capitalist vision favoured by Sardar Vallabhai Patel. The policy that was eventually adopted by the Government of India was based largely on Nehru's vision and focused mainly on the modernization of India through industrial growth and urbanization. Until the years following Nehru's death in 1964, relatively less attention was given to the rural poor who, altogether account for over 70% of the labour force and 80% of India's population.¹⁸

Rural Development Programmes in India

India has a very long history of experimenting various approaches to rural development. Even in the pre independence period, a number of rural reconstruction experiments were initiated by nationalist thinkers and social reformers. Well known among them were the Gurgaon Experiment of F. L. Brayne (1920), the Marthandam Experiment of Spencer Hatch (1921), the Sriniketan Experiment of Rabindranath Tagore (1920s), the Sewagram Experiment by Mahatma Gandhi (1933), the Firka Development Scheme (1946), and Etawah Pilot Project of Alber Mayer (1948). Besides these experiments by social reformers and missionaries, various departments of the Government – Agriculture, Cooperation, Irrigation, Health, Education – also

tried in their own way to resolve rural problems falling within their respective jurisdictions.¹⁹ Soon after independence planned development of India's economy was started with the goal of increasing income and eradicating poverty. Each successive Five Year Plan laid great emphasis on this goal. Accordingly in different Five Year Plans Government of India systematically adopted various programmes and schemes for rural development with emphasis on different areas, sectors and issues.

The Grow More Food Campaign (GMFC) was India's first organized effort to increase food production which was launched in 1943 in the wake of the Bengal famine. It did not make any headway until 1947. The campaign was reoriented in 1950-51 following the recommendations made by Thakurdas Review Committee (1948). In the following year, the GMFC became a part of the First Plan. In 1952, the Government of India appointed the Grow More Food Inquiry Committee under the chairmanship of T. T. Krishnamachari to evaluate the campaign. The committee found that all aspects of village are interrelated and no lasting results can be achieved if individual aspects are dealt with in isolation; and the movement touched only a fringe of the population and did not arouse widespread enthusiasm or become in any sense a national programme. The Committee made a number of recommendations for the future policy of the GMFC. One of the recommendations was that an extension agency should be set up for rural work which would reach every farmer and assist in the coordinated development of rural life.²⁰

It was with this background and experience that India's Community Development Programme (CDP) was launched during First Five Year Plan (1951-56) which emphasised all round balanced development in different parts of the country. The CDP aimed at overall development of the rural community through effective participation of the rural people, backed by the

coordination of technical and other services necessary for securing the best from such initiative and self-help. It was to provide the necessary institutional structure and services that early attention was given to the development of basic democratic village institutions – especially Panchayat Raj, cooperatives and village schools. It was also emphasised that the problems of rural development have to be viewed from a holistic perspective and the efforts to solve them have to be multifaceted.²¹ The objective of the CDP, described by the Estimates Committee on Community Development Project Administration as “the aided self-help programme or people’s programme with government participation”, was to promote self-help and self-reliance among the rural people through the initial supply of material resources. It was based on the assumption that as the programme caught on and became acceptable to the rural people it would move from officially motivated self-help to self-motivated self-help.²²

By the middle of the Second Plan, it became increasingly evident that whatever the success of the CDP, a new approach would be required if agricultural production was to keep ahead of the demands of India’s mounting population. Therefore, the Intensive Agricultural District Programme (IADP), popularly known as the package programme was launched during Third Plan (1961-65). Its basic premise was that India needed to organize its agricultural production with enough resources to make it effective. The immediate goal of the IADP was to achieve rapid increases in agricultural production through a concentration of financial, technical, extension, and administrative resources. Its aim in the long run was to achieve a self-generating ‘break-through’ in productivity and raise the production potential by stimulating the human and physical processes of change. The programme was also intended to provide lessons for extending such intensified agricultural production programmes to other areas.²³

The failure of the growth-oriented strategy of the sixties to make any significant dent on the problems of rural poverty and unemployment led to its re-examination in the late sixties. Especially the conditions of small and marginal farmers, and the agricultural labourers began to worsen in spite of Green Revolution. Also, there was no direct evidence of their participation in social, economic or political affairs of the villages. Absolute decline in their standards of living also caused concern among the planners and politicians. There were clear signs of marginalization and subordination of rural poor to the politico-economic structures within and outside the village. Inequitable distribution of the benefits of the growth-oriented programmes, between prosperous and backward areas and between rich and poor people within an area, was officially acknowledged and corrective measures in the form of group-specific programmes were initiated in the early seventies i.e. during Fourth Plan (1970-74).

The special programmes introduced for the weaker sections of the rural people and backward areas included the Small Farmer Development Agency (SFDA), the Marginal Farmers and Agricultural Labourers (MFAL) programme, the Drought Prone Area Programme (DPAP), the Desert Development Programme (DDP), Hill Area Development Programme (HADP), Tribal Area Development Programme (TADP), Crash Scheme for Rural Employment (CSRE) and Food For Work (FFW) programme. These programmes were aimed at attacking the problems of rural poverty and backwardness directly by helping the weaker sections increase their incomes.²⁴ To supplement the income effect of these special programmes, a programme geared towards providing civic amenities and community facilities like elementary education, drinking water, hospitals, roads and electricity was launched in the Fifth Plan (1974-79). This is known as the Minimum Needs Programme (MNP). The MNP attempted to raise the level

of social consumption of the poor people in rural areas.²⁵ The major objective of the group-specific and area specific programmes was that their benefits would flow to the weaker sections and backward areas because of the specificity of the target groups and target areas. Progressive reduction and ultimate reduction of poverty has been one of the major goals of India's economic policy since the beginning of the Fifth Plan. The basic strategy of combining the MNP with programmes for employment and income generation took a concrete shape towards the end of the Fifth Plan when IRDP was launched. The Sixth Plan (1980-85) launched a direct attack on the basic problems of rural poverty and unemployment. In the Seventh Plan measures have been designed to raise the productivity and incomes of the poorer sections of society and poorer regions. Therefore, food, work and productivity have been the three basic priorities. The Seventh Plan envisaged an expanded coverage under the various anti-poverty programmes. In pursuance of this strategy, the Seventh Plan gave a wider base to the IRDP by integrating it more effectively with agricultural and other rural development programmes. The IRDP, the single largest anti-poverty programme, aims at providing income generating assets and employment opportunities to the rural poor to enable them to rise above the poverty line once and for ever. The IRDP in effect seeks to redistribute assets and employment opportunities in favour of the rural poor; therefore, the target group of the IRDP consists of poorest of the rural poor – small and marginal farmers, agricultural and non-agricultural labourers, rural artisan and craftsmen, SC and ST families who live below the poverty line. The Seventh Plan paid special attention to the problems faced by the more vulnerable sections of our society like SCs/STs women and children.

The Eighth Plan was launched in the backdrop of widespread changes which have altered the international social and economic order. The Indian

planning system was gradually moving towards indicative planning from a highly centralised planning. The Eighth Plan recognises 'human development' as the core of all development efforts. The priority sectors of the plan that contribute towards realisation of this goal are health, education and basic needs. The Eighth Plan emphasises the essential need to involve people in the process of development. It is realised that the total dependence of the people on the government for developmental activities has been removed. It has to be altered to a proactive attitude of people taking initiative themselves. In the development process, people must operate and the government must cooperate. In this plan, therefore, for the first time a new direction had been given to achieve these objectives by the adoption of institutional approach which was meant for creating and strengthening various people's institutions at the district, block and village level in order to synthesise the purposes of investment, envisaged in the central plan with optimisation of benefits at the grassroots level by relating these programmes to the needs of people. The Panchayats and Nagarpalikas had been given larger role to play in formulating and implementing developmental projects in their areas. The involvement of voluntary organisations and other people's institutions was welcomed for effective micro-level participatory planning. The institutional approach has changed the existing programme-oriented approach. It was to provide a community instrument which would determine what people really need and how it could be achieved most effectively. The Eighth Plan paid special attention to generate employment opportunities in the rural areas. Such an expansion of employment opportunities called for a shift in emphasis in the rural development programmes from the creation of relief type of employment to the building up of durable productive assets in the rural areas. These assets can enhance productivity and create more job opportunities leading to sustained development.

In the Ninth Plan a new era of people-oriented planning was ushered in, where not only the Central and the State Governments, but the people at large, particularly the poor, could fully participate. A participatory planning process was an essential precondition for ensuring equity and accelerating the rate of growth of the economy. In this plan priority was given to agriculture and rural development with a view to generating adequate productive employment and eradication of poverty. The plan emphasised the empowerment of women and socially disadvantaged groups (SCs/STs/OBCs/minorities etc) as agents of socio-economic change and development. The plan also focused on promoting and developing people's participatory institutions like Panchayati Raj, cooperatives and self-help groups and strengthening efforts to build self-reliance.

All these objectives were intended to achieve 'growth with equity' and they should get reflected in four dimensions of state policy like – a) quality of life of the citizens; b) generation of productive employment; c) regional balance; and d) self-reliance.²⁶ In the Ninth Plan it was recognised that under the self-employment programme of IRDP there would be a progressive shift from the individual beneficiary approach to the group and / or cluster approach. A holistic approach would be adopted with an integration of the existing sub-schemes of TRYSEM, DWCRA, SITRA and GKY in IRDP. However, at the block and district level the Employment Assurance Scheme (EAS) would be the single wage-employment programme. Efforts would be made to bring about a greater integration between the poverty alleviation programmes and the various sectoral programmes as well as the area development programmes under the umbrella of the Panchayat Raj Institutions (PRIs). In the area of basic minimum services, the Ninth Plan had placed greater emphasis on primary health care, primary education and provision of safe drinking water and shelter.²⁷

The process of development in any society should ideally be viewed and assessed in terms of what it does for individual. The decade of the 1990s saw a visible shift in the focus of development planning from the mere expansion of the production of goods and services and the consequent growth of per capita income to planning for enhancement of human well-being. It is now realized that human development is much more than mere rise or fall of national income. It is about the quality of life, the level of human well-being and the access to basic social services.

Today there is a broad-based consensus to view human development in terms of three critical dimensions of well-being. These are related to longevity – the ability to live a long and healthy life; education – the ability to read, write and acquire knowledge and command over resources – the ability to enjoy a decent standard of living and have a socially meaningful life. Similarly, poverty is viewed not only in terms of lack of adequate income but as a state of deprivation that prevents people from effective participation in the development process. Good education, health, nutrition and low fertility rate help reduce poverty by increasing the opportunities to generate incomes. In view of the above thinking in the Tenth Plan (2002-2007) there has been a renewed focus on development indicators in the area of education and health attainments – which are critical for capacity building – and other social and environmental consequences that have a direct bearing on the state of well-being. Progress in these social sectors is both a vital yardstick and key element in the reduction of poverty. Most of the monitorable targets of the Tenth Plan relate to significant improvements in social indicators, particularly in the areas of human development indicators – education, health and family welfare. These are not only important on their own men but they also have an important bearing on the achievement of the growth and employment targets.²⁸

Rural development as in the overall development of the country, received due attention from all quarters, particularly since implementation of the development plans. But the approaches and strategies employed from time to time to realise its objectives could not yield satisfactory results. In the history of rural development in India various programmes were introduced from time to time under different names, although their contents remained almost the same and the fate of the people marked no substantial change.

Any analysis of the last few decades of planned rural development indicates that there has been no dearth of programmes, sectoral, area-based, target-oriented and projects for the disadvantaged groups and huge investments are made under these programmes, compared to the overall resources of the country. But the past experiences of rural development in India have amply demonstrated that meeting the target of eliminating poverty and unemployment is still a far cry. The rural poor have been deprived of the benefits of various rural development programmes undertaken under the Five Year Plans. The programmes and schemes of rural development are ad hoc, partial, segmented in nature. As a result, most of these programmes could neither solve the immediate problem nor provide any long-term benefit to the rural poor. These programmes created further economic imbalances and social tensions.

Despite the implementation of land reform programmes and agricultural development there has been little change in the agrarian sector in favour of the rural poor. There is still a heavy burden of exploitation upon the masses of the peasantry and agricultural labourers, whose standard of living is kept consequently squeezed. The productive forces in agriculture do not adequately develop. The masses of the peasantry who are excluded from land ownership have neither the means nor the incentive to undertake any

productive investment on land while the money lenders still squeeze the rural pauperized peasantry. Under the circumstances, whatever is sought to be done in the name of rural development has failed to bring about any improvement in the living condition of the rural poor.

The policies, plans and programmes for development, especially rural development, can only be influenced by direct and active popular participation at the regional and local levels by utilizing the instrumentalities of local-self government and by ensuring the active leadership of the state-level administration, at the same time de-bureaucratizing the whole machinery and the process of management of change. In the wake of market economy and liberalization, the very concept of achieving integrated and comprehensive rural and urban development through elected bodies at the district, block and village levels has tremendous appeal as an administrative and political innovation seeking to combine rapid economic development and social change.

West Bengal's experiment and experience in democratic decentralization through Panchayati Raj for achieving comprehensive rural development, initiated in 1978 assumes tremendous significance in contemporary India. During the last few decades of its working, Panchayati Raj in West Bengal has been able to carve out a crucial role for itself in the programmes and processes of economic development and social change in several distinct and interrelated dimensions, viz. a) administrative decentralization, b) political decentralization, c) participatory democracy at the grassroots level, d) comprehensive rural development through Operation Barga and land reforms. The main directions of the West Bengal Government's policy and working in the field of panchayats have been acceleration of organizational development, development of human resources in all aspects, and effective implementation of various rural

development programmes, central and state, by and through the three tiers of panchayat institutions.²⁹

Studies conducted on the Panchayati Raj institutions, during the 1970s and 1980s by several scholars and also by some state level committees show that in spite of some sporadic achievements, the Panchayati Raj did not develop as a very successful system. It had, so far, worked for the rural elite or the group of big farmers and rich traders. The masses of the poor did not gain much from the working in the Panchayati Raj institutes. It failed to involve the rural poor in development activities either as beneficiaries or as decision-makers on any significant scale.

Development Administration and Bureaucracy

The concepts of development and development administration are interrelated. Simply because a nation remains under-developed unless a necessary administrative machinery is there to implement the development strategy. It is believed that without proper administrative machinery all strategies of development applied in the developing nations are bound to fail. The term development administration as the sub-discipline of the broader discipline of modern public administration came into use in the 1950s to represent those aspects of public administration which are needed to carry out policies, projects and programmes to change and improve the socio-economic conditions. In the field of comparative public administration, endeavours to modernize administration (that is, bureaucratic administration) of developing countries were essentially an attempt for the attainment of developmental goals. This way, the key role of bureaucracy was seen as a processor to provide planning and an institutional infrastructure to convert inputs of objectives, capital and know-how into developmental outputs.³⁰ In the words of Donal Stone: Development Administration is the blending of all the resources (human and physical) into a concerted effort to achieve agreed

upon goals. It is the continuous cycle of formulating, evaluating and implementing interrelated plans, policies, programmes, projects, activities and other measures to reach established development objectives in a scheduled time sequence.³¹ The concept revolves round two key assumptions – efficient management of public development programmes, and stimulation of private development programmes and the acceptance of bureaucracy as the effective instrument of development.

Development administration had its origin in 1950s which was the decade of optimism, expectations and establishment of international aid agencies in various industrialized countries. Development administration was concerned, in this decade, primarily with the transferring of the techniques of public management from the western industrial countries to the developing countries. The aim was to create rational, politically neutral and impartial, efficient bureaucracies in Weberian tradition. In the 1960s, development had become the dominant issue in developing nations. In this decade the west responded to this development challenge in a number of ways. The first was to conceptualize the notion of development administration by blending all necessary elements of human endeavour with financial and material resources in order to achieve developmental goals that were generally recommended by the western experts. Development administration was seen as concerned with the will to mobilize existing and new resources, and to cultivate appropriate capabilities to achieve developmental goals. Thus, development administration became an essentially action-oriented, goal-oriented, administrative system, geared to realize definite programmatic goals. The task of the North was perceived to be the supplier of external inducement to change through technical assistance and transfers of technology and institutions. Development administration was supposed to be based on a professionally-oriented, technically

competent, politically and ideologically neutral bureaucratic machinery.³² The focus of development administration in the 1970s was to expand the capacity of organizations not only to manage development projects and programmes efficiently, but also to bring about more equitable distribution of the benefits of development activities to the marginalized poor groups of rural areas and elicit participation of that marginalized groups of rural areas in development planning and management and deliver essential public services to them. In the decade of 1980s, the very foundations of the development administration paradigm were severely in question. Not only their usefulness was in doubt in the Third World itself, but an intellectual crisis had set in among students of development administration in the west. Instead of development and nation building, turmoil and fragmentation proliferated throughout the Third World countries. Urban crises, energy crises, cessation of growth, unemployment and breakdown of public institutions and public morality had dampened the early optimism about the ability of the First World administrative technology to solve problems everywhere.³³ The decade of 1990s did not represent an improvement. Administrative culture and morality remained problematic, and improvements within the administrative infrastructure were few. With the advent of liberalization or market economy newer approach emerged which sought to cut back scope of government activities through privatization, deregulation, decentralization, and similar efforts, all of which might be subsumed under the rubric 'de-bureaucratization'. In this decade public administration was seen more as problem than solution. In de-bureaucratization, downsizing of bureaucracy was being demanded. In the situation, administered development would co-exist alongside private sector entrepreneurship and private voluntary organizations (PVOs) and non-governmental organizations (NGOs) with public officials providing an enabling environment and the necessary security, infrastructure, and

financial regulation (market-friendly development administration). If the dominant concern of development administration is the management of change in countries which have development as a major national goal, an effective bureaucracy should function more as an agent of change than as an instrument of stability and continuity. In the context of development administration the Weberian model of bureaucracy which contains features like organizational rules and procedures, division of duties etc. may not be conducive to the fulfillment of developmental objectives. Rule-bound behavior, precise delineation of jurisdiction, centralization of authority and system of promotion based upon seniority in the administrative organization are dysfunctional in the context of development.

A developmental bureaucracy is supposed to be concerned with promoting creativity and growth with a stable system. A developmental bureaucracy needs different kinds of values, orientations and attitudes. The problem of bureaucracy is somewhat complex in developing countries where social and political institutions are relatively less developed and where the state has mainly to depend upon the administrative structure for the accomplishment of its goals. Developing countries require a band of competent people for complex and highly specialized tasks of socio-economic development. Here, all development programmes require considerable direct involvement and participation by the bureaucracy at all stages of their formulation and implementation. Thus, the entire development administration movement focuses on the crucial role of bureaucracy in bringing about speedy socio-economic change. From the developing countries perspective, however, development administration is bureaucracy with a difference, since some of structural features, operational

styles and behavioural implications of traditional Weberian bureaucracy are thought to be unsuited to the needs of developmental tasks.

The New Economic Policy and The Role of the State

The Constitution of India established a sovereign, democratic, secular, socialist, welfare state. A full-blown democracy, as envisioned by the Founding Fathers of the Constitution embodies democratic governance, democratic management of the economy, pluralistic society, a welfare state and welfare economy as well as welfare society. Both as a goal and means of development. The state in India must remain a welfare state, and it is a mandatory goal of development as laid down in Art. 38 of the Constitution. The state should promote the welfare of the people by securing and protecting as effectively as it may a just social order.

The underlying philosophical orientation of the Indian Constitution makers was that an activist state through positive and egalitarian action could promote the quality of life of the under privileged, deprived and vulnerable strata of society. Total development has been the goal of our national policy. India since independence followed a protectionist development strategy on the basis of the Nehruvian model of development through centralized planning and mixed economy. There has been a commitment to democratic socialism, a socialistic pattern of society and welfare state ideology with bureaucracy on the centre stage, directing the economy to ensure growth with industrialization and modernization. For this, various measures have been undertaken for rural development.

After becoming a republic in 1950 India started with planned development. The First Five Year Plan envisaged the development of villages through community development programmes. Though it brought about awareness of development among the people, it started losing ground during 1960s. Various segmented programmes and schemes were undertaken

for rural development that ultimately resulted into rural disparities and created rural unrest in general. The state has only lent a sympathetic ear to the problem of rural development. It has not been seriously considered as an integrated part of the total social and economic development of the country. Rural development can be a reality only if it is related to the core value system of the villagers. The human needs structure will have to be analysed in terms of 'survival' or a 'social minimum' and the social supplies will have to be shared equitably or proportionately to one's needs.³⁴

To implement the development programmes and projects the state needs implementing mechanism. Bureaucracy is the main implementing cum development instrument of the state. So, bureaucracy has been given the responsibility to implement the rural development programmes and schemes. Throughout the Five Year Plans various rural development programmes have been introduced but with little success. While most business and professional organizations have been changing with the change of time, the government bureaucracy by and large remains the same – hierarchical, insensitive, sluggish and monopolistic. Apart from many other reasons, the bureaucracy, the main implementing agency, is responsible for the unsuccessful implementation of the developmental schemes. The district collector represents the tendency of the central government to retain a degree of political control at the local level despite considerable efforts on the part of the central government to decentralize the development process and to empower the rural poor in many areas of local decision making. To decentralize control of the development process, the creation of village panchayats has not automatically resulted in improved delivery of government efforts. In many areas, the district collector is an official or de-facto member of panchayat institutions, in some cases the collector has the

capacity to inspect the activities of local panchayats, and can even cancel or suspend the implementation of their decision.³⁵

The beginning of the 1990s saw the initiation of far reaching changes in the economic policy framework of India. These policy changes were undertaken through the introduction of a significantly comprehensive New Economic Policy (NEP) in July, 1991. (It was new in the sense that previously there was no such economic policy at the macro level. There were only sectoral policies like Industrial Policy, Energy Policy etc.) With the failure of the planned economy and development strategy and acute crisis in the economy in 1990s, the Government of India launched this New Economic Policy to revive the Indian economy and integrate it with the world economy. For this purpose, it was sought to dismantle ‘license-permit-subsidy Raj’ system and thereby to infuse liberalization in the management of the economy. Through this NEP, it was also sought to reform the whole structure of the Indian economy. As such the NEP is also called ‘Economic Reforms’. The avowed aim of the NEP is economic development in the long term. Through this, it is sought to bring about realignment of domestic demand with available resources and initiate changes in supply and production structure with a view to eliminating the external imbalance. The economy was to be liberalized from unnecessary controls and gradually integrated with the world economy through renovating the tariff walls, protecting foreign direct investment, and upgrading the technology of production in various fields. From this, it is found that the NEP has three important features— liberalization, privatization and globalization. Liberalization is meant for liberalizing the control system; privatization is for the improvement of the domestic production process to enhance efficiency

and competitiveness and thus integrating domestic economy with the global economy that is globalization.

The reform process consists of two dimensions, macro-economic stabilization in the short-run along with structural adjustment programme (SAP) in the medium-term and economic development in the long run. For the long-term economic development, macro-economic stability is necessary. Because macro-economic stability is a necessary condition for market prices playing their role in the efficient allocation of resources. The macro-economic stabilization programme (IMF inspired) essentially focuses on reducing the twin deficits on the balance of payment and on the state budget. The SAP (World Bank inspired) focuses on structural change of the economy in the field of “tax reform, deregulation of prices, delicensing of investment, liberalization of foreign trade and foreign investment regime as well as certain measures of reforming the financial sector and public enterprises.”³⁶

According to market economy concept the state cannot do business, it has to roll back from the market. But market cannot solve the social problems, rectify the social handicaps. In this case state’s role is inevitable. State can play a regulatory role in market economy so that the society cannot be shattered by the negative effects of the market. In the liberalized market economy the poor will be the most disadvantageous group. Corruption, personal interests, financial management withered away the state’s welfare character. Consequently, a question arises that who will provide social security to the poor people. In this context the responsibility has to be shouldered by the civil society, and voluntary organizations and non-

governmental organizations as institutions of civil society can play a very important role.

The Role of Civil Society: Transition from Absolutist State to Limited State

The idea of civil society is both appealing and ambiguous but positive. It began to enter into discussions of society and politics in the West from the 17th and 18th centuries where it figures, though not very systematically, in the writings of Locke and Rousseau. A certain line of argument about the nature and limits of civil society was established by Hegel in the early part of the 19th century. Hegel was the first to break the connection of civil society and state, hence in effect to render civil society independent. Hegelian civil society is economic and his notion became the dominant meaning of civil society in modern political thought. To the Marxists civil society was a confused (obfuscatory) name for the interests of capital, the social forms dictated by the ruling class, for the marketeers it was a suspicious mystification of what really mattered, namely markets and individual rights.³⁷

The assertion of democratic social movements in the contemporary world is inextricably linked with the concept 'civil society'. Civil society provides the conceptual apparatus to comprehend the implications of these social movements. Civil society can be identified with democratization and political liberalization, but it is a far more comprehensive and deep concept than democracy. The concept of civil society embraces an entire range of assumptions, values and institutions such as political, social civil rights, the rule of law, plurality of associations, representative institutions and public sphere which are indispensable preconditions for democracy.³⁸ As Gellner says : The ideas associated with this expression are indeed intimately connected with the establishment of a democratic or liberal, social and

political order. In fact democracy though accepted as a shorthand code term of participatory and accountable government, carries with it a model which is less useful than the one suggested by 'civil society'.³⁹

Gramsci's approach to civil society explains that society is not merely a matter of legal rights guaranteed by the state or of economic interests driven by the market. It is also a matter of ideas, beliefs, values, habits and customs that act on market and state and are acted upon by them in complex ways and different level. State and market contribute something but not the whole towards holding together the fabric of society.

The value of the concept of civil society can be understood if we remember that it has been resurrected whenever the power of the state has been challenged and sought to be controlled. The concept historically came into existence when classical political economists grappled with the question of controlling the power of the mercantilist state. The freedom of civil society formed the central plank of democratic movements against absolutist states in 18th century Western Europe. In liberal theory, civil society came to embody a whole range of emancipator aspirations which focused on the defence of human liberties against state oppression and which marked out an autonomous sphere of social practices, rights and dignity for the individual. It is this meaning that has come to inform the current focus on civil society. The assertion of civil society in the West is thus, based upon a shared collective memory of how absolutist states were limited and constrained by the activities of the self-conscious, right-bearing individual in association with others.⁴⁰ For the people of the post-colonial world, the context is different. It is not the remembrance of, but the creation of civil society as the sphere where the democratic politics can be constructed. It is the arena of movements struggling to free themselves from tyrannical, unresponsive post-colonial elites. If the first wave of liberation took place along with

decolonization, the second wave comes up against those very elites who had taken over power after decolonization. Obviously then, the resurgence of civil society is a political statement against the first or the second generation of leadership in the post-colonial world.⁴¹

The new emphasis on civil society represents a major inversion in development theory and strategy. This can be described as a transition from state and market to civil society and from centralism to localism.⁴² In the optimistic post war beginnings of development theory, the ideology of developmentalism and the concept of the interventionist public interest state were inseparable.⁴³ Mackintosh argues that this public interest view of the state rests on three assumptions – “1. It is possible to identify a public interest 2. The state is competent to identify that public interest. 3. The state will in practice serve (or at least, can be made to seek to serve) that public interest.”⁴⁴ The public interest was commonly defined with reference to the market and the claimed severity of market failure was used as an economic justification for granting the centralized state a key role in correcting market failures and ensuring economic efficiency, growth, macro-economic stability and social development. The 1980s brought a dramatic shift away from this public interest view of the state. Instead of being the ‘engine of development’ the state now came to be seen as the central problem. According to Neo-liberals like market governments can fail to work. This can happen if the organization of governments allows individuals to exercise undue power and exploit political positions for rent-seeking, or if the bureaucracy and the state are allowed to grow and become overextended.⁴⁵ So, just as market failure suggested a role of the centralized state in the early days of development theory, government failure led back to the market in the 1980s. However, by the early 1990s it had become clear that the structural adjustment programmes had failed to achieve this kind of dynamic growth.

Instead structural adjustment had furthered absolute and relative poverty while the pressure to reduce government expenditures had diminished social welfare programmes. Moreover, these marginalization processes created a potential for political instability that could jeopardize the adjustment programmes themselves. In this situation, a shift occurred from a singular emphasis on market deregulation to an additional emphasis on institutional reforms and social development.^{46 47 48}

In this context, civil society emerged as the arena in which a host of development objectives are to be achieved. Civil society can exert organized pressure on autocratic and unresponsive states and thereby support democratic stability and good governance.^{49 50} Civil society institutions can also be vehicles for participation in development programmes and empowerment of target groups of poor people. This move has in part challenged the centralization of the top-down state through planning couched in terms of stakeholders and local governance.⁵¹ This new conceptualization of development has three major characteristics. First, it has a top-down strategy in the sense that it is an effort by state agencies and collaborating non-governmental organizations (NGOs) to mobilization and empower identified target groups. From the late 1980s neo-liberals have changed their view on state market-relations and are emphasizing a division of labour between these two sectors. Rather than seeing the state, market and society as discrete and opposed arenas, the emphasis is on partnership between them. This means that the state should be restructured to become an efficient and capable ensemble of institutions that can enable market-led social development. The state should refrain from intervention in areas where markets function and rather concentrate on policy areas where market solutions cannot be relied upon, e.g. poverty alleviation programmes.⁵²

Second, the key actors in the empowerment process are to be the poor themselves and NGOs. This new strategy is driven by a desire to promote social development without large-scale government expenditure on social welfare. Self-help and community mobilization is emphasized as a strategy that can ensure cost-saving and increased project efficiency. Entrepreneurial development schemes supported by microcredit are strategic interventions that are expected to enable the process of community empowerment. Non-governmental organizations are assigned a key role as non-bureaucratic and efficient organizations that can mobilize community members for individual and collective empowerment.⁵³ Third, the new strategy for poverty alleviation is based on an understanding of power as a variable sum. Power resides with individual members of a community and can increase with the successful pursuit of individual and collective goals.

This concept of community participation and empowerment has another explanation. For post-Marxists, empowerment is a matter of collective mobilization of marginalized groups against the disempowering activities of both the state and the market.^{54 55} Friedmann argues that power and development have been concentrated along an axis between the state and the market. The developmental activities of these two sectors have resulted in a marginalization of civil society as a whole and especially of poor individuals and groups. Social movements emerge as a reaction to these processes and seek to define an alternative development altogether that will empower marginalized groups. This notion of empowerment emphasises bottom-up conceptualization of societal transformation. Empowerment processes are initiated through collective mobilization among marginalized social groups. This mobilization is based on shared experiences with economic and political marginalization. Conscientization and collective identity formation around these shared experiences are key elements in this

process.⁵⁶ Collective action for empowerment is in opposition to the state and the market. Non-governmental organizations and social movements are central to the radical politics of empowerment, but these are characterized by their autonomy rather than partnership with institutions and actors within the state and the market. Power is conceptualized in relational and conflictual terms. The disempowerment of poor people is rooted in material dominance and ideological hegemony of dominant classes and groups. Empowerment of marginalized groups requires a structural transformation of economic and political relations towards a radically democratized society.⁵⁷ States or market cannot and should not be solely responsible for ensuring social equality and welfare growth. Local actors, knowledge and interventions are important features of the present day development practice. Therefore, the new emphasis of current development practice is on local development, local civil society holding out the promise of bringing about more localized, relevant and, ultimately, sustainable development.

REFERENCES

1. Hope, Kempe Ronald (1986), *The Dynamics of Development and Development Administration*, London, Greenwood Press, p.64
2. Janvry, Alain de (1988), "The Search for Styles of Development, Lessons from Latin American and Implications for India" in *Institute for Economic Growth, Development Perspectives (Silver Jubilee Series)* Delhi, BR Publishing Corporation, pp.61-62
3. Grant, George F. (1979), *Development Administration: Concepts, Goals and Methods*, Wisconsin, Madison, University of Wisconsin Press. p.6
4. Ray, S. N. (1995), *Communication in Rural Development, A Public Policy Perspective*, Simla, Indian Institute of Advanced Study. p.20
5. Todaro, Michael (1977), *Economic Development in the Third World*, London, Longmans. p.62
6. Ray, S.N. (1995) op.cit, no.4. p.21
7. Srivastava, S.P. (1991), *The Development Debate, Critical Perspectives*, New Delhi, Rawat Publication. p.22
8. Ibid p.23
9. Korten, David C. (1992), *Getting to the 21st Century, Voluntary Action and the Global Agenda*, New Delhi, Vijay Primalani for Oxford and IBH Publishing Co. Pvt. Ltd. p.4
10. Srivastava, S.P. (1991), *The Development Debate, Critical Perspectives*, New Delhi, Rawat Publication. p.24
11. Ibid p.25
12. Singh, Katar (1986), *Rural Development: Principles, Policies and Management*, New Delhi, Sage Publication. p.18

13. Ray, S. N. (1995), *Communication in Rural Development: A Public Policy Perspective*, Simla, Indian Institute of Advanced Study. p.32
14. Chambers, Robert (1983), *Rural Development, Putting the Last First*, Essex, Longman Scientific and Technical / New York, John Wiley and Sons. pp.140-147
15. Ray, S. N. (1995), *op.cit*, no.13. p.33
16. Korten, David C. (1980), "Community Organization and Rural Development, A Learning Process Approach", *Public Administration Review*, Sept-Oct, 40(5), pp. 480-481
17. Ray, S. N. (1995), *op.cit*, no.13. p.35
18. Rudolf and Rudolf, (1987), *The Pursuit of Laxmi, The Political Economy of the Indian State*, Chicago, The University of Chicago Press, p.312
19. Singh, Katar (1986), *op.cit*, no.12. p.163
20. Sing, Katar (1986), *Ibid*, pp. 163-164
21. *Ibid* p.164
22. Chaturvedi, H. R.(1982), *Citizen Participation in Rural Development*, Oxford, IBH Publishing Co. p.181
23. Singh, Kartar *op.cit*, no.12, p.181
24. *Ibid* p.196
25. *Ibid* p.196
26. Dutt, R. and Sundaram, K.P.M. (1998), *Indian Economy*, New Delhi, S.Chand and Co. Ltd. p.250
27. GOI, *Ninth Plan Document, Vol. II, 1996-2001*, New Delhi, Planning Commission, pp.5-6
28. GOI, *Tenth Five Year Plan Document, Vol. II, 2002-2007*, New Delhi, Planning Commission, p.9

29. Ray, S.N.(2000), “Decentralized and Participatory Rural Development in West Bengal in a Comparative Perspective”, *The West Bengal Political Science Review*, Vol. III, No. 2, July-Dec., pp. 80-81
30. Dwivedi, O. P. (1997), *Development Administration, An overview*, IJPA, Special Issue, p.309
31. Stone, Donald C. (1966), “Tasks, Precendents and Approaches to Education for Development Administration” in Donal C. Stone (ed), *Education for Development Administration*, Brussels, International Institute of Administrative Sciences. p.41
32. Dwivedi, O.P.(1997), *op.cit*, no. 30, IJPA, Special Issue, p.311
33. *Ibid*, pp. 313-314
34. Mehta, S. R. (1984), *Rural Development Policies and Programmes, A Sociological Perspective*, New Delhi, Sage. pp. 23-25
35. Tummala, Krishna K. (1994), *Public Administration in India*, Singapore, Times Academic Press. p.130
36. Sengupta, Arjun (1995), “Sustainable Economic Reform”, *Mainstream*, Feb. 25, Vol. 33, no. 14. p.22
37. Lawrence, E. Cahoone (2002), *Civil Society, The Conservative Meaning of Liberal Politics*, Black well. pp. 215-217
38. Chandhoke, Neera (1998), “The Assertion of Civil Society Against the State : The Case of the Post colonial World” in *People’s Rights: Social Movements and the State in the Third World*, (ed.) by M. Mohanty, P. N. Mukherjee, New Delhi, Sage Publications, p.29
39. Giner, Salvador (1996), “Civil Society and its Future” in *Civil Society, Theory, History Comparison*, (ed.), by John H. Hall, Cambridge, Polity Press. p.302.
40. Chandoke, Neera (1998), *op-cit*, no. 38, p.30.
41. *Ibid*, p. 30.

42. Stokke, Kristian and Mohan, Giles (2001), "The Convergence Around Local Civil Society and the Dangers of Localism", *Social Scientist*, Vol.29, No.11-12, Nov.-Dec. p.4.
43. World Bank, (1997), *World Development Report 1997*, "The State in a Changing World" quoted in *The Convergence Around Local Civil Society and the Dangers of Localism*, by K. Stokke and G. Mohan, *SOCIAL SCIENTIST*, Vol. 29, Nos. 11-12, Nov-Dec. p.4
44. Mackintosh, M. (1992), "Questioning the State", in *Development Policy and Public Action* by M. Wuyts, M. Mackintosh and T. Hewitt (ed.), Oxford, Oxford University Press, p.65
45. Bates, R. H. (ed.), (1988), "Toward a Political Economy of Development, A Rational Choice Perspective", quoted in *The Convergence Around Local Civil Society and the Dangers of Localism*, by K. Stokke and G. Mohan, *SOCIAL SCIENTIST*, Vol. 29, Nos. 11-12, Nov-Dec. p.5
46. World Bank, (1990a), *Strengthening Local Governments in Sub-Saharan Africa*, quoted in *The Convergence Around Local Civil Society and the Dangers of Localism*, by K. Stokke and G. Mohan, *SOCIAL SCIENTIST*, Vol. 29, Nos. 11-12, Nov-Dec. p.5
47. World Bank (1990b), *World Development Report 1990*, *Poverty*, quoted in *The Convergence Around Local Civil Society and the Dangers of Localism*, by K. Stokke and G. Mohan, *SOCIAL SCIENTIST*, Vol. 29, Nos. 11-12, Nov-Dec. p.5
48. World Bank (1997), *World Development Report 1997*, *The State in a Changing World*, quoted in *The Convergence Around Local Civil Society and the Dangers of Localism*, by K. Stokke and G. Mohan, *SOCIAL SCIENTIST*, Vol. 29, Nos. 11-12, Nov-Dec. p.5

49. Hyden, G. (1997), "Civil Society, Social Capital and Development : Dissection of a Complex Discourse, Studies" in Comparative International Development, Vol. 32, No.1. pp.3-30
50. McIlwaine, C. (1998), "Civil Society and Development Geography", Progress in Human Geography, Vol. 22, No.3, pp.415-424
51. Desai, V. and Imrie, R. (1998), "The New Managerialism in Local Governance, North-South Dimensions", Third World Quarterly, Vol. 19, No.4. pp. 635-655.
52. World Bank (2001), World Development Report 2001: Attacking Poverty, quoted in The Convergence Around Local Civil Society and the Dangers of Localism, by K. Stokke and G. Mohan, SOCIAL SCIENTIST, Vol. 29, Nos. 11-12, Nov-Dec. p.6
53. Guljart, B. (1995), "Counter-development : Possibilities and Constraints" cited in The Convergence Around Local Civil Society and the Dangers of Localism, by K. Stokke and G. Mohan, SOCIAL SCIENTIST, Vol. 29, Nos. 11-12, Nov-Dec. p.6
54. Escobar, A. (1995), "Encountering Development : The Making and Unmaking of the Third World", quoted in The Convergence Around Local Civil Society and the Dangers of Localism, by K. Stokke and G. Mohan, SOCIAL SCIENTIST, Vol. 29, Nos. 11-12, Nov-Dec. p.6
55. Friedmann, J. (1992), "Empowerment: The Politics of Alternative Development", quoted in The Convergence Around Local Civil Society and the Dangers of Localism, by K. Stokke and G. Mohan, SOCIAL SCIENTIST, Vol. 29, Nos. 11-12, Nov-Dec. p.6
56. Freire, P. (1996), "Pedagogy of the Oppressed", quoted in The Convergence Around Local Civil Society and the Dangers of Localism, by K. Stokke and G. Mohan, SOCIAL SCIENTIST, Vol. 29, Nos. 11-12, Nov-Dec. p.7
57. Laclau, E. and Mouffe, C. (1985), "Hegemony and Socialist Strategy : Towards a Radical Democratic Politics", quoted in The Convergence Around Local Civil Society and the Dangers of Localism, by K. Stokke and G. Mohan, SOCIAL SCIENTIST, Vol. 29, Nos. 11-12, Nov-Dec. p.7

Chapter-III

Voluntarism: Concept and Approaches

The term voluntarism is derived from Latin word 'Voluntas' which means 'will'. The will assumes various forms of impulses, passions or desires. It is prior to or superior to the intellect or reason. All the theories of voluntarism, whether psychological, ethical, theological or metaphysical which interpret various aspects of experience and nature in the light of the concept of the will, subscribe to the thesis. All voluntary associations which are the expression of human impulse (will), have been the subject of study of, by and large, three disciplines: sociology, social psychology and public administration. Sociologists study voluntary associations as part of the social system; social psychologists are concerned with voluntary associations in an environment of their (voluntary associations) individual members while the scholars of public administration study voluntarism as part of organizational processes.¹

Inequality among individuals is an important source of motivation for voluntary action in any society, whatever be the stage of its development. There are five sources of voluntarism: religion, government, business, philanthropy and mutual aid if the delivery system for human services is analysed. The missionary zeal of religious organizations, the commitment of government organizations to the public interest, the profit making urge in business, the altruism of the social superiors and the motive of self-help among fellow men - all reflect in voluntarism. At the operational level, the above mentioned components may not differ much from one another but each of them is moved by an impulse with service as the common motivation. Bourdillon and Beveridge viewed mutual aid and philanthropy as the two main sources from which voluntary social organizations would have developed. They spring from individual and social conscience,

respectively. Bourdillon observed that the schemes based on these two motivating factors, are converging on each other and it is this mixture of the two elements which is the peculiar characteristic of the voluntary organizations today.²

The voluntary sector has many names. It is also called the non-profit sector, the independent sector, the quasi- private sector, and, the quasi-public sector. It is also called the third sector along with public and private sector. Each of these names attempts to describe the nature of the set of agencies, organizations and institutions that fall between the profit-making private sector and the service-oriented public sector. But each name connotes only one aspect of the system. It is deemed to be independent of the public sector and has a rationale other than profit motive. The term voluntary sector indicates that the effort comes from ‘volunteers’ – time, money and materials. Voluntary sector is a complex creature for three reasons. First, there are relationships between the public and private sectors that include vastly varied roles, purposes, and efficiency. Secondly, the voluntary sector includes multi-billion dollar umbrella agencies. Third, the voluntary sector is multi-functional, including fund raising, education and service delivery. Varied in size, function and degrees of interdependence and relationship between aspects of the system, the voluntary sector is in many ways undefined or misdefined and little understood in terms of its role in the delivery of human services. Despite definition and identity problems, a huge non-governmental network, or set of networks does indeed function in the delivery of human services. Some are part of national network, some are international networks, some are single organizations in a specific city, some co-operate with local, state or federal government, receiving financial support. Some have no ties to government at all.³

Voluntary Organization has been defined by different writers. According to Lord Beveridge “A voluntary organization, properly speaking, is an organization which, weather its workers are paid or unpaid, is initiated and governed by its own members without external control.”⁴ Smith and Freedom defined voluntary organization as “Structured, formally organized, relatively permanent, secondary groupings as opposed to less structured, informal, ephemeral or primary groupings, identified by the presence of offices filled through some established procedures; periodic, scheduled meetings; qualifying criteria for membership; and some formalized division and specialization of labour”.⁵ David sills, a sociologist, writes that definitions of the term “Voluntary association” differ widely but they generally contain three elements: A voluntary association is an organized group of persons: a) that is formed in order to further some common interest of its members; b) in which membership is voluntary in the sense that it is neither mandatory nor acquired through birth; and c) that exists independently of the state.⁶ David Sills defines voluntary organization as “a group of persons organized on the basis of voluntary membership without state control, for the furtherance of some common interests of its members.”⁷ Michael Banton, an anthropologist, characterized it as a group organized for the pursuit of one interest or of several interests in common. Usually, it is contrasted with voluntary groups serving a greater variety of ends, such as kin groups, castes, social classes and communities.⁸ Attempting a comprehensive definition of voluntary organization, N.R. Inamdar observes: “A voluntary organization in development to be of durable use to the community has to nurse a strong desire and impulse for community development among its members, to be economically viable to possess dedicated and hard working leadership and command resources of expertise in the functions undertaken.”⁹

The choice of strategy to be adopted by a voluntary organization differs from organization to organization and depends on the ideology, motivation, capability of the organization. Generally, voluntary organizations follow four clear cut strategies, as pointed out by J. B. Singh.¹⁰ These are:

1. Simple charity, supplementing welfarism of the state;
2. Encouraging people's participation and in implementing programmes launched by the government for larger benefit of the community or village;
3. Involving people in programme planning, raising resources, implementing activities and sharing fruits of development;
4. Conscience instilling and organizing people for enabling them to demand and undertake planning and implementation of development programmes beneficial to them.

The voluntary organizations at present adopt a target group approach but aim at self-reliance of the people they are serving . Voluntary organizations generally adopt a holistic approach to rural development and plan and organize their programmes in such a way as to cover all aspects of rural life. Based on the approaches they adopt and the priorities they give, voluntary agencies have been classified into seven categories by J.B. Singh.¹¹ It means that generally voluntary agencies operate in seven distinct areas. These are:

1. Charity: - Giving food, clothing, medicine, alms, in cash and in kind, land, building etc.
2. Welfare: - Providing facilities for education, health, drinking water, roads, communication, etc.

3. Relief: - Responding to call of duties during natural calamities like flood, draught, earthquake, and manmade calamities like refugee influx, ravages of war, etc.
4. Rehabilitation: - Continuing and follow up of the work in areas struck by calamities and starting activities that are durable in nature.
5. Services: - Building up infrastructure in depressed backward areas.
6. Development of socio- economic environment around human beings.
7. Development of Human Beings:- awakening, raising conscience, organizing, recording of priorities to suit social justice, redeeming the past and opening door for opportunities to the oppressed and the exploited.

Voluntary associations have been classified on a variety of bases. The size of the organization, the structure, the social functions, the sources of their support, the location, the characteristics of the members, the independence or dependence on outside control, and the beneficiary activities are the prime considerations for the classification of the voluntary organization.

Some writers like Sherwood Fix made the classification on the basis of distinction between majoral, minoral and medial organizations.¹² Majoral associations are those which serve the interest of the majority institutions of society, such as business, professional, scientific, educational, labour and agricultural associations. Minoral associations serve the interest of significant minority in the population, such as women's club, church organizations, hobby clubs and above all, ethnic organizations. Medical associations mediate between major segments or institutions in the society. Like a parent-teacher association mediates between the family and the school system.

David Sills developed a structural distinction between corporate type and federal type organizational structure and control in national organizations, while others have used other structural variables like accessibility or eligibility for membership as a basis for classification.¹³ Voluntary organizations have certain distinguishing features and characteristics:

1. It is registered under an appropriate Act to give a corporate status to a group of individuals, so that they get a legal personality, and an individual liability may give place to group liability;
2. It has an administrative structure, and a duly constituted managing/executive committee;
3. It has definite aims and objects, and programmes in fulfillment of these;
4. It is an organization initiated and governed by its own members on democratic principles without any external control. ¹⁴

Norman Johnson¹⁵ points out the following main characteristics of voluntary organization:

1. Method of formation, which is voluntary on the part of a group of people;
2. Method of governance, with self governing organization to decide on its constitution, its servicing, its policy and its clients;
3. Method of financing, with at least some of its revenues drawn from voluntary sources;
4. Motives with the pursuit of profit included.

D. Paul Chowdhary has given the following characteristics of a voluntary organization.

1. It is the result of the voluntary effort, which though motivated by different factors, is spontaneous in nature.

2. It is an organization initiated and governed by its own members on democratic principles without any external control.
3. It is registered under an appropriate Act to give a corporate status to a group of individuals so that they get a legal personality and individual liability may give place to group liability.
4. It has a general body and a regularly constituted managing committee, representing all interests, men, women, professional, public men etc.
5. It is known and accepted by the community in which it is formed.
6. It has considerable autonomy and flexible planning and management of its programmes and services.
7. It has a sense of commitment to human development/welfare.
8. It undertakes people's needs and helps to solve their socio-economic problems.
9. It plans and implements its own programmes through its own voluntary and paid workers.
10. It raises its funds from the community.
11. It maintains its accounts and is accountable to people and the government since it receives grant.¹⁶

In spite of these above mentioned features of voluntary organization the roots of these organizations lay in virtues like human touch, dedication, flexibility, innovation, nearness to the community. Therefore, the voluntary agencies strive for certain virtues.

Non-Governmental Organizations (NGOs): Its Rise in the World Scen

Non-governmental organizations (NGOs) movement is people-centered and it has a long tradition. It is not a new concept but an idea developed from time immemorial. Recently various efforts have been made to define the concept. Voluntary Organizations are known by several other names: NGOs, private voluntary organizations (PVOs), grassroots organizations (GROs), non-profit organizations (NPOs) and so on, depending on the geographical and time of reference. In general, all these organizations regardless of terminology used, have certain characteristics: that they are non-government (although many of them might work in partnership with the Government on projects, or receive funding from government agencies) and non-profit; that they are voluntary (they might have paid staff, but in general are working in the area because they volunteer to, not because they have to – hence voluntary). The term NGO has become especially popular in the 1980s and is used widely in the field of development; whereas the term ‘voluntary organization’ had been in use for several decades earlier, and it was widely used for social welfare and charity organizations.¹⁷ The term ‘NGO’ also embraces a huge diversity of institutions, international NGOs like ‘Save the Children and Christian Aid’ (commonly referred to as Northern NGO or NNGOs); intermediary NGOs in the South (SNGOs) who support grassroots work through funding, technical advice and advocacy; grassroots movements of various kinds (Grassroots organizations or GROs and community based organizations or CBOs) which are controlled by their own members and networks and federations composed of any or all of the above. Clearly, each of those NGOs plays a distinctive role in development and faces a different range of choices and strategies when considering the question of impact.¹⁸

The term non-governmental organization (NGO) came into vogue in the early 1950s.¹⁹ The term NGO was coined by the U.N.O. mainly to

indicate the difference between the sovereign nation-states and the organizations that collaborate with or receive grants from its agencies to implement the developmental programmes. However, the term is so well spread now that all institutions other than the direct government departments are loosely referred to as NGOs. The various governmental agencies (including NCERT, NIPCCD etc) which are registered as societies, the universities and colleges etc. are also often referred to as NGOs. Of course, all other registered societies are brought under the broad umbrella called NGO.²⁰ The term 'NGO' is used to denote those organizations which undertake voluntary action, social action and social movements. The term is negative in the sense that it logically excludes governmental or quasi-governmental agencies. NGOs possess the characteristics/features not possessed by the Government, and undertake activities otherwise normally not undertaken by the Government.

A NGO is defined in many ways, for example, it is defined as a non-profit making, voluntary, service-oriented/development-oriented organization, either for the benefit of members (a grassroots organization) or of other members of the population (an agency). It is termed, as an organization of private individuals who believe in certain basic social principles and who structure their activities to bring about development to communities that they are servicing; as a social development organization assisting in empowerment of people; as an organization or group of people working independent of any external control with specific objectives and aims to fulfill tasks that are oriented to bring about desirable changes in a given community or area or situation. Again it is defined, as an organization not affiliated to political parties, generally engaged in working for aid, development and welfare of the community; as an independent, democratic, people's organization working for the empowerment of economic and/or

socially marginalized groups; as an organization committed to the root causes of the problems trying to better the quality of life especially for the poor, the oppressed, the marginalized in urban and rural areas. A NGO is an Organization established by and for the community without or with little intervention from the government; It is not only a charity organization, but works on socio-economic and cultural activities. A NGO is an organization that is flexible and democratic in its organization and attempts to serve the people without profit for itself.²¹

David Korten argues that any organization that is both non-governmental and non-profit earning is generally considered to be a NGO.²² NGOs are voluntarily formed in the sense that there is no compulsion from government or others which leads to their formation. They are development-oriented in the sense that they are concerned with improving the condition and position of oppressed sections of society, as opposed to other goals like entertainment, promotion of religion etc. They are relatively independent from the government in the sense that their policies are determined by their Board of Directors or Trustees. However, the NGOs have to work within the parameters of government legislations and policies formulated for NGOs.²³

NGO sector is bestowed with noble features like 1) Less bureaucratic, 2) spirit of voluntarism, 3) non-profit making, 4) effective in reaching out the masses , 5) possessing ability to operate in remote and inaccessible areas, 6) being in the forefront during natural calamities and 7) above all effecting in delivering goods at grassroots level.

The NGO sector differentiates itself from government and corporate enterprises in terms of its purpose, which is said to be driven by values like altruism, philanthropy and voluntarism whereas the primary objectives of government and private sectors remains to govern and make profits respectively.²⁴ Thus, it is placed in an advantageous position in comparison

to other formal bureaucratic organizations as far as achieving its objectives are concerned. Non-Governmental organizations, in recent years, have been considered by scholars, donors, and many outside governments as a positive alternative to government led approaches to development. They are no longer viewed as implementors of development programmes, but as a vehicle that may usher in a new overall approach to the problems of development. Jessica Vivian²⁵ writes that many Western Governments and funding agencies view NGOs (as a whole) as “magic bullet” that can be fired in any direction and still find its target and deliver positive results, despite the fact that NGOs generally leave little evidence to support the results of their activities. They are often expected to be able to come up with quick, simple answers to complex, long standing problems that have long eluded attempts by institutions with greater resources and power, many of which have themselves sought easy, quick highly visible answers.

Of the qualities most often attributed to NGOs, perhaps the most commonly held is related to their autonomy. It is widely held that freedom from government constraints gives NGOs greater latitude to attempt untried approaches to development, to adapt new techniques to unique situations, and to combine known, successful practices with untested ones. This is attributed to the belief that the organizational structures of most NGOs are informal rather than bureaucratic or hierarchical, and that NGOs pay greater attention to results than to regulations and the protection of their own political power.²⁶

A number of other positive attributes has been enumerated by the supporters of NGOs regarding their ability to out-perform government agencies. Judith Tendlers (1982) notes several truisms of NGO activities: NGOs succeed in reaching the poor; the poor participate in NGO projects; there is greater emphasis placed by NGOs on teaching people how to gain

better control over their lives than the attainment of specific tasks and goals; NGO programmes/projects can be (and are) more flexible and experimental than official ones because they are smaller in scale; their costs tend to be lower than government led ones; and, as private organizations, NGOs have “a special ability to work with and strengthen local institutions.”

NGO interventions are also perceived as more effective and sustainable over long term than the government programmes.²⁷ NGO workers are characterized as inherently highly motivated, committed to their work, and providing a more continuous, long-term presence in a community than frequently transferred government employees.²⁸

Though voluntary organizations in different guises existed well before the 20th century in Northern and Southern World. NGOs as they are properly known today have a more recent history. The early Southern NGOs typically arose out of the independence struggles. The first Northern NGOs to enter the stage after the First World War were the Catholic Church and Save the Children Fund. They were increased in number towards the end of and immediately after the Second World War. When Oxfam started in 1942, Catholic Relief Services in 1943 and American Co-operative Agency for Relief Everywhere (CARE) in 1945. Initially these NGOs were engaged in relief work, primarily in war-torn Europe. They gradually shifted their attention to the third world and also broadened their scope of action and included welfare activities. During 1950s and 1960s the number of Northern NGOs multiplied and their focus moved progressively to development activities. At the start of this period their development work fitted into a conventional modernizing school of thought – helping poor communities to become more like Northern societies by importing Northern ideas, technology and expertise. Initially they were oblivious of their Southern counterparts, of village committees and other indigenous structures. And

gradually many of them came to criticise the effects of the traditional development model and to seriously question their contribution to it. They started to shift to new role, that of providing a services to the popular grassroots organizations and self-help movements. By 1961, for example, Oxfam had made a policy decision to move away from financing missionary organizations to switch funding to support indigenous efforts. Many of the earliest organizations it funded have gone on to become significant NGOs in their own right. The increased funding opportunities from Northern voluntary sources led to a mushrooming of Southern NGOs. Many of these grew rapidly to become national level institutions which served as intermediate organizations, channelling the assistance from the Northern NGO to the grassroots level. New political concept, emerging from Third World intellectuals, Development Theory, once dominated by Northern practitioners, was becoming an indigenous process, led by the people themselves. In the early days there was homogeneity among NGOs. They more or less pursued a common agenda. Some remained with their traditional activities. Others progressed to new activities and analysis at different rates. And many Southern NGOs became more assertive. Up till the 1960s the NGO community was almost exclusively a Northern preserve, thereafter it has become increasingly a shared ground, albeit initially shared with Southern NGOs created by their Northern partners. In the 1970s the spectrum broadened many NGOs engaged in self-help activities came to realize that there was a limit to how far self-help activities could go, governed by the vested interests of the political and economic elite. Development was increasingly viewed as a process of liberating the poor, both from their physical oppressors and from their poverty. New approaches were called for Brazilian NGOs (particularly inspired by the ideas of Paolo Freire) pioneered the approach of conscientization – a combination of political education, social organization and grassroots development –

designed not just to improve living standards, but to help the poor to perceive their exploitation and to realize the opportunities they have for overcoming such exploitation through mass organizations.²⁹ Throughout much of the third world, NGOs concentrated on fostering structures to help the poor in their struggle against injustice. The gradual realization throughout the 1970s that poverty is political in nature also gave birth to advocacy as a new activity. The 1980s has been an important leap forward in advocacy work.

Another trend in influencing change is in Southern official structures. David Korten calls this “micro-policy reform.” Official aid agencies have, through structural adjustment, positioned themselves as primary actors in the promotion of macro-policy reform in the conviction that more effective and sustainable development is only possible given a conducive policy environment. Equally, if not more important, are the reforms in local government structure and institutions. Some of the more thoughtful NGOs have come to realize that their projects by themselves can never hope to benefit more than a few chosen communities and that these projects are only likely to be sustainable when local public and private organizations are linked into a supportive national development system. The prevailing local or national policy environment may actively discourage the self-reliant local initiative. Some NGOs have therefore attempted to increase substantially their development impact on policy debates as catalysts for appropriate micro-policy reforms.

There are some reasons for the proliferation of NGOs in the recent world. First, the neo-liberal project, as expressed through structural adjustment in the South, and as promoted in the North by its leading political ideologues (most notably Ronald Reagan and Margaret Thatcher), required a curbing of state spending, and a rolling back of social sector investment. In

theory an unfettered market would provide more efficient services and create the jobs that would generate the wealth needed to sustain them. As private voluntary agencies, NGOs could occupy this new niche quite comfortably, participating in the social safety-net project and social investment funds that were supposed to alleviate the immediate effects of SAP. Hence NGOs were encouraged to present themselves as appropriate channels for aid to the poorest, for those at risk of falling through the net. Second, the break down of the Soviet bloc, culminating in the collapse of the Berlin Wall in 1989, was associated with and, by some observers, attributed to the emergence of people's organizations through which opposition to - the prevailing political system was powerfully articulated. These included church-based groups, union's professional bodies, and also a nascent NGO sector. The idea of autonomous civil society organizations holding government accountable, and at the same time pushing forward a democratization agenda, was appealing to observers from different points in the political spectrum. Third, in Latin America there had been a long tradition of radical social organization as a form of resistance to military dictatorship, particularly once the space for political dialogue was effectively closed off. NGOs had played a vital role in countries such as Brazil, Chile, often maintaining what little space might exist for debate, or holding on to an alternative vision of society.³⁰

The decade of the 1980s and 1990s was the expansion period for NGOs and GROs both North and South of the world. The rise of NGOs and GROs (Grassroots Organizations) on the world scene is an important phenomenon which has implications for the development prospects of poor people, for the future of these organizations themselves, and for the wider political economy of which they form a small but growing part. The rise of NGOs is not an accident, nor is it solely a response to local initiative and voluntary action. Equally important is the increasing popularity of NGOs

with government and official aid agencies, which is itself a response to recent developments in economic and political thinking. Since the end of the Cold War, development policy and aid transfers have come to be dominated by a policy which is called as New Policy Agenda which based on the beliefs organized around the twin poles of neo-liberal economic and liberal democratic theory.³¹

NGOs have provided welfare services to poor people in countries where governments lacked the resources to ensure universal coverage in health and education. The difference is that now they are seen as the preferred channel for service provision in deliberate substitution for the state. Under the New Policy Agenda, NGOs are seen as vehicles for ‘democratization’ and essential components of a thriving ‘civil society’, which in turn are essential to the success of the agenda’s economic dimension. NGOs are supposed to act as a counter weight to state power – protecting human rights, opening up channels of communication and participation, providing training grounds for activists and promoting pluralism. The rise of citizens’ movements around the world documented by Korten (1990) and crystallized most recently in the establishment of CIVICUS (1994) (the World Alliance for Citizen Participation), is not just a result of developments in official aid, but it cannot be separated entirely from the political ideas of the New Policy Agenda.³²

As a result of these developments, government has been prepared to channel increasing amounts of official aid to and through NGOs. Although accurate and comprehensive data are hard to come by, there is a good deal of evidence to suggest that the rise and growth of NGOs (and less so of GROs) is directly related to the increasing availability of the official funding under the New Policy Agenda. NGOs are seen as effective vehicles for the delivery of the agenda’s economic and political objectives.

The reduced importance of the development state is the cause of the rise of NGOs is contentious because widely accepted theory is that it is inefficiency, trained incapacity and corruption of the bureaucratic machinery, corrupt and inept political leadership of the state to deliver the goods, lack of accountability, lack of will and lack of commitment to the development goals and lack of people's participation which are responsible for the rise of NGOs in the Third World.

The government agencies and political parties of developing countries like India failed to bring in people-centered rural development. In this context, Webster notes that:³³ A government rarely does, or will fulfill more than a few of the wide range of demands that effective democratic decentralized government requires. Rarely, if ever, is there an adequate devolution of power, of responsibilities or of resources to decentralized government institutions. Secondly, the government is rarely willing to implement the types of structural reforms and policies that can bring about a transformation in the abilities of marginalized groups and other disadvantaged social actors to contest more successfully in key markets that determine the economic, social and political conditions. Third, institutions of local government are rarely willing to bring about the mobilization of disadvantaged groups in order to place demands upon the state. Fourth, the electoral focus of political parties upon the institutions of government at the local and national levels tends to mitigate against taking up specific local problems or, given the patrimonial nature of local politics, problems that challenge local political elites. Because of the above reasons, NGOs have come to occupy a central position in facilitating development at the local level, and hence, have considerable space to initiate development directed at improving the condition of the more marginalized and disadvantaged social groups. This is one of the important opportunities that the NGOs have.

Rural development is a strategy to promote the social life of common villagers and to extend social and economic benefits to the very groups followed by social and political awareness. People's dependence on government for organizing them and bringing about their development has proved to be wrong and ineffective. It underscores the importance of NGOs' role in development as social mobilizers of people for development.

Because of their proximity to grassroots, flexibility of approach, ability for experimentation and people centered and people oriented model of development, the NGO have emerged as one of the most viable alternatives in the search of development planners to bring about sustainable development and effective structural change from centralized to decentralized delivery system. The NGOs optimize the institutionalization of the time- honoured practice all over the world of rendering noble, selfless community services on voluntary and non-profit basis by resourceful, enlightened, public spirited, active citizens and social workers. The NGOs have a crucial role to play in the process of nation building and planned socio-economic development everywhere, particularly in developing nations like India. Development plans, programmes or projects initiated by the government have little or no chance of success without the total involvement and full and active cooperation and participation of the people in the various interfaces of the development process. Herein lies the critical importance of NGOs as the dynamic instruments of the civil society, as citizen groups, as community organizations and as people's own institutions for mobilizing the participation of local people into the government/voluntary agency sponsored development process in planning, implementing and monitoring development programmes on their own initiative to suit the felt needs of the people at the grassroots levels.

It has become almost a truism in the eyes of many that NGOs are more successful than governmental bodies in attaining the goals of rural development, in terms of implementing projects and programmes. NGOs are increasingly considered important in bringing about other aspects of rural social change serving as agents in the creation of (or strengthening of existing) civil societies and good governance and also fostering democratic and alternative approaches to mainstream development policy and practice.³⁴

Types of NGOs and their Functions

NGOs, reflecting largely their historical evolution, can be divided into six categories.

1. Relief and Welfare Agencies (RWA) like Catholic Relief Services, various missionary societies, and so on.
2. Technical Innovation Organizations (TIO) - NGOs which operate their own projects to pioneer new or improved approaches to problems, and which tend to remain specialized in their chosen field. Like the International Aga Khan Foundation and the Grameen Bank of Bangladesh.
3. Public Services Contractors (PSC) - these NGOs are mostly funded by Northern World Government and work closely with Southern Government and official aid agencies. The NGOs are contracted to implement components of official programmes because it is felt that size and flexibility would help them perform the tasks more effectively than government departments. Like CARE.
4. Popular Development Agencies (PDA) - Northern NGOs and their Southern World intermediary counterparts which concentrate on self-help, social development and grassroots democracy, Like BRAC (Bangladesh Rural Development Committee)

5. Grassroots Development Organizations (GDO) - Locally based Southern NGOs whose members are the poor and oppressed themselves, and which attempt to shape a popular development process. They often receive support from PDAs, though many receive no external funding at all. Like Self Employed Women's Association (SEWA) of Ahmedabad, Credit and Savings Groups in the Indian Sub-continent.

6. Advocacy Groups and Network (AGN) - Organizations which have no field projects but which exist primarily for education and lobbying. For example, the Third World Network based in Penang, Freedom from Debt Coalition in the Philippines.³⁵

There is another classification of NGOs under four broad categories,³⁶

- a) Operational or grassroots NGOs;
- b) Support NGOs;
- c) Network NGOs; and
- d) Funding NGOs.

The functions of each type of NGO are —

- a) Operational or Grassroots NGOs

Grassroots NGOs directly work with the oppressed sections of society. Some NGOs are big, while some are small. The grassroots NGOs could be either local based, working in a single or and small project location, or be working in multiple project area in different district, states and regions covering a larger population. The approach and orientation of grassroots NGOs also differ. Based on this, the following distinction can be made among grassroots NGOs- i) charity and welfare NGOs focus on providing charity and welfare to the poor, ii) 'development NGOs' focus on implementation of concrete development activities, iii) 'social action groups' focus on

mobilizing marginalized sections around specific issues which challenge the distinction of power and resources in society and iv) empowerment NGOs combine development activities with issue based struggles. Charity and welfare NGOs are involved in charity, welfare, relief and rehabilitation. A large number of church based on NGOs operating in South and North- East India still have charity and welfare component in their programme. Development NGOs may be involved in providing (facilitating the provision) development services such as credit, seeds fertilizers, technical knowhow, etc. Such NGOs concentrate on development of socio-economic environment of human beings. Social action groups focus on mobilizing marginalized sections around specific issues which challenge the distinction of power and resources in a society. These NGOs are involved in raising of consciousness of the people, awakening, organizing, recording of priorities to suit social justice, redeeming the past and opening doors to opportunities to the oppressed and exploited. Empowerment NGOs combine development activities with issue based struggles. They may be involved in making provisions of services such as savings and credit; but, they utilize such activities for social, economic, political and cultural empowerment of the poor. MYRADA utilizes credit management groups and watershed programmes for not only to bring development among the oppressed communities but also for social and political empowerment.

The main difference between social action groups and empowerment NGOs is that former do not normally undertake development activities as they believe in addressing the root causes of poverty. On the other hand, the empowerment NGOs undertakes development activities because the people cannot undertake the struggles with 'empty stomachs'. They believe that empowerment of the people is an essential prerequisite for development.

Hence, they strive hard to enable the people to become free from all the exploitative structures.

The approaches followed by the charity, welfare and development NGOs are related to delivery system. As the activities undertaken by the first two types of NGOs are non controversial and do not lead to clash of interests in the countryside, the government too extends full support to NGOs working in these areas. The support from donor agencies to NGOs involved only in charity and welfare is on the decline as it is felt that this strategy is based on giver and receiver relationship and not of building the capacity of the people. It is also believed that it is paternalistic in nature and causes human degradation. However, activities undertaken by the last two types of NGOs, namely, organization of the people belonging to the disadvantaged groups, bringing in social and political consciousness among them, enabling them to realize and assert their right etc, are basically related to the development of the target group communities and the approach to development is political. Hence, their activities are often politicized. With the increased government funding for anti-poverty programmes through NGOs and the growing legitimacy for NGOs, many government officials and political leaders also joined the fray often by floating their own NGOs. Grassroots NGOs now undertake a host of activities including environmental projects, dry land development, savings and credit programmes schemes for income generation, health and education projects, the formation of agricultural labour unions, etc.

b) Support NGOs

Support NGOs provide services that would strengthen the capacities of grassroots NGOs, Panchayati Raj institutions, Co-Operatives and other to function more effectively. Examples of these types of NGOs are SOSVA, SEARCH, etc. Some of the support NGOs render support in specific

thematic areas such as health, education and environment, while others provide support in generic issues such as perspectives, leadership, human resource development, management, etc.

c) Umbrella or Network NGOs

Network NGOs are formal associations or informal groups of grassroots and or support NGOs which meet periodically on particular concerns. An example to this is FEVORD-K (Federation of Voluntary Organizations in Karnataka). They act as a forum to share experiences, carry out joint development endeavors as well as engage in lobbying and advocacy. The participation of network NGOs in lobbying and advocacy is, however, a recent phenomenon.

d) Funding NGOs The primary activity of these NGOs is funding grassroots NGOs, support NGOs or people's organizations. Most funding NGOs in India generate a major part of their resources from foreign sources; though there is an effort by some to raise funds from within India. The organizations such as CRY, Dorabji Tata Trust, Aga Khan Foundation, in India provide funds to NGOs. Foreign NGOs like Action Aid, Oxfam, etc., with headquarters in the developed Western countries, mobilize resources from both the public and governments in their respective countries to help grassroots NGOs in their efforts to initiate and implement pro-poor rural development activities. Foreign NGOs do have field offices here. Some bilateral agencies like German Development Corporation (GTZ) DANIDA, Canadian International Development Agency (CIDA) etc, do provide funding support to NGOs, but, these cannot be called as NGOs.

In India there are six types of NGOs which have been classified on the basis of their position and the scope of functions. These are:-

1. Big indigenous NGOs which are working in various regions of India.
2. Big Indian NGOs which are working in various districts of a particular Indian region.
3. Medium size indigenous NGOs engaged in one or more than one village.
4. Small indigenous NGOs functioning in various villages.
5. Big international NGOs giving financial aid to the indigenous NGOs.
6. Small international NGOs which directly work at the provincial level.³⁷

Changing Strategy of NGO

Historically the functions of NGOs have been changing according to the changes in the vision of development organizations. As individual NGOs have grown in sophistication regarding the nature of development and the potentials of their own roles, many have undertaken increasingly effective strategies involving longer time perspectives, broadened definitions of the development problem, increased attention to issues of public policy, and a shift from exclusively operational to more catalytic roles. David Korten identified four generations in the evolution of NGOs programme strategy in order of

- a) Relief and welfare;
- b) Local self-reliance;
- c) Sustainable systems development; and
- d) Peoples movement.

Since all sections of the society may not have simultaneously completing all stages of evolution, all generations of NGOs are available in the same society.³⁸ All the four strategic orientations appropriately co-exist within the larger NGO community – and sometimes even within a single NGO. At the

same time there is an underlying direction of movement that makes it appropriate to label these orientations as first, second, third and fourth generation.

Generation-I: Relief and Welfare

Many of the larger international NGOs like Catholic Relief Services, CARE, Save the Children, and the World Vision began as charitable relief organizations, to deliver welfare services to the poor and unfortunate throughout the world. The same pattern is observed in some national NGOs such as the Bangladesh Rural Advancement Committee (BRAC). Many of them were focused originally on natural disaster and refugee situations relating to floods, famine, and war. The objective was meeting immediate needs through direct action. The focus of attention was on individuals or families and the benefits they received depended entirely on amount of resources at the disposal of the NGO. But as a development strategy, relief and welfare approaches offer little more than temporary alleviation of the symptoms of underdevelopment.³⁹

Generation-II: Small Self-reliant Local Development

Recognizing the limitations of relief and welfare approaches as a development strategy, in the late 1970s many NGOs undertake community development style. Projects in area such as preventive health, improved farming practices, local infrastructure development and other community development activities. What distinguishes these efforts from relief and welfare approaches is the stress on local-self reliance, with the intent that benefits would be sustained beyond the period of NGO assistance. Often second generation NGO activities parallel those of government, but are defended on the grounds that the government services are inadequate in the villages in which the NGO works. Second generation strategies by definition

do not attempt to address the causes of the inadequacy of other services providers or the larger institutional and policy context of the NGO's own activities. The scope of attention is limited to individual village or neighborhoods and to the specific local groups the NGO is assisting.⁴⁰

Generation-III: Sustainable System Development

Currently segments of the NGO community are again engaged in a re-examination of basic strategic issues relating to sustainability, breadth of impact, and recurrent cost recovery. At the heart of the re-examination is a realization that: 1) Acting on their own they can never hope to benefit more than a few favoured localities; and 2) Self-reliant village development initiatives are likely to be sustained only to the extent that local public and private organizations are linked into a supportive national development system.⁴¹

A growing number of NGOs are coming to realize that they need to exert greater leadership in addressing dysfunctional aspects of the policy and institutional setting of the villages and sectors within which they work. This means moving to a third generation strategy in which the focus is on facilitating sustainable changes in these settings in a regional or even national basis. It will likely mean less direct involvement at village level for these particular NGOs and more involvement with a variety of public and private organizations that control resources and policies that bear on local development. These may include local and national governments, private enterprises, other independent sector institutions etc. The more fully the NGO embraces third generation programmes strategies, the more it will find itself working in a catalytic, foundation-like role rather than an operational service-delivery role - directing its attention to facilitating development by other organizations, both public and private, of the capacities, linkages, and commitments required to address designated needs on a sustained basis.

Generation-IV: Peoples Movement

This generation of NGO strategy is characterized by a shift in the emphasis from reform to transformational activity through people's movements.⁴²

Voluntarism in India

While associations called NGOs may appear to be a new phenomenon in India, in the past several of their roles, activities and functions were performed by a variety of local organizations. History bears constant testimony to non-state efforts and initiatives towards building structures of socio-economic security by the people for themselves. The state did not constitute a frame of reference for these activities; the traditional mode of organizing self-help and philanthropy was essentially societal in nature. It is only with a growing centrality of the modern state that terms such as 'voluntary' and 'non-governmental' sectors came into prominence to describe those few welfare and developmental activities which originate outside the state structure and within society. On the other hand, as part of anti-colonial resistance, the 19th and the early 20th century saw the emergence of numerous indigenous organizations devoted to social and religious reform.

The second major shift in the 19th century paradigm of organizing voluntary work occurred at the turn of the century when Gandhiji entered the Indian political scene. Gandhiji sought to recapture the constructive spirit within society which drew upon the innate resources of the people. Gandhian movement focused on reorganizing people's own resources for goals of material and spiritual wellbeing. Over a period of time, several organizations were formed in different fields-education, health, women, animal husbandry etc. In the process it drew the hitherto excluded sections of society into the national movement, but more particularly into the growing voluntary sector which was now described in terms of social service and constructive work. It

was during this phase that social action acquired a pronounced political content. This fusion of social action and politics resulted in viewing the colonial states as a road-block rather than facilitator to the process of social transformation. Instead of making demands on the state for extending its protection and patronage to voluntary or social reform action, it emphasized people's own empowerment through constructive work. The third trend emerged from the new realities created by the growing hegemony of the congress party during the independence movement. Its root lies not in the world of social action but in politics, which then spilled over into the world of social action. Beginning with the ideological splits in the independence movement, this trend got consolidated in the early decades after independence. It owes its origin to the mobilization and organization activities of the communist and socialist parties. Several groups of activists working either in their front organizations, or later independently, began to take up, issues ignored by the groups belonging to social reform or the Gandhian genre.⁴³

After independence, a change in the perception of development and the role of NGOs in rural development took place. In 1950s and 1960s, it was assumed that the economic growth through state investment was the answer to poverty. This was to be accompanied by welfare programmes for the disadvantaged which were thought to be incapable of participating in programmes aimed at economic growth. The Ministries of Agriculture and Rural Development initiated community development effort in rural areas to enable the people to participate in economic growth programmes. On the other hand, the responsibility of the welfare programmes was vested with Social Welfare Ministries of the state government. Non-governmental Organizations were approached by national Government and aid agencies to assist in the implementation of these Community Development and Welfare

Programmes, especially in rural areas. Many of the NGOs which were active during independence movement were involved in the implementation of Community Development Programme. Christianity based aid agencies supported the work of Missionaries involved in welfare activities with a focus on health and education especially in South India and tribal areas of central and eastern India. During the 1960s, it was found that economic growth, combined with welfare activities at the micro-level, were not adequate to alleviate poverty. Hence, the Indian government initiated Small and Marginal Farmers Development Programmes with a view to alleviate poverty. Indian NGOs were called upon by the government to enlist support of the local population for these programmes and help out in their implementation. This was in addition to their involvement in welfare vocational training programmes.⁴⁴ During this period, alternative perspectives or development and role of NGOs were also emerging. A large number of people with liberal and radical ideologies were attracted to the Marxist analysis to understand the fundamental causes behind poverty and exploitation. The causes of poverty were understood to be the class nature of the society with rich exploiting the poor. They, therefore, rejected the development models followed by the government on the grounds that they mainly addressed the symptoms rather than the root cause of poverty. Therefore, a large number of young people and section of intelligentsia with Marxist perspective sought to organize the poor and the exploited in rural areas.

The period of the later 1960s and early 1970s also witnessed the rise of the Naxalite movement in various parts of India especially in Telengana area of Andhra Pradesh. The movement criticized the way in which the land reform programmes was being implemented by the government. The Lohiaites and Gandhians came together under Jayaprakash Narayan and

launched total revolution movement. Emergency was imposed all over the country. These developments paved the way for the emergence of NGOs working around issue based struggles (often referred as social action groups) in different parts of the country.⁴⁵

These social action groups focused upon issues such as price rise, emergency rule, corruptions, deficiencies in the implementation of land reforms, and inability to enforce minimum wages. By the mid 1970s, the impact of Marxism was felt on the Church. With the advent of liberation theology, there was a split in the church based institutions. Further, the Janata Party's rise to power in 1977 raised hopes among the poor as well as in social action groups. This hope was soon dispelled. As a result the social action groups lost faith in the ability of the formal political processes to bring about transformation in the society. The early 1980s also witnessed the emergence of idea on the need for people's participation, conscientisation and empowerment in poverty alleviation, as well as the need to take the diversity among the poor on the basis of class, caste, gender, ethnicity, etc, into account.⁴⁶ Thus, the post emergency period witnessed the people coming out of the church, and the left, Gandhian and Lohiaite movements getting converged as far as the development at the grassroots level was concerned. They focused on raising awareness and conscientisation with the objective of mobilizing the poor to influence the social and political structure.

The need to improve the quality of life of the poor made the activists from different backgrounds to talk of development by the mid 1980s. The fragmented and compartmentalized development models which still had charity and welfare components were replaced by integrated development models. The gender justice, environmental concerns and human rights were understood as part and parcel of structural aspects of the society which together with class, caste and ethnicity were responsible for the exploitation

of the marginalized sections within the society. The priorities and agenda of donor agencies also influenced the development perspective and programmes at the grassroots level.⁴⁷

The trends contributed to the emergence of two distinct types of grassroots NGOs. Development NGOs sought to work around concrete sectoral activities relevant to different poverty groups in the countryside (agriculture, watershed, environment, off-farm and non-farm income generation activities, health, literacy, etc.) Although the charity and welfare NGOs were also undertaking these activities, the crucial difference was the development NGOs sought to adopt participatory and innovative approaches. The other type of NGOs that came into existence was empowerment NGOs which formed organizations for different poverty groups in the countryside and strengthened their effort to address the root causes of poverty such as class, caste system, lack of access to the market, etc. The main difference between social action groups and empowerment NGOs was that the latter were not transient, did not focus on a single issue, and were not averse to accepting foreign funding. Thus by the late 1980s there were four different grassroots NGOs which often coexisted in the same locality - welfare NGOs, development NGOs, empowerment NGOs and social action groups. While the first two types of the groups often entered into collaboration with the government, the last two often confronted with state policies, legislations and practices. Support and network NGOs also emerged during the late 1980s, to lend capacity enhancement support to grassroots NGOs and create a platform for NGOs to meet, share experience and carry out coordinated action.⁴⁸

The development NGOs were called upon by international aid agencies and Indian government to supplement the government micro level poverty alleviation and basic needs programme in areas where development

NGOs were perceived to have comparative advantages. These comparative advantages are of reaching the poor, eliciting and enabling people's participation, promoting innovative and cost-effective approaches to poverty alleviation, identifying and disseminating appropriate technology, making the government's delivery system accountable, etc. Thus, a broader role was perceived by the Indian Government for NGOs. For the first time, the planning commission included a separate sub-section on 'Involvement of Voluntary Agencies' in the Seventh Five Year Plan document (1985-1990) under the chapter Rural Development and Poverty Alleviation Programmes. Plan expenditure of Rs.100-150 crore was earmarked towards the collaboration between the government and NGOs. In order to channelize these resources for NGOs involved in poverty alleviation and rural development programmes, the Council for Advancement of People's Action and Rural Technology (CAPART) was established in 1986. This agency was also entrusted with the responsibility of providing support to the NGOs.

By 1990s, significant development started taking place in India and across the world. NGOs have become popular with government and aid agencies in response to certain development in economic and political thinking.⁴⁹ The development policies of the World Bank, bilateral and multi-lateral agencies, and aid transfers from them, have come to be dominated by what is referred to as a New Policy Agenda, which gives a prominent role to the NGOs in poverty alleviation and the development of civil society.⁵⁰

The agenda has two elements: economic and political.

The economic agenda, followed in India since 1991, see the markets and private sector as efficient in producing the goods, services and in achieving rapid economic growth. Liberalization, globalization and privatization of the economy are the key elements of this agenda. The economic growth is considered as a key strategy for poverty alleviation. However, the strategy

proposed to achieve economic growth is different to the one promoted in the 1970s. It is market-led rather than state-led, export-oriented rather than capital intensive and women inclusive rather than women exclusive. The aid agencies prescribed that Indian government should gradually reduce its role in service provision and development, and leave this task to the NGOs as these are seen as cost-effective and efficient service providers.

India is a home to a large number of NGOs. Estimates of the total number vary, from the thousands to the tens and hundreds of thousands, depending on the definition of the term. The number and concentration of NGOs varies by states and regions, with the greatest aggregation of Indian NGOs existing in the Southern states, stemming in part, from a long history of Christian social welfare and humanitarian efforts in the region. As elsewhere, Indian NGOs involved in rural development exhibit a wide range of attributes. In general, though, the typical Indian NGO is a small agency, concentration on the delivery of specific services and projects to a few villages within a limited geographical area, with a handful of operatives, and limited funds and other sources. Despite their diversity, one widely perceived similarity among Indian NGOs (and of government as well) is their focus on poverty alleviation and the empowerment of the poor. How that is to be achieved, though, is a point of departure.⁵¹

According to Riddle and Robinson (1995), there are two approaches towards rural development taken by Indian NGOs. The first has as its basis a concentration on the mainstream practice of addressing the systems of poverty and underdevelopment by delivering a range of integrated programmes and projects with the involvement of NGOs and grassroots organizations as implementers. According to Farrington and Lewis (1993), there is a consensus among these NGOs and government which operate

under this approach, that the existing social and economic structures, although inherently important, (are) not directly challenged.⁵²

The second, contrasting approach based on the idea of social action – that effective rural development requires a fundamental transformation of the existing economic and social structure established and maintained by the state. Under this the role of NGOs consists of mobilizing the poor to make direct challenges and demands on government for equitable service delivery, improved wages and working conditions, and other entitlements.⁵³

This focus, which takes a closer look at the underlying cause of poverty and underdevelopments can be seen in the proliferation of issue based groups representing such concerns as women's issues, child labour, occupational health hazards, and displacement projects as well as those advocacy groups that work directly on behalf of the political rights of the rural poor. The growing focus on popular participation and social action is, according to Robinson et.al. (1993), a major point of difference between NGOs and the Indian government.⁵⁴ Although the approaches have fundamental differences, some NGOs believe “that the two are not inimical and that equatorial improvements and empowerments and complementary and can reinforce one another.”⁵⁵ While a NGO which adopts the social action approach to improving rural people's conditions may find it difficult to enter into cooperative or collaborative relationships with certain government organizations, this does not automatically preclude such possibilities.

Development, Participation and the Role of NGOs

Nation-building signifies the citizen's socio-psychological and political sense of unity, oneness and belongingness to the nation – the supreme feeling and emotion of national unity and his duty of allegiance to and protection and safeguarding of the unity, territorial integrity and sovereignty

of the nation-state in the midst of cultural diversity. A unity of the people is the hallmark of a nation. It has to be fostered, nurtured and maintained by the care and concern of its state and its agencies for the citizens' welfare and all round development through recognizing and safeguarding citizen's rights and freedoms, by effectively enforcing the rule of law and removing the constraints that inhibit their participation in administrative and political life of the nation and enjoyment of the fruits of development.

Milton Esman observes, "One of the tasks of nation-building and development is to bring members of the national community into a network of relationships and institutions which enables them to participate actively in decisions affecting their individual and group welfare."⁵⁶ According to democratic theory, participation is the process by which goals are set and means are chosen in relation to all sorts of social issues in such a way as to increase the allocation of benefits in a society to match the needs and aspirations of the people. In other words, it denotes development participation.

The modern notion of participation is one of citizen involvement in the various interfaces of the developmental decision-making process: planning, implementation and evaluation of plans and policies. Unless there are real opportunities for people to have a say in planning and implementation of the development programmes the adult franchise alone may mean nothing at all. As Hari Mohan Mathur opines, the real purpose of participation is to develop human capabilities for development, decision-making and action. Participation means a kind of local autonomy in which people discover the potentialities of exercising choice and managing their own development.⁵⁷ Participation of citizens in the development process is most important aspect of development administration. It is the sine quo non of success, viability, efficiency, economy, effectiveness and equity of

development administration and legitimacy of the government. People's participation also renders speedy but less costly implementation of development policies possible by providing useful information to administration in programme planning and implementation.

Development to be successful has to be people oriented i.e. people should become both the subject and object of development. During the era of economic growth and top-down planning people were viewed merely as the object of development. For administrators and development bureaucrats, people usually did not count for much and local knowledge and capacity were undermined even for simple changes in rural life. Most administrators wanted the public to be passive recipients (object) of the services provided by government agencies. What development administration failed to see was that the immense capacity of people to contribute to their own development. People are greatest assets and resources waiting to be tapped. The development of human resources should one of the top priority goals of socio-economic development in all developing nations like India.

The responsibility for the task of creating awareness among the people about their rights and motivating, inspiring and guiding them to participate in the development programmes has to be shared both by the government and voluntary agencies. The latter can cope with the problem more efficiently as catalysts, motivators, conscientisers, innovators and educators. The government by itself cannot achieve the development goals and objectives without people's support and cooperation. Being citizen action groups and community based social service units the NGOs should rise to the occasion and become joint partners in the challenging task of people-centered participatory development and nation-building.

In fact NGOs' participation in development planning, implementation and evaluation and monitoring of programmes and projects, irrespective of

whether these are self-initiated or sponsored and funded by the government is the manifestation of citizen' participation and involvement in the development process. For, it is important to realize the fact that the NGOs are peoples' own, non-profit, service-oriented grassroots (local) agencies, for bringing about collective welfare of the people and the country as a whole.⁵⁸

In developing countries like India the realization of development goals, such as strengthening of national integration and alleviation of poverty, unemployment, inequality, illiteracy, ignorance and environmental degradation hinges upon active participation and full involvement of the citizens of the state in public life (affairs) and development tasks. While citizen participation is the means of attainment of national and individual development, decentralization - political and administrative, territorial and functional, economic and financial is the means of promoting people's cooperation and support for democratic decentralized development. There exists a triangular relationship between decentralization, democracy and development.⁵⁹ Institutions of local self-government (PRIs and municipalities) signifying political decentralization are essential for development; for they alone make popular participation in decision-making effective and informed. Further, achievement of social change and economic development requires spreading of efforts so that local communities and individuals can participate and bring under ideal conditions the local energy, enthusiasm and initiative for local development activities. Experience suggests that it is only when people have control over decisions and their execution that administration can become responsible and responsive to the people's needs and aspirations.⁶⁰

As the UN document specifies:

“An important reason for decentralization is to develop more effective popular participation in local affairs including activities of central

government carried out locally, such participation not only enhances the dignity of the individual and the sense of community at all levels, but also adds and provides a means for local control over them. It makes the programme more responsible and better adapted to local needs. Moreover, through participation, members of the community may be induced to do more on their own initiative and make a further contribution to government programmes.”⁶¹

Here lies the importance of NGOs as organizations of the “members of the community” prepared to take initiative and undertake developmental tasks on their own and contribute to the implementation of government programmes. The NGOs are the outcome of the process of decentralization and debureaucratization.

REFERENCES

1. Muttalib, M.A. (1987), "Voluntarism and Development, Theoretical Perspectives", Indian Journal of Public Administration (IJPA), vol.33, No.3, July-Sept. p.399
- 2a. Bourdillon, A.F.C. (ed.), (1945), Voluntary Social Services, Their Place in Modern State, London, Methuen. p.7
- 2b. Beveridge, William (1979), Voluntary Action in a Changing World, London, Bedford Square Press, National Council of Social Services. p.100
3. Tobin Gary A. (ed), (1985), Social Planning and Human Service Delivery in the Voluntary Sector, London, Greenwood Press. p. xxi
4. Lawani, B.T. (1999), NGO in Development, New Delhi, Rawat publications. p.18
5. Smith, C. and Freedman, A. (1972), Voluntary Association, Perspective on the Literature, Cambridge, Harvard University Press. p.44
6. Sills, D. L. (1968), "Voluntary Association, Sociological Aspects", in International Encyclopaedia of the Social Sciences, vol. 16, Collier McMillan. pp. 363-367
7. Muttalib, M.A. (1987), "Voluntarism and Development, Theoretical Perspectives," IJPA, vol. XXXIII, No.3, July-Sept. p. 402
8. Ibid. p. 402
9. Inamdar, N.R. "Role of Voluntarism in Development" quoted in Social Welfare Administration by D.R. Sachdev, Allahabad, Kitabmahal. p.200
10. Sundaram, I.S. (1986), Voluntary Agencies and Rural Development, Delhi, B.R. Publishing Corporation. p.67

11. Ibid. pp. 67-68
12. Muttalib, M.A. (1987), op.cit. no.1. IJPA, p. 405
13. Ibid, p.405
14. Gangrade K.D.(1987), Encyclopaedia of Social Work in India, New Delhi, Ministry of Information and Broadcasting, Govt. of India, pp.220-221
15. Norman Johnson, (1999), quoted in NGOs in Development by B.T. Lawani, New Delhi, Rawat Publications, p.24
16. Paul Chowdhary, D. (1990), Voluntary Efforts in Social Welfare and Development, New Delhi, Siddhartha Publishers, p.33
17. Pulavarti, Lalita (1998), “Sumangali Seva Ashram: Contributions of Local NGO in Urban Bangalore” in Social Change through Voluntary Action by Dantwala, Sethi and Visaria, New Delhi, Sage p.144
18. Edwards, M. and Hulme, D. (1992), Making a Difference NGOs and Development in a Changing World, U.K., Earthscan Publications Ltd, p.14
19. Tandon, Rajesh (2002), Voluntary Action, Civil and the State, New Delhi, Mosaic books, pp.14-15
20. Kaushik, Susheela (1997), “NGOs and Development some Issues” in NGOs in Development – Theory and Practice (ed) by Noorjahan Bava, New Delhi, Kanishka Publishers, p.71
21. How the World Bank Works with Non-Governmental Organization. The World Bank and Workshop notes: “NGO Workshop” organized at the Asian Institute of technology, Bangkok, October, 1988 quoted in Unnayaner Khonje NGO (2005), Kolkata, Development Communication and Research Centre, pp.140-141
22. Korten, David C. (1992), Getting to the 21st Century, Voluntary Action and the Global Agenda, New Delhi, Oxford and IBH, p.95
23. Murthy, R.K. and Rao, N. (2000), quoted in “NGOs in India Opportunities and Challenges” by D. Rajasekhar, Indian Journal of Rural Development, vol. 19 (2), pp.250-251

24. Brown and Korten (1992), cited in “Building Partnership between Northern and Southern Development NGOs: Issues for the Nineties” by A. Flower, *Development Journal of SID*, vol.1, p.40
25. Vivian, Jessica (1994), “NGOs and Sustainable Development in Zimbabwe : No Magic Bullets”, *Development and Change*, vol. 25. no. 1, pp.167-193
26. Mars, Theodor Friedrich, (1992), “Public Sector Organization: Where Next?”, *IDS Bulletin*, 23(4), Oct-1, pp.18-30
27. Riley, J.M. (2002), *Stakeholders in Rural Development, Critical Collaboration in state-NGO Partnership*, New Delhi, Sage, p.72
28. Clark, J. (2002), quoted in J.M. Riley , *ibid*, p.72
29. Clark, J. (1991), *Democratizing Development*, London, Earthscan Publication Limited, p.36
30. Deborah Eade (2005), (ed.) *Development, NGOs and Civil Society*, New Delhi, Rawat Publications, pp.10-11
31. Edwards, M. and Hulme, D. (ed) (1995), *NGOs – Performance and Accountability, Beyond the Magic Bullet*, London, Earthscan Publications Ltd., p.4
32. *Ibid*, p.4
33. Webster, Neil (2000), quoted in *NGOs in India, Opportunities and Challenges* by D. Rajasekhar, *Journal of Rural Development*, vol. 19(2), pp.269-270
34. Riley, J.M. (2002), *op.cit.* no. 27, pp. 269-270
35. Clark, J. (1991), *op.cit.* no. 29, pp.40-41
36. Rajasekhar, D. (2000), “NGOs in India: Opportunities and Challenges”, *Journal of Rural Development*, vol. 19(2), pp.251-254

37. Kundu, Subrata (2005), (ed.), Unnayaner Khonje NGO, Kolkata, Development Research Communication and Services Centre, p.80
38. Korten, David C. (1992), Getting to the 21st Century Voluntary Action and the Global Agenda, New Delhi, Oxford and IBH, p.123
39. Korten, David C. (1987), “Third Generation NGO Strategies: A Key to People-centered Development” World Development, vol.15, supplement, pp.147-148
40. Ibid, p.148
41. Ibid, p.149
42. Mahbubul Karim, (1995), “NGOs in Bangladesh: Issues of Legitimacy and Accountability” in NGOs Performance and Accountability – Beyond the Magic Bullet by M. Edwards and D. Hulme, London Earthscan Publication Ltd., p.112
43. Sheth, D. L. and Sheth, H.(1991), “The NGO Sector in India Historical Context and Current Discourse”, Voluntas, vol. 2(2), pp.49-68
44. Murthy, R.K. and Rao, Nitya,(2000), quoted in D. Rajasekhar, journal of Rural Development, op.cit. no. 36, pp. 255-256
45. Stephen, F. (2000), quoted in D. Rajasekhar, ibid, p.256
46. PRIA, (2000), quoted in D. Rajasekhar, ibid, p.256
47. Rajashekhar D., (2000), quoted in D. Rajasekhar, ibid, p.257
48. Murthy, R.K. and Rao, Nitya (2000), quoted in D. Rajasekhar, ibid, p.257
49. Edward and Hulme, (1996), “Too close for comfort? The Impact of Official Aid on NGOs”, World Development, vol. 24, no.6, June, pp. 961-973
50. Robinson, M.(2000), quoted in D. Rajasekhar, ibid, p.258
51. Riley, J.M. (2002), op.cit. no. 34, p.83
52. Ibid, pp.83-84

53. Ibid, p.84
54. Ibid, p.84
55. Ibid, p.34
56. Esman, Milton, (1966), "Politics in Development Administration" in John D. Montgomery and William J. Siffin, (ed), Approaches to Development : Politics, Administration and Change, New York, MacGraw Hill Com, p.63
57. Mathur, Hari Mohan, (1986), Administering Development in the Third World: Constraints and Choices, New Delhi, Sage Publications, p.19
58. Bava, Noorjahan (1997), (ed.) NGOs in Development-Theory and Practice, New Delhi, Kanishka Publishers, p.266
59. Maddick, Henry (1963), Democracy, Decentralization and Development, Bombay, Asia Publishing House, p.30
60. Bava, Noorjahan (1984), People's Participation in Development Administration in India, New Delhi, Uppal Publishing House, p.47
61. United Nations, Decentralizing for National and Local Development, New York, Division of Public Administration, Department of Economics and Social Affairs, Sales No, UN Publication 62, HH-2, p.32

Chapter-IV

Concept of Health

Promotion of human development reduces human deprivation (at least in urban fringes and rural pockets). The purpose of development is to improve the quality of life of people by expanding their choices, freedom and dignity. Health is one of the most important indicators of human development. Disease and squalor anywhere in the world are a threat to the health of mankind. Health is a basic necessity of life. Every individual irrespective of class or gender must have access to health care facilities, safe drinking water and sanitation facilities and a minimum level of food required to maintain good health. Good health is both the means and the end of development. A healthy population is a prerequisite for economic growth which in turn can be channelized to improve the standard of living through making provisions for descent education, good health care facilities, increased job opportunities, improved security, good governance and all other requirements for human well-being.¹ Health generates human resources not mere wealth, which helps better health.

Health is a multidimensional phenomenon. Generally a person is considered healthy if his body is performing all its physiological functions normally. This is, however, only one aspect of being healthy, since we now know that apart from physiological well-being; several other factors (like environment, society and psychology) determine human health. Studies by medical anthropologists have revealed the diversity in the concepts of health, illness and disease. The definition of health has now been enlarged to include the spheres of emotional, spiritual and intellectual well-being also.² The World Health Organization (WHO) defines health in positive terms as “a state of

complete physical, mental and social well-being, and not merely the absence of disease or infirmity.”³ Health is also defined in negative terms as the absence of or the ability to resist disease or death. A sound health means the attainment of proper physical functioning of the human body so that one is able to perform the daily activities of life, and fulfils one’s role in society. Good health is itself a valuable resource for human beings. From the point of view of human development, freedom from disease and illness implies sound and better health (both physical and mental) the ability to get better education, the acquisition of better skills, as well increased participation in economic and socio-political life.⁴ Health is both the means and the product of development and is, therefore, a major factor in the development. It is imperative that health and other development sectors work together to achieve the goal of “Health for All” as established by Alma Ata Declaration in 1978.⁵ The emphasis in the Declaration is on quality of life. Health is one of the essential means of achieving economic and social goals of development. Development is meaningless unless it is accompanied by considerable decrease in the number of premature death particularly among the poor, the diversely rich human resource. Increased investment in health leads to the formation of human capital by way of increasing productive capacity which in turn results in the increased rate of economic growth. Investment in health has the potential to deliver socio-economic returns in the long run. Ill health and poverty are inextricably intertwined.

Health is necessary for individual well-being at the micro-level, and for growth and development of a country at the macro-level. Higher health status increases rates of economic growth. There is a strong linkage between health and economic growth. “Nobel Laureate Robert Fogel studied the historical relationship between health and economic growth in Europe and concluded that improvement in health status contributed significantly to the rates of

economic growth in France and Great Britain.” More recently, the economic prosperity attained by the East Asian countries has been associated with significant improvement in public health and nutrition. On the other hand widespread disease may retard economic growth.⁶ The healthy status of a nation has a significant impact on productivity, on demography, on trade, investment and on over all social development. Robust health is a self perpetuating total development.

Public Health

‘Public health’ can be defined as ‘what we as a society do collectively to ensure the conditions in which people can be healthy’. [Institute of Medicine, US]⁷ .This definition demonstrates how public health is concerned with the whole society, and not just individuals. For instance, the action of draining a swamp near a village (to prevent mosquitoes from breeding) is a public health action. It is not directed towards the wellbeing of any particular individual, but towards the entire community. Public health is also concerned with collective action to secure the health of all members of community. Such measures include community action to ensure environmental hygiene, nutrition, food and pure drinking water, safe roads and the prevention of systemic and infectious diseases. Correspondingly, if the majority of a population lacks the adequate resources to safeguard their health, it necessitates the collective action of several institutions (government, civil society, international organizations, and community organizations) to safeguard the health of the society, particularly the poverty-stricken population. There are many social problems that increase individuals’ vulnerability to disease. These include lack of education, housing and access to safe drinking water; improper sanitary conditions; malnutrition; discrimination based on socio-economic status,

ethnicity, and gender; and political inertia/powerlessness. In order to make public health work effective and to have a positive long-term impact on health status of all people, all these social problems must also be addressed and corrected. To prevent disease and promote better health of all people, public health can work at three different levels.⁸

Primary: Public health work at this level attempts to prevent occurrence of health problems. Public health work at this stage is of preventive in nature that includes ensuring immunization to protect against measles and others, iron intake to protect against anaemia, and creating awareness about the harmful effects of needle sharing to protect against HIV/AIDS and such others.

Secondary: If the first line of defence (that of primary prevention) is not successful, and an individual's health is compromised due to some condition, it swifts to detection and treatment to avoid lasting damage to the body.

Tertiary: In case an individual's body has already been damaged because of the failure of the primary and secondary strategies, tertiary prevention attempts to ease the burden of disability and prolong life.⁹

The focus of public health at the primary level is more important for the majority of people in poor countries. Indian Government has often invested in huge projects catering to tertiary level prevention for urban population, at the cost of more wide-spread primary level prevention for the entire population. A much wider impact is possible through affordable public health projects at the primary level than through expensive tertiary level provisions.

The public health system in our country has various drawbacks. The conceptualization and planning of all programmes is centralized instead of relevant local strategies. The approach towards disease control and prevention is fragmented and disease-specific rather than comprehensive. This leads to vertical programmes for each and every disease. These vertical programmes are technology centric and work in isolation of each other. The provision of infrastructure is based on population norms rather than habitations leading to issues of accessibility, acceptability and utilization. Inadequate resources also lead to lack of client conveniences and non-availability of essential consumables and non-consumables. The gap between requirement and availability of human resources at various levels of health care is wide and where they are available, the patient-provider interactions are beset with many problems, in addition to waiting time (opportunity cost) for consultation treatment. The system lacks a real and working process of monitoring, evaluation, and feedback. Quality assurance at all levels is not adhered to due to lacunae in implementation, besides lack of will to total health commitment. This results in partially or dysfunctional health infrastructure. There is lack of convergence with other key areas affecting health as the system has been unable to mobilize action in areas of safe water, sanitation, hygiene and nutrition. Despite constraints of human resources, practitioners of Indian Systems of Medicine (ISM), Registered Medical Practitioners (RMPs), and other locally available human resources have not been adequately mobilized and integrated in the system.

In order to improve the health care services in the country, the Eleventh Five Year Plan (2007-2012) insists on Integrated District Health Plans and Block Specific Health Plans. It mandates involvement of all health related sectors and emphasizes partnership with (Panchayat Raj Institutions) local

bodies, communities, NGOs, voluntary and civil society organizations. During the Eleventh Five Year Plan, major focus will be on NRHM (National Rural Health Mission) initiatives. Efforts will be made for restructuring and reorganizing all health facilities below district level into three tiers Rural Primary Health Care System. Population-centric norms, which continue to drive the provisioning of health infrastructure, will be modified. These will be replaced with flexible norms formulated on the basis of habitation-based needs, community-based needs, and disease pattern-based needs. The Approach Paper on Eleventh Five Year Plan states accessibility as a major issue, especially in rural areas, where habitations are scattered and women and children continue to die en route to health centres and urban hospitals. Policy interventions, therefore, have to be evidence based and responsive to area specific differences. Concerted action will be taken such as enabling pregnant women to have skilled attendance at birth and receive nutritional supplements. PHCs and CHCs will be connected by all weather roads so as to reach quickly in emergencies. Home-based neonatal care will be provided, including emergency life saving measures. Achievement of health objectives will, therefore, involve much more than curative or even preventive health care; an integrated approach will be adopted.

In order to meet the objectives of reducing various types of inequalities and imbalances, inter-regional and rural-urban, the Eleventh Five Year Plan has decided to increase the sectoral outlay in the primary health sector. While recognizing the role of primary health sector, the National Health Policy (2002) sets out an increased allocation of 55% of the total public health outlay for primary care; the secondary and tertiary health sectors being targeted for 35% and 10% respectively.¹⁰ The policy also states that the increased aggregate outlays for primary health care should be

utilized for strengthening existing facilities and opening additional public health service outlets, consistent with the norms.

Health Situation in South Asia

The health scenarios in the world vary regionally. Among the developing countries, South Asia is a region where the level of deprivation in health and education is very high. South Asia, with nearly 25 percent of the world's population, is the home of 40 percent of the world's malnourished people; 33 percent of the world's child mortality 35 percent of maternal mortality.¹¹ Economic growth does not contribute better health for the majority of the people in South Asia. Whatever improvement registered in the health sector has been for better of sections of the society. The delivery system in health services is marred by inefficiency and lack of accountability both in public as well as private sector. Low budgetary allocation and poor implementation of health policies are responsible for sluggish human development in South Asia. Except for a few pockets there is neither inner growth nor outer development.

Despite significant progress in 1990s, the Alma Ata goal of "Health for All" is still a distant dream for South Asia. Life expectancy in South Asia has increased from 44years to 63years over the four decades. Infant and under-five mortality have both declined. During 1990-2000, 145 million more people had access to improved water resources and 130 million more has access to sanitation.¹² However, this progress has been uneven and unequal among different countries and within each country. Compared to other region, the South Asia performance in the health sector is poor. South Asia still has the highest infant and under-five mortality rates in the world. One out of every three child deaths in the world occurs in South Asia; two-third of the malnourish children of the world live in this region; and infant mortality rate is still very high. There are some 329 million children in the region who live in poverty or are vulnerable to significant insecurities.¹³

South Asian women bear a greater burden of disease and deprivation than men. South Asia is the only region in the world where men outnumber women (94 women to 100 men). The high rate of mortality among girls and women are the result of discriminatory practices in health care provisions and lack of decision-making power of women. Majority of women suffer from malnutrition and severe micronutrient deficiencies. It is estimated that more than 30 percent of women in the child bearing age are underweight and around 15 percent are stunted as a result of poor nutrition during their childhood. More than half of the women in the region are anaemic.¹⁴ This results in high rates of maternal mortality and also higher risks of infant deaths. Nearly half of the maternal deaths in the world occur in South Asia.¹⁵ Each day 507 women in South Asia die due to pregnancy and delivery complications.¹⁶ Antenatal care, which is very important in reducing the risks of fatality of mother and child, is also insufficient with nearly half the mothers in the region not receiving such care. Fertility rates are falling in South Asia, but the region still has one of the highest fertility rates in the world.

The health care system in South Asia is also very poor in terms of infrastructure and management. Health systems in South Asian countries are weak and poorly managed. Public health provision suffers from poor accounting, inventory control, human resource and control system. Governments lack commitment to health and the focus is not on providing primary health care for all but tertiary level facilities mostly based in urban areas. The facilities, if any, in rural areas are understaffed and lack essential requirements in the delivery system. Even eight years after the UN Millennium Summit in 2000, September where Millennium Development Goals, with three goals explicitly for health, were adopted by the world leaders of 189 countries, the situation remains unsatisfactory in South Asia. South Asian Governments have failed to keep pace with the increasing demands for

the provision of basic health, safe drinking water and sanitation facilities, and maintaining a healthy environment. In order to meet the Millennium Development Goals (MDGs) particularly the health goals, it is necessary for South Asian countries to increase public spending in the social sectors. With the governments spending only 1 percent of their Gross Domestic Product (GDP) (Table 4.1) on health it is no wonder that this important service sector has remained so undernourished¹⁷ (Table 4.3).

Table 4.1

Health Expenditure by Region of the World, 2002

Region	Total health expenditure as % of GDP	Public health as % of GDP	Public % of total	Health expenditure per capita (US \$)
East Asia and Pacific	4.9	1.9	38.8	48
Europe and Central Asia	5.8	4.3	72.4	123
Latin America and Caribbean	7.0	3.4	48.0	255
Middle East and North Africa	4.9	2.8	59.3	166
South Asia	4.8	1.0	21.6	22
Sub – Saharan Africa	6.0	2.5	41.3	29
High income countries	10.8	6.3	62.1	2841
Europe EMU	9.3	6.8	73.5	1856

Source: World Bank 2004-World Development Indicators – Washington D.C., World Bank.

In South Asia the average health expenditure of both public and private sectors taken together stands at 4.8% of the GDP while the expenditure in

public sector is 1% of the total GDP per capita health expenditure in South Asia is lowest in the world compared to other regions. (Table 4.1). The Health Index of South Asian countries shows very poor picture of the health status of these countries (Table 4.2).

Table 4.2
Health Index for South Asia, 2002

<i>Countries</i>	Health Index Value	Status Index	Infrastructure Index	Limitation Index	Human Development Index (HDI) Value
Maldives	0.751	0.830	0.704	0.769	0.752
Sri Lanka	0.751	0.892	0.618	0.875	0.74.
Bhutan	0.544	0.743	0.417	0.596	0.536
India	0.476	0.708	0.310	0.575	0.595
Bangladesh	0.458	0.733	0.332	0.435	0.509
Pakistan	0.458	0.701	0.283	0.565	0.497
Nepal	0.379	0.681	0.275	0.285	0.504

Note: Data obtained from UNDP 2004 and World Bank 2004 used in calculating the indices.

Source: UNDP 2004 - Human Development Report 2004, Cultural Liberty in Today's Diverse World. New York: Oxford University Press. World Bank (2004), World Development Indicators 2004, Washington D.C., World Bank., Mahbulul Haq Human Development Center Staff Calculations.

Health Sector in India

So far as India is concerned the impact of the poor health conditions of South Asia affects India as it is one of the component countries of this region. India

is lagging behind Sri Lanka, Maldives in terms of its health index. Indian economy is on a fast-track growth path. Economic liberalization, started in 1990s has taken a sharp upward turn with an impressive growth rate. However, despite India's strong growth performance which has unleashed enormous potential for economic advancement, there is growing concern that economic liberalization has been less successful in protecting people from the risk of new vulnerabilities, inequalities and insecurities specially in the social sector. Health sector proves this proposition. There is a huge discrepancy in health outcomes and in health care utilization between rich and poor and between richer and poorer states. Poor people have worse health, are less entitled to public subsidies, and are less protected against the financial shock hazards. In India it may happen in future that the poverty reducing impact of economic growth is countered by poverty enhancing impact of health if the system continues to remain inequitable and people remain largely unprotected against financial risks related to health shock. In India the performance on the health sector is not very satisfactory and encouraging. Per capita incomes steadily have increased. Over the years spectacular gains have been made in the field of food production. An enormous band of skilled scientific, technical and managerial manpower has been built up. A massive infrastructural development and building up of industrial base have been done. In spite of these achievements, millions of people lack basic necessities; they lack access to basic food, shelter, safe drinking water, education, health and healthy environment to live.¹⁸ India's relatively poor performance in the health sector will be clear when compared to international data on healthcare infrastructure and utilization (Table: 4.5, 4.6). The primacy of good health as an essential component of human development implies that the focus of policy interventions ought to be more broad-based and multipronged. The attention of policy-makers has to be shifted from focusing narrowly on an increasing

provision for health services to a more logistic and equitable approach that looks at people's access and social security.

Table 4.3

Number of Undernourished People in South Asia, 1990-2001

Countries	1990 – 1992	1995 – 1997	1999 – 2001
India	214.5	194.7	213.7
Pakistan	29.0	24.1	26.8
Bangladesh	39.2	47.9	44.1
Nepal	3.4	5.0	3.8
Sri Lanka	5.0	5.0	4.6
South Asia	291.1	276.5	293.1

Source: FAO 2003 – The State of Food Insecurity in the World, Rome, FAO.

Table 4.4

Health Expenditure in South Asia, 2001

Countries	Total expenditure of health as % of GDP		General Government expenditure on health as % of total expenditure on health		Private expenditure on health as % of total expenditure on health		Health index (Rates)
	1997	2001	1997	2001	1997	2001	
India	5.3	5.1	15.7	17.9	84.3	82.1	140
Pakistan	3.8	3.9	27.2	24.4	72.8	75.6	147
Bangladesh	2.9	3.5	33.7	44.2	66.3	55.8	146
Nepal	5.4	5.2	31.3	29.7	68.7	70.3	162
Sri Lanka	3.2	3.6	49.5	48.9	50.5	51.1	79
Bhutan	3.6	3.9	90.4	90.6	9.6	9.4	132
Maldives	6.5	6.7	81.9	83.5	18.1	16.5	78
South Asia		4.8		22.1		77.9	

General Government expenditure on health is defined as public expenditure on health.

Source: WHO 2003 – HIV/AIDS Business Plan South Asia FY – 04 – FY – 06.

Table 4.5

**International Comparison of Health, Manpower and Hospital Beds
1990-1998**

	Physician per 1000 population	Nurses per 1000 population	Midwives per 1000 population	Hospital beds per 1000 population
Indian public sector	0.2	-	0.2	0.4
India total	1.0	0.9	0.2	0.7
World	1.5	3.3	0.4	3.3
Low income countries	1.0	1.6	0.3	1.5
Middle income countries	1.8	1.9	0.6	4.3
High income countries	1.8	7.5	0.5	7.4

Source: World Bank, 2001 – India: Raising the Sights Better Health Systems for India's Poor.

Table 4.6

**International Comparisons of Health Service Utilization and Disability
Adjusted Life Years (DALYs) lost per 1000 Population 1990-1998**

	Inpatient admission per capita per year in (%)	Average length of inpatient stay (days)	Outpatient visits per capita per year	DALY (per 1000 population)
India public sector	0.7	14.0	0.7	–
India total	1.7	12.0	3.9	274
World	9.0	13.0	6.0	234
Low income countries	5.0	13.0	3.0	256
Middle income countries	10.0	11.0	5.0	–
High income countries	15.0	16.0	8.0	119

Source: World Bank, 2001, India : Raising the Sights Better Health Systems for India's Poor.

The recent Government policies related to health and population implicitly acknowledge the need to address the question of inequality and vulnerabilities in a more effective way. Government should increase its spending on health, at the 2 percent of GDP by the year 2010 from its current allocation level 0.9 percent. This would require the states to raise their budgetary allocation on health to 8 percent from 5-6 percent and the centre's contribution from 15 percent to 25 percent.¹⁹ But there is a doubt as to whether the increased public expenditure will ensure better health for the poor. The present health scenario fails to explain this doubt. The primary reason behind this failure is gross inequity in the distribution of public health resources. Inequity reflects not only in widening gap of public spending between poor and rich states, but also in substantial absorption of public subsidies by the richer people within a given state.²⁰ As shown by a recent study, about Rs.3/- is received by the richest section for every Rs.1/- of public health subsidy received by the poorest 20 percent.²¹ The disproportionate absorption of public subsidies reflects poor targeting in the public health care facilities. The disparities and inequity in India's health sector distribution leads to such a situation where people in the same country live in entirely different condition in terms of health. The illness burden and nutritional status of the Indian population continues to be a grey area, with very little information available. Inadequate public expenditure, coupled with its poor targeting, results in uncontrolled proliferation of private providers delivering health services at a high cost. Although government provided health care is meant to be heavily subsidized and, as such, to benefit the poor, the majority of health care users who go for the public facilities have to spend large amount on their own. For example, a study in West Bengal demonstrates that users of public sectors facilities pay between 18 percent (for birth delivery) and 72 percent (for major ailments) of what users of qualified private sector facilities pay for similar services. About 75 percent and 87 percent of

expenditure in case of treatment of major ailments and minor ailments respectively in public facilities go towards medicine and diagnostic tests. Most of the users of public hospital are compelled to purchase drugs and medicine in the private sector due to shortage of prescribed drugs in hospital pharmacy.²²

According to a recent national survey, about 79 percent of Indians, who were suffering from minor illness, sought treatment from private providers.²³ It is also notable that a large number of these private providers are unqualified medical practitioners.

The above evidences indicate two fundamental problems of Indian health care system –

- 1) resources flowing through the public administrative channels do not necessarily benefit the poor; and
- 2) even if it does, a common person in general and a poor in particular remains significantly unprotected against the unanticipated burden of treatment of ailments.²⁴

India's poor health performance may be presumed to be associated with shortcomings in national development. Though India's development policy since independence has indeed been concerned with equity, the most immediate concern was of course with raising the rate of economic growth in the country. It was felt that India needed first and foremost to develop a strong industrial base at the same time raising agriculture output. Thus the Indian development strategy emphasized planning of commodity sectors to the detriment of planning of social sectors. Health outcomes in the country clearly reflected these shortcomings in the development strategy.

Health Policy during Plan Period

The evolution of planning in India shows that the health chapters of the Five Year Plans becomes bulkier over time, but with poor substance. In India before independence the political leadership represented by the Indian National Congress (INC) had advocated state intervention to achieve rapid socio-economic development. The report of the sub- committee on national health prepared for the consideration of National Planning Committee of the INC has recommended that the preservation and maintenance of health of the people should be the responsibility of the state which should organize and control health care to achieve proper integration of curative and preventive services.²⁵

After independence health planning was declared an integral part of socio economic planning and the blue print for national health policy was provided by the Bhore Committee which after surveying the nature of health problems and health care organization had recommended the universal and free provision of health care services with heavy emphasis on preventive and rural services under full government responsibility and with specific focus on women and children, control of communicable diseases and monitoring.²⁶

The successive Five Year Plans reiterated the principles underlying the Bhore Committee report. In health sector planning, the First Five Year Plan (1951-56) placed drinking water, communicable diseases, building health infrastructure and manpower, maternal and child health, self sufficiency in drugs etc as priorities. The plan outlay for health was Rs.131 crore.²⁷ In Second Five Year Plan (1956-61) emphasized developing an integrated health service with a focused effort of building a network of peripheral institutions, along with training of manpower. The issues that were considered along with the need to enhance quality and availability of hospitals to support the network

of primary units were, self sufficiency in drugs and equipment, building a data base for further planning and a constant learning through inbuilt evaluations and external assessment. The plan placed the highest priority on building the infrastructure, manpower, control of communicable diseases, and environmental hygiene. In this plan period maternal and child health programmes were proposed to be integrated with the primary health unit services. The plan outlay on health was 267 crore.²⁸ The Third Five Year Plan (1961-1966) moved towards increasing the pace of growth of urban services specially the speciality hospitals and training facilities. The plan emphasis was on technological growth and expansion and acquiring higher standards of technical competence (GOI, 1961). The Third Plan accords very high priority to family planning. The programmes for family planning in this plan provide for

- a) education and motivation for family planning
- b) provision of services
- c) training
- d) supplies
- e) communication and motivation research
- f) demographical research
- g) medical and biological research.²⁹

The total plan outlay in health during the Third Plan is about 342 crore.³⁰ The Fourth Five Year plan (1969-74) raised the status of the family welfare programmes to such a height that more than 80 percent of the total allocation in the health sector was earmarked for spending on family welfare.³¹ During this plan, efforts were made to provide an effective base for health services in rural areas by strengthening the primary health centers. These centers were supported to render preventive and curative health services, to implement the communicable diseases control programmes for malaria and small pox and

becomes the focal point for a nation wide family planning programmes. The plan outlay for public health and medical programmes is 435 crore.³² The Fifth Five Year plan (1974-79) attempted to integrate the nutrition, maternal and child health and family welfare programmes and introduced the Minimum Needs Programme.³³ However the implementation of the programmes under this plan was hampered, because of the promulgation of the National Emergency. The Sixth Five Year Plan (1980-85) made amends by expanding the Minimum Needs Programme and increasing investments in eradicating communicable diseases. The Family Welfare programme was reverted to a less oppressive child survival and safe motherhood strategy and the investments were also scaled down. Rural infrastructure was significantly expanded through setting up a 30 bed Community Health Center (CHC) (a first referral unit) that replaced the Primary Health Center (PHC) with six beds for a population of 100000. The new PHCs and their sub-centres now cover 30000 and 5000 population respectively. Family Welfare Programme enjoyed the highest priority at the state and the central planning levels.³⁴ The Sixth Plan diverted resources for controlling communicable diseases, put restraints on pumping more resources into family planning but the upgraded infrastructure continued to serve the latter as it enjoyed the highest priority at the central level. By the 1980s medical care emerged as an important area for market expansion. The state complied with the liberalizing influences and went for more debts and market expansion. Therefore, instead of taking the lessons forward, the five year plans after the mid-1980s reflected a dilution of the initial objectives of planning due to penetration of markets.³⁵ During this plan period Government of India adopted the first National Health Policy (1983) (NHP) with the aim of achieving “Health for All” by the year 2000 by establishing an effective and efficient health care system for all citizens, particularly for vulnerable sections like women, children and underprivileged. The creation of an infrastructure for primary health care was emphatically

stressed in the NHP (1983). Other major priority areas were:- close coordination of health related services and activities like drinking water supply, sanitation and nutrition; the active involvement and participation of voluntary organizations and provision of essential drugs and vaccines. In addition, qualitative improvement in the family welfare services and provision of adequate training and medical research were also taken into consideration. The 1980s witnessed massive infrastructure expansion and programmes for providing family health care facilities to achieve the target of one PHC for 30,000 people and one sub-center per 5000 people in the plains and one PHC for 20000 people and one sub-centre for 3000 people in tribal and hilly areas. This target was more or less attained in almost all the states.³⁶ However, inspite of the vast expansion in infrastructure it remained grossly underutilized because of poor facilities, inadequate supplies, insufficient and ineffective manpower, the lack of proper monitoring and evaluating mechanisms, poor managerial skills among doctors etc. In the Seventh Five Year Plan (1985-90) new initiatives and innovative measures were contemplated in health sector. The plan sought to provide adequate drinking water facilities for the entire population both in urban and rural areas. But the end of the plan period, it was proposed that the infrastructure for primary health care would be fully operational with regard to village health guides, sub-centers, primary health centers and multi purpose health workers with a balanced mix of preventive, promotive and curative services. The Seventh Plan under pressure of neoliberal policies scaled up investment in Family Planning and opened up NGO and private sector partnerships.³⁷ The Eighth Five Year Plan (1992-97) recognized “human development” as core of all development effort. It is only healthy and educated people who can contribute to economic growth and this growth in turn, will contribute to human well being. To realize this goal the priority sectors of this plan are therefore, health, education, literacy and basic needs, including drinking water, housing and welfare programmes for the

weaker sections. The plan talked of privatization of medical care of targeting the underprivileged for providing primary health care and national health programmes.³⁸ Over the last five decades a massive health care infrastructure has been built up in urban and rural areas. National programmes to combat major health problems have been evolved and implemented through this infrastructure. These have resulted in a steep fall in mortality rate. However, there has not been any reduction in the communicable diseases and nutrition related morbidity. There has been a progressive increase in the non-communicable disease burden, occupational and environmental health related problems. The focus during the Ninth Five Year Plan (1997-2002) was on providing integrated preventive, promotive, curative and rehabilitative services for communicable, non-communicable and nutrition related health problems, through appropriate strengthening of the existing health care institutions and ensuring that they are optimally utilized. Efforts were to be made to achieve substantial reduction in morbidity and mortality rates by taking advantage of the ongoing demographic transition and progressive increase in the population in the 15-59 age groups. Over the last five decades there has been a steep decline in severe grades of under-nutrition and related health problems.³⁹ During the Ninth Plan, efforts were undertaken to achieve substantial reduction in Chronic Energy Deficiency (CED) and its health consequence through universalisation of Integrated Child Development Scheme (ICDS), screening of pregnant and lactating women, growth monitoring and better targeting of food supplements to those with CED, close monitoring of persons receiving food supplements; close intersectoral co-ordination to ensure early detection and management of health problem leading to or associated with under nutrition. Prevention, early detection and effective management of micro-nutrient deficiencies and associated health hazards received due attention.⁴⁰ Over the last five decades, India has built up a vast health infrastructure and manpower at primary, secondary and tertiary

levels in government, voluntary and private sectors. Technological advances and improvement in access to health care technologies, which were relatively inexpensive and easy to implement, had resulted in substantial improvement in health indices of the population and a steep decline in mortality. During 1990s, the mortality rates reached at a high level and the country entered into an era of dual disease burden – communicable and non-communicable diseases. Under nutrition, micro-nutrient deficiencies and associated health problems coexist with obesity and non-communicable diseases. The existing health system suffers from inequitable distribution of institutions and manpower. In order to address these problems the center and the state have embarked on structural and functional health sectors reforms. However, the pace of implementation is slow. Traditionally health service (both government and private) was perceived as a social responsibility (of course paid one). Growing commercialization of health care and medical education has eroded this commitment adversely affecting the quality of care, trust and rapport between health care seekers and providers.⁴¹ In view of the importance of health as a critical input for human development, the Tenth Plan approach is that there will be continued commitment to provide : essential primary health care, emergency life saving services, services under the National Disease Control programmes and the National Family Welfare Programmes totally free of cost to all individuals; essential health care service to people below poverty line based on their need and not on their ability to pay for the services. The focus of the Tenth plan was on -reorganization and restructuring the existing government health care system including the health infrastructure at the primary, secondary and tertiary care levels with appropriate referral linkages; the institutions will have the responsibility of taking care of all the health problems and deliver residing in a well defined geographic urban and rural areas; increasing the involvement of voluntary and private organizations, self-help groups and social marketing organization in improving access to health

care; evolving and effectively implementing programmes for improving nutritional status of the population.⁴²

The Tenth Plan stated the dismal picture of the health services infrastructure and emphasized on restructuring and developing the health infrastructure, especially at the primary level. The plan high-lighted the importance of decentralization but did not state how this would be achieved.⁴³ Programme driven health care was in focus. Verticality and technical solution were given more importance than comprehensive primary health care. The review of the plan not only throws light on the gap between the rhetoric and reality but also the framework within which the policies were formulated.⁴⁴ The question that has come in the force was whether it is only the low investment in health that causes the present status of the health system or is it also to do with the framework, design and approach within which the policies were formulated. Keeping this in view the National Rural Health Mission was launched in 2005 to address infirmities and problem across primary health care and bring about improvement in the health care system and health status of those who live in the rural areas.⁴⁵ Considerable achievements have been made over the six years in the efforts to improve health standard like life expectancy, Child Mortality Rate (CMR), Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR) etc. Nevertheless, problems are huge, malnutrition affects a large proportion of children. The country has to deal with the rising costs of health care and the growing expectation of people as well as the challenge of quality health services in remote rural areas. Given the magnitude of the problem the Eleventh Five Year Plan (2007-2012) provide an opportunity to restructure policies to achieve a new vision based on faster, broad-based, and inclusive growth. One objective of the Eleventh Plan is to achieve good health for people, especially the poor and underprivileged. The plan will facilitate convergence and development of public health needs and

aspirations of people. Importance will be given to reducing disparities in health across regions and communities by ensuring access to affordable health of marginalized groups like adolescent girls, women of all ages, children below the age of three, older persons, disabled and primitive tribal groups. It will view gender as cross-cutting theme across all schemes.⁴⁶ To achieve these objectives, aggregate spending on health by the centre and the states will be increased significantly to strengthen the capacity of the public health system to do a better job. The plan also ensures a large share of allocation for health programmes in critical areas like HIV/ AIDS. The contribution of the private sector in providing primary, secondary and tertiary services will be enhanced through private public partnership. Good governance, transparency and accountability in the delivery of health services will be ensured through involvement of PRIs, community, and civil society groups. Health as a right for all citizen is the goal that the plan will strive towards.⁴⁷

Time bound goals for the Eleventh Five Year Plan are:

Reducing MMR to 1 per 1000 live births.

Reducing IMR to 28 per 1000 live births.

Reducing TFR to 2.1

Providing clean drinking water for all by 2009 and ensuring no slip backs.

Reducing malnutrition among children of age group 0-3 to half its present level.

Reducing anaemia among women and girls by 50 percent.

Raising the sex ratio for age group 0-6 to 935 by 2011-12 and 950 by 2016-17.

Status of Health

At the beginning of the 20th century India experienced life expectancy at birth of 22 years. The crude death rate stood at 42.6 per 1000 live births and crude birth rate stood at 49.2 per 1000 live births. The IMR rate during 1911-1915 was 204 per 1000 live births.⁴⁹ However, there have been substantial gains in the health sector in terms of IMR, Crude birth rate and death rate since independence. The IMR which was 134 per 1000 live births at the time of independence, declined to around 70 in 1999 and 68.0 in 2000.⁵⁰ The crude birth rate, which stood at 39.9 in 1941-51, reflecting the huge mortality load, dropped down to 26.1 in 1999, 25.8 in 2000. The crude death rate declined from 27.8 in 2000. The crude death rate declined from 27.4 in 1941-51 to 87 in 1999, 8.5 in 2000 and the life expectancy at birth is 64 in 2001.⁵¹ However, there is a wide gap between policy commitment and its application. Also there are marked differences regarding the performance in the health sector across regions in India. Inequalities are also evident among the marginalized social groups in India like, SC, ST and other disadvantaged groups.⁵²

Table 4.7
Infant Mortality Rate (IMR) by Locality
in India 1971 –1999

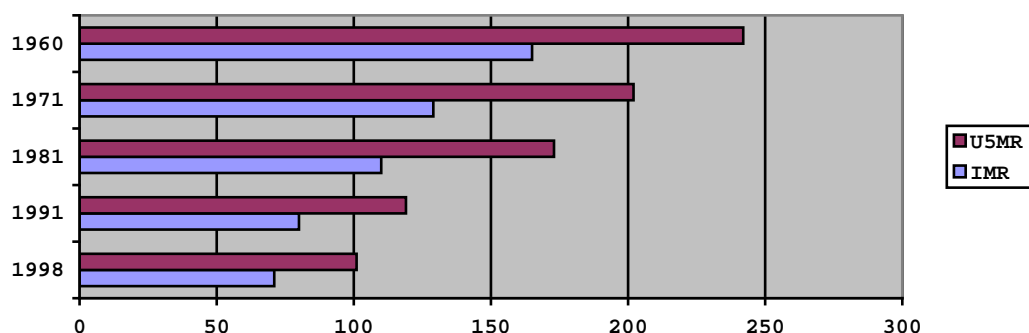
Year	Total	Rural	Urban
1971	129	138	82
1976	129	139	80
1981	110	119	62
1984	104	113	66
1985	97	107	59
1986	97	105	62
1987	95	104	61
1988	95	102	62
1989	91	98	58
1990	80	86	50
1991*	80	87	53
1992*	79	85	53
1993*	74	82	45
1994*	74	80	52
1995*	74	80	48
1996*	72	77	46
1997*	71	77	45
1998	71	77	45
1999	70	75	44

Source: Human Development in South Asia 2004

Note: * excludes Jammu and Kashmir

The data in the table 4.7 shows declining trend in IMR. But during the period 1991-99 there appears a marked stagnation in the rate of decline of IMR. In 2002, IMR was recorded as 67 in India. The current IMR in India is 58.⁵³ As the data in the table reveals, despite policy commitments to provide equal access to health care provisions in rural and urban areas there are marked rural-urban disparities primarily due to inept implementation of these policies. Commitments to provide equal access to health care provision in rural as well as urban areas, marked rural-urban differences remain unchanged due to lack of implementation of these policies.⁵⁴ Apart from this general stagnation, significant IMR differences exist among states. Kerala recorded lowest IMR-14 by 2006, while Maharashtra, Tamil Nadu, Punjab, Karnataka and Himachal Pradesh have met the national goal of reducing IMR to less than 60 by 2006. However, major states like Madhya Pradesh, Uttar Pradesh, Bihar, Orissa and Rajasthan still lag far behind.⁵⁵ Significant disparities still exist among different economic classes, and amongst the marginalized groups.⁵⁶ Thus SC (83) ST (84.2) OBC (76) and all 'other' (61.8)⁵⁷ bear a disproportionate burden of infant deaths, as do the poor in general. The National Family Health Survey III, 2005-2006 reveals that infant and child mortality rates are higher in rural areas. In 2001-05, the IMR was more than 50 percent in rural areas (62 deaths per 1000 birth) when compared to urban areas (42 deaths per 1000 births). Nationally girl child's chances to survival are less than male child under-five year. 79 girls per 1000 births die before their fifth birthday, compared to 70 boys per 1000 birth.⁵⁸ Though the rate of under-5 MR is declining since 1960 in rural areas the U5-MR is higher than the national average.⁵⁹

Figure4.1: Trends of IMR and Under-5MR in India, 1960-98



Source: Human Development in South Asia, 2004.

In rural areas the U5MR was 103.7 while it stood at 63.1 in urban areas. In rural areas, the U5MR was a surprising 127.3 among SC (Dalit) household, 311.4 among ST (Adivasi) household, and 112.2 among the OBCs compared to 93.1 among others. A cross-regional and cross-class comparison reveals that rural household with a low standard of living experienced U5MR of 131.8, more than three times higher than in better of household in urban areas.⁶⁰ While there has been a decline in the overall Under-5 MR, the pace of decline is slow and currently it is hovering around 95. During 1971-81 the percentage was 14.4. The decline was much sharper during 1980s, with a percentage of 31.2. However, during the 1990s, with the market economy policy, cuts in public sector expenditure and privatization of health services, the rate of decline has reduced to 15.1 percent.⁶¹

India's maternal mortality ratio (MMR) is still extremely high in comparison to countries like China, and Sri Lanka.⁶² The high rate of MMR in India is the result of the poor health status of women. Over half of mothers had three or more antenatal care (ANC) visits.

Table 4.8

MMR in Selected Developing Countries, 2000

(per 100000 live births)

Countries	MMR	
Korea Republic	20	
Sri Lanka	92	
Malayasia	41	
China	56	
Pakistan	500	
Indonesia	230	
India	540	301 (2001-2003) current level
Bangladesh	380	
Nepal	740	

Source: Human Development in South Asia, 2004

The percentage of women who had three or more ANC visits ranges from 17 percent in Bihar and 27 percent in Uttar Pradesh to at least 90 percent in Kerala, Goa and Tamil Nadu. Many do not receive high quality care. Less than 3 in 4 had their abdomen examined, and less than two in three received other services, including being weighed, having blood pressure measured, and urine and blood samples checked. Only 36% received information about pregnancy complications. 65 percent received iron and folic acid (IFA) supplements for their most recent birth; and only 23 percent took IFA for at least 90 days, as recommended. 76 percent of mothers received the two or more tetanus toxoid injections during pregnancy. Only 4 percent of women took a drug for

intestinal parasites during their pregnancy.⁶³ India was one of the few countries in the world to initiate an official policy and programmes for family planning and the focus during the initial years was on antenatal care and training of traditional birth attendants to provide safe deliveries. Despite these initiatives, the Government so far has not been able to achieve its target in reducing the MMR, IMR and CMR. India's national fertility rate (TFR) is 2.9. But the TFR vary from state to state. While in Goa it is 1.8, in Kerala 1.7, in Andhra Pradesh 2.1, in Tamil Nadu 1.5, it stands at 4.4 in UP, 3.7 in MP and Rajasthan and 4.3 in Bihar.⁶⁴

A large number of population especially rural people lives under the poverty line and is therefore unable to meet its daily caloric requirements. Data from the National Nutrition Monitoring Bureau (NNMB) indicate that there has been an improvement in getting nutrition among one to five year old children; the declining level was 11.1 percent in 1992 and 6.9 percent in 1995. Overall, the percentage of nutritionally normal children has increased from 7.2 percent in 1992 to 8.5 percent in 1995. Although the percentage of moderate under-nutrition remains substantially unchanged at 43.5 percent while mild under-nutritional has increased from 36.6 percent 1992 to 40.6 percent has increased from 36.6 percent in 1992 to 40.6 percent in 1995. The NNMB notes that the average caloric consumption in 1995 was below the recommended daily allowance. Under nutrition is substantially higher in rural areas than in urban areas.⁶⁵ Over half of the children under the age of five in India are moderate or severely malnourished, 30 percent of newborn children are significantly under-weight and nearly 60 percent of women are anaemic. This is despite the country having attained self sufficiency in food production well over a decade, with mounting public food stocks at its command. The prevalence of under nutrition is wide spread. Protein/energy malnutrition is the most common form of malnutrition among children in the age group 0-4 years.

Iron deficiency/anaemia is quite common in children, as well as women, particularly pregnant women.⁶⁶

Table 4.9

Percentage of Children under age 3 who are Stunted, Wasted or Underweight

Stunted (too short for age)	Wasted (too thin for height)	Under weight (too thin for age)
38	19	46

Source:- National Family Health Survey -3, 2003-2006. Ministry of Health and Family Welfare, Government of India

One of the important reasons for high mortality and morbidity along with widespread hunger and poverty is the remarkably low public investment in health. The National Health Policy itself acknowledges, public health investment over the years has been comparatively low, and as a percentage of Gross Domestic Product (GDP), has declined from 1.3 percent in 1990 to 0.9 percent in 1999.⁶⁷

The problems facing public health care system are various and complex like— poor staffing, absence of staff, absence of simple consumables, poor referral linkage and so on. The staff itself preoccupied with the implementation of family planning. These shortcomings in the primary health care system often force people to resort to treatment from quacks or the exploitative private sector. Moreover, the non-availability of drugs and consumables implies that the PHC system not only unable to bring about a reduction in suffering, but also to prevent the transmission of infections and communicable diseases.⁶⁸

People spend substantial on healthcare largely provided by unqualified persons in the private sector where quality services are not available. In spite

of this situation, state spending on health declined during the 1990s as India adopted market economy policy and structural adjustment programmes.

The comparative picture with regard to health indicators like life expectancy, TFR, IMR and MMR status that countries placed in almost similar situation such as Indonesia, Sri Lanka and China have performed much better than India.⁶⁹ The following table 4.11 reveals the fact.

In India there are persistent extreme inequality and disparity both in terms of access to health care as well as health outcomes. The health indicators of 16 major states point out that, Kerala compares favourably with most middle-income countries in West Asia. But Bihar, MP, Orissa, Rajasthan, and UP are well below the average of low-income countries and just above the levels of sub-Saharan Africa. Kerala's life-expectancy at birth is about 10 years more than that of MP and Assam. IMRs in MP and Orissa are about five times more than that of Kerala. MMR in UP is four times more than that of Kerala and three times more than that of Haryana.⁷⁰ However, there has been a substantial decline of MMR in India between the period of 1997 and 2003. However, the rate of decline is not sufficiently encouraging the present rate of decline [301 per 10000 live births (RGI, 2006)], it will be difficult to achieve the goal of 100 by 2012 (11th Five Year Plan goal).⁷¹ Crude death rate among states also reveals wide variations. Crude death rates in Orissa and MP are about twice the crude death rates in Delhi and Nagaland. This high degree of variation of health indices is itself a reflection of the high variance in the availability of health services in different parts of the country.⁷² Public health care system in rural areas in many states and regions is in shambles. Extreme inequalities and disparities exist both in terms of access to health care as well as health outcomes. The following table 4.12 reflects this truth.

Table 4.10**Trends in Expenditure on Health and Family Welfare, 1951-2002**

Plan	Period	Amount	Total plan investment (All development heads)	Health (Centre and states)	Family welfare	Control of communicable diseases
				Outlay/exp % of total plan	Outlay/exp % of total plan	Outlay/exp % of total plan
First	1951-56	Actuals	1,960	650 3.33	1 0.01	231 16.5
Second	1956-61	Actuals	4,672	1,408 3.01	50 0.11	640 28.4
Third	1961-66	Actuals	8,576.5	2,259 2.63	249 0.29	690 27.7
Annual	1966-69	Actuals	6,625.4	1,402 2.12	704 1.06	231 10.2
Fourth	1969-74	Actuals	15,778.8	3,355 2.13	2780 1.76	1270 11.1
Fifth	1974-79	Actuals	39,426.2	7,608 1.93	4918 1.25	2681 11.5
	1979-80	Actuals	12,176.5	2231 1.83	1185 0.97	-- --
Sixth	1980-85	Actuals	97,500	1831 1.87	10,100 1.04	5240 27
Sixth	1980-85	Actuals	109,291.7	20252 1.85	13,870 1.27	-- --
Seventh	1985-90	Actuals	180,000	33929 1.88	31,208 1.81	10,127 7.7
Seventh	1985-90	Actuals	218,729	36,886 1.69	31,208 1.43	-- --
	1990-91	Actuals	61,518	9609 1.56	7849 1.28	-- --
	1991-92	Actuals	65855	10422 1.58	8,506 1.3	-- --
Eighth	1992-97	Actuals	434100	75822 1.75	65000 1.5	10,450 4.2
Ninth	1997-02	Actuals	859200	51181 0.6	151200 --	-- --

Source: GOI 1997 Ninth Five Year Plan 1997-2002. Vol. II, New Delhi, Planning Commission.

Table 4.11**Health Indicators among Selected Countries**

Country	IMR per 1000 live births	Life expectancy M/F in years	MMR per 1000 Live births	TFR
India	58	63.9 / 66.9*	301	2.9
China	32	76.6 / 74.2	56	1.72
Japan	3	78.9 / 86.1	10	1.35
Republic of Korea	3	74.2 / 81.5	20	1.19
Indonesia	36	66.2 / 69.9	230	2.25
Malaysia	9	71.6 / 76.2	41	2.71
Vietnam	27	69.5 / 73.5	130	2.19
Bangladesh	52	63.3 / 65.1	380	3.04
Nepal	58	62.4 / 63.4	740	3.40
Pakistan	73	64.0 / 64.3	500	3.87
Sri Lanka	15	72.2 / 77.5	92	1.89

Main source: 11th Five years plan 2007-12

* Note: Projected (2001-2006) Source: India-RGI Government of India (GOI) (Latest figures);

Others – State of world population (2002)

Table 4.12**Urban/ Rural Health Indicators**

Residence	Crude Birth rate (per 1000)	Crude Death rate (per 1000)	IMR	Prevalence of anaemia among children (6-35 months) (%)	Prevalence of anaemia among pregnant women (%)
Urban	19.1	6.0	40	72.7	54.6
Rural	25.6	8.1	64	81.2	59.0

Total	23.8	7.6	58	79.2	57.9
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Source: Ministry of Health and Family Welfare, GOI (2006) and NFHS – 3, IIPS (2005-2006)

These large disparities across India place the burden on the poor, especially women, SCs and STs. While metropolitan cities have modern tertiary care facilities of international standards, people in many remote areas do not have access to even basic primary care.⁷³

Another most important problem in India is gender disparity. The largest gender disparities in India are prevalent in Northern states, notably Haryana and Punjab, despite their relative prosperity. Kerala had more females than males in 2001. The low ratio of women to men is usually due to a preference for sons, discrimination against girls, female foeticide, and higher mortality levels among females. The relative neglect of women is also reflected in poor reproductive health indicators. A major reason for the poor maternal health outcomes are the high levels of malnutrition among women. In 1998-99 52% of all women in the reproduction ages were found anaemic. Currently it is raised to 56.2%.⁷⁴

Health Sector Reform

The health sector reforms have been carried out in the developing countries across the world under the aegis of international financial institutions since the early 1980s. In essence, these reforms intend to reduce the role of the state in the financing and provision of healthcare, and to confine its role to that of regulation. However, given the acute poverty of larger sections of the population, in widespread prevalence of hunger, the huge morbidity, and mortality loads, the abysmal role of the state in health sector, the direction of such reforms can potentially curtail further healthcare access to the poor.

Health sector reforms in India have applied a variety of methods aimed at improving efficiency, effectiveness, and the quality of care provided by public health services. These are – contracting, public-private partnerships, user fees, privatization and more. Many non-clinical support services in public hospitals have been also contracted out. A future possibility suggests that NGOs can be invited to provide primary health services in rural areas. During nineties several studies show a sharp increase in medical care costs. There are far reaching changes in drug policies. Thus India earlier noted for low costs of drugs and pharmaceuticals, along with significant indigenous productions of drugs has witnessed a greater concentration of drug production, a larger role of MNCs, a higher proportion of imported drugs. At the same time there is a marked shift in the use of public health care system. Private sector health care system is being used increasingly even in rural areas. In 1995-96, 55% in rural areas and 57% in urban areas were hospitalized in the private sector, compared to 40% in 1986-87.⁷⁵ National Sample Survey data indicates greater inequality in use of health facilities. The steep fall in rural hospitalization rates along with increasing use by the better-off, indicates that the poor are being squeezed out. Fees for services are undoubtedly the primary reason for this happening.

Costs of both outpatient and inpatient care increased sharply in both rural and urban areas in mid 1990s, compared to the mid eighties. Private outpatient costs increased by 142% as against 77% in public sector in rural areas. In urban areas it is 150% compared to 124% in the public sector. The increase in costs in in-patient care is more striking: average costs have risen by 436% in rural areas and 320% in urban areas.⁷⁶ In any effort to improve public health in the country the emphasis should not only be on health determinants but also on the salient role of public spending. The reforms lack a health system perspective and instead comprise of an agglomeration of projects with a belief

that the market will cure the problems that ail the health system. Since 1990s the larger macro-economic changes have increased regional, rural-urban and class inequalities which have compounded the problem.⁷⁷

Table 4.13

India - Selected Health Indicators

Sl No.	Parameter	1981	1991	Current level
1	Crude Birth Rate(CBR) per 1000 population	33.9	29.5	23.5(2006)
2	Crude Death Rate(CDR) per 1000 population	12.5	9.8	7.5(2006)
3	Total Fertility Rate(TFR) (per women)	4.5	3.6	2.9(2005)
4	Maternal Mortality Rate(MMR) (per 100000 live Births)	NA	NA	301(2001-03)
5	Infant Mortality Rate(IMR) (Per 1000 live births)	110	80	57(2006)
6	Child (0-4) years Mortality Rate CMR (per 1000 children)	41.2	26.5	17.3(2005)
7	Life expectancy at birth	(1981-85)	(1989-93)	(2001-05)
	Male	55.4	59.0	62.3
	Female	55.7	59.7	63.9

NA: not available

Source: office of the Registrar General of India.

Health Status in West Bengal

The status of health in West Bengal is better than that of the national average by almost all indicators. The notable thing is that West Bengal can now be grouped with few relatively better performing states in terms of its some

vital statistics. For instance, according to the Sample Registration System (SRS) data, the state has the fourth lowest birth rate after Kerala, Punjab and Tamil Nadu, the lowest death rate (same as Kerala), and fourth lowest IMR after Kerala, Maharashtra and Tamil Nadu among the major Indian states. However, a few indicators also show less than average status. Special concern is about women's reproductive health problem, which seems to be higher (45.3%) in the state in comparison to the national average (39.2%).⁷⁸

TABLE 4.14

Health Outcomes: West Bengal and India

Source	Indicators	Year	West Bengal			India
			Rural	Urban	Total	
Sample Registration System	Birth Rate (per 1000 population)	2005	21.2	12.6	18.8	23.8
Sample Registration System	Death Rate (per 1000 population)	2005	6.3	6.6	6.4	7.6
NFHS-3 (2005-06)	Infant Mortality Rate (per 1000 live births)	2005	40	31	48	58
Sample Registration System	Neo-natal Mortality Rate (per 1000 live births)	2003	33	16	30	27
Sample Registration System	% of U-5 deaths to total deaths	2003	19.5	8.6	17	23.9
NFHS-3 (2005-06)	% of children aged 6-35 months with any anaemia	2005-2006	71.9	58.2	69.4	79.2
NFHS-3 (2005-06)	% of children under age 3 under weight	2005-2006	46.7	30.0	43.5	45.9
Sample Registration System	Total Fertility Rate (per 1000 women)	2005-2006	2.5	1.6	2.27	2.68
NFHS-3 (2005-06)	% of ever married men age 15-49 anaemic	2005-2006	35.4	26.9	33.1	24.3
NFHS-3 (2005-06)	% of ever married women age 15-49 anaemic	2005-2006	65.5	59.0	63.8	56.2
Sample Registration System	Maternal Mortality Rate (per 1,00,000 live births)	2001-2003	NA	NA	194	301
NFHS-2 (1998-99)	% of women reporting at least one reproductive health problem	1998-1999	-	-	45.3	39.2

Source : a) Sample Registration System; b) NFHS-3 (2005-06); c) NFHS -2(1998-99)

Table -4.15

Utilization of Selected Health Services in West Bengal

Health Service Indicator	Rural (%)	Urban (%)
Women who received antenatal care	55.8	87.3
Deliveries in medical facilities	33.8	79.2
Women who received Postnatal care	29.9	67.4
Children received all vaccinations	62.8	70.3
Women who use any modern contraceptive method	49.9	49.9
Children with diarrhea treated in a health facility	50.0	67.6

Source: National Family Health Survey (NFHS-3) West Bengal (2005-2006)

While overall health outcomes are quite impressive in the state the gap between rural and urban areas (regarding health outcomes) is also evident (Table - 4.14). The gap may be partially explained by the rural/urban inequalities in health service utilization. Though health service utilization in West Bengal is better than many other states, Table - 4.15 shows that significant problems exist especially in rural areas. For example, only a half of the diarrhea affected children were treated in rural areas in contrast to two-third of the same in urban areas. A little less than half of the pregnant women in rural areas received no antenatal care compared to only 13% of the urban women.⁷⁹

There is wide gap between rural and urban locations in respect of some health indicators in West Bengal like Birth Rate, Total Fertility Rate (TFR),

Neo-natal Mortality Rate (NNMR), Perinatal Mortality Rate (PMR) and Infant Mortality Rate (IMR). The following tables explain the fact (Tables 4.16, 4.17, 4.18, 4.19 and 4.20).

Table 4.16

Birth Rate for West Bengal

Year	Rural	Urban	Total
1991	30.3	18.5	27.0
1996	25.3	16.0	22.8
2001	22.9	13.8	20.6
2005	21.2	12.6	18.8

Source: Health on the March, Government of West Bengal : 2003-2004

Table 4.17

TFR of West Bengal

Year	Rural	Urban	Total
1994	3.4	2.0	3.0
1996	2.9	1.8	2.6
1998	2.7	1.7	2.4
2001	2.7	1.6	2.4

Source: Health on the March, Government of West Bengal : 2003-2004

Table 4.18

Neo-natal Mortality Rate of West Bengal

Year	Rural	Urban	Total
1994	42.3	28.8	39.8
1996	39	25	36
1998	33	21	30

2001	34	19	31
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Source: Health on the March, Government of West Bengal : 2003-2004

Table 4.19

Perinatal Mortality Rate of West Bengal

Year	Rural	Urban	Total
1994	42.6	39.4	42.0
1996	41	30	39
1998	33	21	30
2001	32	17	29

Source: Health on the March, Government of West Bengal : 2003-2004

Table 4.20

IMR of West Bengal

Year	Rural	Urban	Total	India
1991	76	47	71	80
1996	58	44	55	72
2001	54	37	51	66
2005 ^a	40	31	38	58

Source: Health on the March, West Bengal – 2003-2004, a: Sample Registration System

This wide gap in urban and rural areas in these indicators indicates that the health support in rural areas is inadequate than urban areas.

Since one of the basic parameters of assessing the health situation of any given population is the Infant Mortality Rate (IMR), a detail discussion on this variable is important. The IMR of West Bengal at 38 (2005) per

thousand is quite good by aggregate Indian standards (58) (2005) (Table - 4.20). In terms of reduction of IMR over time (table - 4.20) during 1991-1996, 1996-2001, 2001-2005 periods West Bengal's position is better than India as a whole which suggests a gradual improvement in health facilities over the years in the state.⁸⁰ The better performance of West Bengal with respect to the health of infants becomes evident when the aggregate reduction of the IMR is compared across West Bengal and India on the whole. The table - 4.21 shows, in the period 1994-96, the rate of reduction of the IMR in West Bengal was more than four times that of the national average. In 1996-98 the IMR for all of India was stagnant, showing no improvement at all whereas in West Bengal the IMR declined by 3.6% over this period.⁸¹ Although infant mortality is lower in West Bengal than in India as a whole, it is higher than 16 other Indian states like Goa (15), Kerala (15), Manipur (30), Tamil Nadu (30), Sikkim (34), Mizoram (34), Himachal Pradesh (36), Maharashtra (38), Nagaland (38), Delhi (40), Haryana (42), Punjab (42), Uttarakhand (42), Karnataka (43), Meghalaya (45), Jammu & Kashmir (45), West Bengal (48) [NFHS-III, India, 2005-06].⁸²

Table 4.21

Percent Reduction in IMR, India and West Bengal

	1994 - 1996	1996 - 1998
India	2.70 %	0
West Bengal	11.29 %	3.63 %

Source: West Bengal Human Development Report 2004

The district-wise pattern of IMR in the rural areas, for the period 1996-2000, according to Sample Registration Surveys conducted by the Census of India, is presented in table - 4.22.

Table 4.22

Rural IMR by District, 1996-2000 (number of infant deaths per 1000 live births) in West Bengal

District	IMR	District	IMR
Darjeeling	41	Jalpaiguri	54
Kochbihar	52	Uttar Dinajpur	65
Dakshin Dinajpur	74	Malda	61
Murshidabad	58	Birbhum	49
Bardhaman	57	Nadia	54
24 Parganas (North)	51	24 Parganas (South)	51
Hugli	24	Bankura	61
Purulia	74	Medinipur	49
Howrah	34		

Source : Office of the Director of Census Operations, West Bengal

There are very substantial variations in rural IMRs ranging from the low of 24 in Hoogli to the highest rate of 74 in Dakshin Dinajpur and Purulia, both of which are relatively badly served in terms of health infrastructure and transport networks.⁸³ According to NFHS-II report (1998-99) the Under-5 mortality rate in West Bengal is much better than the national average. The U-5 IMR is 67.6 of the former and 94.9 of the later. There is a striking inter-

district variation in infant and neonatal mortality (table - 4.23) as revealed from a recent survey (Study of Infant and Neo-natal Mortality in Six Selected Districts, Health and Family Welfare [HFW], 2003) of six districts of West Bengal. One district Purulia has an estimated IMR 73% above the state mean rate. Another district Jalpaiguri has an estimated neonatal mortality rate 133% higher than the state mean rate, comprising 85% of infant mortality in the district. ⁸⁴

Table 4.23

**Infant, Neonatal and Perinatal Mortality from
six Districts of West Bengal**

Districts	IMR*	NMR*	NMR as % IMR	PNMR**
Malda	50.7	36.6	72%	14.2
Dakshin Dinajpur	61.7	44.6	72%	17.1
Murshidabad	56.0	46.8	84%	9.2
Purulia	87.8	58.2	66%	29.6
Jalpaiguri	82.5	69.9	85%	12.5
Paschim Medinipur	41.2	32.6	79%	8.7
West Bengal	51	30	58%	-
India	68	45	66%	-

* Per 1000 live births ** Perinatal Mortality

Source: Health Strategy, Document-2, Department of Health and Family Welfare, Government of West Bengal.

The average level of nutrition in the state, and especially among women, is relatively low. However, malnutrition among children is lower than the national average. The nutritional status of children in the age group of under-3 years is better in West Bengal as compared to the all India average for weight for age (under nutrition) as well as height for age (Stunting) (table

4.24). By these criteria, West Bengal also has a lower percentage of severely malnourished children (16.3%) as compared to the Indian average of 18%. West Bengal ranks sixth among the major states in India.⁸⁵ Adults age 15-49 in West Bengal suffer from a dual burden of malnutrition, mostly under nutrition. More than one-third of adults are too thin (39% women) and 35% men). Under nutrition is particularly serious among the young (especially those in the age group 15-19 years), those with no education, those in the lower wealth sections and those belonging to the scheduled-tribes.⁸⁶

Table 4.24

**Nutritional Status of Children under 3 years of age
West Bengal and India**

Source Indicators Year	West Bengal			India		
	Rural	Urban	Total	Rural	Urban	Total
% of Children Stunted	35.4	22.7	42.0	40.7	31.1	38.4
% of Children Wasted	20.2	14.2	19.0	19.8	16.9	19.1
% of Children Underweight	46.7	30.0	43.5	49	36.4	46

Note: Stunted – Too short of age ; Wasted – Too thin for height; Underweight – Too thin for age

Source: NFHS – III (2005-06) Ministry of Health & Family Welfare, Govt. of India.

NFHS – III (2005-06) Provisional Data (Fact Sheet)

The overall anaemia status of children in West Bengal is very poor as the state ranks as 19th among 25 states. The proportion of children with anaemia (78%) is higher compared to national average of 74%.⁸⁷ The situation is worse in the rural areas where as many as 82% children are estimated to have anaemia compared to a rate of 64% in urban West Bengal.⁸⁸ Severe anaemia is also higher in rural West Bengal, at 5.3% compared to 4.6% in the urban areas. Such nutritional deficiencies among children have negative effects in their future health and capability patterns.⁸⁹ Among children between the ages of 6 and 59 months, a majority, 61% are anaemic. This includes 30% who are mildly anaemic, 29% who are moderately anaemic,

and 2% who suffer from severe anaemia. Girls in West Bengal are slightly more anaemic than boys, In West Bengal the highest anaemia rates are found among ST children 86%.⁹⁰ The nutritional status of women in West Bengal is a great concern, because it is significantly worse than the national average. In a survey conducted by the National Nutrition Monitoring Bureau (NNMB), West Bengal ranked eighth among 9 states in important variables such as chronic energy deficiency among women. In terms of the Body Mass Index (BMI) the state ranks as low as twenty fourth among 25 states of NFHS-II survey. In case of anaemia West Bengal ranks as low as 19th in the NFHS-II survey. (NFHS-II,1998) Rural women are to be worse off in terms of anaemia. The rates of anaemia tend to be quite high all through life for girls and women in West Bengal. The highest rates of anaemia tend to be found among women in the age groups 12-19 years and 19-49 years.⁹¹ Therefore, anaemia is a critical problem for the state. Because anaemia can result in maternal mortality, weakness, diminished physical and mental capacity, increased morbidity from infectious diseases, perinatal mortality, premature delivery, low birth weight. About two-thirds (63%) of women in West Bengal have anaemia, including 46% with mild anaemia, 16% with moderate anaemia, & 1% with severe anaemia. 63% of women who are pregnant and 71% of women who are breast feeding are anaemic compared with 61% of women who are neither pregnant nor breast feeding. The likelihood of anaemia is much higher among ST women 78%, than all other groups of women.⁹²

Development of Health Sector in West Bengal

The Government of West Bengal though has always accorded high importance to the health sector and successfully implemented several health initiatives in the state, the efforts of the state in the health sector have not always been adequately coordinated and converged to improve basic health

care services for the growing population, especially the poorest and those in greatest need. There are still significant inter-district and rural-urban differences in the health status of the people. The health indices have also not been uniform for SC / ST and other backward groups of population.

Table 4.25

Medical Institutions and Health Centres of West Bengal

2001-02 (Provisional)				Nos.	Beds
Hospitals (Govt. / Local bodies / Voluntary Organizations)				429	58,721
Health Centres :				1267	12,353
Rural Hospitals (RH)		95	3538		
Block Primary Health Centre (BPHC)		252	3507		
Primary Health Centre		920	5284		
Sub Centres :				8126	
Hilly Area		115			
Tribal Area		303			
Backward Area		711			
General		6997			
Total Health Units				9822	71,074

Source : State Bureau of Health Intelligence Directorate of Health Services, 2001-02, Government of West Bengal and Economic Review, Government of West Bengal and Economic Review, Govt. of West Bengal, 2002-03.

* Rural Hospital in West Bengal is equivalent term for community Health Centre.

The state of West Bengal has a fairly large health infrastructure, comprising of 429 medical hospitals (allopathy) with 58,721 beds, and 1,267 health centres (RH/BPHC/PHC/SC) with 12,353 beds.⁹³ Table -4.25

However, the development of infrastructure over the last two decades has been minimal. The state added only 31 hospitals taking the total from 398 in 1980 to 429 by the end of 2001-02. Similarly, population served per bed increased from 936 in 1987 to 1136 in 2001-02 representing a meager compound annual growth rate (CAGR) of 2.7%. Besides slow pace of capacity addition, there exists striking rural-urban disparity in accessibility to modern health care services in the state. Although the rural population accounts for 72% of total population, out of 429 hospitals in the state only 107 hospitals, or about one-fourth of the total, are located in rural areas. Rural share in total number of hospital beds is still lower – around 11%.⁹⁴

The real backbone of basic health care services is the rural health centres, namely sub-centres (SC), primary health centres (PHC), block primary health care centres (BPHC), and rural hospitals (RH). These institutions are designed to deliver a wide range of health and family welfare services. Recognising the importance of primary centres in improving rural access to health and family welfare services, the Planning Commission, Government of India (GOI) had laid down norms for establishment of primary health care institutions. The Planning Commission has also set goals for infrastructure development for each state, including West Bengal to meet the primary health care needs of the 1991 population as per the norms. It may be noted that even after meeting the goals set by the Planning Commission, the state would have significant gap in primary health infrastructure. (Table 4.26)

Table 4.26

Gap in Primary Health Centres in West Bengal

Institutions	Required as per 1991 Census	In Place	Tenth Plan Goal
Sub-Centre	13616	8126	2230
PHC	2269	920	464
BPHC	567	252	332
Total	20970	9392	3026

Source : Health Strategy Document : 4 Integrated Financial and Economic Plan for the Health Sector (Department of Health and Family Welfare, Government of West Bengal (2003).

Family Welfare Set-up

Family welfare is a centrally sponsored programmes partly implemented through state health infrastructure and partly through the infrastructure created by the Department of Family Welfare (DFW), GoI. The objectives of family welfare programme are to ensure the overall health of mother and child, to offer birth control, safe maternity and child health services. West Bengal has made significant progress in family welfare services. NFHS-III Survey (2005-06) results point out that 71% of women in the reproductive

age group in the state are using contraceptive methods. The performance of routine immunization has also improved from 67% coverage to 73% as assessed by an independent study.⁹⁵ There has been a basic change in the strategy of implementation of family welfare programme in the state. It now includes a range of family planning, maternity and child health services all of which have been brought under the reproductive and child health programme (RCH). Some special projects on RCH programme like referral transport, dai training, RCH outreach, RCH camps etc. are being implemented in some of the districts of West Bengal to implement family welfare programmes, West Bengal has developed service units that include: 19 district welfare bureau; 78 government and 2 voluntary post-partum centres (PPCs), 64 urban family welfare centres (UFWCs); and 335 rural family welfare centres (RFWCs).⁹⁶ The state has now taken up special programmes and projects to upgrade the existing facilities. The rapid growth of the private health care services in India happened between 1970 and 1990. The private health sector's mainstay is curative care. Various studies show that the private health sector accounts for over 70% of all primary care treatment sought, and over 50%, of all hospital care. Besides, qualified and registered private sector doctors or private sector institutions are not readily available in remote rural tribal areas because people do not have ability to pay and there is lack of social infrastructure. West Bengal shows all these national trends at a varied degree.⁹⁷

According to a study, private expenditure accounts for the vast majority of health spending in West Bengal, estimated to be over 75%. Outpatient care is generally provided by private sector whilst the public sector plays a more significant role in terms of delivering inpatient care. The reliance on private providers occurs despite the fact that the cost of accessing the private sector are roughly 50% higher than the public sector and much

higher in urban than rural areas.⁹⁸ As a policy Government of West Bengal intends to develop public – private partnership in health sector. In fact it is now collaborating with private sector in the provision of health care services by participating in joint ventures like Advanced Medical and Research Centre (Kolkata), Rabindra Nath Tagore Heart Institute (Kolkata), private CT Scan facilities (NRS, CNMC, BSMC, KMC, R.G. Kar Medical College etc.), a MRI facility in Medical College (Kolkata), state of the art pathological and diagnostic centre in one of the medical colleges, fair price drug and accessories in Government Hospitals and private facilities for health care waste management. The state has also initiated two pilot projects of tele-cardiology in Bankura and Siliguri.⁹⁹ This public-private partnership is basically for curative care services. In West Bengal, NGOs are actively involved in many health and family welfare services. For instance, in public health programme like blindness control, NGOs contribute more than 80% of the cataract operations. Another recent example of NGO involvement is the Sundarbans mobile health care service (MHCS) under SHSDP-II (State Health Systems Development) project. MHCS is designed to provide medical services by organizing mobile clinics in 382 remote villages of Sundarbans. For this work the state has engaged reputed NGOs like SHIS, SRKA, TSRD, BSS and SVGSS.¹⁰⁰

Unlike health services planning, health manpower planning has not received adequate attention in West Bengal like many other states in India. There has been meagre strengthening of availability of doctors over the last two decades. However, the population served per doctor has decreased from 2236 in 1981 to 2041 in 2001. But there has been a wide disparity in availability of doctors to rural and urban population. Urban population served per doctor was 830 in 2001 (808 in 1983) as against the rural population of 4727 per doctor (5386 in 1983). The rural population served

per doctor has declined by 12.2%, while urban population served per doctor has marginally gone up from 1983 level. The improved availability of doctors in rural areas is a welcoming trend and needs to be strengthened.¹⁰¹ Lack of health manpower in the primary health care institutions is evident from the fact that wide gap exists between required number of personnel and sanctioned post as well as sanctioned posts personnel in position.

Government of West Bengal has taken several initiatives for health sector reforms. The most important of the reform agenda initiated by the Government is the policy decision to decentralize health sector governance through involvement of Panchayati Raj Institutions (PRI) in planning, implementing, monitoring and evaluating health, family welfare, nutrition and sanitation services in rural areas. In doing so, the Government has recognized the importance of vesting people's health in people's hand. In keeping with the decentralisation policy, all the societies/committee in each district, dealing with different health programmes, have been abolished. Government of West Bengal has now brought all health care activities in each district under one umbrella by establishing only one registered body, namely, District Health and Family Welfare Samiti. In order to enable the field functionaries to discharge their duties efficiently and effectively the district samitis are vested wide administrative and financial powers. In addition to district level samitis, Government of West Bengal has constituted Block Health and Family Welfare Samitis. These samitis follow the same pattern as district samitis with the only variation that they involve the members and functionaries of gram panchayats (GPs) and gram sansads (GSs). It is expected that members and functionaries of GP/GS would play an important role in bottom up micro planning for basic health programmes and services.¹⁰² The Tenth Five Year Plan, Govt. of India identifies mismatch between personnel and infrastructure as one of the major factors

responsible for the poor functional status of the health care system at all levels for improving the efficiency in health services. In line with this, West Bengal Government has already initiated steps for restructuring primary health centres including relocation and strengthening of manpower. Significant emphasis has been laid on strengthening of sub-centres and PHCs. Government intends to upgrade PHCs into BPHCs and all BPHCs into rural hospital.¹⁰³

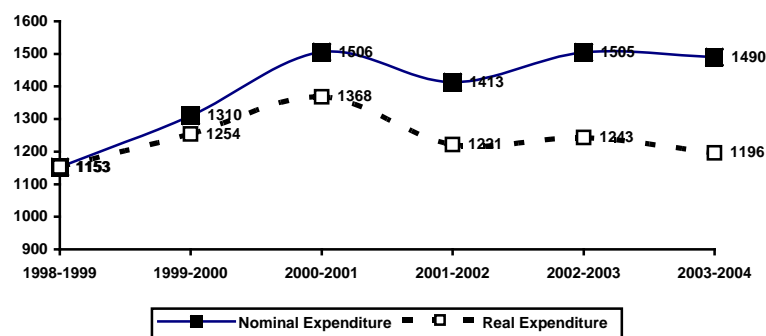
Another notable initiative has been the renewed emphasis on user charges. The user charges are revised, streamlined and introduced in all hospitals including rural hospitals since Nov. 2001. At present 50% of incremental charges are earmarked for plough back to the hospitals, with the exception of rural hospitals. So far, the mechanism for user fee collection and ploughing back to revenue to the hospitals has not yet been effectively implemented. Revenue generation from hospital fees and pay-clinics has hardly improved.¹⁰⁴ Government of West Bengal has recently developed an essential service package (ESP) and published a list of essential drugs and equipments necessary to improve quality of basic health care services at primary health centres. ESP is intended to facilitate sector-wise planning for decentralized health services and optimal use of resources. It would build on the existing Government programmes and schemes and support shifting focus on health planning from infrastructure to services. The government intends to implement ESP in a phased manner and for that seeks financial assistance from donor partners.¹⁰⁵

Budgetary Allocation and Expenditure in Health in West Bengal

There has been a persistent deterioration in budgetary balances and macro economic stability of the state finances in West Bengal. The increasing fiscal pressure on the state is quite evident in the fact that the contribution of Revenue Deficit in Gross Fiscal Deficit is higher in West Bengal than

anywhere else in the Country (RBI, 2006).¹⁰⁶ High and increasing level of Revenue Deficit indicates a growing burden of non-plan expenditure in a constrained revenue-generating environment. Fallout of severe fiscal strain has led to declining share of social sector spend including health sector, in the total budget expenditure. In terms of statistics, the social sector share has declined by about 6% point, from 38% in 1999-2000 to 24% in 2003-04.¹⁰⁷ The state has drawn up a mid term fiscal reforms programme (MFRP) which aims at imposing restraint on budget expenditure. Therefore, it is a matter of great concern how the state would allocate adequate funds to achieve its health mission and strategic goals. The impact of resource constraints is already visible in the recent trends in health financing. Health financing impacts in two ways 1) on the supply side by ensuring that essential services are adequately financed and delivered; and 2) on the demand side by reducing financial barriers to accessibility of health care services by all people, including poor and unreached groups.¹⁰⁸ In real term, health spend of Government. of West Bengal has grown at a negligible rate of 0.7% since 1998-99. In fact, the budget expenditures, both in nominal and real terms, has come down significantly since 2000-01. The following figure explains the fact.¹⁰⁹ (Figure – 2)

Figure-4.2 : Nominal and Real Health Budget Spends



Source : DHFW, Government of West Bengal, Document – 4

Over the years, the share of health expenditure in the overall state budget has consistently declined from 6% in 1999-2000 to 4.2% in the fiscal year 2003-04. This share of health sector is well below the financial goals set by in the National Health Policy (2002). In NHP (2002) the share of health spends must attain 7% by 2005 and 8% by 2010. The state's budget outlay of Rs.1490 crores in 2003-04 for health and family welfare services accounts a negligible share of 0.87% of GSDP.¹¹⁰

Along with the decline in health budget spends, the share of primary sector has also come down from 36% in 1999-2000 to 35% as per the budget estimate of the fiscal year 2003-04 – a clear decline by 1% point (Table 4.27). In contrast, budget allocation to secondary and tertiary health services has increased by 2% point, from 42% in 1999-2000 to 44% in the fiscal year 2003-04. Thus, the health spend in the state shows inefficient sector allocation with the result that share of resources going to primary sector remains far below the NHP (2002) target of 55%.¹¹¹ (Table -. 4.27)

Table 4.27
Sector-wise Health Budget Allocation in West Bengal

	1999-00 (Actual) Rs. (Crores)	2000-01 (Actual) Rs. (Crores)	2001-02 (Actual) Rs. (Crore)	2002-03 (RE) Rs. (Crore)	2003-04 (BE) Rs. (Crores)
A. Revenue Expenditure	1227.49	1376.62	1322.78	1414.97	1413.90
Primary Health Services Share in Total Expenditure	473.40 36%	524.12 35%	480.98 34%	551.59 37%	524.24 35%
Secondary/Tertiary Health Services Share in Total Expenditure	553.23 42%	610.06 41%	624.13 44%	619.95 41%	648.24 44%
Medical Education Training and Research Share in Total Expenditure	90.70 7%	109.36 7%	107.14 8%	120.84 8%	113.22 8%
Direction and Administration/Medical Stores Depot/Health Statistic and Evaluation Share in Total Expenditure	110.16 8%	133.09 9%	110.53 8%	122.58 8%	128.20 9%
B. Capital Expenditure Share in Total Expenditure	82.70 6%	129.38 9%	90.43 8%	90.26 6%	76.53 5%
Total Expenditure A+B	1310.19	1505.99	1413.21	1505.22	1490.43

RE: Revised Estimate BE : Budget Estimate

Source: DHFW, Govt. of West Bengal Health Strategy document – 4.

The share of medical services, public health and family welfare in total health spends (revenue expenditure) have remained more or less stagnant at 78%, 10% and 12% respectively over the period 1998-99 to 2002-03. In absolute terms, budgeted revenue expenditure of Rs.1337 crores for fiscal year 2003-04 is being split among three service categories – Rs.1081 crores for medical services, as 145 crores for public health and Rs.111 crores for family welfare. The large part of expenditure for medical services (mostly curative health care) is attributable to allopathy system of medicine (96%). In terms of urban-rural divide, allocation is skewed in favour of urban medical services.¹¹² For the fiscal year (2003-04) the bulk of revenue expenditure under public health represents (a) administrative overheads (17%), largely the pay component and (b) spends on prevention and control of diseases (71%), once again mainly the salary bills. The budget allocations for individual activities like drug control (5%), prevention of food adulteration (0.7%), etc. are very low.¹¹³ Inefficiency in budget allocation is also evident from rural-urban disparity in spending on medical care services (allopathy). On the average, the rural share in expenditure on medical Services (allopathy), which mostly stand for curative care, is only 22%. Such allocation of public resources does not appear to be equitable, given the fact that 72% of population and majority of those below poverty live (BPL) in rural areas.¹¹⁴

Women as the most Vulnerable Group in Health Sector

In the national context, there is wide disparity in the health status of Indian population within the states. Among the districts of the states there is also wide variation in the health indicators of the people. The negative impact of this disparity is mostly suffered by the large portion of the rural poor. Among the rural poor women are the most vulnerable groups that face

greatest health problems. “Like any other field of social development, women’s status in the field of health is characterized by inequality based on gender. In the Indian situation gender-based inequality is further aggravated when associated with the factors like poverty, illiteracy, rural background, lower caste, widowhood, desertion, disability, single marital status or childlessness.”¹¹⁵ The burden of disease and deprivation that Indian women bear, particularly in poor areas and in poor income brackets, is much heavier than that of their male counterparts. In Indian society women are denied the rights and privileges afforded to their male counterparts both within and outside the domestic spheres. Throughout their lives, women endure discrimination based on gender. They also suffer greatly from a lack of access to health care not only on an absolute lack of health facilities, particularly in rural areas but also on the relative inaccessibility of such facilities to them. The linkage of women’s lower educational, health and employment status and their participation in political and economic life to their overall low status in society, thus highlights the vicious cycle that perpetuates women’s deprivation through out their life time.

The average sex ratio (the number of females per 1000 males) is 990 in today’s world. Western Europe has a figure of 1064 females per 1000 males and Africa has a ratio of 1015 females. The overall female to male ratio in Asia is 953, but India, along with a number of her close neighbours, is associated with highly negative sex ratios. In India the sex ratio has experienced a steady decline over the years.¹¹⁶ The child sex ratio (CSR) is also declining which is a matter of great concern.

In West Bengal the sex ratio and CSR is declining over the years but the sex ratio is marginally high than the national average. The declining sex ratio explains the severe vulnerability of women in our society. Women’s risk of premature death and disability is greatest during their reproductive

years. Many conditions that occur in this period affect the health of women long after their reproductive years are over and the health of their children as well.

Table 4.28

Sex Ratio (Females per 1000 Males) of Total Population and Population aged 0-6 years, 1961-2001 in India and West Bengal

Year	Sex ratio in India *		Sex ratio in West Bengal	
	Of Total Population	Of Population 0-6 Years	Of Total Population	Of Population 0-6 Years
1961	941	976	878	1008
1971	930	964	891	1010
1981	934	962	911	981
1991	927	945	917	967
2001	933	927	934	963

* Excludes Assam and Jammu & Kashmir

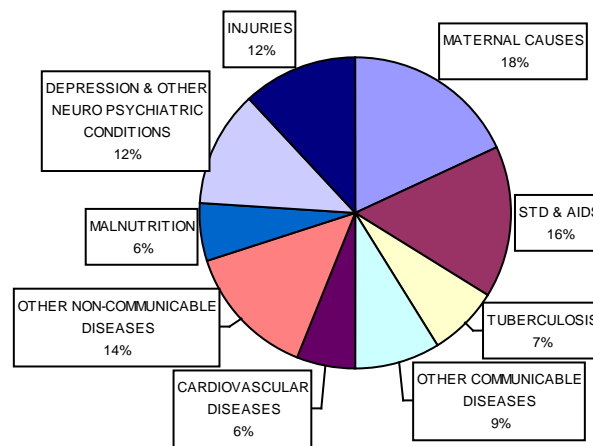
Source: Health on the March, West Bengal, 2002-03, State Bureau of Health Intelligence, Directorate of Health Services, Govt. of West Bengal.

Of the many health indicators by which developed and developing countries can be compared, Maternal Mortality shows the greatest disparity. Every year over half a million women, (99% from poor countries, 20% in India) die as a result of common complications of pregnancy and child birth.¹¹⁷ Poor maternal health also affects a newborn's chance of survival and a mother's death can have a catastrophic affect on family livelihoods.

Maternal death and morbidity make a major contribution to poverty and poor human development.

Maternal mortality ratio is the most sensitive health indicator. Its reduction by three quarters by 2015 is a central Millennium Development Goal no. 5. Complications of pregnancy and child birth are believed to be the leading cause of death among women in most parts of South Asia.¹¹⁸

Figure-4.3: Burden of Disease in Females aged 15-44 in Developing Countries



The trends and levels of male-female ratio in India's population are unfavourable. Higher risks of mortality and the poorer health conditions are important problems that women face. High mortality rates among women are revealed by maternal deaths due to sepsis, anaemia, fomenia, haemorrhage and abortions, indicate that women's health in general and reproductive health in particular remain largely neglected. A significant proportion of such deaths among women are the combined effects of poor health, poor nutrition, and a prolonged and closely spaced period of fertility stretching

from adolescence to menopause. Poor nutrition of girls especially in childhood and adolescence has serious consequences. It is not just early marriages and adolescent child bearing that leads to this situation but the low levels of health service utilization, the poor quality of healthcare received during pregnancy and lack of awareness generation are also responsible for both the high level of neonatal mortality and maternal mortality.

More access to health care is much more important aspect than the focus on the supply of health-related goods and services. The integration of women and women's health into the mainstream of the development process is important necessity.

Table 4.29

Maternal Mortality Ratio – India and Major States

India and Major States	MMR 1998	Per 1,00,000 live births	
		MMR 2001-03	Eleventh Five Year Plan Goal
India	407	301	100
Assam	409	490	163
Bihar / Jharkhand	452	371	123
MP / Chhattisgarh	498	379	126
Orissa	367	358	119
Rajasthan	670	445	148
UP / Uttarakhand	707	517	172
Andhra Pradesh	159	195	65
Karnataka	195	228	76
Kerala	198	110	37
Tamil Nadu	79	134	45
Gujarat	28	172	57
Haryana	103	162	54
Maharashtra	135	149	50

Punjab	199	178	59
West Bengal	266	194	64

Source : Special Survey of Deaths, RGI (2006) in Eleventh Five Year Plan, Government of India 2007-2012, Planning Commission, New Delhi.

The key elements of the elaborate reproductive and child health care system that has been set up in the country over the last few decades, so far as pregnant women and mothers of newborn children are concerned, are as follows:

- Provision of antenatal care (ANC), including at least three ANC checkups, iron prophylaxis for pregnant women and lactating mothers, two doses of tetanus toxoid vaccine, detection and treatment of anaemia and management and referral of high pregnancies.
- Encouragement of institutional delivery or home delivery assisted by trained health personnel.
- Provision of postnatal care, including at least three visits.¹¹⁹

With respect to these cares where do women in West Bengal stand?

The Table - 4.30 shows that 91.9% pregnant women receive at least one ANC check up which is much better than the all-India average (76.4%). When it comes to all three check ups 62% women in the state are covered. Though it is above the national coverage but West Bengal is behind 13 states in this respect. In case of all the recommended ANCs West Bengal is behind 15 states with only 12.3% women being fully covered (Table - 4.34). Table -

4.31 provides data based on the RCH survey. The RCH Survey indicated that over 84% pregnant women in West Bengal received ‘any’ ANC (India 65.3%). While this is impressive, only one in three pregnant women in West Bengal (33.4%) received full ANC and the state was behind 6 major states. In certain specific parameters, like receiving ANC in the first trimester, abdominal check ups and IFA tablets, West Bengal’s progress was poor and the state was behind 8 to 10 states.¹²⁰

Despite the network of sub-centres and PHCs in the state, among these women who received any ANC service, only 18.2% received home visits from health workers in West Bengal (table - 4.32). This is below the national average (22.0%) and at least of the 15 major states are doing better than West Bengal in home visits. But there is an other side of the picture. Table - 4.32 also shows that in West Bengal, 49.3% of these women who had any ANC went to government facilities to avail of the services. The state ranks number one among the major states of the country in this respect. The

Table No. 4.30**Antenatal care indicators by state**

Among women with a live birth in the five years preceding the survey, percentage who received different types of antenatal care (ANC) during the pregnancy for their most recent live birth by state, India, 2005-06									
State	Percentage who had at least one ANC visit	Percentage who had three or more ANC visits	Percentage with an ANC visit in the first trimester of pregnancy	Percentage who received information about specific pregnancy complications ¹	Percentage who received two or more TT injections during the pregnancy	Percentage who received one TT injection during the pregnancy and at least one more in the three years prior to the pregnancy	Percentage given or bought IFA	Percentage who took IFA for at least 90 days	Percentage who took an intestinal parasite drug
India	76.4	52.0	43.9	36.0	76.3	1.5	65.1	23.1	3.8
North									
Delhi	88.8	75.1	63.8	72.4	90.3	0.5	77.6	39.5	5.9
Haryana	88.3	59.2	51.4	41.1	83.4	0.7	61.3	26.7	1.1
Himachal Pradesh	86.4	62.6	56.8	64.3	72.1	5.3	84.2	37.9	2.8
Jammu & Kashmir	88.9	74.8	60.4	31.0	81.0	1.4	67.6	27.6	1.6
Punjab	74.9	41.2	34.0	63.6	83.8	0.6	65.5	27.9	2.5
Rajasthan	69.4	44.9	43.3	29.3	65.2	1.7	57.7	13.1	1.4
Uttaranchal				38.2	68.5	1.7	62.6	26.4	2.5
Central									
Chhatisgarh	88.5	54.2	46.0	38.3	74.6	2.7	74.6	20.7	1.1
Madhya Pradesh	79.5	40.7	39.3	34.3	70.6	3.2	62.8	12.4	3.2
Uttar Pradesh	66.0	26.6	25.7	14.2	64.5	1.4	53.2	8.8	2.1
East									
Bihar	34.1	17.0	18.7	15.8	73.2	1.3	29.7	9.7	3.7
Jharkhand	58.9	35.9	33.2	23.4	67.6	1.3	49.5	14.2	4.9
Orissa	86.9	61.8	48.3	37.6	83.3	0.1	83.1	33.8	4.3
West Bengal	91.9	62.0	38.6	40.8	90.9	1.4	81.9	25.7	4.4
Northeast									
Arunachal Pradesh	52.6	35.5	24.2	32.3	40.1	0.5	47.7	11.2	4.0
Assam	70.7	39.3	40.0	20.8	65.4	1.4	62.1	16.2	2.4
Manipur	86.3	68.6	64.5	38.6	79.2	2.3	65.2	13.1	2.8
Meghalaya	67.6	54.0	32.6	28.1	51.8	1.6	54.7	16.7	2.7
Mizoram	74.3	59.3	42.9	51.4	51.4	10.9	61.9	24.7	4.0
Nagaland	57.8	32.7	29.2	24.5	50.7	1.7	25.6	3.5	1.4
Sikkim	89.3	70.1	57.9	70.9	81.1	2.2	86.4	38.7	2.3
Tripura	78.3	60.0	47.2	42.9	74.9	0.3	68.8	18.0	4.1
West									
Goa	97.3	94.9	85.7	60.1	86.8	1.2	87.4	68.6	10.1
Gujarat	86.7	67.5	55.0	59.4	80.4	1.8	82.4	37.0	7.1
Maharashtra	90.8	75.1	62.1	46.2	85.1	1.7	80.9	31.4	3.7
South									
Andhra Pradesh	94.3	85.4	66.1	49.9	85.3	0.4	76.6	41.2	4.6
Karnataka	89.3	79.5	70.9	47.6	78.6	0.9	74.3	39.3	6.8
Kerala	94.4	93.6	91.9	72.9	88.7	1.9	96.4	75.1	10.1
Tamil Nadu	98.6	95.9	75.3	84.4	95.9	2.0	91.9	41.6	6.5

TT = Tetanus toxoid; IFA = Iron and folic acid tablets or syrup. ¹ Vaginal bleeding, convulsions,

prolonged labour, or where to go if she had pregnancy complications.

Source : NFHS – III, 2005-2006, Govt. of India

Table 4.31**Type of Antenatal Care (ANC) for Women in India and 15 States**
(Per Cent)

	ANC provided						Check up						Treatment given					
	Any		In first trimester		3 + visits		Weight Taken		Measured		Abdominal Check up		IFA Tablets		At least 1 TT injection		Full ANC	
	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
Andhra Pradesh	94.2	3	56.1	4	87.5	3	81.9	3	84.2	3	85.9	3	72.9	4	89.9	3	63.4	3
Assam	56.0	12	28.2	10	29.2	11	28.4	9	38.9	9	52.5	8	57.7	8	68.3	12	24.8	10
Bihar	29.7	15	14.4	15	17.1	15	11.8	14	16.2	13	25.4	15	16.9	15	64.6	13	10.1	15
Gujarat	79.1	8	36.5	6	55.0	8	40.7	7	43.4	8	53.0	7	68.1	6	77.9	10	42.7	6
Haryana	77.7	9	31.8	8	41.3	10	27.5	10	30.6	10	50.1	9	48.7	10	81.0	8	23.9	11
Karnataka	88.9	4	59.5	2	78.0	4	54.3	5	67.1	4	82.4	4	72.6	5	83.0	7	60.1	4
Kerala	99.3	1	83.2	1	98.3	1	83.0	2	96.0	1	87.8	2	90.0	1	95.7	2	86.1	1
Madhya Pradesh	52.4	13	18.5	13	28.0	13	17.8	12	19.9	12	40.1	12	45.3	11	69.8	11	20.2	12
Maharashtra	87.6	5	41.0	5	65.8	5	66.0	4	65.5	5	79.7	5	76.8	3	89.5	4	54.8	5
Orissa	72.9	10	28.8	9	43.7	9	27.3	11	28.6	11	43.8	11	60.8	7	79.7	9	32.5	8
Punjab	87.2	6	32.4	7	56.4	6	33.9	8	47.4	7	64.9	6	42.7	12	88.5	5	25.4	9
Rajasthan	62.3	11	19.9	12	28.3	12	13.2	13	19.9	12	33.5	13	34.5	13	62.0	14	16.6	13
Tamil-Nadu	98.4	2	56.2	3	94.2	2	89.2	1	87.5	2	89.3	1	79.1	2	98.0	1	75.3	2
Uttar Pradesh	46.8	14	14.6	14	19.6	14	8.0	15	10.0	14	25.7	14	27.7	14	60.5	15	11.2	14
West Bengal	84.1	7	27.5	11	55.4	7	46.8	6	47.9	6	48.9	10	54.7	9	86.4	6	33.4	7
India	65.3		29.7		44.2		34.5		38.2		49.4		48.7	10	74.7		31.8	

Source : RCH-RHS, 2001, Table 3.4, p. 32

Source : The Changing Status of Women in West Bengal 1990-2000 : The challenge ahead by J. Bagchi (ed). 2005, sage.

national average is 31.6%. Another way of interpreting the data is that West Bengal ranks highest among the 15 states in respect of women being conscious (and free) enough to go out of their homes to avail of health services during pregnancy.¹²¹

Table 4.32

Percentage of Women who Received any Ante-natal Care (ANC) by Source in India and 15 States

	Percentage of Women who had any ANC		Source of ANC					
			At Home from Health Worker		In Govt. health facility		In private health facility	
	%	Rank	%	Rank	%	Rank	%	Rank
Andhra Pradesh	94.20	2	48.00	2	34.70	11	55.80	3
Assam	56.00	12	10.30	12	40.80	7	12.90	10
Bihar	29.70	15	4.60	15	7.10	15	19.30	9
Gujarat	79.10	8	34.10	5	23.90	13	37.90	5
Haryana	77.70	9	5.70	14	39.50	9	22.90	8
Karnataka	88.90	4	40.00	3	41.90	5	41.10	4
Kerala	99.30	1	39.30	4	35.80	10	65.60	1
Madhya Pradesh	52.40	13	22.00	9	25.30	12	12.90	10
Maharashtra	87.60	5	31.90	7	41.20	6	37.90	5
Orissa	72.90	10	33.40	6	43.30	4	12.10	12
Punjab	87.20	6	6.70	13	47.80	2	37.20	6
Rajasthan	52.30	11	23.50	8	39.90	8	8.80	13
Tamil-Nadu	98.40	2	48.40	1	43.80	3	59.70	2
Uttar Pradesh	46.80	14	13.60	11	23.60	14	12.80	11
West Bengal	84.10	7	18.20	10	49.30	1	34.90	7
India	65.30		22.00		31.60		26.20	

Source: RCH-RHS, Table 3.2, Source: *ibid.*

Institutional delivery is considered safer compared to home delivery and the government policy is to encourage it. Table-4.34 shows that women in West Bengal are behind 15 States in institutional delivery.

Table 4.33**Pregnancy, Delivery and Post Delivery Complications in India and 15 States (percent)**

Percentage of Women										
	Who had pregnancy complication during pregnancy		Who had delivery complication		Who had post delivery complication		Who sought treatment for pregnancy complication		Who sought treatment for post delivery complication	
	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
Andhra Pradesh	41.3	15	31.4	7	24.5	14	70.2	6	69.1	6
Assam	60.5	10	66.2	3	39.9	8	38.6	13	38.9	13
Bihar	76.4	2	73.4	2	64.2	1	31.5	15	29.0	15
Gujarat	66.5	7	76.0	1	49.7	5	59.8	7	51.2	7
Haryana	49.1	13	14.4	15	22.5	15	53.7	9	58.0	9
Karnataka	43.4	14	21.6	11	28.4	12	72.9	4	71.3	4
Kerala	80.4	1	28.8	8	28.2	13	86.3	1	80.8	1
Madhya Pradesh	62.9	8	45.5	5	46.7	6	39.2	12	33.5	12
Maharashtra	69.1	6	56.0	4	54.6	4	71.1	5	64.9	5
Orissa	72.8	4	35.1	6	62.9	2	41.5	11	25.7	11
Punjab	59.3	11	20.0	12	29.5	11	75.7	2	48.9	2
Rajasthan	57.1	12	19.0	13	30.9	10	42.0	10	56.4	10
Tamil-Nadu	69.5	5	27.6	9	36.9	9	73.8	3	41.4	3
Uttar Pradesh	62.0	9	17.8	14	41.3	7	37.1	14	48.4	14
West Bengal	74.3	3	25.3	10	59.2	3	56.3	8	46.2	8
India	63.6		37.0		44.4		46.7		46.6	

Note: * % refers to those who had complications.

Source: RCH-RHS, Table 3.12

Source: The changing status of Women in West Bengal 1970-2000 : The challenge Ahead ed. by J. Bagchi (2005) (Sage)

Table 4.34**Maternal Care Indicators by State Maternal Care Indicators for Births during the Five Years Preceding the Survey by State, India, 2005-06**

State	Percentage who received all recommended types of antenatal care ¹	Percentage of births delivered in a health facility	Percentage of deliveries assisted by health personnel ²	Percentage of deliveries with a postnatal check-up ³	Percentage of deliveries with a postnatal check-up within two days of birth ³
India	15.0	38.7	46.6	41.2	37.3
North					
Delhi	29.0	58.9	64.1	60.9	58.4
Haryana	14.7	35.7	48.9	57.6	55.9
Himachal Pradesh	17.4	43.0	47.8	50.6	43.2
Jammu & Kashmir	17.5	50.2	56.5	51.6	48.4
Punjab	19.6	51.3	68.2	63.7	62.0
Rajasthan	8.6	29.6	41.0	31.8	28.9
Uttaranchal	16.1	32.6	38.5	35.8	32.4
Central					
Chhatisgarh	11.3	14.3	41.6	36.5	28.4
Madhya Pradesh	7.2	26.2	32.7	33.8	28.5
Uttar Pradesh	4.1	20.6	27.2	14.9	13.3
East					
Bihar	5.8	19.9	29.3	17.8	15.9
Jharkhand	7.5	18.3	27.8	19.6	17.0
Orissa	18.4	35.6	44.0	40.9	33.3
West Bengal	12.3	42.0	47.6	44.3	40.7
Northeast					
Arunachal Pradesh	6.5	28.5	30.2	23.7	22.7
Assam	9.6	22.4	31.0	15.9	13.9
Manipur	10.5	45.9	59.0	50.1	46.4
Meghalaya	8.1	29.0	31.1	33.2	28.8
Mizoram	8.7	59.8	65.4	53.5	50.6
Nagaland	1.9	11.6	24.7	11.8	10.6
Sikkim	27.2	47.2	53.7	52.4	44.9
Tripura	10.6	46.9	48.8	33.7	30.3
West					
Goa	55.7	92.3	94.0	82.8	75.5
Gujarat	25.6	52.7	63.0	61.4	56.5
Maharashtra	21.6	64.6	68.7	64.0	58.7
South					
Andhra Pradesh	28.2	64.4	74.9	73.3	64.1
Karnataka	29.6	64.7	69.7	66.9	58.5
Kerala	63.6	99.3	99.4	87.4	84.9
Tamil Nadu	34.0	87.8	90.6	91.3	87.2

¹For the last in the five years preceding the survey, mother received three or more antenatal check-up (with the first check up within the first trimester of pregnancy), received two or more tetanus toxoid injections and took iron and folic acid tablets or syrup for three or more months

² Doctor, auxiliary nurse midwife, nurse, midwife, lady health visitor, or other health personnel

³ Based on the last live birth in the five years preceding the survey. Postnatal check-ups are checks on the Source: National Family Health Survey – III, 2005-06, Government of India.

About 42.0% births in the state take place in medical institutions, 47.6% births are taken place at home but assisted by health personal. ¹²²

Table - 4.33 shows that women in West Bengal are poorly placed vis-à-vis other states in terms of several other delivery related parameters. Over 74% pregnant women have pregnancy related complications, against national average of 63.6%. One in four such women have delivery complications in West Bengal (India, 37%). Very high 59.2% women have post delivery complications, against a national average of 46.7. West Bengal is behind 12 major states in this point. Less than half (46.2%) such women seek treatment in West Bengal, which is almost at par with the national average. ¹²³

REFERENCES

1. The Mahbub Ul Haq Human Development Centre, (2005), Human Development in South Asia (2004), The Health Challenge, Oxford, Oxford University Press,p.1
2. Ibid. p.7
3. Shanmugassundaram, Y. (1994), Theory and Practice of Health Economics in India, Institute for Advanced Studies and Research, Madras, Allied Publishers Limited, p.5
4. Human Development in South Asia (2004), op.cit, no. 1. p.7
5. Ibid, p.7
6. Ibid, p.14
7. Fidler, D. (2000), quoted in Human Development in South Asia – 2004, op.cit.,no.1, p.8
8. Ibid, p.9
9. Ibid. p.9
10. GOI, Eleventh Five Year Plan (2007-2012), New Delhi, Planning Commission p.74
11. Human Development in South Asia (2004), op.cit., no.1,p.25
12. Ibid, p.25
13. Ibid, p.26.
14. Ibid, pp.69-70
15. Ibid, pp.73-74
16. Ibid, pp.73-74
17. Ibid, p.33

18. Kanjilal, B., Mukherjee, M. et. al (2007), Health, Equity and Poverty, Exploring the links in West Bengal, India, Future Health Systems Research Monograph, India, p.1
19. GOI, (2002), National Health Policy (NHP) 2002, quoted in B. Kanjilal, M. Mukherjee, Ibid p.1
20. Kanjilal, B., Mukherjee, M. et.al (2007), Ibid, p.1
21. Peter, D. et al.(2007), cited in B. Kanjilal, M. Mukherjee, Ibid p.1
22. Kanjilal, B., Pearson, M. (2007), Health Financing in West Bengal, Structure, Challenges and Options cited in B. Kanjilal, M. Mukherjee, Ibid p.1
23. National Sample Survey Organization (NSSO) (2004), Morbidity, Health Care and Condition of the aged, report on NSS 60th round, cited in B. Kanjilal, M. Mukherjee, Ibid p.2
24. Kanjilal B., Mukherjee M. et.al (Dec. 2007), Health, Equity and Poverty, Exploring the Links in West Bengal, India – Future Health Systems – Research Monograph, India, pp. 1-2
25. National Planning Committee, Report of the Sub-Committee on National Health cited in Political Economy of State Intervention in Health Care by V.Kethineni, EPW, vol.26 (42), 1991, p.2431
26. Report of Health Survey and Development Committee, (Bhore Committee), vol. IV, cited in V.Kethineni, Ibid, p.2431
27. Government of India (GOI) (1951), “First Five Year Plan”, New Delhi, Planning Commission, pp.194-199
28. Government of India (1956), Second “Five Year Plan”, New Delhi, Planning Commission, pp.150-155
29. Government of India, (1961), “Third Five Year Plan”, New Delhi, Planning Commission, pp.651-678
30. Ibid, p.651

31. Government of India, (1969), "Fourth Five Year Plan", 1969-74, New Delhi, Planning Commission, pp.386-397
32. Ibid, p.386
33. Government of India, (1974), "Fifth Five Year Plan", New Delhi, Planning Commission, p.231.
34. Qadeer, Imrana (2008), Health Planning in India, Social Scientist, vol. 36, nos.5-6, May-June, p.57.
35. Qadeer, Imrana (2008), Health Planning in India, Social Scientist vol. 36, nos.5-6, May-June, p.62.
36. Qadeer, Imrana (2008), Health Planning in India, Social Scientist vol. 36, nos.5-6, May-June, p.57
37. Government of India, (1985), "Seventh Five Year Plan", New Delhi, Planning Commission, pp.270-305
38. Government of India, "Eighth Five Year Plan", (1992-97), vol. II, New Delhi, Planning Commission, pp.2-3
39. Qadeer Imrana (2008), Health Planning in India, Social Scientist. vol. 36, nos.5-6, May-June, p.58
40. Ibid, pp. 59-60
41. Ibid, pp. 60-62
42. Government of India, (2002-07), "Tenth Five Year Plan", Vol. II, New Delhi, Planning Commission, pp.82-83
43. Government of India, (2007-12), "Eleventh Five Year Plan", New Delhi, Planning Commission, p.68
44. Ibid, pp.68-69
45. Ibid, p.69
46. Ibid, p.58
47. Ibid, p.58

48. Ibid, p.58
49. Human Development in South Asia (2004), op. cit no. 1, p.145
50. Ibid, p.145
51. Ibid, p.145
52. Ibid, p.146
53. SRS (2005), cited in “Eleventh Five Year Plan”, 2007-12, New Delhi, Planning Commission, p.59
54. Human Development in South Asia (2004), op. cit. no. 1, p.147
55. Ibid, p.147
56. Ibid, p.147
57. Government of India, (2001), Draft National Health Policy, 2001, cited in Human Development in South Asia, 2004, op.cit., no.1, p.147.
58. GOI, National Family Health Survey (NFHS) – III, 2005-06, vol.-I, New Delhi, Ministry of Health and Family Welfare, p.XXXIV – XXXV
59. Human Development in South Asia (2004), op. cit. no.1, p.147
60. Ibid, p.148
61. Misra, R. and Chatterjee, R. et.al. (2003), India Health Report cited in Human Development in South Asia, 2004, op. cit. no.1, p.148.
62. Human Development in South Asia (2004), op. cit. no. 1, p.149
63. GOI, National and Family Health Survey (NFHS) III (2005-2006), New Delhi, Ministry of Health and Family Welfare, Government of India, p.XXXV
64. Government of India, “Eleventh Five Year Plan”, 2007-12, New Delhi, Planning Commission, p.124
65. National Nutrition Monitoring Bureau (NNMB) (1997), Twenty Five Years of NNMB 1970-1995, quoted in Human Development in South Asia, 2004, op. cit. no. 1, pp.151-152

66. Human Development in South Asia (2004), op. cit. no. 1, pp.150-152
67. Ibid, p.153
68. Ibid, p.159
69. GOI, "Eleventh Five Year Plan", 2007-12, New Delhi, Planning Commission, p.58
70. Ibid, p.60
71. Ibid, p.59
72. Ibid, p.60
73. Ibid, p.61
74. India Social Development Report 2006, p.24
75. Human Development in South Asia, 2004, op. cit. no.1, pp.168-170
76. Ibid, pp.170-171
77. Ibid, p.171
78. Kanjilal, B. et. al (2007), op.cit. no. 24 p.7
79. Ibid, p.7
80. Govt. of West Bengal, West Bengal Human Development Report (2004), Kolkata Development and Planning Department, p.121
81. Ibid, p.122.
82. GOI, (2008), NFHS-III, India, 2005-06, West Bengal, New Delhi, Ministry of Health and Family Welfare, p.11
83. West Bengal Human Development Report, (2004), op. cit. no. 80, p.123
84. Govt. of West Bengal, Health Strategy, Doc-2, Kolkata, Department of Health and Family Welfare, p.62
85. West Bengal Human Development Report, (2004), op. cit. no. 80, p.125

86. NFHS- III, India, 2005-2006, op. cit. no. 82, pp.19-20
87. West Bengal Human Development Report, 2004, op. cit. no. 80, p.125
88. Ibid, p.125
89. Ibid, p.125
90. NFHS – III, India, 2005-2006, op. cit. no. 82, p.20
91. West Bengal Human Development Report 2004, op. cit. no. 80, pp.126-127
92. NFHS-III, India, 2005-2006, op. cit. no. 82, pp.20 – 21
93. Govt. of West Bengal, Health Strategy Document – 4, Integrated Financial and Economic Plan for the Health Sector, Kolkata, Department of Health and Family Welfare, p.1
94. Ibid, pp.1-2
95. Govt. of West Bengal, Health Budget Speech, (2002-03), cited in Health Strategy Document – 4, Integrated Financial and Economic Plan for the Health Sector, Kolkata, Department of Health and Family Welfare, p.3
96. Health strategy document – 4, op. cit. no. 93, pp.3-4.
97. Ibid, p.4
98. Ibid, p.4
99. Health Budget Speech, 2002-03 and West Bengal Health Systems Development Project, Status Report, Nov. 2003, cited in Health Strategy Document – 4, op. cit. no. 93, p.4
100. Ibid, p.5
101. State Bureau of Health Intelligence Directorate of Health Services, Government of West Bengal, cited in Health Strategy Document – 4, op. cit. no. 93, p.5

102. Government of West Bengal, Health Strategy Document – 4, Integrated Financial and Economic Plan for the Health Sector, Kolkata Department of Health and Family Welfare, pp.7-8
103. Ibid, p.8
104. Ibid, p.8
105. Ibid, p.8
106. Kanjilal B., et al, op. cit. no. 24, p.9
107. Health Strategy Document – 4, op. cit. no.93, p. 11
108. Ibid, p.11
109. Ibid, p.11
110. Ibid, p.12
111. Ibid, p.12
112. Health Strategy Document – 4, op. cit. no.93, pp. 12-13
113. Ibid, p.13
114. Ibid, p.13
115. Voluntary Health Association of India, (1997), Report of the Independent Commission on Health in India, New Delhi, p.40
116. Human Development in South Asia (2004), op. cit. no. 1, pp.69-70
117. Government of West Bengal, Health Strategy Document – 2, Background and Rationale for the Priorities in the Health Strategy, Dept., of Health and Family Welfare, p.42
118. Ibid, p.42
119. Bagchi, J. (ed.) (2005), The Changing Status of Women in West Bengal 1970 – 2000 : The Challenge Ahead, New Delhi, Sage, pp.43-44

120. Ibid, p.44

121. Ibid, p.44

122. Ibid, p.44

123. Ibid, p.44

Chapter-V

Introduction

Developing countries like India have embarked on an all-out effort for socio-economic and cultural transformation of their societies. The acceptance and indiscriminate adoption of western technologies in the developing countries without giving adequate consideration to the abilities of the social structures of those countries to absorb them has led in many countries to the erosion of indigenous cultures and values and the vitality of social structures. The result is growing economic inequalities and social injustice. This has been aggrandized again by the adoption of market economic policy and thereby the reduced role of the state in the social sector. To curb this tendency, there is an immediate need to refashion development strategies in order to ensure social justice for all. Health constitutes one of the important components of overall economic and social development. The study jointly undertaken by the ICSSR and ICMR observed that health is a function, not merely of medical care, but of the overall development of society— cultural, economic, educational, social and political.¹

The International Conference on Primary Health Care, organized jointly by the WHO and UNICEF at Alma Ata in the USSR in 1978 argues that any distinction between economic and social development is untenable. Economic development is necessary to achieve most social goals and social development is necessary to achieve most economic goals. Indeed, social factors constitute the real driving force behind development. The purpose of development is to permit people to lead economically productive and socially satisfying life.² The declaration further recommended that “Government (should) encourage and ensure full community participation through effective propagation of relevant information, increased literacy and

the development of the necessary institutional arrangements through which individual families and communities can assume responsibility for their health and well being.”³

With the reduced role of the state or failures of the government programmes in the social sector like health, education, welfare, etc. the NGOs’ role to ensure social sector development becomes necessary and important.

The differential exposure, reduced access to treatment and culturally imposed restrictions are disproportionately harmful to women at specific stages of their life cycle. In the life cycle of women’s health there are three stages. These are (1) Infancy and childhood which includes the age-group between zero to ten (0-10); (2) Adolescent includes the age-group between ten to nineteen (10-19); (3) Reproductive years comprises the age-group between fifteen to forty-four (15-44). Women’s risk of premature death and disability is greatest during their reproductive years. The living conditions during these years affect the health of women long after their reproductive years are over and the health of their children as well. In this stage of life cycle women are biologically vulnerable, as the physical drain of pregnancy and lactation increases women’s vulnerability to poor health status. The poor nutritional and growth status of the mother (especially in the disadvantaged sections of the society) is a reflection of her own growth as a foetus, newborn, child and adolescent. Nutritional status is recognized as a major risk factor for maternal and peri /neonatal mortality as well as the incidence of low birth weight and pre-term infants.⁴

In the developing countries, women in this age-group have higher rates of disability than men, primarily because of their reproductive role. In the burden of disease in females aged 15 to 44 in developing countries the

maternal causes are of highest percentage i.e. 18% (Figure-3). Therefore, maternal health of women is a great concern in health sector.

Location of the Study

The present field study was undertaken in Birbhum district of West Bengal. Birbhum is the south-west district of West Bengal. It is bounded on the north and west by the Santal Parganas, on the east by the district of Murshidabad, Burdwan, and on the south by Burdwan, from which it is separated by the Ajoy river.

Extending over an area 4545 sq.k.m. (2001) the district is inhabited by 3015422 persons, of which 1546633 males and 1468789 females according to the census of India 2001. In terms of population it ranks thirteen among the districts of West Bengal with 3.76 percent of the state's population (80176197)⁴. The density of population and sex ratio in Birbhum is 664 and 950 respectively. The child sex ratio (0 – 6 age-groups) is 964. The rural and urban population is 2757002 and 258420 respectively⁶. In Birbhum the caste wise population is:-

(General – (1922401) 63.8% of total population.

SC – (889894) 29.5% of total population

ST – (203129) 6.7% of total population)⁷

The literacy rate in this district is 61.5 percent with male 70.89 percent and female 51.55 percent. In rural area the male and female literacy rate is 69.5 percent and 49.7 percent respectively. In urban area the same is 84.7 percent and 70.2 percent respectively. The total rural literacy is 59.9 percent and the total urban literacy 77.7 percent.⁸

In this district there are 10 hospitals, 77 health centres, 23 clinics, 13 dispensaries, total beds 2211 and 244 doctors in the year 2004. In 2004-05 the family welfare centres were 428 (public).⁹

The district comprises 3 sub-divisions namely Rampurhat, Sadar, and Bolpur. Suri is the headquarter of the district. Birbhum has 18 police stations viz. Nalhati, Murarai, Mayureswar, Rampurhat, Margram, Md. Bazar, Sainthia, Dubrajpur, Rajnagar, Sudaipur, Suri, Panrui, Khoyrasole, Kankartala, Bolpur, Labpur, Nanoor and Illambazar. It has 19 blocks viz. like Nalhati-I, Nalhati-II, Murarai-I, Murarai-II, Mayureswar-I, Mayureswar-II, Rampurhat-I, Rampurhat-II, in Rampurhat sub-division; Md. Bazar, Sainthia, Dubrajpur, Rajnagar, Suri-I, Suri-II, Khoirasole in Sadar Sub-division; Sriniketan, Labpur, Nanoor, Illambazar in Bolpur sub-division. Birbhum consists of 19 Panchayat Samities, 167 Gram Panchayats, 2138 Gram Sansads.¹⁰

The list of NGOs which were working on health was collected from the DM Office and the Family Welfare Office, at Suri, the head office of Birbhum district and from some renowned NGOs. But most of the NGOs in the list either extinguished, or not working properly, or not viable to be studied or some are newly established and some could not be traced. And therefore, only 12 NGOs out of 40 found fulfilling the objective of the study. These NGOs are:

1. Elmhirst Institute of Community Studies [EICS]
2. Kirnaher Tarun Samity [KTS]
3. Mallarpur Nai Suva [MNS]
4. Organization for Protection of Environment and Consumers [OPEC]
5. Birbhum Society for Community Development [BSCD]
6. Nayantara Memorial Charitable Trust [NMCT]

7. Dubrajpur Kacharipara Rural Energy Development Association [DKREDA]
8. Nityagopal Welfare Organization [NWO]
9. ST. John Ambulance Association [SJAA]
10. Ikra Pally Mangal [IPM]
11. Tarapur Social Development Society [TSDS]
12. Kopai Social Change Society [KSCS]

NGOs and Health: Field Study

To examine the activities of the organizations, their techniques, methods and mode of work and how they run the organizations the questions were on:-

- a) The target groups
- b) The mode of operation
- c) The techniques used in disseminating information and creating awareness on health matters
- d) Methods adopted to make the people aware about the project
- e) The sources of funding

Table 5.1

Target Groups of the Organizations

Target Groups	Yes		No	
Children	12	100%		
Youth	8	66.66%	4	33.33%
Women	12	100%		
Tribal	10	83.33%	2	16.66%
Rural Poor	12	100%		
Urban Slum	2	16.66%	10	83.33%

The table 5.1 shows that all the organizations (100%) work on the target groups like children, women and rural poor. 66.66% work on youth the rest do not have youth as their target groups. 83.33% work on tribal people and 16.66% do not work on tribal people. 83.33% organizations do not work on urban slum but 16.66% work on urban slum.

Therefore, it is found that the main target groups of the organizations are children, women and rural poor, the most vulnerable groups in society and economy. Secondly, the majority of organizations also work on tribal people suffering from several forms of socio-economic deprivations. Therefore, the organizations' choice of target groups is very pertinent to social development.

The table 5.2 indicates that 75% organizations are active in disseminating information about health issues to the people and 25% organizations probably lack interest in disseminating information to the people.

Table 5.2

Mode of Operation of the Organization

Mode of Operation	Yes		No	
Disseminating information	9	75%	3	25%
Awareness creation	12	100%		
Providing health services	10	83.33%	2	16.66%
Giving health related advices	11	91.66%	1	8.33%
Persuading people to adopt the practices advised	8	66.66%	4	33.33%
Delivering free treatment and medicines	8	66.66%	4	33.33%

The most important function of creating awareness about health matters is carried out by almost all the organizations, 83.33% organizations provide health services to the people and the rest 16.66% do not . Majority of the organizations i.e. 91.66% give advices on health related issues while 8.33% do not. 66.66% of organizations try to persuade people to adopt the practices advised and 33.33% organizations are lacking in this respect. 66.66% organizations deliver free treatment and medicines and the rest 33.33% organizations are lacking in this respect. 66.66% organizations deliver free treatment and medicines and the rest 33.33% organizations do not.

It is clear that the mode of operation on health matters of most of the organizations is very positive. Ignorance, one of the most important causes of maternal death, can be wiped out through creating awareness among the target groups. Not only awareness creation but also giving proper advice and accordingly delivering services are also important. In this case majority of the organizations adopted positive measures for their operation barring a few.

Table 5.3

Techniques used by the Organizations for Disseminating Information and Awareness Creation on Health Matters

Techniques	Yes		No	
Group meeting	11	91.66%	1	8.33%
Involving local clubs	10	83.33%	2	16.66%
Involving organized women groups	11	91.66%	1	8.33%
Involving panchayats	9	75%	3	25%
Organizing health camps	12	100%		

The organizations adopt various techniques to spread information and awareness generation (table 5.3). 91.66% organizations adopt the techniques like holding group meeting with organized women groups and 8.33% organizations do not apply this technique. Group meeting helps quick spread of information and involvement of organized women groups facilitates more organized delivery of services on health matters among women. 83.33% organizations involve local clubs and 16.66% do not use this technique. 75% organizations involve panchayats and 25% do not involve panchayats. The above techniques are indirect techniques which take time to yield result. But 100% organizations adopt the most effective technique of organizing health camps. Through health camps the beneficiaries can participate directly in the camps which make the beneficiaries more conscious about their health and they can take the facility directly and also gather knowledge about health matters.

This analysis maintains that the organizations have adopted the most positive and effective techniques for the dissemination of information and awareness creation on health which help to expedite the implementation of programmes among the beneficiaries.

Group meeting and health camps which involve the target population directly by the concerned organizations seem to be more effective for delivery of health services and awareness generation than through the involvement by local clubs or panchayats.

It is clear from the Table 5.4 that all the organizations (100%) adopt the method of holding group meeting with the people. 83.33% organizations arrange cultural programmes the rest 16.66% do not . 75% organizations give practical training to the beneficiaries and 25% organization do not. 91.66% organizations show their previous programmes through demonstration, in pictorial form etc. While 8.33% organizations do not.

Table 5.4
Methods of the Organizations to Aware the People about the Project

Methods	Yes		No	
Holding group meeting with the people	12	100%		
Arranging cultural programmes	10	83.33%	2	16.66%
Giving practical training to the people	9	75%	3	25%
Exposure of the organization's project	11	91.66%	1	8.33%

The above data indicate that all the organizations directly meet the people through group meeting to make the people aware about their project and show them their previous programmes to the people. The organizations work in the remote villages where most of the people lack knowledge about health, about various programmes meant for them. Direct meeting with the people and video show of their project make the people know about the necessity and practicality of the health programmes. Generally, due to their ignorance, illiteracy the village people are reluctant to avail the services provided by the organizations. In this context, the organizations' method of

stimulating people to participate in their project through entertainment programmes like the cultural show and practical training serves the purpose to a great extent.

Table 5.5

Sources of Funding of the Organizations

Sources of funding	Yes		No	
	Count	Percentage	Count	Percentage
Foreign aid	4	33.33%	8	66.66%
<i>Government aid</i>	9	75%	3	25%
Membership subscription	11	91.66%	1	8.33%
Indian funding agencies	2	16.66%	10	83.33%
Revenue earned from delivery of services	2	16.66%	10	83.33%
Donation	7	58.33%	5	41.66%

The table 5.5 shows that the organizations are funded by numerous sources. 91.66% of organizations generate fund primarily from the subscriptions of the members, 75% organizations get aid from Government and for 58.33% of organizations a major share of their income comes from donations. They have also other sources of funding like foreign aid which is received by 33.33% of organizations, Indian funding agencies give aid to 16.66% of organizations, and 16.66% organizations earn revenue from the delivery of services.

Therefore, majority of the organizations run their programmes from the membership subscription, donations and Government aid. In fact, the organizations suffer from financial paucity. Due to that reason the organizations mostly organize those projects and programmes funded by Government or other agencies. Without adequate fund running the organizations, performing various programmes successfully is very difficult.

The relation between the organizations and the community, Government agencies and panchayats are known from questions on–

- a) The relation between the community and the organization; (Table- 5.6)
- b) Relation between the community and the organizations, the Government agencies and panchayats; (Table -5.7)
- c) And the role of NGOs vis-a-vis Government in delivering services to people. (Table-5.8)

Table 5.6
Relation between the Communities and the Organizations

Relation	Yes		No		No Answer	
Authoritative			11	91.66%	1	8.33%
Consultative	10	83.33%	1	8.33%	1	8.33%
Participatory	11	91.66%			1	8.33%

In terms of relation between the community and the organizations the table shows that 91.66% organizations answered that there was no authoritative relation between the organizations and the community and 8.33% organizations did not answer on this point. 83.33% organizations said that their relation with the community was consultative and 8.33% organizations answered in the negative on this point and 8.33% did not answer. 91.66% organizations (majority of the organizations) answered that the relation between them and community was participatory and 8.33% did not answer.

Therefore, it can be summerised from the data that the relation between the community and majority of the organizations is participatory and consultative which is most important factor for effective and successful delivery of services from the organizations’ part and at the same time availing the services easily and being aware about the health matters from

the beneficiaries' part. Because it is widely accepted that to provide services to the rural poor for their development the provider-beneficiaries relationship needs to be very close and cordial. In this context, the majority of the organizations are successful in their performance. It is evident from the above that participation, consultation evince better receptivity and co-operation than authoritativeness.

Table 5.7

Relation between the Organizations, the Government Agencies and Panchayats

Relation	Yes		No	
	Count	Percentage	Count	Percentage
Mutually supportive	5	41.66%	7	58.33%
Smooth	4	33.33%	8	66.66%
Obstructive			12	100%
Adversarial			12	100%
Cooperation	10	83.33%	2	16.66%

The table 5.7 shows that the relation between the organizations and the government agencies and panchayats is highly cooperative, since 83.33% organizations voiced positive relating to co-operative relation. 41.66% organizations felt the relation as naturally supportive and 58.33% organizations viewed negative on this point. 33.33% organizations replied positive and 66.66% negative about smoothness of relation. All the organizations agreed that the relation between them and the Government agencies and panchayats was not obstructive and adversarial at all.

Table 5.8

Role of NGOs vis-a-vis Government in Delivering Services to People

Role	Yes		No	
Alternative to Government			12	100%
Intermediaries between rural people and the Government agencies	10	83.33%	2	16.66%
Supplementary to Government agencies	7	58.33%	5	41.66%
<i>Co-partner of the Government</i>	11	91.66%	1	8.33%

The above data indicate that 83.33% organizations are infavour of NGO's role as intermediaries between rural people and the Government agencies, 91.66% supported their role as co-partner of the Government and 58.33% organizations are of the view that their role may be supplementary to Government agencies. But all the organizations (100%) agreed that NGOs could not be alternative to Government.

Therefore, it may be concluded that the role of NGOs in delivering rural development interventions has been conceived as mediators between government agencies and rural people; co-partners of government and supplementary to government agencies but never the alternative to Government. Because, whatever be the role of the state, the role of NGOs cannot be equalized with state's role, state's role in the society is much higher, wider and important. In spite of that NGOs can help expedite the vast activities of the state and smoothen the easy passage for the state in rural development intervention. NGOs can only meet the requirements of the beneficiaries in getting the health facilities in selected pockets of rural, tribal and urban fringes. Hence, commitment and fulfillment of social development objectives by NGOs can only be partial even amongst targeted population, which in spite of enormous resources state may be unable to achieve. It is

evident that NGOs are complementing the efforts of state than supplementing state.

Table 5.9

Reasons behind the Limited Health Access of the People according to the Organizations

Reasons	Yes		No	
	Count	Percentage	Count	Percentage
Low social status	6	50%	6	50%
Poverty	8	66.66%	4	33.33%
Distance	9	75%	3	25%
Ignorance	12	100%		
Lack of awareness	12	100%		

The table 5.9 data shows that all the organizations (100%) answered that the main reasons for limited health access were ignorance and lack of awareness. Second reason is the distance on which 75% organizations answered positive and 25% answered negative. 66.66% organizations answered poverty was another reason for limited health access and 50% answered low social status as a reason for limited health access.

From the above data analysis it can be ascertained that poverty, distance, are important reasons for limited access to health but rural people's ignorance and lack of awareness play most important role in preventing people's access to health. Here, NGOs can put emphasis on creating awareness about health problems and providing on health related education to the rural people. NGOs through their limited dedicated workers can

motivate and create fertile ground for self sustaining activity, where their voices can be receptive.

Out of 12 organizations only three organizations, Elmhirst Institute of Community Studies (EICS), Tarapur Social Development Society (TSDS) and Kopai Social Change Society (KSCS) exclusively work on maternal health. But the EICS has started providing maternal services very recently from 2007 and its service provisioning is mainly based on government project like Reproductive Child Health (RCH) and other NGO (PRIA) sponsored project. The other two organizations (TSDS and KSCS) work on their own.

In order to identify the total number of beneficiaries covered by the organizations providing services on maternal health and the infrastructure available to them for the purpose the questions were asked on –

- a) The percentage of women identified during last five years
- b) The percentage of pregnant women registered in the last five years
- c) The percentage of pregnant women with access to maternity care
- d) The infrastructure existing for maternal care

As the EICS is working only from 2007 and the other two organizations are working more than five years, the separate table has been constructed for each organization on the first three questions.

Table 5.10

Percentage of Pregnant Women Covered by EICS

In percentage	(A) Pregnant Women Identified			(B) Pregnant Women Registered			(C) Access to Maternity Care		
	Yes	No	*NA	Yes	No	NA	Yes	No	NA
11% - 20%	16.83%			16.83%			16.83%		
21% - 30%									
31% - 40%									
41% - 50%									
51% - 60%									
61% - 70%									
Above 70%		83.17%			83.17%			83.17%	

* NA- No Answer

The table 5.10 shows that pregnant women identified, registered and given access to maternity care – each being only 16.83%.

The table 5.11 reveals that 47% pregnant women identified, 34% registered and only 37% women got access to maternity care.

The table 5.12 shows that KSCS identified 35% pregnant women, registered 31% pregnant women and regarding pregnant women's access to maternity care the organization did not answer at all.

From the data of the three tables (5.10, 5.11, 5.12) it can be ascertained that the performance of EICS in all the three respects is very poor. The reason may be the short period of its work and project based programme.

Table 5.11

Percentage of Pregnant Women Covered by TSDS

In percentage	(A) Pregnant Women Identified			(B) Pregnant Women Registered			(C) Access to Maternity Care		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
11% - 20%									
21% - 30%									
31% - 40%				34%			37%		
41% - 50%	47%								
51% - 60%		53%							
61% - 70%					66%		63%		
Above 70%									

Table 5.12

Percentage of Pregnant Women Covered by KSCS

In percentage	(A) Pregnant Women Identified			(B) Pregnant Women Registered			(C) Access to Maternity Care		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
11% - 20%									
21% - 30%									
31% - 40%	35%			34%					
41% - 50%									
51% - 60%									
61% - 70%		65%			66%				
Above 70%									100%

The TSDS performed little better than EICS and KSCS in identifying pregnant women. In registering pregnant women KSCS did much better than EICS and TSDS. In case of women access to maternity care EICS and TSDS performed very poor and the performance of KSCS was ambiguous or confusing. But overall performance of the three organizations on the issue of pregnant women access to maternity care is poor. The financial paucity could be one of the reasons for medium performance of the TSDS and KSCS, besides inadequacy of infrastructure and professional personnel.

Table 5.13

**Infrastructures for Maternal Care Services
of the Organizations**

Infrastructure	EICS		TSDS		KSCS	
	Yes	No	Yes	No	Yes	No
Health post		I		I	I	
Mobile health units for outreach		I	I			I
Health centres		I		I	I	
Maternity waiting rooms		I		I		I
Delivery room for normal delivery		I		I	I	
Emergency transport vehicle		I	I		I	
Antenatal clinic		I		I	I	
Postnatal clinic		I		I	I	

The table 5.13 shows that the EICS has no such infrastructure for maternal care services. The TSDS has only mobile health unit for outreach and

emergency transport vehicle. The KSCS has all the infrastructures except mobile health unit for outreach and maternity waiting room.

The organisations except KSCS do not have adequate infrastructures for maternal care services. Perhaps, inadequate infrastructure may be the reason for poor performance of the organisations in identification and registration of pregnant women and also poor access of women to maternal care services.

In order to make an assessment of the effectiveness of the maternal services rendered to the pregnant women by the organizations during last five years (2004-2008), questions were asked to the co-ordinator of the organizations include:

- A: Pregnant women were counselled on prenatal self-care including nutrition, hygiene and danger sign during pregnancy;
- B: Pregnant women received tetanus-toxoid;
- C: Pregnant women given iron and folate tablets;
- D: Mothers receiving postnatal check-up from trained medical staff;

Separate tables for the three organizations have been formed as the EICS started to work from 2007 and the other two organizations are working more than five years.

Table – 5.14

**Maternal Services provided by the EICS during two years
(2007 – 2008)**

Question No.	Yes (In Percentage)	No (In Percentage)	Not Answered (NA) (In Percentage)
A	16.83%	83.17%	
B	13.54%	86.46%	
C	12.86%	87.14%	
D	15.59%	84.41%	

Evidently by EICS 16.83% pregnant women were counselled, 13.54% pregnant women received tetanus toxoid, 12.86% women took iron and folate tablets and 15.59% women received post natal check-up from trained medical staff.

Table – 5.15

**Maternal Services provided by the TSDS during five years
(2004-2008)**

Question No.	Yes (In Percentage)	No (In Percentage)	Not Answered (NA) (In Percentage)
A			100%
B			100%
C	74%	26%	
D	21%	79%	

TSDS gave 74% women iron and folates, 21% women postnatal check up and TSDS was silent on pregnant women counselling and tetanus toxoid distribution.

Table – 5.16

**Maternal Services provided by the KSCS during five years
(2004-2008)**

Question No.	Yes (In Percentage)	No (In Percentage)	Not Answered (NA) (In Percentage)
A	65%	35%	
B	90%	10%	
C	80%	20%	
D	50%	50%	

The above table 5.16 depicts that the KSCS performed well in providing services to the pregnant women. Under KSCS 65% pregnant women were counselled, 90% had received tetanus toxoid, 80% women received iron and folate tablets and 50% women took post natal check up.

From the analysis of the three tables (5.14, 5.15, 5.16) it can be said that the KSCS performed very satisfactory in providing maternal services to the pregnant women than the other two organisations (EICS and TSDS). It may be that the KSCS has almost all the infrastructures for maternal care services. The KSCS's performance in all the segments is more than 50%. On the other hand the performance of the EICS is poor. It may be due to the short period (2 years) of its service provision and project based programme, absence of adequate infrastructure. And the TSDS's performance is very unsatisfactory. Its service related to women counselling and providing tetanus toxoid is nil. The reason is mainly paucity of fund, inadequate infrastructure, and inadequate staff. The overall performance in maternal care services is not up to the mark.

Therefore, in providing maternal care services the organisations are less successful. Apart from awareness generation among women regarding health the role of the organizations in health sector is not satisfactory from practical point of view. The major hurdle in arranging programmes and implementing those programmes into practical field is lack of adequate fund of the organisations. Without adequate financial support it is very difficult to materialise the initiative taken by the organizations and to carry on successfully the programmes launched by them.

REFERENCES

1. Report of the Study Jointly undertaken by Indian Council of Social Science Research and Indian Council for Medical Research, 1980, p.v
2. Report of the Study jointly undertaken by WHO and UNICEF, 1978, p.44
3. Ibid, p.44
4. Tinker, Anne et. al. (1994), 256 World Bank Discussion Papers, Women's Health and Nutrition Making a difference, The World Bank, Washington D.C, pp.12-15
5. Govt. of India (GOI), Census of India 2001, vol. I, series 20, p.lxiii
6. Government of West Bengal, District Statistical Handbook, (2005), Kolkata, Bureau of Applied Economics and Statistics, pp.10-19
7. GOI, Census of India 2001, vol. I series 20, p.16
8. Government of West Bengal, District Statistical Handbook, (2005), Kolkata, Bureau of Applied Economics and Statistics, p.83
9. Ibid,pp.40-42
10. Ibid,pp.5-8

Chapter-VI

Gender Inequality and Development

Every human development report has argued that the purpose of development is to improve people's lives by expanding their choices, freedom and dignity. During the 1990s debates over development focused on three important issues viz., the need for economic reforms to establish macro economic stability; the need for strong institutions and the system governance– to enforce the rule of law and control corruption; and the need for social justice and people's involvement in decision making that affects them, and their communities. These issues are all crucial for sustainable human development. ¹

In spite of dramatic improvement in the developing world the pace of human development is still very slow. For many countries the 1990s was a decade of despair.² Why human development proceeds slowly? To understand this question the conceptual understanding of human development is important and necessary.

Human development is a broad and comprehensive concept. It broadens the development dialogue from a discussion of mere means (GNP growth) to a discussion of the ultimate ends. It is as concerned with the generation of economic growth as with its distribution, as concerned with basic needs as with the entire spectrum of human aspirations, the concept of human development does not start with any predetermined model. It draws its inspiration from the long term goals of a society. It weaves development around people, not people around development. If the objective of development is to improve people's choices, it must do so not only for the

current generation but also for future generations. That is development must be sustainable.³ Previous concepts of development have often given exclusive attention to economic growth— on the assumption that growth will ultimately benefit everyone. Human development offers a much broader and more inclusive perspective. It demonstrates that economic growth is vital— no society has in the long run been able to sustain the welfare of its people without continued injection of economic growth. Growth on its own is not sufficient— it has to be translated into improvements in people’s lives. Economic growth is not the end of human development. It is one important means. Thus, economic growth and human development are closely connected. People contribute to growth, and growth contributes to human well-being. The emphasis that human development places on human capabilities has led to some misunderstanding that human development is limited to social sectors like, health, education etc. Human development is not limited to any specific sector. Human development is concerned with the improvement of human capabilities so that they can participate actively in social, political and economic decision making and can work productively and creatively for development.⁴

Each country may have its own human agenda, but the basic principle should be the same— to put people at the centre of development and to focus on their needs, choices, opportunities, capabilities, and potentials. Human development spans the full range of human needs and ambitions. Human development, as a concept is broad and comprehensive, but guided by a simple idea— people always come first. To make development successful all sections of people will have to be included in the development process.

The development benefits in most of the developing countries have failed to trickle down to all sections of the society. Most importantly, the women section of the population is highly affected section especially poor,

deprived, vulnerable and marginalized women. These women live in abject poverty. Poverty makes human beings vulnerable and deprives a person from social, cultural and political freedom simply because of low income and low consumption. This further leads to premature deaths, malnourishment and illness, lack of education and skills and most importantly social exclusion. Poor women are more vulnerable than poor men. Women's poverty is self-perpetuating because of their powerlessness. It is estimated that nearly 40% of the world's poor who earn less than a dollar a day, live in south Asia.⁵ Poverty has other attributes like powerlessness, dependence or isolation. Low income status and social exclusion combine to influence health and education status, nutritional levels, access for sanitation and safe drinking water, to credit and skill training, and ability to exercise one's democratic rights. The incidence of poverty among women in South Asia is especially high, with women and men experiencing poverty differently. The process of feminization of poverty in South Asia is closely linked to the cultural and institutional constraints that restrict women's participation in economic activity. Women continue to be largely concentrated in informal employment, as unprotected and sub-contracted labour. There are persistent wage gaps between men and women, and women bear the total responsibility for care and nurture. With increased migration and displacement, new groups of vulnerable women and greater numbers of female headed households have emerged. A significant section of the society (poor rural women) is deprived of free choices, freedom, dignity, opportunities, capabilities, productive participation etc., and the issues on which human development also emphasises. Until and unless women are actively, qualitatively involved in the development process, the development and progress of a society cannot be actualized in the true sense of the term.

Research by UNDP, UNIPEM, and the World Bank, among others, indicates that gender inequalities in developing societies inhibit economic growth and development. For example, a recent World Bank report confirms that societies that discriminate on the basis of gender experience greater poverty, slower economic growth, weaker governance and a lower living standard of their people.⁶ The UNDP has found a very strong correlation between its gender empowerment measure and gender related development indices and its human development index. Improved gender equality is a critical component of any development strategy.⁷ Gender equality is a constituent of development as well as an instrument of development. No country can develop if half of its population is deprived of basic needs, livelihood options, access to knowledge, opportunities and political voice. Without gender equality the achievement of other goals like poverty reduction, economic growth, environmental sustainability and overall social development will be difficult. It is generally accepted that women are disproportionately represented among the world's poorest people. In its 1995 Human Development Report, the UNDP reported that 70 percent of the 1.3 billion people living on less than \$1 per day are women.⁸ According to World Bank's gender statistics database, women have a higher unemployment rate than men in virtually every country. In general, women also make up the majority of the lower paid, unorganized informal sector of most economies. These statistics are used to justify the necessity of giving priority to increasing women's access to financial services on the grounds that women are relatively more disadvantaged than men.

Status of Women in India

Though the constitutional commitment of the nation to women was translated through the planning process, legislation, policies and programmes over the last six decades yet the situational analysis of social and economic status of women reflects less than satisfactory achievements judged by almost all important human development indicators. There exists wide gap between the goals enunciated in the constitution and the real situation of the status of women.

The maternal mortality rate is estimated at 407 per 100000 live births (2000) in India compared to 92 in Sri Lanka, 56 in China and 130 in Vietnam; the growing female face of HIV/AIDS is reflected in the fact that the number of pregnant women (between 18-24 years) with HIV prevalence comprise 0.86 percent in 2003 of the total women pregnant compared to 0.74 percent in 2002. The growing incidence of female foeticide is the result of the decline of child sex ratio. While the literacy rates have shown an improvement from 39.3 percent to 54.3 percent of the total female population between 1991 and 2001, yet much more needs to be done especially for socially and economically backward regions and groups.⁹

Economic empowerment as reflected by the work participation rate shows that the percentage of women in the work force increased by on 13 percent (from 22.5 percent to 35.7 percent) between 1991 and 2001. The average wage differential in between men and women showed a marked deterioration between 2000 and 2004 for both rural and urban areas. The violence against women continued unabated with the absolute number of crimes against women increasing from 128320 in 2000 to 143615 in 2004.¹⁰

There are a number of generic reasons, which give rise to the dismal picture depicted above. Poverty is increasingly becoming feminized – mainly on account of the fact that with globalization and liberalization a paradigm shift in the country's economy has taken place skewed towards technology dominated sectors, rendering traditional sectors like agriculture unviable and without any security cover. Unfortunately, it is in these sectors that women are predominantly involved for a sustenance livelihood. The lack of alternate employment, skill training, or credit facilities for women, who seek it, is another factor that keeps them in poverty. Traditional patriarchal systems too play in keeping women at a lower rung in the social and economic hierarchy by denying them basic rights to land, assets etc. and also child marriage is fallout of these factors. The weak social infrastructure like the lack of adequate schools or health centres, drinking water, sanitation and hygiene facilities inhibits a very large section of women from accessing these facilities. It is also one of the reasons for the high incidence of MMR and Infant Mortality Rate (IMR).

The changing socio-economic scenario and the phasing out of the joint family system along with poor community based protection systems are some of the reasons why women are becoming increasingly prone to violence and abuse. The weak law enforcement machinery and gender insensitivity of the various functionaries fail to check the growing violence against women. At the same time, the extremely poor levels of awareness amongst women themselves about their rights also perpetuate violence against them. The lack of adequate rehabilitation and reintegration facilities is another crucial factor that finds victimized women further victimized or ostracized by the community.¹¹

Table 6.1**Status of Women in India**

Expectation of life at birth for female in years	1989-93 – 59.7
	2001-05 – 63.9
Literacy rate for female in percent	1991 – 39.3
	2001 – 54.2
Maternal Mortality Rate per 100000 life births	1998 – 407
	2001-03 - 301
Sex ratio	1991 – 927
	2001 – 933
HIV prevalence among pregnant women aged 15-24 years (in percent)	2002 – 0.74
	2003 – 0.86
HIV prevalence among pregnant women aged 25-29 years (in percent)	2002 – 0.80
	2003 – 0.88
Work participation rates for female (in percent)	1991 – 22.3
	2001 – 25.7
Wage differentials between male and female in rural areas	1999-2000 – 15.83
	2004-2005 – 20.38
Wage differential between male and female in urban areas	1999-2000 – 24.55
	2004-2005 – 31.23
Crimes against women (no. in lac)	2000 – 1.28
	2004 – 1.44

Source: Report of the Working Group on Empowerment of Women for the XI Plan, 2006.

Gender disparity manifests itself in various forms, the most obvious being the trend of continuously declining female ratio in the population in the last few decades. Social stereo-typing and violence at the domestic and societal levels are some of other manifestations of discriminating treatment against women. Discrimination against girl children, adolescent girls and women persists in large parts of India. The underlying causes of gender inequality are related to social and economic structure, which is based on informal and formal norms and practices. Consequently, the access of women particularly those belonging to weaker sections including SCs/STs/OBCs and minorities, majority of whom are in rural areas and in the informal, unorganized sectors – to education, health and productive resources, among others, is inadequate. Therefore, they remain largely marginalized, poor and socially excluded.

Policies for Development of Women under Five Year Plans

The constitution of India is progressive not only in granting equality to women, but also in empowering the state to adopt measures of affirmative discrimination in favour of women. Within the framework of democratic polity, Indian laws, development policies, plans and programmes have aimed at women's advancement in different spheres. Throughout Indian plan period different steps have been undertaken for women's advancement.

The First Five Year Plan (1951-56) saw social welfare programmes and measures, that is, orphanages, homes for destitute women and girls, craft centre to teach women skills, and nursery schools, with women identified as the main recipients. The plan made an important distinction between social

welfare and social services. While social welfare was directed essentially at children and women, social services in health, housing and education were seen as an investment in betterment of human resources in general.¹² In the Second Five Year Plan there were no philosophical or conceptual changes and the welfare approach to women's issues persisted along with detailed discussion on the activities of social welfare boards. The plan recognized special needs of women workers such as maternity benefit and crèche facilities for their children. It also suggested speedy implementation of principle of equal pay for equal work and provision for training to women in order to enable them to compete for better paid jobs. Health concerns included maternal and child health care with special emphasis on paediatric treatment of children. In general, however, credit facilities for women, their absorption in industries, science and technology were issues that remained largely unattended in the plan.¹³ The Third Five Year Plan (1961-66) once again laid emphasis on the welfare approach. The Plan recommended increased allocation for the Central Social Welfare Board and proposed to link maternal and child health care with general health facilities and referral institutions. Female education was seen as a major welfare programme and the enormous gender gap in elementary schools prompted the Government to come up with several recommendations through the Council for Women's Education for the education of adolescent girls and training/recruitment and housing for women teachers. The largest share was assigned to expansion of rural welfare services and condensed courses of education. Women's economic role was underplayed and confined by the plan to the introduction of the spinning wheel— Ambar Charkhas — as far as opportunities in industries meant for women was concerned.¹⁴ The Fourth Five Year Plan (1969-74) continued with its emphasis on women's education. The basic policy was to promote women's welfare within the family as the basic unit of operation. The outlay on family planning was stepped up and women

were seen as the major agency in the implementation of population control measures.¹⁵ the Fifth Five Year Plan (1974-79) overlapped with the United Nations International Decade for Women (1976-85) and for the first time there was a shift in the approach from 'welfare' to 'development'. The scope of social welfare was enlarged to cover training of women in need of income together with functional literacy to acquire skills and knowledge to perform the household duties including child care nutrition, health care and home economy. However, the plan did not make any policy statements. In 1971 in response to the UN initiative, the Government of India had established a committee on the status of women in India to undertake comprehensive examination of all questions relating to the rights and status of women in the context of the changing social and economic conditions in the country. The report entitled Towards Equality: Report of the Committee on the Status of Women in India (1975) brought forth issues of gendered socialization processes inherent in a hierarchical society as well as asymmetrical resources and asset distribution located in the diverse cultural milieu of the country. A major outcome of the report was the National Plan of Action in 1976, which provided the guidelines based on the UN's World Plan of Action for women. The Plan identified areas of health, family planning, nutrition, education, employment, legislation and social welfare for formulating and implementing action programmes for women and called for planned intervention to improve the condition of women in India. Subsequently, the Women's Welfare and Development Bureau (under the then Ministry of Social and Women's Welfare) was established in 1976.¹⁶ One of the most significant documents to emerge as a part of the International Decade for women was the Forward Looking Strategies for the Advancement of Women, which was intended to provide a blue print for action to advance the status of women in national and international, economic, social, cultural and legal spheres by the year 2000 and to which the Government of Indian has

been a signatory. As a follow-up gesture, the Government, within the broad constitutional and developmental paradigms, set up a separate Department of Women and Child Development under the Ministry of Human Resource Development in 1985. The Earlier Women's Welfare and Development Bureau was merged with this new department, which functions as the nodal agency for issues related to women. The National Perspective Plan for Women was drawn up in 1988 to facilitate mainstreaming of women's issues in policies and programmes.¹⁷ The cumulative impact of the UN International Decade for Women, a more sensitive international environment, and various efforts by the Indian Government is visible to some extent in the Sixth Five Year Plan (1980-85), in which women's development received recognition as a specific development sector, claiming for the first time in India's planning history, a separate chapter on Women and Development. The Plan conceived of a multi-pronged strategy as essential for women's development including : employment and economic independence; education; access to health care and family planning; support services to meet practical gender needs; and the creation of an enabling policy, and institutional and legal environment. The Government of India appointed the working group on employment of women. Two other important reports on village-level organizations and participation of women in agriculture and rural development were prepared. Recognizing lack of resources as a critical impending factor in the women's development, the Sixth Five Year Plan undertook initiatives inter alia, to provide joint land titles to men and women.¹⁸ The Plan also established a cell on science and technology for women in the Department of Science and Technology with specific mandate to devise efficient technologies in four key sectors of drudgery reduction, employment generation, improved health and sanitation and reduced occupational hazards.¹⁹ Despite several progressive steps, the state, through its planning apparatus, still perceived women's place within

the confines of home and family, which remained the basic site for intervention rather than the constituency of 'women' for their own shake.²⁰ The Seventh Five Year Plan (1985-90) continued development programmes for women with the objective of raising their economic and social status. The plan appropriated some of the language of the International Decade for Women and showed some concern at operationalizing the concepts of equity and empowerment and at integrating women into the mainstream of national development. Women were seen as a crucial resource, and the question of their access to critical inputs and productive resources included support through credit and small scale capital, marketing, training in skills, management and technology. The plan also acknowledged the long hours spent in the collection of fuel, fodder and water, etc. A significant step was to indentify and promote 'beneficiary-oriented programmes' specifically focused on women. The UN Commission on the status of women in its 25th Report, had recommended the establishment of national commissions for women or similar bodies with a mandate to review, evaluate and recommend measures to ensure equality between men and women and the full integration of women in all sectors of national life. Following the recommendation and other proposals spring at the national level the Ministry of Human Resource Development prepared the National Commission for Women Bill and introduced it in the Lok Sabha in 1990. The Bill was passed in the same year and the National Commission for Women was constituted in January 1992 as an autonomous statutory body. This has been replicated at the state level also; as for the 2001 Report, 18 states now have their own commissions for women.²¹

India has also ratified various international conventions and human rights instruments committed to securing equal rights for women such as

ratification of Convention on Elimination of all Forms of Discrimination against Women (CEDAW) in 1993.²² Yet the Eighth Five Year Plan (1992-97) has at times been seen as a step backward in the sense that once again women were part of social welfare concerns, which included, besides women, children, the disabled, and the aged, although measures were proposed to ensure that the benefits of development from different sectors did not ignore women. Special programmes aimed at women were to be identified within general development programmes and the flow of benefits to women in the three key sectors of education; health and employment were to be monitored. The development approach to gender equity acknowledged women as equal partners and participants in the development process and emphasized on empowerment of women. The plan period witnessed the highest ever enrolment of girls (83.60 percent) in the 6-11 years age cohort. The Department of Women and Child Development initiated new legislation, employment schemes, and assistance to the voluntary sector. It also prepared a Plan of Action for Women (1989-2000) and set up the Sharm Sakti Commission to assess the conditions of women workers in the informal sector and ways to improve these conditions.²³

The Ninth Plan 1997-2002 changed the conceptual strategy on women in two major ways. First, empowerment of women became one of the nine primary objectives of the Plan whereby utmost importance was given to creating an enabling environment for women for free exercise of their rights, both inside and outside the home as equal partners. Identifying women as agents of social change and development, it proposed the formulation of the National Policy for Empowerment of women. The Plan for the first time, also discussed the need for reservation of seats in Parliament and the state legislative assemblies along with women's enhanced representation in the

public sector and civil services. Second, the plan attempted a convergence of existing services' – in women-specific as well as women-related sectors. To this effect, the plan directed the centre and states to ensure 30 percent of funds/benefits from all general development sectors to women.²⁴ The year 2001 was celebrated as 'Women's Empowerment Year', which saw various activities and programmes specifically aimed at women including the many talked-about women self-help groups. However, the Ninth Plan refrained from making any commitment for achieving any specific goal or target. This was overcome to some extent in the Tenth Plan where for the first time; monitorable targets were set for a few key indicators of human development. The targets include, among other things, reduction in gender gaps in literacy and wage rates and reduction in Maternal Mortality Rate (MMR).²⁵

The Tenth Five Year Plan called for the three pronged strategy of social empowerment, economic empowerment and gender justice to create an enabling environment for the development of women and elimination of all forms of discrimination against them as well as advancement of gender equality goals. The Tenth Five Year Plan (2002-2007) proposes to be different from that of earlier Plans as it borrows from the Platform for Action with definite goals, targets and a time-frame and expects to continue the process of empowering women initiated during the Ninth Plan. The Plan also charts out the operational strategy in terms of a time-bound action plan; responsibilities of the executing agencies, both Government and Non-Government; built-in mechanism for coordination, monitoring, and evaluation of impact through measurable indices etc. The Plan also proposes to encourage SHG mode to act as the agents of social change, development and empowerment of women.²⁶

The vision of the Eleventh Five Year Plan (2007-2012) is to end the multifaceted exclusions and discriminations faced by women. In the Eleventh Plan, for the first time, women are recognized not just as equal citizens but as agents of economic and social growth. The Plan focuses to address the problems (violence, neglect, justice that women face) by looking at gender as a cross-cutting theme. The approach to gender equity is based on the recognition that interventions in favour of women must be multipronged and they must : i) provide women with basic entitlements , ii) address the reality of globalization , and its impact on women by prioritizing economic empowerment, iii) ensure an environment free from all forms of violence against women (VAW)- physical, economic, social, psychological etc. , iv) ensure the participation and adequate representation of women at the highest policy levels , particularly in Parliament and State Assemblies, and create new ones for gender main streaming and effective policy implementation.²⁷

In India the self-help group (SHG) movement has been supported through schemes of a large number of departments including the Women and Child Development, Rural Development, Urban Development, Handlooms and Handicrafts, Sericulture, Agriculture etc.; at the national and state levels. Rastrya Mahila Kosh (RMK) provides credit for livelihood and related activities to poor women. An estimated 1.9 million women are beneficiaries of schemes run by the NABARD and RMK (March 2003). Self-help. groups have also been formed under the South Asia Poverty Alleviation Programme (SAPAP). Skill and capacity building interventions for self-employment are supported through programmes. Such as STEP (Support to Training and Employment Programme), Swawalamban, Swasakti, Swayamsiddha, Integrated Women's Empowerment Programme and Swarnajoyanti Gram Swarozgar Yojana (SGSY). Wage employment programmes like Sampoorna Grameen Rozgar Yojana (SGRY) aims at 30 per cent of the employment

opportunities created to be provided to women. Programmes such as the targeted Public Distribution System, Antodaya Anna Yojana are also run by the Government to ensure food security to the poor. The Indira Awas Yojana stipulates that houses under the scheme are to be allotted in the name of the female member of the beneficiary household.²⁸

A National Policy for the Empowerment of Women has been adopted in 2001 by the Government of India .The goal of this Policy is to bring about the advancement, development and empowerment of women. The Policy will be widely disseminated so as to encourage active participation of all stakeholders for achieving its goals. Specifically, the objectives of this Policy include–

- Creation of an environment through positive economic and social policies for full development of women to enable them to realize their full potential.
- The de-jure and de-facto enjoyment of all human rights and fundamental freedom by women on equal basis with men in all spheres– political, economic, social, cultural and civil.
- Equal access to participation and decision making of women in social, political and economic life of the nation.
- Equal access of women to health care, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office etc.
- Strengthening legal systems aimed at elimination of all forms of discrimination against women.
- Changing societal attitudes and community practices by active participation and involvement of both men and women.

- Mainstreaming a gender perspective in the development process.
- Elimination of discrimination and all forms of violence against women and the girl child; and
- Building and strengthening partnerships with civil society, particularly women's organizations.²⁹

The planning in India continues to view women in terms of their biological role becomes clearly evident in the formulation of family planning programmes incorporated in various Five Year Plans. Despite an expressed concern to link family planning with the wider development processes, efforts to monitor population growth in India have placed an overwhelming responsibility of family planning in the hands of women without actually equipping them to take decisions. Although since the International Conference on Population and Development (ICPD), there has been a paradigm shift in terms of locating population stabilization programmes in the reproductive rights and choices framework, family and children continue to remain the site of interventions for women. The gender budgeting in India shows in 2001-02, the major emphasis in the women-centric programmes of Department of Women and Child Development has been on schemes for 'child welfare rather than for overall empowerment of women'. At the same time significantly enough, there is a decline in the budget allocation on such programmes. (excluding those aimed at child welfare) from Rs.31.9 billion in 2000-01 to Rs.19.5 billion in 2001-02, although the revised estimate was Rs.26.3 billion. Further despite the Ninth Plan's explicit commitment to increase allocations of development resources to women, the budgetary share of programmes under various ministries have not shown any major increase. More importantly, crucial ministries/departments such as education, agriculture, textiles, tribal affairs, social justice and empowerment have, at the most, about 1 per cent of their total expenditure for women specific

programmes during the years 2001-03 as against about 30 percent of the total outlay of the Department of Family Welfare allocated to women related programmes, especially to reproductive and child health until 2001-02. By and large, the Indian scene, as it relates to women, is characterized by contradictions of this sort with an underlying tension to confine to conventional role models for women and a desire to break away from that model at the same time. This confusion has, however, led to an increasing awareness that constitutional commitment to equality of opportunity is not enough unless it is backed by strategic interventions by women themselves, and a new vocabulary of empowerment emerged whereby mass-based local movements and the State joined hands in creating enabling conditions to support, reinforce and match efforts by women and legitimize women's entry into new spaces.³⁰

Women and Empowerment

The Millennium Development Goals (MDGs) have opened new vista for the advancement of gender equality. In September 2000 at the Millennium Summit the member states of United Nations issued the Millennium Declaration committing to a series of targets to be achieved by 2015. 189 countries including India were signatories of the Declaration to achieve targets on human rights, democracy, strong governance, environmental sustainability and poverty eradication. The countries also agreed on the need for an urgent and collective commitment required to overcome poverty, the greatest menace and obstacle to development.³¹ Millennium Development Goals make up of eight goals of which no. 1 is to eradicate poverty and hunger and no. 3 is to promote gender equality and empower women. Both the goals of MDGs call for women empowerment. Because, nowadays, there

is increased realization that a country's development model should be engendered, giving equal opportunities to both women and men so that the benefits of development are equally enjoyed by all. This emphasizes the need to recognize women as agents and beneficiaries of change. As a corollary of the fact investing in developing their capabilities and empowering them to make their own choices are deemed crucial not only for their own development but also contributing to the overall economic growth and development.³²

Empowerment literally means becoming powerful. It is often used to describe a process whereby the powerless or disempowered gain a greatest share of control of resources and decision making power. The empowerment of women in general, poor women in particular is a process of changing the existing power relations in favour of the poor and the marginalized women and requires changes in knowledge, attitude and behaviour of not only women, but also of men and the society at large. Empowerment is a process of awareness and capacity building leading to greater participation to greater decision-making power and control and to transforming action. Women, particularly poor women, are relatively powerless because they do not have control over resources and therefore little or no decision-making power. Empowerment occurs both at individual as well as collective levels.³³ Movements to empower women increase opportunities available to individual women. At individual level, a new confidence and sense of self-efficacy emerges as the person redefines her role as a more capable and worthy individual in terms of knowledge, competency, skills, resources and opportunities.

Empowerment of women can be visualized as a process, a continuum of several inter-related and mutually reinforcing components, such as:-

1. Awareness building regarding discrimination against women and their rights and opportunities as steps towards gender equity. Collective awareness building provides a sense of group identity and a power of working as a group.
2. Capacity building and skills development, especially the ability to plan, take decisions, organize, manage and carry out activities to deal with people and institution around them.
3. Participation, greater control over decision making power at home and community.
4. Action to bring about greater equality between men and women.³⁴

The process of empowerment begins in the mind from woman's consciousness, from her very beliefs about herself and her rights, capabilities and potential, from her self-image and awareness of how gender as well as other socio-economic and political forces acting on her; from breaking free of the sense of inferiority which has been imprinted since earliest childhood, from recognizing her strengths, above all, from believing in her innate right to dignity and justice.³⁵ The parameters for women empowerment are:

- Building a positive self-image and self-confidence;
- Developing ability to think critically;
- Building up group cohesion and fostering decision-making and action;
- Ensuring equal participation in the process of bringing about social change;
- Encouraging group action in order to bring about change in the society; and
- Providing the wherewithal for economic independence.³⁶

The experts on gender issues hold that women's advancement involves the process of empowerment and define it as a process, by which women achieve

increased control over public decision making. The male domination of society and Government are often seen for the purpose of serving male interests and continued subordination of women. The experts also contend that there are five levels of the women's empowerment framework, namely—welfare, access, conscientisation, mobilization and control.

- Welfare means an improvement in socio-economic status, like improved nutritional status, shelter or income, which is the zero level of empowerment, where women are the passive recipients of benefits that are given from top.
- Access to resources and services stands for the first level of empowerment, since women improve their own status, relative to men, by their own work or organization.
- Conscientisation is defined as the process, by which women collectively urge to act to remove one or more of the discriminatory practices that impede their access to resources. Here, women form groups to understand the underlying causes of their problems and to indentify strategies for action for gender equity.
- Mobilization is the action level of empowerment by forging links with the larger women's movement to learn from the successes of women's similar strategic action elsewhere and to connect with the wider struggle.
- Control is the level of empowerment when women have taken action so that there is gender equality in decision making over access to resources, so that women achieve direct control over their access to resources. Absence of the above, would more clearly address the underlying causes of women's powerlessness and the discrimination they experience in their daily lives.

Most popular version of empowerment often shared by the NGOs and action groups, envisages awareness building, capacity creation and participation that lead to transformation of unequal relationships, increased

decision making at home and community and greater participation in politics. This approach has the advantage of providing a space for challenging the existing social, political and economic structures, with a view to create more equitable and participatory structures in which women can gain control over their lives. According to this approach, empowerment of women must increase their self reliance, provide independent right to make their decisions and challenge their subordination. It is a multi-faced process of development involving the pooling of resources to achieve collective strength, countervailing power and enhance the capacity of women.

Economic Empowerment of Women and Microfinance

Empowerment of women is a holistic concept and multi-dimensional in its approach and of all the facets of women development, economic independence or economic empowerment occupies an area of utmost significance for a lasting and sustainable development of society. Women's economic independence is highly stressed by many authors. An International Labour Organization study finds that men tend to spend 60 percent of their income in their home and 40 percent on themselves, whereas a woman spends 90 percent of her income on her family and only 10 percent on herself.³⁷ The World Bank studies have shown that enhancement of women's earnings would have a more profound effect on the welfare of the family as a whole since increase in women's income results more directly into better education, health and nutrition for children.³⁸ Research indicates that participation of women in economic activities their increasing presence in the workforce is important not only for lowering the disproportionate levels of poverty among women, but also an important step toward raising household income and encouraging economic development of the nation as a

whole. The term “feminization of poverty” is often used to illustrate the fact that a substantial percentage of poor are women and that the gap between women and men in poverty is not lessened, but may well have widened. Economic empowerment not only benefits women but also men, children and society as a whole. Women’s lack of economic independence on the other hand, not only impedes growth and poverty reduction, but also has a host of other negative impacts on health, education, and wellbeing of the children. Thus it is extremely important to ensure that women are economically empowered. There are various factors that contribute to the economic empowerment of women. These factors operate at various levels.³⁹

Policy Level

Women’s representation in better remuneration jobs; representation of women’s interests in macro-economic policies, national and state

Community Level

Ownership of assets and land; access to credit; involvement and for representation in local trade associations; access to markets.

Household Level

Women’s control over income; relative contribution to family support; access to and control of family resources.

As poverty continues to plague the developing world, there is constant search for policy alternatives that may be able to address this problem more

effectively. Newer alternatives may appear to be promising and may rapidly acquire fame. In this context, microfinance an off shoot of microcredit is seen as one such alternative receiving wide acclaim all over the world as an antidote to poverty. The term microfinance or microcredit has gained much currency in the development literature in the last decade and half. Nowadays, microfinance is considered as the most effective tool for providing institutional financial support to the marginalized poor people. It has become an important credit disbursement system all over the world. The declaration of the microcredit summit held in Washington D.C (1997) defined microcredit as “extending small loans to poor people for self-employment project that generate income; allowing to care for themselves and their families”. Microfinance is a set of financial activities provided to the poor masses, which basically incorporates loans, savings and deposits, insurance, transfer services, etc. International Labour Organization (ILO) defines; microcredit is an economic development approach that involves providing financial services through institutions to low income clients.⁴⁰ World Bank defines microfinance as “the programmes that provide credit for self employment and other financial and business services to very poor persons”.⁴¹ Microfinance is a combination of savings, loans, investment opportunities, insurance options and other financial services, combined with group solidarity. The concept of microfinance is not new. It was existed in every society in one form or another. History reveals that the modern concept of microfinance can be traced out in Marshal Plan at the end of the Second World War in the middle of 20th century.⁴² Many countries started microcredit facilities by establishing various institutions. In 1959 Dr. Akhtar Hameed Khan introduced ideas of microfinance through Comilla Co-operative Pilot Project, Al Whittaker introduced Opportunity International in Washington DC (1971), ACCION International in Brazil (1973); Women’s World Banking, (1976); FINCA International (1980); and APMAS and

OXFAM organizations offered microfinance to poor people. Efforts of Grameen Bank (Started by Muhammad Yunus in 1976) and Bangladesh Rural Advancement Committee (BRAC) of Bangladesh (a pioneer in providing small loans to the poor); Bank Rakyat Indonesia (BRI) in Indonesia; Amanah Ikhtiar Malaysia (AIM) of Malaysia are some other successful examples.⁴³

Empowering women is the top most priority of microfinance programmes. UN Micro Credit Project helps women in rural areas of various nations. The projects like CARE, ZAMBVA in Zambia; ACTION AID in Sierra Leone and Bangladesh; EDUCARE in Pakistan, UGANDA WOMEN FINANCE AND CREDIT TRUST in Uganda aim at supporting women in taking loans; starting their own business; gaining them access to land; and benefiting them from adult education. The Micro Credit Summit Campaign was launched in 1997. The year 2005 was celebrated by the United Nations as International Year of Micro Credit. The pioneering efforts at providing microcredit was made by Prof. Yunus in the seventies, the world wide impetus really took off after the 1997 World Microcredit Summit – held in Washington D.C. – which targeted at eradicating poverty of 100 million poorest families within 2005. Declaration of 2005 as the international year of microfinance and awarding Prof. Yunus and Grameen Bank with the Nobel Peace Prize in 2006 are recent events and which highlight the significance and recognition of this movement.⁴⁴

Microfinance has been regarded as a promising strategy for financial inclusion in India (RBI 2006). “Financial inclusion has been officially defined in India as the provision of affordable financial services to those who have been left unattended or under attended by the formal agencies of the

financial system”⁴⁵ Eradication of poverty has been on the agenda of Government of India since early fifties. However, the strategy of direct attack on poverty was formulated in the early seventies and special programmes for the poor were introduced in the Fourth Five-Year Plan (1969-74). Expansion of employment generation programme was mainly based on financial assistance or loan. Micro-credit in India is not a new phenomenon. The enactment of the Co-operative Societies Act in 1904 could be considered as the beginning of micro finance in India. The formal financial sector has been making efforts to facilitate access to credit to small farmers, to the weaker sections of the society, marginal farmers, agricultural and landless labourers since 1960s. Creation of All India Rural Credit Review Committee (1966); the Small Farmers’ Development Agencies (1969-74); Marginal Farmers and Agricultural Labourers (MFAL), Development Agencies; Regional Rural Banks Act (1976); introduction of IRDP (1978-79) NABARD (1982) are the steps taken in this direction.⁴⁶

The Government of India launched many programmes like IRDP, DWCRA, TRYSEM, SITRA etc, which aimed to finance micro enterprises. As a significant initiative towards antipoverty programme Government of India launched Integrated Rural Development Programme in the year 1979-80, which aimed at providing self employment opportunities to the rural poor through assistance in the form of subsidy and bank credit to enable them to acquire productive assets and appropriate skills to cross the poverty line in a sustained manner. However, it is estimated that only 20 percent of the borrowers have crossed the poverty line after assistance.⁴⁷

Despite massive infrastructure of banks, as per all India Debt and Investment Survey 1991-92, 36 percent of the rural indebted households are

still dependent on the informal sector. The dependence on informal sector was much higher in the case of lower asset group.⁴⁸ In this context, women's situation is much more devastating. The efforts to involve women more intensively in the microfinance mechanism started in early 1990s. In the early 1990s the National Bank for Agricultural and Rural Development (NABARD) launched a new nation-wide microfinance initiative linking banks, NGOs and informal local groups (self-help groups or SHGs). This SHG-bank linkage programme is expected to become a dominant form of financial assistance for the rural women. With the aim to meet the Millennium Development Goals and microfinance programmes role in supporting it, there has been an increasing expectation on their impact on women empowerment. A series of research studies conducted by NABARD during the early 1980s revealed that despite having a wide network of rural branches which implemented a variety of poverty alleviation programmes seeking creation of self employment opportunities through bank credit for almost two decades, a large number of this poorest of the poor continued to remain outside the formal banking system. These studies also showed that the existing banking policies, systems and procedures, and deposit and loan products were, perhaps, not suited to meet the most immediate needs of the poor. It also appeared that what the poor really needed was better access to these services and products, rather than cheap subsidized credit.

Thus began a search for alternative policies, systems and procedures, savings and loan procedures, savings and loan products, other complementary services and new delivery mechanisms which would fulfill the requirements of the poorest, especially the women members of such households.

The emphasis was, therefore, on improving the access of the poor to microfinance. NABARD focused on finding out ways and means to improve the access of the poor to existing banking network. Many research studies, done in-house as well as sponsored by professional institutions, and some action research projects funded out of the research and development fund of NABARD, led it to develop the SHG-bank linkage model as a core strategy that could be used by the banking system in India for increasing its outreach to the poorest of the poor, hitherto bypassed by them. It was in this scenario that the SHG-bank linkage programme was launched by NABARD in 1992 with the firm policy back up of the Reserve Bank of India. The SHG-bank linkage programme is the flagship microfinance intervention mechanism of NABARD. It is a landmark development in the microfinance movement and in the annals of banking with the poor. The informal thrift and credit groups of the rural poor came to be recognized as bank clients under the pilot phase. NABARD has been playing the role of propagator and facilitator by providing a conducive policy environment, training and capacity building besides extending financial support for the healthy growth of the SHG-bank linkage programme in the country. Microfinance services in India are provided mainly by two different models viz. SHG-bank linkage model and MFI-bank model. The SHG-bank linkage model has emerged as the more dominant and successful model due to its adoption by state-owned formal financial institutions like, Commercial, Regional Rural and Cooperative Banks.⁴⁹

The links between banks on the one hand, and NGOs and SHGs on the other, as a mechanism for channelizing credit to the poor on a sustainable basis have been established under the SHG-bank linkage model/approach. Linking SHGs to banks helps in overcoming the problem of high transaction costs to banks in providing credit to the poor, by transferring some banking responsibilities, like loan appraisal, follow-up, recovery etc. to the poor themselves.⁵⁰

Since, the early 1990s with the launch of this SHG-bank linkage approach led by NABARD has made big strides in India as micro finance facilities have become accessible to a considerable number of poor people, especially women. The success of the SHG-bank linkage model in microfinance can be judged from the following table.

Table 6.2**SHG-Bank Linkage in India**

Year	New SHGs financed by banks	Bank loan provided to SHGs (Rs. Million)	Cumulative progress upto end March (Rs. Million)		Number of families assisted (in million)	Number of participating banks			Model wise linkage		
			SHGs financed	Bank loan		CB	RRB	Co-operative Banks	I	II	III
2001-2002	197653	5454	461478	10263	7.8	44	191	209	16	75	9
2002-2003	255882	10224	717360	20487	11.6	48	192	265	20	72	8
2003-2004	361731	18555	1079091	39042	16.7	48	196	316	20	72	8
2004-2005	539365	29942	1618456	68985	24.3	47	196	330	21	72	7
2005-2006	620109	44991	2238565	113975	32.9	47	158	342	20	74	6

Source: NABARD, Progress of SHG-Bank Linkage in India, 2005-06, Micro Credit Innovation Department.

The table 6.2 explains the increasing importance of micro finance in empowering poor people, especially women in India. In order to promote micro financing, the Government of India and regulatory bodies in India have taken some strategic policy initiatives in the area of microfinance by establishing (1) Working Group on credit to the poor through SHGs, NGOs, NABARD, 1995; (2) The National Micro Finance Task Force, 1999; (3) Working Group on Financial Flows to the Informal Sector, 2002; (4) Micro Finance Development and Equity Fund, NABARD, 2005; (5) Working Group on Financing NBFCs by Banks-RBI.⁵¹

REFERENCES

1. UNDP, (2003), Human Development Report 2003, Millennium Development Goals: A Compact among Nations to end Human Poverty, Oxford, Oxford University Press, p.27
2. Ibid, p.1
3. UNDP (1992), Human Development Report 1992, Oxford, Oxford University Press, p.2
4. Ibid, p.3,
5. Progress of South Asian Women 2005, Accountability to the World's Women, A Series for the Fifth South Asia Regional Ministerial Conference Celebrating Beijing Plus Ten (UNIFEM) UNO, New Delhi, Institute of Social Studies Trust Development Fund for Women, pp.6 - 7
6. World Bank, (2001), Engendering Development : Through Gender Equality in Rights, Resources and Voice - Summary cited in Empowering Women through Microfinance by S. Cheston, Lisa Kuhn, UNIFEM, New York, Oxford University Press, p.7
7. Cheston, Susy and Kuhn, Lisa, Empowering Women Through Microfinance, UNIFEM, UNO, New York, Oxford University Press, p.7
8. UNDP, (1995), Human Development Report 1995, New York, Oxford University Press, p.36
9. GOI, (2006), Report of the Working Group on Empowerment of Women for the XI Plan, 2006, New Delhi, Ministry of Women and Child Development, p.9
10. Ibid,p.9
11. Ibid, p.10
12. Raju, S. (2006), "Locating Women in Social Development" in India Social Development Report, Council for Social Development, Oxford, Oxford University Press, p.78

13. Ibid, p.78
14. Seth, M. (2001), Women and Development, The Indian Experience, quoted in "Locating Women in Social Development" by S. Raju, India Social Development Report (2006), op.cit. no.12, p.79
15. Raju, S. op. cit. no.12, p.79
16. Ibid, p.79
17. Ibid, p.79
18. Ibid, p.79
19. Government of India, (1998), Draft National Perspective Plan for Women 1988-2000, mimeo, Department of Women and Child Development, quoted in "Locating Women in Social Development" by S. Raju, India Social Development Report 2006, op.cit. no. 12, p.79
20. Swaminathan, P. (1991), "Science and Technology for Women, A Critique of Policy", EPW, vol. 26 (1 - 2), pp. 59 - 63
21. Raju, S. op. cit. no.12, p.80
22. Ibid, p.80
23. Ibid, p.80
24. Seth, M. (2001), Women and Development, The Indian Experience, quoted in "Locating Women in Social Development" by S. Raju, India Social Development Report 2006, op.cit. no.12, pp. 80-81
25. GOI, (2006), Report of the Working Group on Empowerment of Women for the XI Plan, 2006, New Delhi, Ministry of Women and Child Development, p.8
26. GOI, (2004), Tenth Five Year Plan (2002-2007), New Delhi, Planning Commission, p.238
27. GOI, Eleventh Five Year Plan (2007-2012), Vol – II, Social Sector, New Delhi, Planning Commission, p.16

28. Progress of South Asian Women 2005, op.cit. no. 5, pp. 9-10.
29. GOI, (2006), Report of the Working Group on Empowerment of Women for the XI Plan, op.cit. no. 9, p.60
30. Raju, S. (2006), “Locating Women in Social Development” in India Social Development Report 2006, op.cit. no.12, p. 80
31. GOI, Mid-Term Appraisal of the Tenth Plan (2002-07) Reality-check, New Delhi, Planning Commission, pp.62-63
32. UNDP, (1995), Human Development Report 1995, New York, Oxford University Press pp.1-2
33. Gender Framework Analysis of Empowerment of Women 2008 NIPCCD, p.25
34. Ibid, p.25
35. Narayana, Shashi S. (1998), “Empowerment of Women through Social Mobilisation”, Women’s Link, vol.4, no. 1, January–March p.12
36. Indian Association of Women’s Studies, (1995), “The State and the Women’s Movement in India”, A Report, New Delhi, December, p.75
37. Aggraval, P. (1987), “Role of Women in Socio-Economic Development”, Social Welfare, March, pp.13-16.
38. Viswanathan, Sujatha (1997), “Grouping Women for Economic Empowerment”, Yojana, vol-14, no.3, March, p.37.
39. Government of India (2006), Report of the Working Group on Empowerment of Women for the XI Plan, Ministry of Women and Child Development, op. cit. no. 9, p.22
40. Gaur, G.L. (2009), “Micro-Credit : Rural Orientation”, Economic Affairs, vol.54 (1 - 2), p.35
41. World Bank, (1997), Introducing Savings in Micro-Credit Institutions, when and how quoted in Micro-Finance and Rural Development – A Critical Review by K.K. Bagchi, (2009), New Delhi, Abhijit Publication, p.136

42. Gaur, G.L. (2009), “Micro-Credit : Rural Orientation”, Economic Affairs, vol.54 (1-2), p.35
43. Bagchi, K. K. (2009), Micro-Finance and Rural Development – A Critical Review, New Delhi, Abhijit Publication, p.138
44. Ibid, p.138
45. Gaur, G.L. (2009), “Micro-Credit : Rural Orientation” Gaur, Economic Affairs, vol.54 (1 - 2), p.35
46. Jayaram, B. (2001), “Micro Finance Retrospect and Prospects”, Occasional Paper 20, cited in Micro-Finance and Rural Development – A Critical Review by K.K. Bagchi, (2009), op.cit.no. 43, p.139
47. Bagchi K.K. (2009), Micro-Finance and Rural Development – A Critical Review Delhi, Abhijit Publication, p.11
48. Sing, S (2008), “SHG-Bank Linkage Programme : Progress and Prospects” in Microfinance in India by K.G. Karmakar, New Delhi, Sage, p.113.
49. Ibid, p.115-117
50. Bagchi, K.K. (2009), op.cit. no. 47, p.142
51. Bagchi, K.K. (2009), op.cit. no. 47, p.145

Chapter-VII

Introduction

Human development is a process of enlarging the choices for all people not just for one section of the society. The process of development becomes incomplete and inequitable if women are excluded from the benefit of it. “Human development encompasses elements that constitute the critical issues of gender and development. There are four major elements in the concept of human development productivity, equity, sustainability and empowerment. Through enhanced capabilities, the creativity and productivity of people must be increased so that they become effective agents of economic growth. Economic growth must be combined with equitable distribution of its benefits. Equitable opportunities must be available both to present and future generations resulting in sustainability. And all people, women and men must be empowered to participate in the design and implementation of key decisions that shape their lives.”¹

Where gender determines the access to resources and power the process of empowerment helps individuals to recognize and oppose the forces that deny such access. Power accrues to those who gain control over the distribution of resources. In India women in general, poor rural women in particular are relatively powerless with no control over resources and little decision-making power. Often the decisions are imposed on them. The prevailing patriarchal system which demands submission and sacrifice of women often undermines their capability and deprives them of their share of resources.

The process of challenging existing relations and gaining greater control over the forces of power may be termed as empowerment. Empowerment of women must be an integral part of sustainable human

development. The goals of women's empowerment challenge the patriarchal system by way of transforming the structures and institutions that reinforce and perpetuate gender discrimination and social inequality and enabling poor rural women to gain access to and control of both material and informational resources.²

Empowerment of rural women calls for and requires equality of work and elimination of wages, expansion of girls education, autonomy over reproductive life, access to ownership of land and property, training and technology, access to bank credit and markets, safe water sanitation and energy. Among these various determinants of women's empowerment, access to bank credit is one crucial factor. Women are the most preponderant segment of the rural society who have long been overlooked by the formal banking sector. In order to improve the status and position of rural women at home and society at large, economic empowerment through income generating activities is indispensable. Economic empowerment helps the rural women to understand and avail various social opportunities for their social empowerment and development. In the promotion of self employment, lack of credit has been a major constraint especially for rural women. Being economically vulnerable rural women often fall victim into the debt trap by getting into the clutches of exploitative money lenders.

The underprivileged in rural areas especially rural women have been engulfed in a vicious circle of poverty and patriarchal grip for a long time and have lost their initiative to come out of it and have developed a passive attitude towards development programmes meant for the well-being of rural areas.³ To get rid of these social hurdles and traps the rural women need to be organized, aware. Rural women have to realize the significance of their empowerment economic, social and political. In this context, the role of NGOs assumes significance and importance to a great extent. Economic

empowerment is not an automatic consequence of the provision of financial resources to women. Mere disbursement of loan in the name of women alone does not contribute to their empowerment⁴ Who uses the loan and controls the business and how to use the loan are the factors which need to be probed into. It is NGO which can play a catalytic or intermediary role in this perspective. By acting as intermediaries the NGOs that support women borrowers can play an effective role in culture where rural women's contact with bankers is limited by custom, religion, shyness, timidity, hesitancy or where the gap in education between women and men are so great that women borrowers are unable to compete on their own for resources and facilities or where the gender gap is so great due to patriarchal structure that women are dominated and prevented by male member from coming out of their narrow circle.

Microfinance, the current buzzword in the developmental sector is often hailed as a panacea for the problems of community development. Microfinance commonly works through group systems like the Grameen Bank of Bangladesh, Solidarity Groups of Latin America and Self-help Groups (SHGs) in India. SHGs the most common microfinance institutions in India are small voluntary associations of poor people from the same socio-economic background who came together for the purpose of solving their common problems through self-help and mutual help.⁵

Through microfinance poverty can be reduced and the resultant increased access and control over financial resources by women can itself become an empowering instrument. The popularization of microfinance has given feminist scholars an opportunity to put gender back in focus in the discussions of development planning. Microfinance, SHG has become a ladder for poor to bring them up not only economically but also socially, mentally and attitudinally.⁶

Location of the Study

The study has been conducted in Darjeeling district of West Bengal. Darjeeling is the northernmost district of West Bengal. Of all the frontier district of India the boundary of Darjeeling is most complicated. It is hemmed in by international frontiers. There is Nepal to the West, Sikkim a State of India to the north, Bhutan and Bangladesh to the east and Bihar a state of India and North Dinajpur a district of West Bengal to the South.

Extending over an area of 3149 sq. K. M. (2001) the population of the district is 1609172 of which 830644 (51.62%) males and 778528 (48.38%) females according to census of India 2001.⁷ In terms of population the district ranks 17 among the districts of West Bengal. The population of the district in the general category is 71.2 percentage, in the SC category 16.1 percentage and in the ST category 12.7 percentage.⁸

The rural population is 1088740 (67.66%) of which males 556633 and females 532107; and the urban population is 520432 (32.34%) of which males 274011 and females 246421.9 The sex ratio of Darjeeling is 937. The child sex ratio (0-6 age group) is 962. ⁹

The literacy rate of Darjeeling district is 71.80 percent with male 80.10 percent and female 62.90 percent. In rural area the male and female literacy rate is 71.1 percent and 55.4 percent respectively. In urban area it is 87.7 percent and 78.5 percent respectively. The total rural literacy rate is 66 percent and in urban area it is 83.3 percent.¹⁰ In this district there are 38 hospitals, 34 health centres, 230 clinics (sub-centres), 25 dispensaries, 2833 total beds, 315 doctors and the number of total family welfare centres in this district is 73.¹¹ The district comprises four sub-divisions namely–SADAR, KALIMPONG, KURSEONG and SILIGURI. Darjeeling is headquarter of

the district. Darjeeling has 17 police station, 640 inhabited villages, 708 mouzas, 4 municipalities, 1 municipal corporation. It has 12 blocks such as Darjeeling/Pulbazar, Sukhiapokhri-Jorebunglow, Rangli-Rangliot under Sadar sub division; Kalimpong I, Kalimpong – II and Gorubathan under Kalimpong sub-division; Kurseong and Mirik under Kurseong sub-division; and Matigara, Naxalbari, Kharibari and phansidewa under Siliguri sub-division. Darjeeling district consists of 12 panchayat samities, 134 gram panchayats, and 1390 gram samsads.¹²

There are three NGOs in Darjeeling which have been entrusted with the SHG bank-linkage programme associated with NABARD. These are – Naxalbari Handicapped Welfare Society, Naxalbari; Krishak Kalyan Sangathan (Federation of Farmers Clubs) Kalimpong; and Hill Social Welfare Society, Kalimpong.¹³

The study has been concentrated on Naxalbari Handicapped Welfare Society (NHWS). The other two NGOs have been excluded from the study due to inaccessibility because of language barrier, communication problems and the recent agitation in the hills by Gorkha Jana Mukti Morcha.

Naxalbari is one of the blocks under Siliguri sub-division. In Naxalbari there are one (1) Panchayat Samiti, six (6) Gram Panchayats, ninety five (95) Gram Sansads and ninety eight (98) Mouzas. It has eighty two (82) inhabited villages and thirty thousand three hundred and five (30305) households. The total population of Naxalbari block is 144915 of which 75831 males and 69084 females. In Naxalbari total rural literacy rate is 64.7 percent of which 75.5 percent males and 52.7 percent females and urban total literacy rate is 84.2 percent of which 91.2 percent males and 76.6 percent females. Total literacy rate in Naxalbari is 66.9 percent of which 77.3 percent males and 55.4 percent females. In Naxalbari total SC

population is 36851 of which 19006 male and 17845 female and total ST population is 27076 of which 13575 male and 13501 female. Naxalbari has one (1) hospital, one (1) health centre two (2) dispensaries, sixty (60) total beds and eleven (11) doctors.¹⁴

For field study the list of NGOs which are working on microfinance programme for women's economic empowerment and welfare under the NABARD sponsored bank-linkage scheme, has been collected from the Regional Head Office of NABARD at 6, Royd Street, Kolkata – 700 016.

The Naxalbari Handicapped Welfare Society formed 64 SHGs – 19 at Upper Bagdogra, 6 at Lower Bagdogra, 6 at Hatighisha, 11 at Manirampur and 22 at Naxalbari. Among these SHGs 20 SHGs are linked with the bank when the interview was conducted. Each SHG has 11-15 members. From each group 6 members were selected randomly for interview. Two SHGs did not turn up for interview. Therefore, interview was conducted in 18 SHGs. The total number of members of these 18 SHGs was 211 of which 108 members were supposed to be interviewed. But among these 108 members only 84 members turned up for interview.

Women and Microfinance: Field Study

Income of the Respondents in Pre-SHG and Post-SHG Stage

The respondents were categorised into 4 groups on the basis of their monthly income like Group-A (no income), Group-B (Rs.100 – Rs.500), Group-C (Rs.501-Rs.1000) and Group-D (above Rs.1000). The SHG members involved themselves in various activities with loan taken from their respective groups. They invested their loan in various income generating activities like small grocery shop, sewing, piggery, goatery, Chinese-grass cultivation, business on cloth, cosmetics, cattle rearing etc.

Table 7.1

Income of SHG Respondents in Pre-SHG and Post-SHG Stage

Monthly Income Group	Pre-SHG		Post-SHG	
(A) No income	67	80%	8	10%
(B) 100-500	7	8%	21	25%
(C) 501-1000	5	6%	28	33%
(D) Above-1000	5	6%	27	32%

The table 7.1 reveals that before joining SHG, 80% of the respondents had no monthly income, 8% of the respondents had monthly income of Rs.100-Rs.500, 6% had monthly income of Rs.501-Rs.1000 and also 6% had monthly income above Rs.1000.

But after joining SHG in Group-A the respondents reduced to 10%, in Group-B the respondents increased to 25% (17% respondents added to this group), in group C the respondents increased to 33% (27% respondents added to this group), and in Group –D 32% respondents increased (26% respondents added to this group).

Therefore, at the post-SHG stage 70% women have been engaged in income generating activities. Before joining SHG a majority of women were unable to contribute towards their family income as they did not have the skills or the opportunities for employment. The increased income helped them to a great extent to reduce the levels of poverty. Further, they get opportunities to help their children for their better education, health and

other development. Therefore, joining SHGs benefited the members economically.

Education and Source of Information Regarding SHG

On the basis of education the members of the SHGs have been categorised into six groups like literate, primary, high school, secondary, higher secondary and graduate in order to workout the percentage of members from each group receiving information about SHG from NGO, panchayats, community leaders and friends.

From the table 7.2 it is found that from literate group 35% respondents got information from NGO, 2% from panchayats, 6% from friends. From primary group 6% respondents had information only from NGO. From high school group 27% respondents got information from NGO, 4% from panchayats and 8% from friends. From secondary group 6% respondents

Table 7.2

Education and Sources of Information Regarding SHG

Education	NGO		Panchayats		Community Leaders	Friends	
	Count	Percentage	Count	Percentage		Count	Percentage
Literate	29	35%	2	2%		5	6%
Primary	5	6%	0			0	
High School	23	27%	3	4%		7	8%
Secondary	5	6%	1	1%		2	2%
Higher Secondary	2	2%	0			0	
Graduation	0		0			1	1%

received information from NGO, 1% from panchayats and 2% from friends. From Higher Secondary group 2% respondents received information only from the NGO and only 1% respondent from graduate group received information only from friends.

From the table it is clear that the respondents from literate group (43%) and from high school group (39%) rank high in getting information regarding formation of SHGs. The table also shows that the NGO plays a greater role in disseminating information regarding SHG formation rather than panchayats, community leaders and friends. 76% respondents from all groups except graduate group received information from the NGO, 7% respondents from all groups except primary, Higher Secondary and graduate groups, received information from panchayats and 17% respondents from all groups except primary and Higher Secondary got information from friends. The panchayats play very poor role in disseminating information rather than NGO and friends. Friends have a moderate role in spreading information. The community leaders have absolutely negative role in this case.

Income and Sources of Information Regarding SHG

The SHG members of different income groups got information about SHG formation from the NGO, panchayats, community leaders and friends. The observation to be studied was to see the percentage of respondents from each income group receiving information from each of the sources and to identify the source that played maximum role in spreading information.

Table 7.3

Income and Sources of Information Regarding SHG

Income Group		Sources of Information						
		NGO		Panchayats		Community Leaders	Friends	
(A)	No income	51	61%	5	6%		11	13%
(B)	100-500	5	6%				2	2%
(C)	501-1000	3	4%				2	2%
(D)	Above-1000	5	6%					

The table 7.3 shows that the majority respondents (61%) from income Group-A received information from the NGO, 6% from panchayats and 13% from friends. From income Group-B 6% respondents got information from the NGO and 2% from friends. From income group-C 4% respondents got information from the NGO and 2% from friends. From income Group-D 6% respondents received information from the NGO only.

Total 77% respondents from all income groups received information from the NGO, 6% from panchayats and 17% from friends. It explains that the NGO is much more active in networking information to the respondents about SHG formation than the other three sources. Panchayats have very negligible role in disseminating information and the community leaders have absolutely negative role.

Age and Sources of Information Regarding SHG

The respondents have been classified into four age-groups like 16-30, 31-45, 46-60 and above 60, to assess the exposure of different age groups to the sources of information – NGO, panchayat, community and friends.

Table 7.4

Age and Sources of Information Regarding SHG

Age	NGO		Panchayats		Community Leaders	Friends	
16-30	26	31%	3	4%		9	11%
31-45	34	40%	1	1%		6	7%
46-60	4	5%	1	1%			
Above 60							

The table 7.4 shows that 31% respondents from age group 16-30 received information from the NGO, 4% received information from panchayats and 11% respondents got information from friends. 40% respondents from the age group 31-45 got information from the NGO, 1% respondent received information from panchayats and 7% got information from friends. 5% respondents from the age 46-60 got information from the NGO, 1% from panchayats.

Here it is clear that the majority of the respondents from the age group 16-30 and 31-45 received information from the NGO. The respondents of these two groups are more active in collecting information. In another way, respondents of all the age groups received information from the NGO. It means, the NGO is highly active in spreading information about SHG formation.

Participation of SHG Members in Group Activity

For assessment of participation of the SHG members in group activities and to know whether they have information about group activities some specific questions in the schedule included:

- A: The group hold regular group meeting.
- B: The total amount of savings of the group.
- C: Amount of loan the group received from the Bank.
- D: The total number of members received loan from the group.
- E: Participation in the decision making process regarding loan disbursement and loan repayment of the group.
- F: Maintenance of ledger books of savings and credit, registrar book, minuets book etc. of the group.

Table 7.5

Participation of SHG Members in Group Activity

Questions Asked	Yes		No		No Answer	
A	84	100%				
B	82	98%	01	1%	01	1%
C	83	99%			01	1%
D	83	99%			01	1%
E	83	99%			01	1%
F	82	98%			02	2%

From the table 7.5 it shows that relating to question no. A 100% respondents answered yes. Regarding question no. B 98% respondents answered yes and 1% answered no and 1% did not answer. In question no. C 99% respondents answered yes and 1% did not answer. In question no. D 99% respondents answered yes and 1% did not answer. In question no. E 99% respondents answered yes and 1% did not answer. In question no. F. 98% respondents answered yes and 2% did not answer.

The above data explain that the participation level of SHG members in their group activities is very high. They are also highly informed about the amount of loan taken by group from the bank, the decisions taken regarding loan disbursement and repayment and maintenance of the books relating to group meeting.

Economic Empowerment of the SHG Members

In order to ascertain the degree of economic independence of the group members the questions that were set relate to:

- A: Receiving loan from the group.
- B: Joining microfinance programme through SHG increased the financial capacity.
- C: Access to microfinance programme through SHG helped increasing access to health and education of the family.
- D: Attending group meeting regularly.
- E: Taking part in the decision-making of the group.

Table 7.6
Economic Empowerment of the SHG Members

Questions Asked	Yes		No		No Answer	
	Count	Percentage	Count	Percentage	Count	Percentage
A	82	98%	02	2%		
B	74	88%	01	1%	09	11%
C	81	96%	03	4%		
D	84	100%				
E	84	100%				

Table 7.6 reveals that 98% respondents answered yes in question no. A and 2% answered no. Relating to question no. B 88% respondents answered yes, 1% answered no and 11% did not answer. In question no. C 96% respondents answered and 4% answered no. Regarding question no. D and E all the respondents answered yes. It explains that joining microfinance programmes through SHG helped them a lot regarding their increase in

financial capacity, availing services like health, education and other development for their family. Their involvement with the SHG made them aware about their economic benefit due to which all of them attended the group meeting and took part in the decision - making process of the group regularly. Therefore, it proved that the degree of economic independence of the respondents became high after being members of SHGs.

Economic Empowerment of the SHG Member

To evaluate the level of economic empowerment questions regarding the relative freedom of taking decision, in matters of availing loan, the manner of using the loan and profit earned from the loan were asked.

A: The decision regarding taking loan.

B: The decision regarding the use of loan.

C: The decision as to what to do with the income earned from the loan.

Table 7.7

Economic Empowerment of the SHG Members

Questions Asked	Myself Independently		Jointly		No Answer	
	Count	Percentage	Count	Percentage	Count	Percentage
A	08	10%	72	86%	4	4%
B	08	10%	72	86%	4	4%
C	08	10%	69	82%	7	8%

From the data in the table 7.7 it is clear that 10% of the respondents decided independently to take loan, 86% respondents had jointly taken decision

regarding taking loan, 4% did not answer. In case of decision to be taken regarding the use of loan 10% respondents took decision independently, 86% took jointly and 4% did not answer. In case of decision to be taken as to what to do with the income earned from the loan 10% took decision independently, 82% took decision jointly and 8% did not answer.

From the above statistics it may be ascertained that economic independence automatically leads to economic empowerment in all cases. There is lack of compatibility between the degree of economic independence and the level of economic empowerment. In all three cases a high percentage of respondents had taken joint decision and very few had acted independently.

Group Activity and Position of Women in Family and Community

To examine the position and status of women in the family and community questions that were set include.

- A: The respondent's status in the family and community has been increased being a member of SHG
- B: The respondent's part of decisions taken regarding children's health and education before joining SHG
- C: The respondent's part of decisions taken regarding children's health and education after joining SHG
- D: The respondent's freedom to take decision on family planning

The table 7.8 shows that regarding SHG members' status in the family and community 99% respondents answered yes and 1% did not answer. In case of their role in decision making regarding children's health and education before joining SHG 40% respondents answered yes,

Table 7.8

Group Activity and Position of Women in Family and Community

Questions asked	Yes		No		No Answer	
A	83	99%			01	1%
B	34	40%	37	44%	13	16%
C	70	83%			14	17%
D	62	74%	01	1%	21	25%

44% answered no and 16% of respondents are in the category of no answer. After joining SHG the percentage of the respondents in this category rose to 83% and 17% of the respondents were in the no answer category. Regarding SHG members' decision on family planning 74% women answered yes and 1% answered no, 25% of women fell in the no answer category.

From this analysis it is clear that the position and status of women in their family and community was improved to a great extent. Before joining SHG women had less say regarding their children's health and education and after joining SHG they took very active and positive role in the decision-making of their children's health and education. Regarding family planning majority women have freedom to take decision. Therefore, women's consciousness about their status and freedom in the family and the community has increased being member of SHG.

Social Empowerment of SHG Members through Group Activity

To examine the extent of participation in group activity that helps the SHG members get socially empowered, questions on participation in village development activity and community development programme were set that include:

- A: Attending Gram Sabha meeting.
- B: Participation in panchayat initiated programmes.
- C: Taking part in health programme like pulse-polio in the village.
- D: Participating in any programme against social discrimination on women.
- E: Participating in children education programme in the village
- F: Taking part in village development programmes organised by NGO

Table – 7.9

Social Empowerment of SHG Members through Group Activity

Questions asked	Yes		No	
A	55	65%	29	35%
B	71	85%	13	15%
C	49	58%	35	42%
D	53	62%	32	38%
E	38	45%	46	55%
F	43	51%	41	49%

The table 7.9 reveals that 65% women attend Gram Sabha meeting and 35% women do not attend; 85% women participate in panchayat initiated programmes and 15% do not participate; 58% women take part in health programme like pulse-polio and 42% do not participate. 62% respondents

participate in social awareness programme like social discrimination against women and 38% do not participate in such programme. 45% SHG members participate in children's education programme and 55% women do not participate.

The above statistics shows that women as members of SHGs and their participation in group activities empowered them socially to a great extent. Their increased awareness regarding village development, social injustice on women moved them to take part in demonstration against social injustice to women, various programmes for village development, programmes on children's health and community development programme.

REFERENCES

1. UNDP, (1995), Human Development Report, New Delhi, Oxford University Press, p.12
2. Batliwala, Srilatha (1997), “The Meaning of Women’s Empowerment, New Concept from Action, Population Policies Reconsidered”, in Rural Women Empowerment and Development Banking by N. Lalitha, New Delhi, Kanishka Publishers, p.2
3. Lalitha, N. (1997), Rural Women Empowerment and Development Banking, New Delhi, Kanishka Publishers, p.3
4. Krishnan, C. (2009), “Role of Microfinance in Women Empowerment, A Study of Selected Experiments in Kerala”, The Microfinance Review, Vol. 1, (0), Jan – June, p.85
5. Ibid. p.85
6. GOI, Census of India, (2001), Vol. I, Series 20, p.lxiii
7. Ibid. p.lxvi
8. Government of West Bengal, District Statistical Handbook, (2005), Kolkata, Bureau of Applied Economics and Statistics, p.23
9. GOI, Census of India, (2001), Vol. 1, Series 20, pp.lxviii, lxix
10. Government of West Bengal, District Statistical Handbook, (2005), Kolkata, Bureau of Applied Economics and Statistics, pp.90-91
11. Ibid. pp. 45-47
12. Ibid. pp. 5-12
13. NABARD Regional Office Kolkata, 6 Royd Street, Kolkata - 16
14. Government of West Bengal, District Statistical Handbook, (2005), Kolkata, Bureau of Applied Economics and Statistics, pp.5-12

Chapter-VIII

Research Findings

Increasing participation of the people in the process of decision-making is an essential prerequisite for democratic movement. The formal base of such participation has been broadened in India by way of introducing the panchayati raj system in the rural sector. The functioning of concerned parties further widened the scope of such participation. But in reality the devolution of power and authority has created a new power structure in rural India and the basic objective of introducing a participatory model of development has been lost sight of. Participation, to be meaningful, requires a high degree of awareness. With the failures of top-down development process the emphasis is now on bottom-up development which requires the rural people to be, for whom the development programmes are undertaken, aware of about the programmes, conscious about their problems, self-reliant to utilize the programmes, active to implement the programmes, participative to take decisions and educated to understand the whole process. In this context, the NGOs or voluntary organizations can play very important role. The concept of development since the late seventies and early eighties has placed emphasis on self-help, grassroots participation and two-way communication for meaningful and real development in the developing countries. Participation to be real and effective should not be prescribed and guided by the government, must be a self-generating process. In this participatory model of development the voluntary organizations or NGOs have a definite role to play by way of creating social consciousness and critical awareness about the needs and problems among the people through providing information, giving skillful training about programmes and strategies and conscientizing people. Thus the NGOs are important in

creating awareness among the people and accelerating participation in the development process.

Chapter one deals with the introductory part and the design of the proposed study.

In chapter two the meaning of the term 'development', its various changing models, concept, and the changing meaning of rural development and various programmes undertaken by the Government of India have been analysed. A study on the aspect of development administration or development bureaucracy which is the administrative machinery responsible for the implementation of development strategy, has been done. With the change of development ideas and strategy the role of the State also changes. Consequently, an analysis of the changing role of the Indian state and the emerging importance of the civil society and its organizations in the development process has been presented.

Chapter three deals with a detail analysis of the concept, features, strategies, various functions of voluntary organizations as well as NGOs. A brief historical analysis with the changing approach of international NGOs, and the changing strategies of NGOs as identified by David C. Korten has been discussed. At the same time a framework for classifying the types and functions of NGOs has been drawn. Finally, an evolutionary analysis of Indian NGOs and their necessity in the process of participatory and decentralized development is undertaken.

Chapter four begins with the analysis of the concept of health, concept of public health - its three level areas of operation, public health situation in India and some incorporated provisions on public health in the Eleventh Five Year Plan of the Government of India, a situational analysis of health status of South Asia has been presented since the impact of South Asian conditions

of health affects India as a component country of South Asia. Then, a brief study about India's performance on health sector is shown followed by an analysis of various policies emphasised during the plan period. An analysis of the health scenario in India from the perspective of health indicators has been investigated with the mention of the health sector reforms. Finally, as one of the field study sectors of the proposed study is women's health in West Bengal, so a brief overview of health sector, its status, its financial trends in West Bengal has been studied with an investigation of women's health condition, especially reproductive health, in West Bengal in comparison with national standard.

Chapter five deals with the field study on health and the primary data analysis. The achievement of the organizations working on health is a mixed story of success and failure. Barring a few organizations, majority of the organizations adopted appropriate and positive methods of work. However, majority of them concentrate on dissemination of health information, awareness creation, providing health services, and related advices, persuasion for adoption of advised practices – all are mostly communication based, while delivery of medicinal materials was done by two third of the organizations. The techniques adopted by them for disseminating information and creating awareness on health matters are effective. Group meetings and health camps among the targeted groups seem to be more effective than through involvement of local clubs or panchayats. As rural people are ignorant, uneducated they do not understand the projects undertaken by the organizations for them and consequently they are reluctant to avail the services provided by the organizations. Therefore, their methods to convince the rural people to participate in their projects through cultural shows and practical training are very effective and appreciable. Paucity of fund is a great hurdle to the success of programmes undertaken by

the organizations. Motivation and willingness to change and adopt progressive self-sustaining culture go a long way in social growth and social development. The motivating factor within the organizations to stimulate the rural people to understand that the programmes are for their own interest is lacking. Most of the organizations are reluctant to disclose the details of their sources of fund or financial resources. The relation between the organizations and community with whom the organizations are working is positive. The relation between the organizations and governmental agencies is a sort of cooperative relation. But the NGOs concerned are governed by the laws and the administrative machineries of the state government.

In delivering rural development efforts the role of the NGOs may be mediators between government agencies and rural people ; co-partners of government and supplementary to government agencies but never alternative to government. Non-governmental organizations can speed up the vast activities of the state. They can only meet the challenge of making the beneficiaries get all the health inputs 1)in selected pockets of rural , tribal and urban fringes 2) can raise resources a) human b) material and c) monetary- sparsely. Though poverty and distance are important reasons for limited access to health but rural people's ignorance and lack of awareness play most important role in preventing people's access to health. Non-governmental organizations through their limited dedicated workers can motivate, create field for self-sustaining activity, where their voice can be receptive.

In the second phase of enquiry, the performance of the three organizations (EICS, TSDS and KSCS) is assessed so far as the identification and registration of pregnant women are concerned . The organizations have covered only a microscopical areas of population. Most of the pregnant women are as they were. Overall, the performance of these

three organizations on the issue of pregnant women's access to maternal care is minimal. In the field level providing overall care services to the pregnant women in the villages the performance of the organizations is less successful. Apart from financial crisis, the inadequate infrastructure of the organizations (except KSCS), shortage of field level staff, are responsible for their poor performance.

From the above it is clear that the NGOs concerned have done some justice albeit to a limited extent to the rural women particularly pregnant women and rural poor in general where the state has failed to do with huge resources at its disposal, both administrative and functional. The state has now recognized the role of the NGOs as supplementary agencies to assist the state in its developmental efforts.

Chapter six focuses on women's development and empowerment through micro-finance. Women's development is an integral part of a total and comprehensive development of a society and economy. A brief critical review of various programmes and policies undertaken by the Government of India under Five Year Plans has been presented here. However, in spite of these programmes and policies, the status of women specially marginalized and poor women of rural India has remained poor and vulnerable. So, the first and foremost imperative for improving the lot of poor women is to make them economically independent. In this context, the concept of empowerment of women especially economic empowerment has been analysed. As a strategy for economic empowerment of women, the importance of micro-finance, and the SHG-bank-linkage micro-finance programme where NGOs play a very important role, has been explored in this chapter.

Chapter seven presents the primary data analysis and survey result on women's economic empowerment through microfinance. The interpretations of findings are as follows -

The achievements of the Naxalbari Handicapped Welfare Society have been impressive. The formation of self-help groups as a basis for the social and economic empowerment of deprived and disadvantaged women has yielded positive contribution in the mobilization and self development of women. Women who have participated in self-help groups have developed strong sense of self-confidence and faith in their ability to interact with power structures and increased their contribution to the household. The poor women are capable of bringing about their economic upliftment given sufficient and necessary support. Self-help groups are instrumental in empowerment as they enable women to work together through collective actions. The nature of social mobilization and capacity building taking place during group formation is very important in influencing the extent of women's empowerment. Notably, more female headed households derive the economic and social benefits from self-help groups.

Linkages with banks have enhanced enormous confidence of women. Breaking of class and caste barriers and sitting together over a period of time is the most significant achievement. Social mobilization has increased considerable control over physical mobility of women. Mobility within and outside village, reduced men's resistance, the acceptance of this mobility in family and community at large has resulted in breaking up geographical isolation and creating social network. Group activity has led to a greater cohesion, serving as a social safety net and reduced the feeling of vulnerability. Besides the usual and impressive contribution of women to the welfare of their family and their increased financial access has consolidated their role in the family. Their opinions in the family became more valuable

which contributed to their increased household decision-making powers . Greater decision- making powers of women within the household does not only improve gender justice but create a more equal dispersion of power in a household.

The savings by the poor women facilitated greater control over financial resources and access to cash in need. This has enabled the women feel secured during emergencies. Women take pride in owning assets in their name. The savings facilities in the SHG programmes have created an opportunity for women to have savings in their names. But there is no information about how these savings are used and whether women really can decide as to how they want to spend the savings. Because women continue to depend on men for support from loan repayment to spending their savings.

Women opined an increase in their self-dignity and self-esteem as a result of their involvement in money matters but this is not a common feature because there is no evidence of an increase in the negotiating power of all members of the groups. Empowerment has taken place but primarily in case of group leaders and office bearers whose mobility and skills are enhanced due to their leading roles in the groups and the capacity building training programmes of the groups given to them rather than each and every member of the groups.

Entrepreneurial activities could not be undertaken by the women of the groups interviewed due to 1) second grading of the groups had not been done by the banks , (at the time of interview) because after second grading such entrepreneurial activities can be started ; 2) lack of marketing knowledge of the women and also the lack of market viability of the goods produced.

There is no regular skill training programme undertaken by the concerned NGO since the NGO does not get financial assistance in time from the sponsored bank i.e. NABARD. Moreover, if the NGO undertakes any such training programme on their own cost for the SHG members the payment is delayed by one or more than one year which discourages the NGO to undertake such programme further.

The local banks are reluctant to this bank-linkage programme which creates an obstacle to the quick bank-linkage of the SHGs. It is a harassment to the SHG members and at the same time the denial of government policy of inclusive growth. However, the free and flexible characteristics of the NGO in the execution of their programmes make it more dynamic to reach all parts of the population irrespective of age, education and income. Women being the members of the SHGs enjoy better standard of living, educational awareness to children concerned and above all a sense of belongingness to the society as productive members than mere witness of social development . It also emphasizes the fact that increased financial benefit helps directly the social benefits contributing to development.

The eighth chapter concludes with the observation of research findings and some suggestions.

Concluding Observations

1. The state is likely to continue to be the major provider of goods and services, particularly for socially and economically vulnerable people of the society. Mere inclusion of this disadvantaged people into the development process is not enough. What is equally necessary is to protect the cultural identities of the rural poor and marginalized people and to ensure their social identity, equality and justice.

2. The successful, equitable and holistic development requires multipronged strategies that need the participation of the state, voluntary organizations, NGOs as well as the rural people for whom the development is meant. Rural people should be involved in the participatory process of development.
3. It is most important to make the rural people understand that they have to identify their own problems and decide on the solutions of the problems. This requires awareness, conscientization and also education of the rural people and the support from the state, non-state actors and agencies. Conscientizing the beneficiaries of the NGO programmes is most important step towards the development process of the rural people. Non-governmental organizations can conscientize the targeted beneficiaries about the actual problems and happenings of the societies as going on around them and the way of solving those problems. This conscientizing process can organize the rural people, particularly the vulnerable sections of the society to struggle for their development and empowerment.
4. Sustainable development depends on how much the rural people are aware about the developmental programmes initiated by the government and the facilities provided for them. In this context, the NGOs should take active and positive initiative in creating awareness among the rural people specially the disadvantaged sections. For instance, the NGOs should aware the rural women of health related matters and facilities available so that the women can have easy access to the health services provided by the government and other organizations. The NGOs have to be more aggressive to ensure the direct participation of the beneficiaries so that development becomes participatory , inclusive and diverse.

5. Non-governmental organizations and voluntary organizations due to their flexible approach as well as their close proximity with the local people are able to facilitate the development process if provided with the necessary professional, technical and obviously adequate financial support. They can mobilize the rural people for participation in the process of development.
6. The goals, objectives and priorities of development must be exclusively decided upon by the targeted people either directly or with the help of the NGOs. Rural development requires long term planning and programme formulation involving implementation of pilot projects. The lessons which are supposed to be learnt and experiences gained from the pilot projects must be incorporated in the next phase of programme implementation including priority identification.
7. Large NGOs working through a number of branches and network spread all over the country and even outside are bound to lose grassroots linkages due to their bureaucratic structure and way of functioning. Judging from that point of view the smaller NGOs despite their other lacunae are able to develop grassroots linkages and function more closely at local level. Therefore, smaller NGOs should be encouraged to be involved in the development process.
8. The NGOs should impart training to all the members of the SHGs rather than only the group leaders. Unless and until each member of the SHG is given practical and skill development training about the programmes the objective of empowering the rural women will be unsuccessful effort in the development process.
9. A close, regular and direct liaison between the NGO and the NABARD head office is necessary so that the Micro Finance Institution (MFI) (NABARD) can get the direct feedback result of its programme from

the NGO. This direct interaction will help the MFI to take necessary follow-up action in time to expedite the empowerment process. A regular monitoring system should be there on the part of the MFI to assess the progress of the programmes.

10. Local banks should be more co-operative and helpful with regard to the implementation of the bank-linkage programme. The bank should not be profit-oriented only but must pay heed to the social sector development as well. In this context, government should take active initiative to make changes at the policy level otherwise the government policy for inclusive growth will not be successful.
11. The NGOs have easy access to rural areas. But they lack adequate infrastructure to provide health services to the rural women. Therefore, NGOs need to be properly equipped with adequate infrastructure and should have financial base to provide necessary health services.
12. The NGOs need educated and dedicated staff to implement their programmes. One of the major problems of NGOs is paucity of fund. With the limited fund and personnel NGOs find it difficult to run their programmes. So, government organizations and NGOs can work in a collaborative way with careful monitoring and evaluation. It must be realized that neither government, nor civil society, nor market possess the knowledge or ability to accomplish on their own such a huge, multifaceted task of socio-economic development. If sincere efforts are made to create a responsive approach to development then collaborative efforts may become more successful and contribute to real improvements in the lives of the rural people.

SELECT BIBLIOGRAPHY

A .PRIMARY SOURCES

Official Documents and Reports

Government of India (GOI), (1999), Various issues, Health Information of India, New Delhi, Ministry of Health and Family Welfare (MOHFW).

GOI, (1946), Bhore, J. Report of the Health Survey and Development Committee, New Delhi, Vol. IV.

GOI, (1983), National Health Policy 1983, New Delhi, MOHFW.

GOI, (2001), Draft National Health Policy 2001, New Delhi, MOFHW.

GOI, (2002), National Health Policy 2002, New Delhi, MOHFW.

GOI,(1951-56), First Five Year Plan (1951-56), New Delhi, Planning Commission.

GOI, (1956-61), Second Five Year Plan (1956-61), New Delhi, Planning Commission.

GOI, (1961-66), Third Five Year Plan (1961-66), New Delhi, Planning Commission.

GOI, (1966-69), Fourth Five Year Plan (1966-69), New Delhi, Planning Commission.

GOI, (1974-79), Fifth Five Year Plan (1974-79), New Delhi, Planning Commission.

GOI, (1978-83), Sixth Five Year Plane (1978-83), New Delhi, Planning Commission.

GOI (1985-90), Seventh Five Year Plan (1985-90), New Delhi, Planning Commission.

GOI, (1992-97), Eighth Five Year Plan (1992-97), New Delhi, Planning Commission.

GOI,(2002-07), Tenth Five Year Plan (2002-07), New Delhi, Planning Commission.

GOI, (2007-12), Eleventh Five Year Plan (2007-12), New Delhi, Planning Commission.

GOI, (1998-99), National Family Health Survey (NFHS) - II, (1998-99), New Delhi, MOHFW.

GOI, (2005-06), NFHS- III, (2005-06), New Delhi, MOHFW.

GOI, (1997), National Nutrition Monitoring Bureau (NNMB), Twenty Five Years of NNMB 1970-95, New Delhi, Ministry of Women and Child Development. .

GOI, (2002), March, National Human Development Report-2001, New Delhi, Planning Commission.

GOI, (2004), National Sample Survey Organization (NSSO)-2004, Kolkata, Ministry of Statistics .

GOI,(2002-03) Annual Report (2002-03), New Delhi MOHFW.

GOI, Draft National Perspective Plan for Women 1988-2000, memio, New Delhi, Department of Welfare and Child Development.

GOI, (2006), Report of the Working Group on Empowerment of Women for the XI Plan 2006, New Delhi, Ministry of Women and Child Development.

GOI, (1957), Balawantraï Mehta Report of the Team for the Study of Community Projects and National Extension Service, vol.- I, New Delhi.

GOI, (1988), Collaborating with Non-Governmental Organization in Implementing the National Strategy for Health for All, New Delhi, Ministry of Health and Family Welfare.

GOI, (1988), National Perspective Plan for Women, 1080-2002 AD. Report of Core Group, Department of Women and Child Development, New Delhi, Ministry of Human Resource Development.

GOI, (2005), Health Information of India 2004, New Delhi, DGHS, Central Bureau of Health Intelligence.

GOI (2001), Census of India, 2001, Vol. I and Vol. II, Series 20, New Delhi.

Government of West Bengal (GOWB), 2004, Human Development Report 2004, Kolkata, Development and Planning Department.

GOWB, (2003-2004), Health on the March, West Bengal 2003-04, Kolkata, State Bureau of Health Intelligence, Directorate of Health Services.

GOWB, Health Strategy, Document-2, Department of Health and Family Welfare, www.wbhealth.gov.in, accessed on 8th September 2008.

GOWB, Health Strategy, Document-4, (2003), Integrated Financial and Economic Plan for the Health Sector, Department of Health and Family Welfare www.wbhealth.gov.in, accessed on 8th September 2008.

GOWB, (2001-02), Health on the March West Bengal 2001-02, Kolkata, State Bureau of Health Intelligence, Directorate of Health Services.

GOWB, (2005), District Statistical Handbook, Kolkata, Bureau of Applied Economics and Statistics.

India, Social Development Report (2006).

Mahbub Ul Haq Human Development Centre,(2005), Human Development in South Asia, The Health Challenge 2004, Oxford, Oxford University Press.

National Institute of Health and Family Welfare, (1989), “Collaboration with Voluntary Organizations in Health Family Welfare and Nutrition, An Overview of the Project on Private Voluntary Organizations for Health (PVOH)”, New Delhi.

Report of the Study Jointly Undertaken by Indian Council of Social Science Research and Indian Council for Medical Research, 1980 New Delhi.

Report of the Study Jointly Undertaken by WHO and UNICEF, 1978.

United Nations Development Programme (UNDP), 1996, Human Development Report 1995, New York, Oxford University Press.

UNDP, Human Development Report, 1999, Globalization with a Human Face, New York, Oxford University Press.

UNDP, Human Development Report, 2003 Millennium Development goals, A Compact among Nations to end Human Poverty, New York, Oxford University Press.

United Nations, Decentralizing for Public Administration, Department of Economic Affairs, Sales No, UN Publication 62, HH-2.

Voluntary Health Association of India, (1997), Report of the Independent Commission on Health in India,(1997), New Delhi.

Voluntary Agencies and Rural Development, (1981), National Literature of Public Cooperation and Child Development Report, New Delhi.

Voluntary Efforts for Rural Development, Report of Seminar held on 12 and 13 August, 1977, New Delhi, Gandhi Peace Foundation.

World Bank, (1990) World Development Report 1990, Poverty, Oxford, Oxford University Press.

World Bank, (1994), 256 World Bank Discussion Papers, Women's Health and Nutrition, Making a Difference by Anne Tinker et.al. (1994), Washington D.C.

World Bank, (1995), India, Policy and Finance Strategies for Strengthening Primary Health Care Services, Report No. 13042 – IN, Washington D.C, Population and Human Resource Division.

World Bank, (1997), World Development Report 1997, The State in a Changing World, Oxford, Oxford University Press.

World Bank, (2000), World Development Report 1999-2000, Entering the 21st Century, New Delhi, Oxford University Press.

World Bank, (2001), World Development Report 2001, Attacking Poverty, Oxford, Oxford University Press .

World Bank, (2001), Engendering Development, Through Gender Equality in Rights, Resources and Voice - Summary, Washington D.C,

World Bank, Peter, D. et.al. (2002), Better Health System for India's Poor, Findings, Analysis and Options, Washington D.C.

B. SECONDARY SOURCES

1. BOOKS

Abusaleh, S. and Krishnaraj,M. (ed.), (2007), State, Markets and Inequalities, Human Development in Rural India. Hyderabad, Orient Longman .

Adler, Peter M.(1981), A Theory of Social Action. London, Sage Publication.

Ahlawat, S. R. (ed.) (2008), Economic Reforms and Social Transformation. Jaipur, Rawat Publication .

Alliband, Terry (1983), Catalysts of Development, Voluntary Agencies in India, West Hartford, Kumarian.

Andemicael, B. (1978), Non-Governmental Organizations in International Cooperation, New York, UNITAR.

Bagchi, J. (ed.), (2005), The Changing Status of Women in West Bengal 1970-2000, The Challenge Ahead, Kolkata, New Delhi, Sage Publications.

Bagchi, K.K. (2009), *Micro-Finance and Rural Development, A Critical Review*, Delhi, Abhijit Publication.

Baru, R.A. (1998), *Private Health Care in India, Social Characteristics and Trends*, New Delhi, Sage.

Basu, K. P., Pattanaik et. al, (ed.), (1995),. *Choice, Welfare and Development*, New Delhi, Oxford University Press.

Bates, R.H.(ed.), (1988), *Toward a Political Development, A Rational Choice Perspective*, Berkeley, CA, University of California Press.

Lalitha, N.(1997), *Rural Women Empowerment and Development Banking* New Delhi, Kanishka Publishers.

Bava, Noorjahan (1984), *People's Participation in Development Administration in India*, New Delhi, Uppal Publishing House .

Bava, Noorjahan (ed), (1997), *Non-Government Organizations in Development, Theory and Practice*, New Delhi, Kanishka Publishers.

Berg, Robert (1987), *Non-Governmental Organizations, New Force in Third World Development and Politics* , Washington D.C., Centre for Advanced Study of International Development .

Beveridge, Lord (1949), *Voluntary Action, A Report on Methods of Social Advance* . London, George Allen and Unwin .

- Beveridge, W. (1984), *Voluntary Action*, London, Allen and Unwin .
- Beveridge, W.(1979), *Voluntary Action in a Changing World*, Bedford Square Press, London, National Council of Social Services.
- Bhattacharya, M. (1997), *Development Administration, Search for Alternatives*, New Delhi, Jawahar Publishers and Distributors.
- Bisnath, S. and Elson, D. (2002), *Women's Empowerment Revisited, Progress of the World's Women, A New Biennial Report (UNIFEM)*.
- Bonner, Arther (1990), *Averting the Apocalypse, Social Movements in India Today*, Durham, Duke University Press.
- Brasnett, M. (1969), *Voluntary Social Action*, London, National Council of Social Service.
- Brodhead, T. and O'Malley, J. (1989), *Non-Governmental Organizations and Third World Development, Opportunities and Constraints*, WHO Doc. GPA/GMC(2)89.5,Dec.).
- Butcher, H. and Others,(1980), *Groups in Action, Case Studies and Analysis*, London, Routledge and Kegan Paul.
- Byres, Terence J.(ed), (1997), *The State, Development Planning and Liberalization in India*, Delhi, Oxford University Press.

Calman, Leslie (1992), *Toward Empowerment, Women and Movement Politics in India*, Boulder Co, Westview Press.

Carroll, T. (1992), *Intermediary Non-Governmental Organizations, The Supporting Links in Grassroots Development*, West Hartford CT, Kumarian Press.

Central Institute of Research and Training in Public Cooperation (New Delhi- 1970), *Voluntary Efforts in a Rural Community, A Case Study*.

Chakraborty, Ashok (2005), *Aid, Institutions and Development, New Approaches to Growth, Governance and Poverty*, New Delhi, Oxford University Press.

Chambers, Robert (1983), *Rural Development, Putting the Last First*, London, Longman Press.

Chandhoke, Neera (1998), "The Assertion of Civil Society Against the State: The Case of the Post-colonial World" in *People's Rights, Social Movements and the State in the Third World*, (1998), (ed) by M. Mohanty et. al, New Delhi, Sage Publication .

Chowdhary, D. Paul (1962), *Social Welfare Administration, through Voluntary Agencies*. Delhi, Atma Ram .

Chowdhary, D. Paul (1971), *Voluntary Social Welfare in India*, New Delhi, Sterling

Chowdhary, D. Paul (1978), *New Partnership in Rural Development*. New Delhi, M.N. Publishers.

Chowdhary, D. Paul (1990), *Voluntary Efforts in Social Welfare and Development*, New Delhi, Siddhartha Publishers .

Charyulu, U.V.N. et. al (1980), *Voluntary Organization - Andhra Pradesh, Case Studies*, Hyderabad, NIRD.

Chatterjee, B. and Ghosh, D. K. (2001), *In Search of a District Development Index*, SIPRD, Kalyani, West Bengal.

Chaturvedi, H.R. and Mitra, S.K. (1982), *Citizen Participation in Rural Development*, New Delhi, Oxford and IBH Publishing Co .

Chavan, P. and Kumar, R.M.S.(2004), *Financial Liberalization and Rural Credit in India*, New Delhi, Tulika Books.

Chestan, Susy and Kuhn Lisa, *Empowering Women through Microfinance* .

Clark, John (1991), *Democratizing Development, The Role of Voluntary Organizations*, London, Earthscan Publication .

Clark, John. (1993), *The State and the Voluntary Sector*, Washington D.C., The World Bank.

Cole, G.D.H. in *Voluntary Social Services* (ed.) by A.F.C. Bourdillon. Methuen (1945), London.

Dantwala, Sethi and Visaria (1998), *Social Change through Voluntary Action*, New Delhi, Sage.

Das, S.K. Nanda, B.P. et.al. (ed.) (2008), *Microfinance and Rural Development in India*, New Delhi, New Century Publications .

Dasgupta, Monica. et.al (1995), *Women's Health in India Risk and Vulnerability*, New Delhi, Oxford University Press .

Dasgupta, P. (1993), *An Inquiry into Wellbeing Destitution*, New Delhi, Oxford University Press .

Dasgupta, Sugata (1973), *Voluntary Organizations in Development (a global model)*, New Delhi, Society for Development Gramdans .

De, Nitish R. *Alternative Design of Human Organizations*, New Delhi, Sage .

Dev, S. Mahendra (2008), *Inclusive Growth in India, Agriculture, Poverty and Human Development*, New Delhi, Oxford University Press.

Dev, S. Mahendra (2008), India, Some Aspects of Economic and Social Development, The CESS Silver Jubilee Lectures, New Delhi, Academic Foundation.

Dharmarajan, Shivani (1997), Non-Governmental Development Initiative and Public Policy, New Delhi, Kanishka Publishers and Distributors .

Directory of Voluntary Action, (1979), Association of Voluntary Agencies for Rural Development, New Delhi.

Downs, Charles et. al. (ed) (1989), Social Policy from the Grassroots, Non-Governmental Organizations in Chile, Bolder, West View Press.

Dreze, J. (1996), Indian Development, Selected Regional Perspectives, Oxford, Oxford University Press.

Dubey, Sumati and Murdia Ratna (ed)(1983), Organizational Designs and Management Methods for Human Services Organizations, Bombay, Himalaya .

Dunham, Arther (1958), Community Welfare Organization, New York, Crowell.

Dutt and Sundaram (1998), Indian Economy, New Delhi, S. Chand and Company Ltd.

Eade, Deborah (ed) (2005), *Development, Non-Governmental Organizations and Civil Society*, New Delhi.

Edwards, M. and Hulme, D. (ed) (1992), *Making a Difference, NGOs and Development in a Changing World*, London, Earthscan Publication Ltd.

Edwards, M. and Hulme, D. (1995), *Non-Governmental Organization's Performance and Accountability, Beyond the Magic Bullet*, London, Earthscan Publication Ltd.

Escobar, A. (1995), *Encountering Development, The Making and Unmaking of the Third World*, Princeton, NJ, Princeton University Press.

Etzioni, Amitai (1968), *Active Society*, New York, Collier- MacMillan .

Farrington, John and Lewis David J. (ed) (1993), *Non-Governmental Organizations and the State in Asia, Rethinking Roles in Sustainable Agricultural Development*, London, Routledg .

Fernandes, Walter (ed) (1981), *People's Participation in Development, Approaches to Non-Formal Organization*, New Delhi, Indian Social Institute.

Fernandes, W. (ed) (1986), *Voluntary Action and Government Control*, New Delhi, Indian Social Institute .

Fidler, D. (2000), International Law and Public Health, Materials on and Analysis of Global Health Jurisprudence, New York, Transnational Publishers.

Fisher, Julie (1997), Non-Governments, NGOs and the Political Development of the Third World, West Hartford, CT, Kumarian Press.

Franda, Marcus (1979), Small is Politics, Organizational Alternatives in India's Rural Development, New Delhi, Wiley Eastern Ltd.

Franda, M. (1979), India's Rural Development, An Assessment of Alternatives, London, Indian University Press

Franda, M. (1983), Voluntary Associations and Local Development in India, New Delhi, Young Asia Publications.

Freire, P. (1996), Pedagogy of the Oppressed, London, Penguin .

Friedmann, J. (1992), Empowerment, The Politics of Alternative Development, Oxford, Blackwell.

Gangrade, K.D. (1987), Development of Voluntary Action, Encyclopaedia of Social Work in India, (Vol.1) Ministry of Information and Broadcasting, New Delhi, Government of India.

Gant, George F. (1979), Development Administration, Concepts, Goals and Methods, Wisconsin, Madison, University of Wisconsin Press .

Gittell, Marlilyn et. al. (1980), Limits to Citizen Participation, The Decline of Community Organizations, London, Sage Publication .

Gordon, C. Wayne and Babchuk, Nicholas (1966), in The Government of Associations by William A. Glasser and David L. Sills (ed), Totawa, New Jersey, Bedminister Press.

Gosden, P.H.J.H. (1973), Self-Help Voluntary Associations in the 19th Century, London, B.T. Batsford.

Guha Roy, Samir and Sen, K. (2002), Patterns of Health Care Utilization and Expenditure, A Household Survey in an Indian State, West Bengal 1999, Kolkata, ISI .

Gulati, Ravi and Gulati, K. (1996), Strengthening Voluntary Action in India, Delhi, Konark .

Guljart, B. (1995), in Community Empowerment, A Reader in Participation and Development by G. Craig and M. Mayo (ed). London.

Hart, Joseph K. (1920), Community Organization, New York, MacMillan.

Hasenffld, Yeheskel (1983), Human Service Organizations, Englewood Cliffs, N.J., Prentice Hall .

Hatch, Stephen and Macraft, Ian (1983), Components of Welfare, Voluntary Organizations, Social Services and Politics in Two Local Authorities,

London, Bedford Square Press of the National Council for Voluntary Organizations.

Heredia, Rudolf C. (1988), *Voluntary Action and Development, Towards a Praxis for Non-Government Agencies*, New Delhi, Concept Publishing.

Hope, Kempe Ronald (1986), *The Dynamics of Development and Development Administration*, Connecticut/ London, Greenwood Press.

Inamdar, N.R. in *Social Welfare Administration* by D.R. Sachdev, Alahabad, Kitab Mahal .

Indian Marchants' Chamber, Economic and Training Foundation, Bombay (1977), *Rural Development, Role of Voluntary Agencies and Business Houses, Round Table Discussions*, Bombay, IMCERTF.

Janvry, Alian de (1988), "The Search for Styles of Development, Lessons from Latin American and Implications for India" in *Institute for Economic Growth, Development Perspectives, (Silver Jubilee Series)* Delhi, BR Publishing Corporation.

Jain, R.B. (ed) (1995), *Non-Governmental Organizations in Development Perspective*, Delhi, Vivek Prakashan.

Jain, R.B. and Heinz-Bongartz (ed)(1994), Structural Adjustment, Public Policy and Bureaucracy in Developing Societies, New Delhi, Har Anand .

Jesani, A., Gupta, M. et. al. (1986), Non-Governmental organizations in Rural Health Care, Bombay, The Foundation for Research in Community Health,.

Johnson, Norman (1981), Voluntary Social Services, Oxford, Basil Blackwell.

Joseph, Mally (1997), Women Participation and Development Strategies, New Delhi, Kanishka Publishers .

Kanjilal, B. and Mukherjee, M (2007), Health, Equity and Poverty, Exploring the Links in West Bengal, India, Future Health Systems Research Monograph, India.

Kapoor, A.K. and Singh, D. (1997), Rural Development through NGOs, Jaipur and New Delhi, Rawat Publications.

Karmakar, K.G. (2008), Microfinance in India , New Delhi, Sage .

Karmer, Ralph M. (1981), Voluntary Agencies in the Welfare State, London, University of California Press.

Kaushik, Susheela (1997), In Non-Governmental Organizations and Development, Theory and Practice, (ed) by N. Bava. New Delhi, Kanishka Publishers.

Kavoori, J.C. and Nath, Baji. (1967), Vol. I, History of Rural Development in Modern India, New Delhi, Impax India.

Khan, A.J. (1973), Social Policy and Social Services, New York, Random House.

Khanna, B.S. (1984), Participation of Non-Governmental Organizations in Integrated Rural Development, An Overview, Camilla, Centre on Integrated Rural Development for Asia and Pacific.

Knight, Barry and Hayes, Ruth (1983), Grant to Voluntary Organizations, London, Voluntary Service .

Knight, Barry (ed) (1984), Management in Voluntary Organizations, Wivenhoe, A.R.V. A. C.

Korten David C. (1986), Micro Policy Reform, The Role of Private Agencies, Working Paper no. 2 of the National Associations of Schools of Public Administration, Washington D.C.

Korten, David C. (1991), in *Non-Governmental Organizations and the World Bank, Cooperation for Development* by Samuel Paul and Aurturo Israel, (ed.) Washington, D. C., The World Bank .

Korten, David C. (1992), *Getting to the 21st Century, Voluntary Action and the Global Agenda*, New Delhi, Vijay Primlani for Oxford and IBH Publishing Co. Pvt. Ltd.

Kothari, Rajni (1989), *Rethinking Development, In Search of Human Alternatives*, New York, New Horizons Press .

Kramer, Relph M. (1981), *Voluntary Agencies in Welfare State*, Berkely, University of California Press.

Krishna, Swami (1980), *Ruralism, A New Socio-Economic Philosophy*, Bangalore, IBH Prakasana.

Kulkarni, V.M. (1969), *Voluntary Action in a Developing Society*, New Delhi, IIPA.

Kundu, S. (1997), *Unnayaner Khonje NGOs*, Kolkata, Development Research Communication and Services Centre.

Laclau, E. and Mouffe, C. (1985), *Hegemony and Socialist Strategy, Towards a Radical Democratic Politics*, London, Verso.

Lalitha, N.V. (1975), *Voluntary Work in India*, New Delhi, National Institute of Public Co-operation and Child Development (NIPCCD).

Lalitha, N.V. and Kohil, M. (1982), *Status of Voluntary Effort in Social Welfare*, New Delhi, National Institute of Public Co-operation and Child Welfare.

Lalitha, N. (1997), *Rural Women Empowerment and Development Banking*, New Delhi, Kanishka Publishers.

Lawani, B.T. (1999), *Non-Governmental Organization in Development, Case Study in Solapur District*, New Delhi, Rawat Publication.

Lawrence, E. Cuhoone (2002), *Civil Society, The Conservative Meaning of Liberal Politics*, Black Well.

Mackintosh, M. (1992), in *Development Policy and Public Action* by M. Wuyts et. al.(ed) (1992), Oxford, OU Press.

Maddick, Henry (1963), *Democracy, Decentralization and Development* Bombay, Asia Publishing House.

Margaret,Harris and Bills David (1986), *Voluntary Agencies, Organizing, A Guide through the Literature*, London, Bedford, Square Press.

Mathur, H. M. (1986), *Administering Development in the Third World, Constraints and Choices*, New Delhi, Sage.

Mehta, Shiv R. (1984), *Rural Development Policies and Programmes, A Sociological Perspective*, New Delhi, Sage.

Melkote, Srinivas R. (1991), *Communication for Development in the Third World, Theory and Practice*, New Delhi, Sage .

Mess, H.A.(1948),*Voluntary Social Service 1918*, London, Routledge and Kegan Paul.

Misra, R., Chatterjee, R. and Rao, S. (2003), *India Health Report*, New Delhi, Oxford University Press.

Misra, S. (ed) (2008), *Engendering Governance Institutions, State, Market and Civil Society*, Delhi, Sage.

Moen, Elizabeth (1991), *Voluntary Sector Grassroots Development in Tamil Nadu*, Tamil Nadu, India, Gandhigram Rural Institute.

Montgomery, John and William J. Siffin (ed) (1966), *Approaches to Development, Politics, Administration and Change*, New York, Mc Graw-Hill.

Morris, Mary (1955), *Voluntary Organizations and Social Progress*, London, Victor Gallancz .

Morris, Mary (1969), *Voluntary Work in the Welfare State*, London, Routledge and K Paul.

Morsins, M. (1955), *Voluntary Organization and Social Progress*, (London, Glenco).

Mukherjee, Asha, Bhattachrya, K. (ed) (2003), *Conditioning and Empowerment of Women, A Multidimensional Approach*, New Delhi, Gyan Publishing House.

Murray, George J. (1969), *Voluntary Organizations and Social Welfare*, Edindurgh, Oliver and Boyd.

Murthy, R.K. and Rao, N. (1997), *Indian NGOs, Poverty Alleviation and their Capacity Enhancement in the 1990s, An Institutional and Social Relations Perspective*, New Delhi.

Nair, Krishna T. (1981), *Social Work Education and Social Work Practice in India*, Madras, School of Social Work.

National Institute of Rural Development (NIRD), (mimeograph), (1984, March 15-21), *Course on Voluntary Action for Rural Development*, Hyderabad.

NIRD, (1979), *Rural Development in India, Some Facets*, Rajender Nagar, Hyderabad.

Norman, Johnson Voluntary Social Services, Oxford, Basil Blackwell.

Osigheh, Chimezie A.B. (1983), Improving Problem Solving Participation, The Case of Local Transitional Voluntary Organizations, London, University Press of America.

Pai Panandikar, V.A. (1978), Bureaucracy and Development Administration, New Delhi, Centre for Policy Research.

Palisi, Bartolemo (1972), in Voluntary Action Research(ed) by D. H. Smith et.al., Lexington, Mass, Lexington Books.

Pandey, S.R. (1991), Community Action for Social Change, Grassroots Organizations in India, New Delhi, Sage.

Pateman, J. (1970), Participation and Democratic Theory, London, Allen, Cambridge University Press.

Pathak, Sankar, Social Welfare, An Evolutionary and Development Perspective.

Parkar, N. (1965), Local Health Welfare Services, London, Allen and Unwin.

Pawar, S.N. and Patil, R.B. (ed) (1994), Problems and Prospects of Development, Co-operation, Voluntarism, Communication, Social Tensions and Weaker Sections in Rural India, New Delhi, Mittal Publications.

Pennock, J. Ronald and Chapmen, John W. (ed) (1969), Voluntary Associations. New York.

Peterson, James C. and Others (1983), Voluntary Organizations, Structure and Process, New York, paraeger.

PRIA, (1991), Voluntary Development Organizations in India, A Study of History, Roles and Future Challenges, New Delhi, PRIA.

Rahman, Anisur (ed), (1984), Grassroots Participation and Self-Reliance, Experiences in South and South East Asia , New Delhi, Oxford and IBH Publishing Co.

Raju, S. and Bagchi, D. (ed) (1994), Women and Work in South Asia, Regional Patterns and Perspective, London and New York, Routledge .

Raju, S. (2006), India Social Development Report, New Delhi, GOI .

Ray, S. N. (1995), Communication in Rural Development- A Public Policy Perspectiv,. Simla, Indian Institute of Advanced Study.

Redcliff, Michael R. (1987), Sustainable Development, Exploring the Contradictions, London, New York, Methuen.

Reed, Ella W. (ed) (1981), *Social Welfare Administration*, New York, Columbia University Press.

Riddell, Roger C. and Robinson, Mark (1995), *Non-Governmental Organizations and Rural Poverty Alleviation*, Oxford, Clarendon Press.

Rijal, K. P. (1986), *Areas and Role of NGO in Local Development*, SAARC Regional Symposium on Local Level Planning, New Delhi Central Panchayat Training Institute .

Riley, J. M. (2002), *Stakeholders in Rural Development, Critical Collaboration in State-NGO Partnerships*, New Delhi, Sage.

Robertson, D. B. (ed) (1966), *Voluntary Associations, A Study of Groups in Free Societies*, Richmond, Virginia, John Know Press.

Robinson, Mark (1991), *Evaluating the Impact of NGOs in Rural Poverty Alleviation, India Country Study*, ODI Working Paper. No. 49, London, Overseas Development Institute.

Robinson, Mark (1993), in *Governance, Democracy and Conditionality, What Role for NGOs?* (ed) by A. Clayton, Oxford, INTRAC.

Rooff, M. (1975), *Voluntary Societies and Social Policy*, London, Routledge and K. Paul .

Rose, Kalima (1992), Where Women are Leaders, SEWA Movement in India. New Delhi, Vistar Publication .

Ross, Jack C. (1976), Voluntary Associations in History, Assembly of Good Fellows, London, Greenwood .

Rudolf and Rudolf, (1987), The Pursuit of Laxmi, The Political Economy of Indian State, Chicago, The University of Chicago Press.

Ruth, Harner and Cummins, Anne (1978), Voluntary Health Association of India, Teaching Village Health Workers, A Guide to the Process.

Sachinandan, Sau. et. al. (2001), Fifty Years of Rural Development in India, Kolkata, Firma KLM.

Sankaran, R. and Rodrigues, Ivo (1983), A Handbook to the Management of Voluntary Organizations, Madras, Alpha.

Sanyal, B. (1994), Cooperative Autonomy, The Dialectic of State, NGOs Relationship in Developing Countries, Geneva, International Institute for Labour Studies.

Sapru, R.K. (1994), Development Administration. New Delhi, Sterling.

Sen, A. C. (ed) (1971), Introducing Voluntary Agencies in India, Delhi, Impex India.

Sen, A. and Dreze, Jean (1999), *Poverty and Famines, Hunger and Public Action*, India, Economic Development and Social Opportunity, Oxford, Oxford University Press.

Sen, Sunanda (2007), *Globalization and Development*, New Delhi, National Book Trust .

Seth, M. (2001), *Women and Development, The Indian Experience*, New Delhi, Sage.

Shah, Kalpana (1984), *Women's Liberation and Voluntary Action*, New Delhi, Ajanta.

Sharma, R.D. (1992), *Development Administration, Theory and Practice*, Delhi, H. K. Publishers and Distributors.

Sheth, D.L. and Sethi, Harsh (1997), in V.A. Pai Panandikar (ed), *A Survey of Research in Public Administration, 1980-1990*. ICSSR, New Delhi, Konark.

Siddiqui, H.Y. (1984), *Social Work and Social Action*, New Delhi, Haram Publication.

Silverman, Phyllis R. (1980), *Mutual Help Groups, Organizations and Development*, Beverly Hills, Sage.

Singh, I. S. (ed) (1995), *Women as a Work Force in an Organized Sector, An Empirical Perspective*, New Delhi, Oxford.

Singh, Katar (1986), *Rural Development, Principles, Policies and Management*, New Delhi, Sage.

Singh, Hoshiar (1995), *Administration of Rural Development in India*, New Delhi, Sterling Publishers Pvt. Ltd .

Smith, Constance and Freedman, Anne (1973), *Voluntary Associations, Perspectives on the Literature*, Cambridge, Harvard University Press.

Smith, David Horton (ed) (1973), *Voluntary Action Research*, Lexington, Mass, D.C. Health.

Smith, D.H. and Elkin, F. (ed) (1981), *Volunteers, Voluntary Associations and Development*, The Netherlands, E.J. Brill, Leiden .

Srivastava, S. P. (1998), *The Development Debate - Critical Perspectives*, New Delhi, Rawat Publications.

Srivastava, Uma Kant and George, P.S. (1977), *Rural Development in Action, The Experience of a Voluntary Agency*, Bombay, Somaiya.

Stephen, F. (1990), *NGOs Hope of the Last Decade of this Century*, Bangalore, SEARCH.

Stone, Donal C. (ed) (1966), Education for Development Administration, Brussels.

Sundaram, I. S. (1986), Voluntary Agencies and Rural Development, Delhi, B. R. Publishing Corporation.

Sundaram, Satya (2006), Microfinance in India, Delhi, B. R. Publishing Corporation.

Tandon, Rajesh (1987), The Relationship between Non-Governmental Organizations and Government, New Delhi, Society for Participatory Research in Asia .

Tandon, Rajesh (2002), Voluntary Action, Civil and the State, New Delhi, Mosaic Books.

Tobin, Gary A. (ed) (1985), Social Planning and Human Service Delivery in the Voluntary Sector, Westport Connecticut, London, Greenwood Press.

Todaro, Michael (1977), Economic Development in the Third World, London, Longman.

Tummala, Krishna K. (1994), Public Administration in India, Singapore, Times Academic Press.

Umpathy, M. (1994), Development Debate, The Missing Question, Development Administration Today, Super or Sub-Discipline, Mysore, Manu Publishing.

Viswanath, Vinita (1993), NGOs and Women's Development in Rural South India , A Comparative Analysis, New Delhi, Vistaar Publication.

Voluntary Organizations India (1980), Academy of Development Science, Information on Voluntary Sector, A Classical List of Voluntary Association in India.

Warner, W. Keith (1972), in Voluntary Action Research, (ed) by D. H. Smith et. al. Lexington Mass, Lexington Books.

Wazir, Rekha (2000), The Gender Gap in Basic Education, NGOs as Change Agents, New Delhi, Sage.

Webb, A., Day, L. et. al. (1976), Voluntary Social Services Manpower Resources, London, Personal Social Services Council.

B. SECONDARY SOURCES

2. Articles from Journals and News Papers

Adisesaiah, Malcom S. (1984), "Testing Voluntary Agencies, No Good for the Big Task" , YOJONA, November .

Aggraval, P. (1987), "Role of Women in Socio-Economic Development".
SOCIAL WELFARE, March.

Ali, A. and Sisodia, P. (1995), "Health Profile of India, An Overview",
HEALTH FOR THE MILLIONS, Vol. 21, New Delhi, Voluntary Health
Association of India (VHAI).

Aminuzzaman, S. (1996), "Development Management and the Role of
NGOs in Bangladesh", ADMINISTRATIVE CHANGE, Vol. 24, No.1,
December .

Amis, William D. and Stern, Samuel E. (1980), "A Critical Examination of
Theory and Functions of Voluntary Associations", JOURNAL OF
VOLUNTARY ACTION RESEARCH,

Anderson, Robert T. (1971), "Voluntary Associations in History",
AMERICAN ANTHROPOLOGIST .

Anderson, R. T. and Anderson, G. (1959), "Voluntary Associations and
Urbanization, A Diachronic Analysis", AMERICAN JOURNAL OF
SOCIOLOGY .

Avina, Jeffrey (1993), "The Evolutionary Life Cycles of Non-Governmental
Development Organizations", WORLD DEVELOPMENT. Vol. 13 (5).

Banerjee, D. et. al. (2004), "Health Care Delivery in Rural Rajasthan", ECONOMIC AND POLITICAL WEEKLY (EPW). Vol.39, No. 9.

Banerjee, D. (1984), "An Escape or A Commitment?", YAJONA. November.

Batliwala, S. (1997), "Empowerment of Women", SEMINAR, Vol. 449 (Annual).

Bava, Noorjahan (1997), "Bureaucracy in Nation-building and Development, A Fifty Year Profile", INDIAN JOURNAL OF PUBLIC ADMINISTRATION, (IJPA) Vol.63, No.3, July-September.

Baxi, Upendra (1986), "Activism at Crossroads with Signposts", SOCIAL ACTION, Oct-Dec.

Bebbingtong, A. and Farrington, John (1993), "Governments, NGOs and Agricultural Development, Perspective on Changing Inter-organizational Relationships", JOURNAL OF DEVELOPMENT STUDIES, Vol.29, No.2.

Benjamin, Joseph (1986), "Voluntary Bodies and Rural Development, Case Study in Barlo Block in Bihar", MAINSTREAM, 19,July .

Bhakther, Solomon (1977), "Voluntary Agencies and Rural Work", ECONOMIC TIMES, 2, June.

Bhat, Anil (1995), "Voluntary Action in India", EPW, Vol.30, No.16.

Bhattacharjee, R. K.(1975), “The Role and Functions of Coordinating Agencies in Social Agencies”, SURVEY, Oct- Dec.

Bhattacharjee, A. (1985), “Voluntary Agencies, Identity Crises”, MAINSTREAM, 27, July.

Biersteker, Thomas J. (1990), “Reducing the Role of the State in the Economy, A Conceptual Exploration IMF and World Bank Prescriptions”, INTERNATIONAL STUDIES QUARTERLY, Vol. 34.

Bose, A. (1982), “Voluntary Sector, the Challenge of the Eighties”, SOCIAL WELFARE, July.

Boyle, Kavin (1994), “NGOs, A Resorting of Power”, NEWSWEEK, Vol. CXXIV,NO.5.

Bulsara, Jal F. (1961), “Public Co-operation, Role of Voluntary Organizations”, IJPA, July-Sept.

Central Regional Conference of Voluntary Agencies, A Report (1975), VOLUNTARY ACTION, March.

Chambers, Robert (1994), “Participating Rural Appraisal(PRA), Analysis of Experience”, WORLD DEVELOPMENT, Vol.22(9).

Chander, M. (1996), "Farmers Participation in Rural Development Programmes, Case Studies of Some Local NGOs in Central Himalayan Region", JOURNAL OF RURAL DEVELOPMENT .

Chandra, S.K.(1993), "Sustainability of Social Service Sector Programmes in India", IJPA, Vol.39,No.3.

Charyulu, U.V.N. (1980), "Voluntary Organizations and Rural Development", KURUKKSHETRA, 1, May.

Charyulu, U.V.N. and Natrajan, V.K. (1982), "The Working of a Voluntary Organization for Rural Development, A Case Study in Tamil Nadu", VOLUNTARY ACTION, April.

Chaturvedi, H. R. (1987), "Role of Voluntary Organizations in Rural Development", IJPA, Vol.30, No.16, July-Sept.

Chopra, P.(1981), "Dilemmas of Voluntary Agencies", INDIAN EXPRESS, 23/24 April .

Chowdhry, D. Paul (1968), "Voluntary Efforts in Social Welfare", SOCIAL WELFARE, August.

Chowdhry, D. Paul (1971), "Field Counseling for Welfare Agencies", SOCIAL WELFARE, August.

Clark, John (1995), "The State, Popular Participation and the Voluntary Sector". WORLD DEVELOPMENT, Vol.23, No. 4.

Curtis, James (1971), "Voluntary Association Joining, A Cross National Comparative Note", AMERICAN SOCIOLOGICAL REVIEW .

Dantwala, M. L. (1977), "Role of Voluntary Agencies in Rural Development", JANATA, 9, Oct.

Dasgupta, S. (1972), "Voluntary Organizations in Rural Development", VOLUNTARY ACTION, Jan-Feb.

De, N.R.(1970), "Organizing and Mobilization, Some Building Blocks of Rural Work Organizations", HUMAN FUTURES, Winter.

De, N. R. (1979), "Rural Voluntary Organizations", BUSINESS STANDARD , Dec.

Delhi Social Welfare Advisory Board (1974), Symposium - "Mutual Perception and Relationship between Governmental and Non-Governmental Agencies", SOCIAL WELFARE, Jan.

Deo, Jao Mangal (1987), "Voluntary Agencies vis-à-vis Government", YOJANA. March.

Desai, V. and Imrie, R.(1998), “The New Managerialism in Local Governance, North-South Dimensions”, THIRD WORLD QUATERLY, Vol.19, No.4.

Dheshi, Autar S.(1996), “From Centralised to Decentralised Development in India, The Communitarian Perspective”, COMMUNITY DEVELOPMENT JOURNAL, Vol.31, No.3.

Deshmukh, B. G.(1998), “Indian Bureaucracy – Facing the Future”, IJPA, Vol. XLIV, No.1, Jan-March.

Deshmukh, Nona (1984), “A Very Welcome Move Indeed”, YOJANA, Nov.

Deshpande, S.H.(1977), “Some Thoughts on Voluntary Work in Rural Areas”, JANATA. 9,Oct.

Deshmukh, Vasant (1982), “Developing Volunterism”, VOLUNTARY ACTION. Jan.

Deva, Satya (1986), “Bureaucracy and Development, Theoretical Perspective”, IJPA, Vol.33, No. 3, July-Sept.

Dey, S. K. (1985), “Reality or Declusion”, YOJANA, 16, June.

Dey, S. K. (1985), “Voluntary Action or Collusion”, KURUKSHETRA, Oct.

Dharmadhikari, C.S.(1985), “Role of Voluntary Action Groups”, BHAVAN’S JOURNAL, 1, Nov.

Dogra, Neera (1971), "Role of Voluntary Organizations in Family Planning Programme", SOCIAL WELFARE, June.

Dwivedi, O.P. (1997), "Development Administration, An Overview", IJPA, Special Issue.

Egbert, Sundar (1983), "Voluntary Effort in the Third World,. SOCIAL WELFARE, May.

Fernandez, A. P. (1979), " Evolution, Who Needs it?" VOLUNTARY ACTION, Oct.

Fernandez, Walter (1981), "Nature of People's Participation in Development, The Role of Voluntary Organizations", SOCIAL ACTION Oct. Dec.

Flower, A.(1992), "Building Partnership between Northern and Southern Development NGOs, Issues for the Nineties", DEVELOPMENT JOURNAL OF SID, Vol. 1.

Galab, S. (1993), "Rural Employment Programmes, Case Study for Involving Voluntary Organisations", EPW.

Gandhi, Jagdish P. (1981), "Role of Voluntary Agencies", Hindu, 21, Aug.

Gandhi, Kanakmal and Others (1982), "Experiment in Organizing People for Development", GANDHI MARG, Jan.

Gangrade, K.D. and Soorjamoorthy, R. (1994), "When Women Lead, Lessons from A Women NGO", IJPA, Vol.XL, No.4

Gellner, E.(1991), "Civil Society in Historical Context", INTERNATIONAL SOCIAL SCIENCE JOURNAL, Vol.29, Aug.

Ghosh, Arun (1988), "Popular Participation and Decentralized Planning in West Bengal", EPW, Jan, 16.

Gokhale, S.D.(1983), "Role of Responsibilities of International Agencies in Social Development", INTERNATIONAL SOCIAL WORK.

Gonsalves, G.J. (1975), "Development and Voluntary Agencies", VOLUNTARY ACTION, March.

Green, Ronald K. and Edward, Pawlak J. (1983), "Ethics and Manipulation in Organizations", SOCIAL SERVICE REVIEW, March.

Guest, P. (2003), "Reproductive Health including Family Planning", ASIA PACIFIC POPULATION JOURNAL, Vol.18, No.2.

Guha, P. (1975), "Voluntary Organizations in Service of Welfare State", SURVEY, April-June.

Gupta, Devendra K. (1973), "Need for Depoliticalisation of Voluntary Agencies". SOCIAL WELFARE, June.

Gupta, Raghuraj (1984), "Voluntary Agencies in Participatory Planning", RADICAL HUMANIST, Jan.

Hamilton Smith E.(1968), "The Role of Social Work Organizations in Social Action", INTERNATIONAL SOCIAL WORKER, July.

Hansman, H. (1979/80), "The Role of Non-Profit Enterprise", YALE LAW JOURNAL,89.

Harichandran, C.(1982), "Futuristic Role of Voluntary Organizations", KHADI GRAMODYOG, April .

Hasenfelo, Y. (1980), "Implementation of Change in Human Service Organizations, A Political Economy Perspective", SOCIAL SCIENCE REVIEW.

Henderson, Keith and Dwivedi, O.P. (1992), "Administered Development, The Fifth Decade-1990s", IJPA, Vol.38, No.1, Jan-March.

Hirschmann, David (1999), "Development Management vs Third World Bureaucracy, A Brief History of Conflicting Interests", DEVELOPMENT AND CHANGE, Vol.30, No. 2, April.

Hyden, G. (1997), "Civil Society, Social Capital and Development, Desection of a Complex Discourse", STUDIES IN COMPARATIVE INTERNATIONAL DEVELOPMENT, Vol. 32, No.1

Inamdar, N.R. (1987), "Role of Voluntarism in Development", IJPA, Vol.33, No.3, July-Sept.

Irudaya, Ranjan S. and Mohanachandran, P. (1998), "Infant and Child Mortality Estimates", EPW, 9 May.

Islam, Nurul and Khan, Niaz Ahmed (1996), "NGOs in Bangladesh, A Commentary", JOURNAL OF RURAL DEVELOPMENT, Vol.15, No. 4.

Jagannadham, V. (1976), "Social Realities and Voluntary Agencies", VOLUNTARY ACTION, July-Aug.

Jagannadham, V. (1985), "Conceptual Essay on the Relationship between Governmental and Non-Governmental Agencies", SOCIAL CHANGE, March.

Jain, Devaki (1976), "Role of Voluntary Agencies", VOLUNTARY ACTION, March-April.

Jain, Devaki (1985), "Voluntary Agencies and Their Role", Indian Express, 1, July.

Jain, G. P. (1985), "Voluntary Agencies for Atmospheric, Not Implementation", KURUKSHETRA, Oct.

Jain, L. C. (1980), "Debates in the Voluntary Sector, Some Reflections", SOCIAL ACTION, Oct- Dec .

Jain, R.B. (1998), "Political Control of Bureaucracy of India", IJPA, Vol. XLIV, No. 1, Jan-March.

Jayaraman, B. (2001), "Micro-Finance Retrospect and Prospects", OCCASIONAL PAPER 20, NABARD, Mumbai.

Jhunjhunwala, Barat (1980), "Voluntary Work as Countervailing Power", EPW, 5, April.

Johnson, Braham E. (1975), "Voluntary Associations and Social Change, Some Theoretical Issues", INTERNATIONAL JOURNAL OF COMPERATIVE SOCIOLOGY, March-June.

Joshi, Sanat T. (1975), "Voluntary Organizations as Catalysts of Change, An Empirical Study of Nadiad Town", SOCIAL WELFARE, July.

Jothi, M. S. (1980), "Voluntary Organizations and Social Change", MADRAS DEVELOPMENT SEMINAR SERIES BULLETIN, Jan.

Kanjilal, B. and Mukherjee, M. et.al.(2007), "Health, Equity and Poverty, Exploring the Links in West Bengal, India, Future Health Systems", Research Monograph, India.

Karunakaran, K. C. (1983), "Voluntary Organizations and Rural Development", VOLUNTARY ACTION, Jan.

Kirby, Richard M. (1973), "Voluntary Action in Developing Countries", JOURNAL OF VOLUNTARY ACTION RESEARCH, Vol. 2, No. 1.

Kishore, Saini C. (1974), "Catalyst Role of Voluntary Agencies, A Conceptual Framework", PEOPLE'S ACTION, Nov.

Knighton, Arf and Heidelman, Nancy (1984), "Managing Human Service Organizations with Limited Resources", SOCIAL WORK, Nov.-Dec.

Kolkara, Sebastian (1977), "Local Organizations for Nation Building" SOCIAL WELFARE, July.

Korten, David C. (1980), "Community Organization and Rural Development, A Learning Process Approach", PUBLIC ADMINISTRATION REVIEW, Sept.-Oct.

Korten, David C. (1984), "Strategic Organization for People-Centered Development", PUBLIC ADMINISTRATION REVIEW.

Korten, David C. (1986), "Micro-Policy Reforms, The Role of Private Voluntary Agencies", Working Paper No. 12, THE NATIONAL ASSOCIATION OF SCHOOLS OF PUBLIC ADMINISTRATION, Washington D. C.

Korten, David C. (1987), "Third Generation NGO Strategies, A Key to People-Centered Development", WORLD DEVELOPMENT, 15.

Kothari, Ashish (1993), "Is Sustainable Development Desirable and Possible?" IJPA, Vol. 39, No. 3.

Kothari, Rajni (1986), "NGOs, the State and World Capitalism", EPW, 13, Dec.

Kramer, Ralph M. (1979), "Voluntary Agencies in the Welfare State, An Analysis of Vanguard Role", JOURNAL OF SOCIAL POLICY, Oct.

Krishna, Kumar and Bhaskar, V. (1973), "Functional-Dysfunctional Dilema in Social Work Practice" INDIAN JOURNAL OF SOCIAL WORK, Jan.

Krishnamurthy, V.(1982), "Voluntary Agencies and Rural Development", KURUKSHETRA, 16,June.

Krishnamurthy, V.(1985), "Voluntary Action in Rural Development", KURUKSHETRA, Oct.

Krishnan, C. (2009), "Role of Microfinance in Women Empowerment, A Study of Selected Experiments in Kerala", THE MICROFINANCE REVIEW, Vol.1, No.0, Jan-June.

Krishnaswami, N.R. (1981), "Success Story of a Voluntary Agency", HINDU, 11, Aug.

Kulkarni, P.D. (1979), "Voluntary Action for Social Development", THE INDIAN JOURNAL OF SOCIAL WORK, Vol.40, No.4, Jan.

Lakshmana, Mamata (1983), "Voluntary Organizations in Population Control", YOJANA, 26, Jan.

Leach, Melissa (1988), "Becoming a People Sector, Indian Voluntary Agencies at a Crossroads", COMMUNITY DEVELOPMENT JOURNAL, Vol.23, No.2.

Lemon, Mona and Others (1972), "Dominant Status and Involvement in Formal Voluntary Associations", JOURNAL OF VOLUNTARY ACTION RESEARCH .

Livernash, Robert (1992), "The Growing Influence of NGOs in the Developing World", ENVIRONMENT, Vol.34, No.5.

Londhe, G.D. (1980), "Role of Voluntary Agencies in Adult Education", SOCIAL WELFARE, Oct.

Luthra, P.N.(1974), "Governmental and Non-Governmental Agencies Co-travelers in Salvation of Mankind", SOCIAL WORK, Jan.

Maheswari, S. R. (1987), "Voluntary Action in Rural Development in India", IJPA, Vol.33, No. 3, July-Sept.

Majumdar, G.(1976), "National Development and Voluntary Agencies", VOLUNTARY ACTION, March-April.

Malare, G. (1976), "Structure and Change of Structure in Social Welfare Organizations", INTERNATIONAL SOCIAL WORK.

Masoni, V.(1985), "Non-Governmental Organizations Role in Development", VOLUNTARY ACTION, March-April.

Mathew, George (1999), "Decentralized Institutions, Government and Voluntary Sector", EPW, Vol 34, No.9, Feb-March.

McIlwaine, C.(1998), "Civil Society and Development Geography", PROGRESS IN HUMAN GEOGRAPHY, Vol. 22, No.3

Mehta, Balraj (1985), "Rural Development Made Easy", KURUKSHETRA, Oct.

Mehta, J.S. (1987), "Challenge and Opportunity for Voluntarism in Rural Development", IJPA, Vol.33, No.3, July-Sept.

Mencher, John (1999), "NGOs, Are they a Force for Change?", EPW, Vol.34, No.30.

Misra, Girish K. (1977), "Spatial Organization of Service Centers in Rural India", IJPA, July-Sept.

Misra, S.N. and Misra, Sweta (1998), "Good Governance, People's Participation and NGOs", IJPA, Vol. XLIV, No.3, July-Sept.

Mitra, Ashok (1985), "Voluntary Organizations", FRONTIER, 16, March.

Mohanty, B.B. (1982), "Helping to Educate, Crucial Role of Voluntary Agencies", STATESMAN, 16, June.

Morris, Robert (1982), "Government and Voluntary Agency Relationships", SOCIAL SERVICE REVIEW, Sept.

Mowbray, Martun (1983), "Localism and Austerity, The Political Economy of Community Welfare Services", COMMUNITY DEVELOPMENT JOURNAL, Oct.

Mukherjee, R. (1985), "Social Disorganization in India", INDIAN JOURNAL OF SOCIAL WORK, April.

Mukherjee, K., Sivapuri, K. (1975), "A Centre for Voluntary Action", VOLUNTARY ACTION, April.

Mukherjee, K., Sivapuri, K. (1980), "Voluntary Organizations in Rural Development", VOLUNTARY ACTION, July-Sept.

Mundle, Sudipto (1992), "Goodbye Statism but State quists Remain", THE SUNDAY TIMES OF INDIA, 2, Aug.

Murdia, R. (1978), "Task Structures and Management Processes in Human Services Organizations", INDIAN JOURNAL OF SOCIAL WORK, Oct.

Muttalib, M. A. (1987), "Voluntarism and Development, Theoretical Perspectives", IJPA, Vol.33, No.3, July-Sept.

NABARD, (2001), "Ten Years of SHG-Bank Linkage, 1992-2002".
NABARD and MICROFINANCE.

Nagasya, D. and Rao, D. K. (2009), "Microfinance and Support Organizations in the Southern States of India", JOURNAL OF RURAL DEVELOPMENT, Vol.28, No.3, July-Sept.

Nandeker, V.G. (1987), "Voluntary Associations, A Strategy in Development", IJPA, Vol.33, No.3, July-Sept.

Narayana Reddy, G. (1987), "Human Resources Development for Voluntary Action", KHADI GRAMODYOG, May.

Narayana, Shashi S.(1998), "Empowerment of Women through Social Mobilisation", WOMEN'S LINK, Vol.4, No.1, Jan-March.

Natarajan, N. (1977), "Role of Voluntary Organization in the Development of Backward Areas, Nagaland", IJPA, July-Sept.

Nayak, Jessie-Tellis (1973), "Voluntary Agencies for Development of Justice", SOCIAL WELFARE, Dec.

Nighat, S.Khan and Kamala, B. (1986), "Role of People's Organizations", IFDA. Dossier, May-June.

Oommen, T.K. (1975), "The Theory of Voluntary Associations in a Cross Cultural Perspective", SOCIOLOGICAL BULLETIN, Sept.

Owens, Raymond L. and Nandy, A. (1975), "Organizational Growth and Organizational Participation, Voluntary Associations in a West Bengal City", CONTRIBUTIONS TO INDIAN SOCIOLOGY, Jan-June.

Panda, S. (1987), "Social Transformation and Voluntary Agencies, A Model", IJPA, Vol.33, No.3, July-Sept.

Parker, Robert Nash (1983), "Measuring Social Participation", AMERICAN SOCIOLOGICAL REVIEW, Dec.

Parvey, Constance F.(1972), "The Role of Voluntary Agencies in Third World Development, Some Questions for Exploration", JOURNAL OF VOLUNTARY ACTION RESEARCH.

Patel, A.R. (1985), "Challenging Task for Voluntary Agencies", KURUKHETRA, Oct.

Paul, Samuel (1989), "Poverty Alleviation and Participation, The Case for Government-Grassroots Agency Collaboration", EPW, Vol.24, No.2 .

Pettilo, M.H. (1973), "Can Voluntary Associations Change?", INDIAN JOURNAL OF ADULT EDUCATION

Phadnis, Uma Shankar (1986), "Kudal Commission and Social Activism", INDIAN EXPRESS, 2, Sept.

Pillsbury, Jolie Bain and Nance, Kathi Newton (1976), "An Evaluation Framework for Public Welfare Agencies", PUBLIC WELFARE, Winter.

Pinto, G. (1982), "People's Participation, the Spurious and Genuine Concern", SOCIAL WELFARE, July.

Prem, Bhai (1979), "Rural Development, An Experiment in Mobilising Voluntary Action for Rural Development", GANDHI VIGYAN, July.

Qadeer, I. (1998), "Reproductive Health, A Public Health Perspective", EPW, Vol.33 No.44.

Qadeer, I. (2008), "Health Planning in India", SOCIAL SCIENTIST, Vol.36, NOs 5-6, May-June.

Radhakrishna, (1993), "Voluntary Organizations in a Critical Decade", GANDHIMARG, Vol. XV, No.3, Oct-Dec.

Rahman, Anisur (1985), "NGO Work of Organizing the Rural Poor, The Perspective", IFDA, DOSSIER, Nov.-Dec.

Rai, Gouri S.(1983), "Reducing Bureaucratic Inflexibility", SOCIAL SERVICE REVIEW, March.

Raj, K. (1984), "Testing Voluntary Agencies, It Would Just be a Futile Exercise" YOJANA, Nov.

Rajashekharan, M.V. (1985), "Voluntary Organizations and Rural Development", KURUKSHETRA, Oct.

Rajendra, N. (1971), "Role of Voluntary Agencies and Rural Development", SOCIAL WELFARE, Oct.

Rajshekhar, D. (2002), "NGOs in India, Opportunities and Challenges", JOURNAL OF RURAL DEVELOPMENT, Vol.19, No.2 .

Rajshekhar, D. (1998), "Rural Development Strategies of NGOs", JOURNAL OF SOCIAL AND ECONOMIC DEVELOPMENT, Vol.1, No.2.

Rajula Devi, A. K. and Srinivasan, E.S. (1979), "Role of Voluntary Agencies in Rural Development", KHADI GRAMODYOG, Sept.

Rajvanshi, J. (1997), "Health Delivery System, Precondition for Effective Role of NGOs", THE ADMINISTRATOR, Vol.62, No.3, July-Sept.

Ramamurthy, S. R.(1985), "Government Functionaries must Whole Heartedly Accept Voluntary Agencies", KURUKSHETRA, Oct.

- Ramchandran, K. R. (1976), "The Role of Government and Voluntary Organizations is not Competitive but Complementary", *SOCIAL WORK*, Aug-Sept.
- Ramachandran, S. (1985), "Implementation of Projects for Enhancement of Rural Prosperity", *KURUKSHETRA*, Oct.
- Ramachandran, S.(1985), "PADI and Voluntary Organizations", *KURUKSHETRA*, Oct.
- Ramachandran, V.(1996), "NGOs in the Time of Globalization", *SEMINAR*, Nov.
- Ramachandran, V. (1995), "Equality Among Unequal Parties, Relationship between NGOs and Government". *THE ADMINISTRATOR*.
- Ramakrishnan, P.S.(1993), "Sustainable Rural Development and Weaker Sections of the Society – Where Do We Stand?", *IJPA*, Vol. 39, No.3.
- Ray, S.N.(2000), "Decentralized and Participatory Rural Development in West Bengal in a Comparative Perspective", *THE WEST BENGAL POLITICAL SCIENCE REVIEW*, Vol.3, No.2, July-Dec.
- Raymond, L . Owens and Nandy, A. (1975), "Organizational Growth and Organizational Participation, Voluntary Association in a West Bengal City", *CONTRIBUTION TO INDIAN SOCIOLOGY*, Vol. IX, No.1, Jan-June.
- Redcliffe, Mand Lord (1970), "The Voluntary Movement Today", *SOCIAL SCIENCE QUARTERLY*, Jan-March.
- Reddy, I. Udaya Bhaskara (1987), "Role of Voluntary Agencies in Rural Development", *IJPA*, Vol.33, No.3, July-Sept.
- Reddy, M. (1977), "Social Work Content in Voluntary Action", *VOLUNTARY ACTION*, Dec.
- Robinson, M. (1992), "Assessing the Impact of NGO Rural Poverty Alleviation Programmes, Evidence from South Asia", *JOURNAL OF INTERNATIONAL DEVELOPMENT*, Vol.4, No.4.
- Rogers, David L. and Others (1975), "Voluntary Association Membership and Political Participation, An Exploration of the Mobilisation Hypothesis". *SOCIOLOGICAL QUARTERLY*.
- Rohadgi, Sushila (1982), "Coordination the Need of the Hour", *SOCIAL WELFARE*, Aug.

Rose, Gordon (1976), "Approaches to the Analysis of Social Service Agencies", JOURNAL OF SOCIAL POLICY, July.

Ross, Jack C. (1976), "Anthropological Studies of Voluntary Associations and Voluntary Action, A Reassessment", JOURNAL OF VOLUNTARY ACTION RESEARCH .

Ross Jack C. (1972), "Toward a Reconstruction of Voluntary Association Theory", BRITISH JOURNAL OF SOCIOLOGY, March.

Roy, S. Bunker (1984), "Voluntarism and the 7th Plan", INDIAN EXPRESS, 17, Aug.

Roy, S. Bunker (1987), "Voluntary Agencies in Development, Their Role, Policy and Programmes", IJPA, Vol.33 No.3, July-Sept.

Roy, S. Bunker (1983), "Government as Donor for Voluntary Action", VOLUNTARY ACTION, Jan.

Roy, S. Bunker (1986), "Power Broker in Voluntary Sector", MAINSTREAM, June.

Rubin, Allen and Irene M. Thorelli (1984), "Egoistic Motives and Longevity of Participation by Social Service Volunteers", JOURNAL OF APPLIED BEHAVIOURAL SCIENCE .

Salaman, Lester H. and Others (1984), "Voluntary Organizations and the Crises of the Welfare State", NEW ENGLAND JOURNAL OF HUMAN SERVICES, Winter.

Samanta, Gopa (2009), "Microfinance and Women, Gender Issues of Poverty Alleviation and Empowerment", THE MICROFINANCE REVIEW. Vol.1, No.0, Jan-June.

Sastri, M.V. (1972), "Role of Voluntary Organizations in Rural Development", VOLUNTARY ACTION, Jan-Feb.

Sastri, M. V. and Mukherjee, K.K. (1975), "A Survey of Development Work of Voluntary Agencies", VOLUNTARY ACTION, March.

Sastri, M.V.(1976), "Scope and Role for Voluntary Agencies", VOLUNTARY ACTION, March-April .

Satish, P. (2001), "Some Issues in the Formation of Self-Help Groups", INDIAN JOURNAL OF AGRICULTURAL ECONOMICS , Vol. 56, No.3, July-Sept .

- Sen, A.C. (1985), "A Case Study of Voluntary Action", VOLUNTARY ACTION, Jan-Feb.
- Sen, B. (1987), "NGO Self-Evaluation, Issues of Concern", WORLD DEVELOPMENT, 15 (supplement).
- Sethi, D.P.(1970), "Volunteers in Welfare Organizations", SOCIAL WELFARE, Oct.
- Sethi, J.D. (1986), "Politics and Voluntary Organizations" , JANATA, Nov.
- Sethi, Harsh (1985), "Wither Voluntary Action", SAMINAR, May.
- Shah, Anil C. (1985), "Ensuring Greater Participation of Voluntary Organization", KURUKSHETRA, Oct.
- Shah, D. (1985), "Voluntary Agencies in the Seventh Plan", VOLUNTARY ACTION, March-April.
- Shah, K. (1973), "Voluntary Agencies", TIMES OF INDIA, 20, Jan.
- Sankar, D.(1981), "Is the Voluntary Sector Viable?", VOLUNTARY ACTION, Sept.
- Sharma, A. (1993), "Rationalising Rural Development, An Approach for Logistic Decisions", IJPA, Vol.39, No.2.
- Sheth, D.L. and Sethi, Harsh (1991), "The NGO Sector in India, Historical Context and Current Discourse", VOULANTAS, 2.
- Sheth, D.L. (1984), "Grassroots Initiatives in India" , EPW, Vol.19.
- Shivkumar, M.S. (1985), "Voluntary Agencies and Planned Development", MAINSTREAM, 22, June.
- Sills, P. (1976), "Voluntary Initiative and Statutory Reactions, A Study in Political Control of Social Reform", COMMUNITY DEVELOPMENT JOURNAL, April .
- Singh, J.B. (1984), "Testing Voluntary Agencies – Lets' First Understand Them", YOJANA, Nov.
- Singh, J. P. (2000), "Indian Democracy and Empowerment of Women", INDIAN JOURNAL OF PUBLIC ADMINISTRATION, Vol.46, No.4.

Smith, David Harton (1975), "Voluntary Action and Voluntary Groups", ANNUAL REVIEW OF SOCIOLOGY .

Smith, David Harton and Fredrick, Elkain (1980), "Volunteers, Voluntary Associations and Development", INTERNATIONAL JOURNAL OF COMPARATIVE SOCIOLOGY.

Smith, D.H. et. al. (1973), "Voluntarism and Socio-economic Development, Some Key Questions for Research", JOURNAL OF VOLUNTARY ACTION RESEARCH, Vol.2, No.2 .

Srivastava, T.N. (1982), " Motivation and Delivery of Services, The Role of Voluntary Agencies", SOCIAL WELFARE, Nov.

Stokke, K. and Giles, M. (2001), "Convergence Around Local Civil Society", SOCIAL SCIENTIST, Vol. 29, Nos. 11-12, Nov.-Dec.

Subramaniam, Ashok (1984) " Designing Development Programmes, Some Pointers from Voluntary Agencies", ABHIGYAN, Autmn.

Swaminathan, P. (1991), "Science and Technology for Women, A Critique of Policy", EPW, Vol.26, Nos. 1-2.

Tandon, Rajesh (1978), "Voluntary Agencies , A Management Perspective", ECONOMIC TIMES, 24, Oct.

Thakkar, N. (1973), "Role of Voluntary Agencies and People's Participation in Planning and Development of Nagaland", VANYAJATI, Oct.

Thapar, S.D. (1975), "The Challenge of Voluntarism", VOLUNTARY ACTION, March.

Thompson, Randall J. and Armer, M. (1980), "Respecting the Effects of Voluntary Association on Individual in a Traditional Society", INTERNATIONAL JOURNAL OF COMPARATIVE SOCIOLOGY.

Tiwari, N. D. (1982), "Voluntary Agencies in a Welfare", SOCIAL WELFARE, Aug.

Tomeh, Aida K. (1973), "Formal Voluntary Organizations, Participation, Correlates and Interrelationships", SOCIOLOGICAL ENQUIRY.

Tripathy, K.K. and Jain, S.K. (2010), "Micro-Finance and Rural Self-Help Empowerment through Self-Help Groups, A Study of Selected District in Orissa and Haryana", JOURNAL OF RURAL DEVELOPMENT, April-June, Vol.29, No.2.

- Unia, Pramod (1991), "Social Action Group Strategies in the Indian Sub-continent", DEVELOPMENT IN PRACTICE, Vol.1, No.2.
- U. N. Economic and Social Commission for Asia and the Pacific, (1985), "Role of the Participatory Organization in Agrarian Reference", Bangkok, UNESCAP.
- UNITAR, (1976), "The Potential of NGOs in Social and Economic Development", Report of a Conference, INTERNATIONAL ASSOCIATION, No.2.
- Varadappan, S. (1977), "The Concept of Voluntary Work Needs Change", SOCIAL WELFARE", July.
- Varma, R.M. (1976), "Voluntary Agencies and Government". VOLUNTARY ACTION, March-April.
- Varma, R.M. (1976), "Voluntary Organizations, The Changing Role", SOCIAL WORK FORUM, Jan.
- Vergheese, B.G. (1977), "Voluntary Action, A New Mission for the New Missionaries", VOLUNTARY ACTION, Vol.19, No.2, Jan-Oct.
- Vergheese, B.G. (1979), "Voluntary Agencies, How Useful", KURUKSHETRA, Oct.
- Vishwanath, L.S. (1985), "People's Organizations for Rural Development", MAINSTREAM, 27, July.
- Vishwanatha, S. (1997), "Grouping Women for Economic Empowerment", YOJANA, Vol.14, No.3, March.
- Vivian, J. (1994), "NGOs and Sustainable Development in Zimbabwe, No Magic Bullets", DEVELOPMENT AND CHANGE, Vol.25, No. 3, March.
- Vohra, Gautam S.G. (1975), "Social Welfare Problems, Voluntary Agencies", TIMES OF INDIA, 16, Jan.
- Walters, Shirley (1987), "A Critical Discussion on Democratic Participation within Community Organizations", COMMUNITY DEVELOPMENT JOURNAL, Jan.
- Ward, John (1978), "Creative Conflict? A Perspective of the Relations between Government, Statutory Agencies, the Voluntary Movement and Community Work", COMMUNITY DEVELOPMENT JOURNAL, 1, APRIL

Webster, Neil (1995), "The Role of NGOs in Indian Rural Development, Some Lessons from West Bengal and Karnataka", THE EUROPEAN JOURNAL OF DEVELOPMENT RESEARCH. Vol.7, No.2

Wiehe, Vernon R. (1978), "Role Expectations among Agency Personnel", SOCIAL WORK, Jan.

Wilson, David C. and Butler, Richard J. (1986), "Voluntary Organizations in Action, Strategy in the Voluntary Sector", JOURNAL OF MANAGEMENT STUDIES, Sept.

Yates, Ian (1982), "Strengthening National Councils on Social Welfare", INTERNATIONAL SOCIAL WORK.

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Empowerment	8, 11, 16, 21,24
World Bank	97,105,117,118,121,204,208,227,229,236,239
World Summit on	
Social	
Development	2
