Chapter-VI

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Health is a fundamental human right and it is the state’s responsibility to provide health care facilities to the people but it is not possible for state alone because of limited resources. So the government decided to involve NGOs in health care programme. These NGOs are important because of their special characteristics like small size, being more participatory, less bureaucratic, more flexible, cost effective and capable of reaching vulnerable population. Thus, this study makes an attempt to understand the role of NGOs in providing health care facilities to the people. The study has been divided into the following chapters:

1. Introduction – Conceptual and Theoretical Framework
2. Review of Literature
3. Methodology – Field and Planning of the Study
4. NGOs: The Providers of Health Care
5. Health Promotion Through Community Action
6. Summary and Conclusion

Chapter I is the introductory part of the study in which we have discussed the following: (1) Concept of Health, (2) Theoretical framework of health, (3) Indian System of Medicine, (4) Historicity of Health In India pre independence and post independence including programmes and policies adopted by the Indian government, (5) Health situation in Haryana State, (6) Concept of NGOs (7) The Origin of NGOs, (8) Theories of the Origin of NGOs (9) The rise of NGOs before independence to post independence, (10) NGOs and health care in India, (11) NGOs and health care in Haryana.

Health at the conceptual level is the capacity of an individual to cure himself and this capacity is achieved when a person possesses a strong body,
a controlled and balanced state of mind, a compassionate heart, a discriminative intellect and a purposeful life. It is a state, where there is a balance in body, its functions, mind, social and spiritual well-being. It is affected by 3 main factors i.e. hereditary, environmental and personal.

In theoretical framework, we have discussed Parsons's Theoretical Model, Freidson's Theoretical Model, Kennedy's Theoretical Model and Rosenstock's Theoretical Model. Parsons's Theoretical Model believes that sickness is the disturbance in the normal condition of human being and the sick person is not responsible for his condition. Parsons described illness as a deviant social state brought about by disruption of normal behaviour through disease.

Freidson's Theoretical Model is based on Becker's Labeling Theory and emphasizes that illness is a socially created label. Freidson describes two types of legitimacy to make distinction among sick role of various varieties. First is the conditional legitimacy which permitted a deviant temporary exemption from normal obligations and provides privileges so that the deviant may seek medical help to get rid of the deviance and second is the unconditional legitimacy exempts a deviant permanently from normal obligations of this role and is granted additional privileges because of hopeless nature of his deviance.

Kennedy's Theoretical Model believes that there are seven types of adaptive behaviour in which society engages in order to cope with health problems i.e. (1) Escape behaviour (2) Precautionary behaviour (3) Emergency response (4) Curative health services (5) Rehabilitative services (6) Scientific research to deal with illness and (7) Acceptance behaviour.

Rosenstock's Health Belief Model is used to study the preventive aspect of health behaviour. This model believes that there are some social- psychological factors which motivate healthy people to seek preventive care to avoid illness.

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The field of our study, Rohtak where there are many health problems and people have their own perspective and understanding for seeking health care. Kennedy's Theoretical Model is appropriate to understand the differential and pluralistic understanding of health behaviour.

In ancient India, six different systems of medicine were used i.e. Ayurveda, Siddha, Unani, Yoga, Naturopathy and Homeopathy in which Ayurveda was dominant. Each system of medicine has its own scientific principle and has been used by the people of India.

Before independence, the health status of people was very low. The dominant system of medicine was the traditional system which had no preventive characteristics and its effectiveness for controlling diseases was very slow. Modern medicine which was introduced in the country through the Britishers first to serve the Indian army and later on for Britishers staying in India, was adopted slowly by the elite in the country. But its coverage was extremely limited. For instance, there was hardly one doctor per 6300 population in India as compared to 1000 population in United Kingdom in 1940s. Similarly, the nurses population ratio was 1:4300 and that of midwife population was 1:60000. These statistics clearly depict inadequacy of health personnel in the country. Even out of this number of doctors, 75 percent practiced in urban areas. After independence, the government adopted British system of administration in the health care system also. The process of spreading modern medicine through primary health centre was adopted in India. At the same time Indian government appointed a number of committees to review the existing health situation i.e. Bhore committee, Mudaliar committee, Kartar Singh committee, Shrivastava committee etc. and started a number of health policies and health programmes to improve the health status of people. As a result, the health status of the people was increased but the government could not achieve the objective of health for all in 2000 A.D. So the Indian government involved Non Governmental Organizations (NGOs) in
health care programmes. These organizations are the main actors of civil society institutions.

The NGOs have concentrated on various issues of current importance such as ecology/environment, human rights, women's empowerment, sharing of natural resources and so on. Often, they want to bring about social transformation and uplift the deprived millions. These organizations seek to play the role of development catalysts and pressure groups to subject the power apparatus of the state under close scrutiny. They mobilize people, encourage them to raise their voices against the establishment and, in the process, build up a cohesive and unified force in the form of people's protest.

We have discussed three types of theories related with the origin of NGOs in India. These are (i) Contract failure theory (2) Subsidy theory (3) Exchange theory. The contract failure theory argues that when consumers feel unable to evolve accurately the adequate quality of goods, they choose voluntary organizations as supplier rather than profit making firm. The subsidy theory explains the phenomenal growth in the number of voluntary organizations as a result of the abundant availability of funds. The exchange theory viewed a voluntary association as a benefit exchange in which the group organizer offers a set of benefit to the members and receive benefits in return. In the present study, subsidy theory is more relevant for the analysis because in Rohtak district the Haryana government also provides a lot of subsidy to the NGOs.

In India, NGOs have a long history. In the nineteen and early twentieth century, Christian churches came into existence to enter the social and religious life of the indigenous population through improvement of health, social welfare and social reform. On the other hand, as part of anti-colonial resistance, numerous indigenous organizations emerged to accelerate other social and religious reforms (Seth and Sethi, 1996). In fact, more involvement and initiatives of NGOs have been occurring in India since late 1970s. For
instance, the Foreign Contribution Regulation Act (1976), the CAARD (Committee to Review the Existing Administrative Arrangements for Rural Development) Report (1985) the Seventh Five Year Plan (1985-1990), etc. motivated the NGO sector for country’s all around development (Garain: 1994).

In the field of health, the government recognized the role of NGOs because of two reasons:

1. Incorporation of various elements of NGOs in to government policy framework.
2. The use of NGOs for various aspects of government planning because they are more effective than governmental organizations and addressed themselves directly to the problems.

At present, these organizations perform different roles in the field of health care. They provide clinical services, health awareness, health care training and at the same time conduct research.

In India, some of the healthcare NGOs include the ‘Parivar Seva Sanstha’ in Delhi. ‘Satreehitkarini’ in Maharashtra, ‘Banwasi Seva Ashram’ in U.P. and Manav Seva Sangh in Rohtak etc. These are the bigger NGOs but there are several other organizations who work at the grassroots level. There is a little information available about the role of NGOs in health care so in order to get some insights, the present study has been conducted.

In the second chapter, we have reviewed the related literature. We have divided the reviewed studies into three categories i.e. (1) Studies related to NGOs in development (2) Studies related to healthcare (3) Studies related to NGOs in healthcare.

The studies related to NGOs in development include the studies of Lalitha, Lawani, Parsad, Rao, Gargrade, Rana, Bose, Goel and Singh. All the studies covered the historical, social and economic background of voluntary organizations and their structure and management and found that NGOs
played a significant role in social welfare, social development and rural reconstruction.

In the second category studies relate to health care, include the studies of Goel, Jeffery, Arnold, Reddy, Punchmukhi, Latha, Nagla and Agnihotri. These studies cover the nature, scope, role of health care, administration and its relationship with socio-economical development. These studies also analyse the process of policy making and planning for health care and administration and the nature of financing of health in India since independence.

In the third category the studies relate to NGOs in healthcare and we find that there is no comprehensive study on NGOs in healthcare. So the present inquiry tries to understand the both aspects of health care from provider point of view (NGOs) and receiver point of views i.e. beneficiaries.

In the chapter III, we have discussed the field of the study. The present study has been conducted in Rohtak in Haryana state. Haryana state is rich in its physical resources. It has fertile land-equipped with a network of irrigation facilities but it does not have very good health infrastructure. For example, there are only 7 Paediatricians and 7 Obstetricians and Gynaecologists in community health centres in Haryana state, while, the requirement is 86. This showed that there is gross negligence of mother and child health care in Haryana state.

We have selected Rohtak as our field of study because there is enough general awareness among the people about the schemes floated by the government due to education, and secondly, a number of NGOs are involved in healthcare in Rohtak.

In the present study, we have taken 10 NGOs working in healthcare in Rohtak. These are – Haryana Nav Yuvak Kala Sangam, Indian Red Cross Society, Baba Banda Bahadur Seva Samiti, Hari Om Seva Dal, Bharat Vikas Parishad, Giriraj Manav Seva Sansthan, Sat Bhai Sai Das Seva Samiti, Baba
Lakshamanpuri Seva Samiti, Manav Sea Sangh and Maharaja Agrasen Seva Samiti.

During our study, we have selected those NGOs which are registered in Rohtak under Society Registration Act and are also functioning during the study period. These NGOs have the experience of Minimum three years after registration and contributed in health services. The study is exploratory in nature and the in-depth interview and participant observation methods are adopted in the study. To know the perception of beneficiaries towards NGOs, we have selected 150 respondents from the selected NGOs during the study period. The selection is based on random sampling. We also interviewed staff members working in these NGOs to know their job satisfaction level etc. There are 108 staff members working in these NGOs out of which 100 responded to our interview process.

The main objectives of our study are:

1. To know the socio-economic differentials and patterns of health care, access and its utilization.
2. To know the role of NGOs in providing health care facilities.
3. To know the strategies of NGO's towards health care.
4. To know the extent of sensitization and mobilization of community resources for the utilization of health care services.
5. To study the people's participation in NGO's health care system.

Chapter IV deals with the background of NGOs i.e. registration year, working area, nature of programmes at the starting of the organization, main target group for delivery of health care, financial condition of the organization etc. health facilities provided by them to the people, their planning for health care programme, problems in implementing the health programme, problems in recruitment, job satisfaction of the staff members working in NGOs etc.

There is a total 11 NGOs working on health care in Rohtak out of which only 10 NGOs gave response. In the selected NGOs, 9 have their own
dispensary, while 1 i.e. Indian Red Cross Society does not have any dispensary but works with government hospitals and medical college etc. In the present study, we find that the NGOs in Rohtak have flat organizational structure. All the 10 NGOs have Board of Members with Secretary as functional head and the President as the nominal head. The Board does not interfere in day to day affairs of the organization but holds the meeting timely to know the progress of work. We also found that the NGOs are functionally divided into different units. Each subsystem is not only independent, but it is also functionally autonomous.

During our study, we found that most of the NGOs are registered in the year 1998-2000 and are working in urban area only. There is not a single NGO in Rohtak district which is working exclusively in rural area. There are two types of organizations in Rohtak i.e. (i) Service Organization and (ii) Research and Consultancy organization. We found that most of the NGOs are service organizations. Actually, these organizations are service oriented from the inception and cater their services to people below poverty line as their main target group. Very few NGOs' chose aged as their main target group from the inception.

A number of health care facilities provided by these NGOs are: Health check-ups, prevention of malaria, prevention of tuberculosis, artificial body parts to the disabled persons, prevention of anaemia, prevention of AIDS, immunization and Ayurvedic treatment. Here, we received multiple responses and found that all the 10 NGOs are engaged in health check-ups.

All the NGOs in Rohtak have a planned for their health care programme in dispensary or in occasional camps. However, this planning is done by discussing with other Board or staff members of NGO without taking community participation. Very few NGOs discussed with beneficiaries about their health care planning. These organizations also faced some problems in implementing these programmes i.e. lack of budget, lack of volunteers etc.
and found that inadequacy of budget is the most common problem in implementing the programme. These organizations got a satisfactorily response from the people towards their programme. A large number of people attended their health care programme.

When we asked the NGOs about their programme planning in future, majority of the NGOs admit that they want to change the programme planning in future i.e. they wanted to involve the beneficiaries in the planning of their health care programmes.

The finance occupies an important place in all human activities and the NGOs are not exception in this sense. Majority of NGOs in Rohtak receive their funds from donation/self-sources. Very few NGOs collected their funds from state government or Indian / foreign funding agency. These NGOs received amounts between 4-7 lacks annually, but these organizations are not satisfied with this amount as it is very less and they are helpless in providing better health care facilities to the people with this little amount. The fund is totally donation based, so the funding agencies do not keep any surveillance on these organizations.

The NGOs in Rohtak have a number of volunteers for their health care programmes but these NGOs do not have continuous liaison with them. Most of the NGOs admit that the people themselves come in the organization to become volunteers. These volunteers are untrained.

The volunteers working in an organization feel that the service they do should be duly recognized. So the majority of the NGOs in Rohtak issues certificates to the volunteers in order to appreciate their work.

Co-operation is a joint behaviour that is directed towards some goals. Most of the NGOs in Rohtak respond that they get cooperation from the community to execute health care programmes. They get working sheds, vehicles, manpower etc. from the community to execute their programmes.
Communication is often used in the sense of imparting knowledge or transmitting information. In our study, we found that most of the NGOs used pamphlets as source of passing information about the schemes to the needy persons.

The NGOs in Rohtak have separate health care staff in their dispensaries or in occasional health camps. Most of the NGOs have 9-12 members in health care staff and thought that the staff was adequate to meet their requirements. During our study, we found that the organizations face some staff related difficulties i.e. competency of staff, difficulties in recruitment, conflict etc. Most of the NGOs in Rohtak faced difficulties in recruitment, whereas the least number of NGOs faced the problem of conflict among staff members. We asked the staff members about their job satisfaction and found that majority of the staff members are satisfied with their job and thought that working in a NGO is a good opportunity for them.

Monitoring is an important instrument in the implementation of the programme. Its main objective is to ensure utilization of services within budgetary allocation and time schedule. An overwhelming majority of NGOs faced some difficulties in monitoring the programmes because of lack of time and budget.

Chapter V deals with the perception of Beneficiaries towards the working of NGOs. Beneficiary is one who directly gets the services from the NGOs and the perception refers to the way of seeing and understanding of the beneficiaries regarding the working of NGOs. So in order to understand the perception, we have discussed the following dimensions:

(i) Necessity of the NGOs health care programme.
(ii) Cost and quality of the NGOs health care services
(iii) Suggestions of beneficiaries towards the functioning of NGOs.

In our study, we have selected total 150 respondents from the selected NGOs. Most of the respondents belong to 41-50 age level. Majority of them
are females. Majority of the respondents belong to backward class category. Majority of the respondents are educated upto 10th class and belong to nuclear family. Majority of the respondents are shopkeepers and most of the respondents belong to Rs. 2000-4000 income group (monthly).

The beneficiaries know the necessity of NGOs' health care programmes because they are not satisfied with the working of Govt. institutions because it is highly time spending and secondly the behaviour of staff members is not friendly with the patients. The majority of the beneficiaries told that the health condition of the area is not satisfactory. Before reaching the NGOs' dispensaries they first visited government health institutions when they fell ill and spent a lot of time there which was not satisfactory.

The health services provided by NGOs under the study are not satisfactory to the beneficiaries. The beneficiaries are also not satisfied with the cost and quality of the health services. They want the health facilities free of cost and better in quality. One interesting thing which we found in our study is that the male respondents want the health facilities free of cost while the female respondents want better quality of health services i.e. quality of medicines, doctors, staff members, medical instruments etc.

Co-operation with the community is one of the main characteristics of NGOs but surprisingly, the respondents reported that the staff members are not cooperative in these NGOs dispensaries. They see the monetary status of patient during treatment. In case of paid services, if the patients are unable to pay, the staff members refuse to treat them. Similarly, if the serious patient come late at night, the staff members do not cooperate with them.

In the present study, we found that community participation in programme planning is very limited. People are neither involved in fund management nor have any right to know the financial status of a programme and therefore cannot participate at top-level decision. Even during health
awareness camps, topic, time, data etc. are not decided by the beneficiaries. People ensure their involvement by attending the programmes only.

During our study, we found that the beneficiaries admit that there is a need for control on NGOs. It is very important for their better functioning. They suggest that this control should be done by both government and the community itself so that the organizations work in a better way.

Thus, in the present study, we found that the NGOs in Rohtak could not contribute much in providing health services because of financial unsustainability but the people started understanding the need of health care and received the health awareness from these NGOs. There is also a lack of people’s participation in these organizations. So there is a need of integration of services of government, community and NGO sector in providing better health care.