Chapter-I

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Conceptual and Theoretical Framework
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Formulation of the Problem

Health of a person is considered as a state of complete physical, mental and social well-being. It is man's most precious possession and influences all the activities. It is the foundation on which his happiness rests.

Health is the capacity of an individual to cure himself. When a person loses this capacity to restore himself or herself he or she is in a state of ill health. Health is an important internal resources, which assures a stable quality of life. The capacity is achieved when a person possesses a strong body capable of working, a controlled and balanced state of mind, a companionate heart, a discriminative intellect and a purposeful life. Thus total health is a state, where there is a balance in body and its functions, mind, social and spiritual well being. Ill health occurs in a gradual manner at any level and affects the individual. Understanding health and related behaviour include range of human activities, which have direct and indirect effect on individual's health status. Many habits, pattern of thinking, emotional experience and attitude influence the overall quality of life. In addition socio-ecological and cultural background does influence many aspects of life style (Joseph and Juliana: 2000).

It is the responsibility of the state to regulate and maintain the health standards of people and provide preventive and curative services and build up the infrastructure for medical and health services, but the government has failed to do so. Most of the people died because of unawareness and lack of quick medical aid.

The state, with its limited resources can not provide information, accessibility, awareness where the people could be saved. However, high
morbidity and mortality rate is perceived as threat to the nation's development. This mortality and morbidity rate has differentials in different states.

In Haryana, the health situation of its people is also not very impressive. It accounts for 11.1% child mortality rate, 22.1% crude birth rate, 72.3% anaemic children, 27% malnutrition in women, 56.1% anaemic women and 41.7% infant mortality rate. Even 72.3% households do not generally use government health facilities due to poor quality of care (NFHS, 2005-06). At one level the discouraging figure of health indicators of a developed state is an indictment of failure of the state to justify its own existence as an institution of social contract. So the government encouraged the non governmental organisations to take over some health programmes. These organisations have played a significant role in providing low cost and effective health services to the people. They also help in filling the critical gap that exists in government health services. The reason is that being worked at grassroots level, these organisations are very close to common people and so easily understand their problems and try to solve them. On the other hand, the people also easily trust them because these people are very familiar to them. NGO intervention in health is very familiar to them. NGO intervention in health has been a dynamic process, ranging from charity orientation to self reliance and people's involvement in their own development from hospital based medical care to health care at the doorsteps. The NGOs relationship with the government health programmes has been supportive at the beginning of the planning process, but now it is more effective than that of public sector in health care. These organizations have gained popularity and have been posed as an alternative to the state since mid 1970s in the welfare sector. The public sector has been described as bureaucratic and tortuous to the need of people. According to a rough estimate, more than 7000 voluntary
organizations are working in health care throughout the country and are more effective than that of public sector in health care (Dharamraj: 2001).

So in order to understand the role of NGO’s in providing health care facilities to the people, we have decided to conduct a study on health care in Haryana. The study was conducted in Rohtak, the important city of Haryana state.

CONCEPTUAL CLARIFICATION

The concept of health may be regarded a situational concept. One may be in health as now and then and the next moment, the same person may become unhealthy, sick and ill, which is the obverse of health. This implies that health is to be viewed in a time framework and in the context of socio-cultural or physical environment. This does not however, mean that one cannot conceive health with a consistent pattern of its presence or absence. Over the years, we have evolved certain indicators, which may have universal application in identifying healthy and non-healthy persons.

To a lay person, health would mean a sound physical body. It is more so, a condition of a body that helps a person to perform his day to day activities to the expectation of others.

Health may be considered as absence of disease which reflects some discontinuity with the everyday state of being of an individual. It may be observed that health is a background feature of daily living and a person’s display of his essential normality. Healthy people are normal and normal people are healthy (Mehta: 1996).

Banerji (1967) stressed the role of health as a contributor to economic growth and the need to integrate health activities into general economic activities so that the formers do not interfere with the latter or vice-versa.

According to First Five Year Plan “Health is a positive state of well-being in which harmonious development of mental and physical capacities of
the individuals lead to the enjoyment of a rich and full life... It implies adjustment of the individuals to his total environment – physical and social.”

Some people even define it as a condition under which an individual is able to mobilize all his resources intellectual- emotional and physical – for optimum living.

The World Health Organization (WHO) defined health as a “State of complete physical, mental and social well-being and not merely the absence of disease and infirmity”.

Thus, health represents a balanced relationship of body and mind and complete adjustment to the total environment. It is not merely the medical matter, but a social goal in the attainment of which social and personal behaviour are equally important. Health is not static; on the contrary, it fluctuates on a scale which ranges between optimum health as defined by WHO to complete lack of health. It is a continuous balancing of the physical, emotional, social, intellectual and spiritual components of individual to produce happiness higher quality of existence.

Health and Constitution

Health has found an important place in the constitution of all states and the UN agencies. Of the 30 articles of the universal declaration of human rights, Article 25 is particularly concerned with the right to health. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary services and the right to security in the event of unemployment, sickness, disability; widowhood, old age or other lack of the livelihood, in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children whether born in or out of wedlock shall enjoy the same social protection. The preamble to the WHO Constitution also states that the enjoyment of the highest attainable standard of health is a fundamental right of every human being and that governments are responsible
for the health of their people and can fulfil that responsibility by taking appropriate health and social welfare measures.

**Health Development**

The health development is the process of continuous progressive improvement of the health status of the population. It's product is rising level of human well-being not only by reduction in the burden of the disease but also by the attainment of positive, physical and mental health related to satisfactory economic functioning and social integration.

WHO claims health as a fundamental human rights and had set up a goal for all countries to achieve health for all by 2000 AD and the chosen strategy is one of primary health care. Health care is defined as a programme of services necessary to promote and maintain the health of mind and body. The primary health care is defined as essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford. It forms an integral part of both the country's health system of which it is the nucleus and of the overall social and economic development of the community.

**Factor Influencing Health:**

A variety of factors influence human development both favourably and unfavourably. Some of these factors are: environmental / natural or man made; physical, chemical, biological; and social, economic, cultural factors: education and genetic factors; prenatal health development factors and nutritional factors. Thus, the promotion of health cannot be achieved by measures that derive from any single health discipline, nor can health measures be considered independently of the broader educational, social, economic and administrative factors that are crucial to human development. Obviously, the relationship between socio-economic development and progress of health is of extreme importance. In fact, every aspect of economy
has a health component which has an important bearing on the overall socio-economic development. Thus as stated in a WHO paper on public health: “The health component and other components of the total system necessarily interact. Health not only affects the remainder of the socio-economic complex, but is also affected by it, sometimes unfavourably (Goel: 2005).

In general, the factors influencing health could be classified into 3 broad categories: hereditary, environmental and personal. Similarly, the various conditions which play a vital role in determining one’s health status can be put under 3 major areas: mental health, spiritual health and physical health.

**Theoretical Framework**

The concept of health and illness becomes institutionalized within the social and cultural milieu of each society and its level of development. In other words, one measure of social development could be a cultural conception of illness primitive human beings relied more on their instincts to stay healthy and since they could not largely comprehend the functioning of the human body, magic became an integral part of the beliefs about the causes and cures of health disorders (DuBos: 1969).

Despite the progress made in public health through bacterial researches for combating disease and restoring normality, they believe in some comprehension. Such a belief is still being held by a large population especially in the developing world. Cockerhan (1978) states that regardless of a society’s level of medical knowledge and technology, the structure of medical science still functions within the context of values, attitudes and beliefs of the people comprising the society.

During the middle ages, illness came to be regarded as a punishment for sins and care of the sick as religious charity. Illness in the present age is a “State or condition of suffering as a result of that disease or sickness” Parsons (1951) was the first to view illness as deviance and to postulate his concepts
of the sick role. Illness can be viewed as a deviant social state brought about by disruption of normal behaviour through disease. The basis on which illness has been defined as a deviant behaviour lies in the sociological definition of deviance as any behaviour violating the social norms within a given social system: This functionalist approach to deviance through the concept of Parsons 'sick role' views sickness as a disturbance in the 'normal' condition of the human being, both biologically and socially and postulates that being sick is not just experiencing the physical condition of a sick state; rather it constitutes a social role since it involves behaviour based on institutional expectations and is reinforced by the norms of society corresponding to these expectations (Parsons, 1951). A major expectation relates to inability of the sick to take care of himself and the consequent need to seek medical help and to co-operate with the medical practitioner to get well. Specifically, Parsons' (1951) 'Sick role' can be described as:

1. The sick person is exempted from 'normal' social roles depending upon the nature and severity of illness,
2. The sick person is not responsible for his or her condition,
3. The sick person should try to get well since being sick is undesirable, and
4. The sick person should seek technically competent help and co-operate with the physician.

Another theoretical framework which has been employed to explain illness behaviour is Becker's 'Labelling Theory' (Becker: 1963). This is based on the concept that what is regarded as deviant behaviour by one person or social group may not be so regarded by other persons or social groups. In the process of seeking medical care, two persons having similar symptoms may behave differently. Lipovski (1970) have pointed out that illness as a deviant behaviour is relative and must be viewed from this perspective of
labelling theory. This has relevance for the seeking of medical care behaviour of the sick roles or illness behaviour.

Labelling theory assumes that all behaviour is self directed upon the basis of symbolic meanings which are shared, communicated and interpreted by human beings while interacting in different social settings and as creative, thinking organisms, they tend to choose their behaviour instead of reacting mechanically to the affects of the social processes. Freidson (1974) provides the concept of legitimacy of making distinction among sick role of various varieties. According to him, conditional legitimacy permits a deviant temporary exemption from normal obligations and provides privileges so that the deviant may seek medical help to get rid of the deviance.

Unconditional legitimacy, on the other hand, exempts a deviant permanently from normal obligations of his role and he is granted additional privileges because of the hopeless nature of his deviance. Applying his framework of legitimacy, Friedson explains the differential behaviour of deviants suffering from minor or serious diseases. This framework, no doubt, goes beyond Parsons' concept of the sick role in describing differing types of illness and by emphasizing that illness is a socially created label. However, Friedson does not explain differences in the way people define themselves as being sick and in need of the professional medical care.

Kennedy has identified seven types of adaptive behaviour in which society engaged in order to cope with illness and other health hazards. These behaviour are:

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.

Kennedy’s thesis is that within any aggregate setting, human beings have discovered different patterns of behaviour that provide a workable adaptation to the threat of a disease and other health related problems for the survival of both the individual and the system. This framework provides a greater range of analysis of illness behaviour than provided by illness as deviance approach as it includes both the social and biological characteristics of illness (Mehta: 1996).

Rosenstock’s (1966) ‘Health Belief Model’ is another important framework often used to study the preventive aspect of health behaviour. There are social-psychological factors which motivate healthy people to seek preventive care to avoid illness. According to this model, as individual’s perception that he is personally susceptible and that the occurrence of the disease would have severe implication of a personal nature motivate him to go in for preventive practices to avoid illness.

Systems of Medicine in India

India has an incomparably rich heritage in ancient system of medicine that make up a veritable treasure house of knowledge for both preventive and curative health care. These system, though their safe, effective, and inexpensive treatments, have the potential to make a significant contribution to the health care of the common people.

The term ISM comprises six different system: Ayurveda, Siddha, Unani, Yoga, Naturopathy and Homeopathy. In terms of registered practitioners, ayurveda is the dominant system in ISM.

Ayurveda

Ayurveda means the ‘science of life’ in Sanskrit. It is one of the oldest and the best documented among the ancient system of medicine. The documentation of Ayurveda is referred to in the Vedas (1500 BC-500 BC), said to be the oldest recorded wisdom in the world. It derives its basic
principles from the Charaka Samhinta (600 BC) and the Surruta Somhinta (500 BC). The approach is essentially philosophic, holistic, and humanistic. Ayurveda emphasizes life and health more than disease and treatment. It presents a comprehensive life science and encompasses total health-physical, mental, spiritual – in a holistic way. The system is based on the laws of nature, and the individual human being regarded as a miniature replica of the universe. The individual and the universe are both essentially panchmahabhuta or made up of the five basic physical factors or elements: Akasha (ether/space), Vaya (air, motion), Teja (Fire, radiant energy), Jala (water/cohesive factor) and Prithvi (earth/mass). The individual (purusa) and the universe (loka) remain in constant interaction with each other and as long as this interaction is wholesome and optimal, the human being enjoys good health. Any disharmony in this interaction is the basic cause of disease and all treatments in Ayurveda attempt to restore this harmony and the normal balance of the fire elements in body and mind. In this sense, ayurveda is a system of medicine very close to nature.

The five physical attributes of panchmahabhuta constitute three major biological components of the living body called Tridosa i.e. Vatta, Pitta and Kapha. All ailments arise out of the imbalance of the three doses and the role of medicine is to assist the natural healing powers of the body.

Ayurveda is a complete and well developed promotive, preventive and curative system of medicine with and major clinical specialties: Kayacikitsa (internal medicine), Salya tantra (Surgery), Salakya (ENT), Kaumarbhryya (pediatrics, obstetrics and gynecology), bhutanidya (psychiatry), agada tantra (Toxicology), rasayan tantra (nutrition, rejuvenation and geriatrics) and vajikarana (Sexology).

Siddha

Siddha, an equally ancient system, is similar to Ayurveda in its fundamental principles. This system got its name from the ancient masters,
who besides practicing medicine, also performed many miraculous acts. Siddha means a master; thus the name denoted the mastery of such practices. The most famous of the Siddhas was Nagarjuna, whose Scaratantra forms the basis of this system. The distinctive features of Siddha are its reliance on minerals and metallic compounds and its emphasis on rejuvenative therapies.

**Unani**

The Unani system originated in the 4th and 5th century BC in Greece under the patronage of Hippocrates (460 BC – 377 BC) and Galen. It gradually absorbed the experience and wisdom of many ancient cultures, including those of Egypt, Arabia, Persia, China, Syria and India. This system is based on the humoural theory, that good health depends on the balance of the 4 humours, blood, phlegm, yellow bile and black bile. Like Ayurveda, this is a holistic system including promotive, preventive and curative interventions.

**Yoga**

Yoga is devoted to the integration of the physical, mental, intellectual and spiritual dimensions of one’s being. The technology of the practice of yoga is based on Pantanjali’s yoga sutra (around 200 BC) containing the scheme of Astanga yoga (eight limbic yoga), while the ultimate goal of attaining Samadhi or union with the cosmic force. Meditation is an essential ingredient of yoga. In common parlance, yoga is associated with certain postures (asana) and breathing exercise (pranayama), which have wide and varied beneficial influences on both physical and mental health.

**Naturopathy**

Naturopathy is based on the fundamental principles of Ayurveda. While Ayurveda used medicines in addition to bio-purificatory and deity practices, naturopathy relies solely on the latter. The basic tenet of naturopathy is according to the laws of nature; disease occurs due to the accumulation of toxins in the body, and to cure the ailment, the body is
purified with the use of natural methods, dietary regulation and exercise. A naturopath uses mud, water, heat and air as the instruments for therapy but never any drugs.

**Homeopathy**

Homeopathy is fundamentally different from other Indian systems. It is based upon a specialized method of treating diseases- administering poetized drugs in very high dilutions, which have been empirically established to have the power of relieving the very symptoms which they normally cause is healthy human beings when administered in their grass form. Homeopathy was discovered by a German physician, Dr. Christian Frederic Hahnemann, in the 17th century. It is also a holistic system, and it treats the patient as a whole not merely the diseased organ. It is particularly useful for constitutional ailments for which modern medicine has few remedies (Mishra: 2003).

Today, the traditional Indian system of treatment along with Homoeopathy has been playing an important role in the prevention and management of certain non-communicable diseases and life style related disorders. Government has paid much importance to this and as a result formation of Department of AYUSH, which includes Ayurveda, Siddha, Unani, Homoeopathy, Yoga and Naturopathy. A vast infrastructure has been created under AYUSH which include 3100 hospitals, 66,366 beds and 20,811 dispensaries. Efforts to mainstream the AYUSH system are continuing with focus on improvement and upgradation of standards of education, standardization of drugs and quality control, ensuring sustained availability of raw materials, i.e. medicinal plants, metals, minerals and materials of animal origin (Reddy & Roy: 2005).

**Health System: Historical Perspective:**

The historical perspective of public health in India can be studied with the help of the following different phases:
India has one of the most ancient civilizations in recorded history. Thousand of years before the Christian Era, there existed a civilization in the Indus valley, known as the Indus valley civilization. Excavations in the Indus valley (e.g. Mohanjodaro and Harappa civilization) showed relics of planned cities with drainage, houses and public baths built of baked bricks suggesting the practices of environmental sanitation, by an ancient people as far back as 3000 BC. India was invaded by the Aryans around 1400 BC. It was probably during this period, the Ayurveda and Siddha system of medicine came into being. Ayurveda or the science of life developed a comprehensive concept of health. The Manu Samhita prescribed rules and regulations for personal health, dietetics and hygienic ritual at the time of birth and death, and also emphasized the unity of the physical and mental and spiritual aspect of life. *Serva Jana Sukhina Bhavantu* (May all men be free from disease and may all be healthy) was an ancient saying of the Indians ages. This concept of happiness has its roots in the ancient Indian philosophy of life, which conceived the oneness and unity of all people, wherever they lived.

The post Vedic period (600 BC – 600 AD) was dominated by the religious teaching of Buddhism and Jainism. Medical education was introduced in the ancient universities of Taxila and Nalanda, leading to the titles of Pranacharya and Pranavishare. A hospital system was developed during the region of Rahula Sankrityana (Son of Buddha) for men, women, animals and the system was continued and expanded by King Ashoka.

The next phase in Indian history (650-1850 AD) witnessed the rise and fall of the Mughal empire. The Muslim rulers introduced into India around 1000 AD. The Arabic system of medicine, popularly known as the Unani system, the origin of which can be traced to Greek medicine. The Unani system since then became part of Indian medicine with changes in the political scenario in India. The torch which was lighted thousand years ago by
the ancient sages grew dim, medical education and medical services became static and the ancient universities and hospital disappeared (Park: 1995).

Public Health in British India

By the middle of the 18th century, the British had established their rule in India which lasted till 1947. About the end of 8th century, when the health conditions had deteriorated and rates of mortality and morbidity very high, some of European doctors came to India under the administration of East India Company and started the development of western medicine known as "Allopathic" a systematic and scientific lines. But the European doctors were too few in number, they could not administer hospital systems and could not cater medical services satisfactorily to all strata of Indian people.

Consequently in 1822, the East India Company established a medical school at Calcutta and in 1835 made it a medical college. Besides this, at the close of the 19th century, there were 4 medical colleges in India in addition to a number of medical school with lower level of instructions.

Moreover, the Britishers appointed a number of commissions and committees and enacted a number of acts in order to develop a systematic Public Health Administration. Some of them are as follows:

(1) The Quarantine Act (1825) was the 1st Act enacted for the purpose of improvement of people suffering from communicable diseases and from contact with such people.

(2) A Public Health Committee was appointed in 1864 for surveying the public health needs of Bengal, Madras and Bombay presidencies.

(3) The Birth and Death Registration Act (1873) was introduced to have a record of births and deaths.

(4) Vaccination Act was passed in 1880 for the immunization from contagious disease.
A Plague Commission was appointed in 1886 and in the same year Local Bodies Act was made for transferring and ensuring the responsibility for the health and sanitation of the people of the local authorities.

In 1887, the Epidemic Disease Act was passed for the purpose of providing the basic framework for the growth of public health policy and its administration.

In the dawn of devolution of authority from centre to the state under ‘Mino-Morlay (1909) and Montague Chelmsford (1919), the subject of public health and medical relief was included in the transferred subjects of the state list.

With the introduction of provincial autonomy under the government of India, Act 1935, the ministries in the states were made totality responsible for health policy and administration.

Drugs Act was enacted in 1940 as a Central Legislation

Though, the above steps were taken by Britishers for the development of health of Indian people, but due to outbreak of 2\textsuperscript{nd} World War and partition of our country, the living conditions of the people become more deteriorated (Rao: 1992).

**Health Status of the People in India**

Before independence, the health status of people was very embarrassing. Before independence, the situation was very critical. The death rate was very high (29.2 per 1000 of population in 1931). 5.75 percent of deaths out of total death in 1940s were due to cholera, small pox and plague. Death due to fever was about 5.75 per cent during this decade. Further material mortality in 1931 was 20 per thousand of the births. Similarly, the life expectancy for male (32.09 years) as well as for female (31.37 year) was
very low in 1941. (Government of India: 1946). All this happened due to lack of basic and preventive medical facilities.

So in order to improve the health status of people, the India government adopting modern medical system after independence. At the same time, the government appointed a committee under the chairmanship of Sir Joseph Bhore, known as Bhore Committee (1946). This committee was appointed by the government of India from time to time to review the existing health situation and recommended measures for further action. A brief review of the recommendations these committees, which are important landmark in the history of public health is given below:

(1) Bhore Committee (1946): Some of the important recommendations of the Bhore committee were:

(i) Integration of preventive and curative services at all administrative levels.

(ii) The committee visualized the development of primary health centres.

(iii) Major changes in medical education which includes 3 month’s training in preventive and social medicine to prepare ‘Social Physicians’ (Government of India: 1946).

The other committees set up by Indian Government are as follows:

1. Mudaliar Committee (1961) : In 1959, the government of India appointed another Committee known as “Health Survey and Planning Committee” under the headship of Dr. A.L.Mudaliar to survey the progress made in the field of health since submission of the Bhore Committee’s report and to make recommendations for further development and expansion of health services. The Committee found the quality of services provided by the primary health centres inadequate and advised strengthening of the sub-divisional and district
hospitals so that they may effectively functions as referral centres (Government of India: 1961).

2. Chadda Committee (1963): In 1963, a Committee was appointed by the Government of India under the chairmanship of Dr. M.S. Chadah to study of arrangements necessary for the maintenance phase of the National Malaria Eradication Programme. The Committee recommended that the "vigilance" operations in respect of the National Malaria Eradication Programme should be the responsibility of the general health services i.e. primary health centres at the block level (Government of India: 1963).

3. Mukherjee Committee (1965): Multiple activities of the mass programmes like family planning, smallpox, leprosy, trachoma, etc. was making it difficult for the states to undertake these effectively because of paucity of funds. This matter came up of discussion at a meeting of the Central Council of Health held in Bangalore in 1966. The Council recommended that those related questions maybe examined by a Committee of health secretaries under the Chairmanship of the Union Health Secretary, Shri Mukherjee. The Committee worked out details of the basic health services which should be provided at the block level (Government of India: 1965).

4. Jungawalla Committee (1967): This Committee popularly known as the Committee on Integration of Health Services was set up in 1964 under the leadership of Dr. N. Jungawalla. It was asked to look into various problems related to integration of health services, abolition of private practice by doctors in government services, and the service conditions of doctors. This Committee recommended integration of all level of health organization in the country (Government of India: 1967).
5. Kartar Singh Committee (1973): This Committee was constituted to form a framework for integration of health and medical services at peripheral and supervisory levels. Its main recommendations are as follows:

(i) Various categories of peripheral workers should be amalgamated into a single cadre of multipurpose workers (male and female). The work of 3-4 male and female multipurpose worker was to be supervised by one health supervisor.

(ii) One primary health centre should cover a population of 50,000. It should be divided into 16-sub-castes (one for 3000-3500 population) each to be staffed by a male and a female health worker. (Government of India: 1973).

6. Shrivastava Committee (1975): This Committee was set up in 1974 as “Group on Medical Education and Support Manpower” to determine the steps needed to (i) reorient medical education in accordance with national needs and priorities and (2) develop a curriculum for health assistants who were to functions as a link between medical officers and multipurpose health workers and who were supposed to provide health care, family welfare and nutritional services. The major recommendation of the Committee were as follows:

(i) A cadre of semi-professional village level health workers should be developed within the community.

(ii) Steps should be taken to develop a referral system from PHC to hospitals at tehsil, district and regional levels and the medical college.

(iii) A medical and health education commission on the lines of University Grant Commission should be established (Government of India, 1975). Acceptance of the
recommendations of the Srivastava Committee in 1977 led to the launching of the Rural Health Scheme.

**Five Year Plans:**

In five year plans, the Indian government gave more emphasis to improve health infrastructure which is discussed under below:

**First Five Year Plan**

In early 1950s the government of India adopted some of the recommendations of the Bhore Committee which were in the form of setting up of Primary Health Centres (PHCs) for providing integrated health services as a part of Community Development Programmes. In all during the First Five Year Plan, family planning Programme were introduced by the government The main objectives of this plan were to improve the quality of health through a variety of training programmes. At the end of this plan, there were 12,600 hospitals and dispensaries through out the country. But these facilities were not satisfactory. So the Government setup Mudaliar Committee to review the infrastructure and functioning of the medical institutions. This committee emphasized the consolidation and integration of health infrastructure (Government of India: 1952).

**Second Five Year Plan**

The main objective of this plan was to improve the health infrastructure i.e. dispensaries, health care staff (doctors, nurses), hospitals etc. throughout the country (Government of India: 1956).

**Third Five Year Plan**

The Third Plan was marked by a very high priority to the family planning programmes and control the communicable health diseases. The main objectives of this plan were to extend health services to bring out progressive improvement in the health of the people by ensuring a certain minimum of physical well-being and to create conditions favourable to greater efficiency and productivity of the workforce. The main stress was laid
on preventive health services. A number of efforts were made to eradicate malaria, smallpox and to control communicable disease. It was also decided to integrate the Mother and Child Health Programme with family planning (Government of India: 1961).

**Fourth Five Year Plan**

In Fourth Plan, targets for Maternal and Child Health (MCH) were also set as recommended by MCH advisory committee. In maternal health services, targets were set for immunization of pregnant mothers against tetanus and also for the prophylaxis programme against nutritional anaemia (Government of India: 1969).

**Fifth Five Year Plan**

During Fifth Five Year Plan, minimum needs programme were launched in order to remove poverty. The package provided elements of health, family planning, nutritional environmental, improvement and water supply apart from elementary adult education, roads, electrification in rural areas and the housing for the landless labours. In keeping with the people oriented strategies of health for all by A.D. 2000. The community Health Volunteers (CHV) joined the PHC network to make service more meaningful for the community and Dai Training Programme was initiated and was supposed to help the MCH work (Government of India: 1974).

**Sixth Five Year Plan**

The Sixth Plan had proposed health to be viewed totally as a part of the strategy of human development. This plan emphasized infrastructural development and integration of services at the PHC level and improved health and nutritional status through various extension programme for immunization, prophylaxis or supplementary nutrition (Government of India: 1980).

**Seventh Five Year Plan**

In Seventh Plan, special emphasis was given to women’s health care. Eradication of communicable diseases, control and containment of newly
emerging health problems like Cancer, Coronary heart diseases, hypertension, diabetes were the other areas considered in the 7th five year plan (Government of India: 1985).

Eighth Five Year Plan

In the Eighth plan more emphasis was given to AIDS Control, which emerged a new public health problem in the country (Government of India: 1992).

Ninth Five Year Plan

In the Ninth plan, the major objective was to control the rapid growth of population. The other objectives of the plan were to provide pure water, primary health care and nutrition to the weaker section of the society. Vendenatrom Health Scheme for pregnant women was introduced by the government under which free health check-ups facilities were to provide on ninth day of every month. The government also introduced the Pulse Polio programme to remove this disease from grassroots level in the country in the same plan. The programme is running successfully (Government of India: 1997).

Tenth Five Year Plan

During the Tenth Plan, efforts were made to improve preventive, curative and rehabilitative services for non-communicable diseases throughout the country at all levels of health care (Primary, Secondary and Territory). The national programme for control of Blindness, National Cancer Control Programme, National Mental Health Programme and Iodine Deficiency Disorder (IDD) control programmes would continue to be implemented during the 10th plan. Further, a new scheme for providing medical assistance in the ‘golden hour’ to the accident victims to reduce death, due to Trauma has been introduced (Government of India: 2002).

Eleventh Five Year Plan

The main objectives of the 11th Five Year Plan are:
(i) To review the goals, objectives, strategies and expected outcomes of the NRHM in the end of 11th Five Year period at all levels.

(ii) To review the implementation of major health and family welfare programmes functioning of infrastructure and manpower in rural and urban areas and suggest measures for rationalizing the infrastructure strategies for improving efficiency and for the delivery of services with a special focus on women and children (Government of India: 2007).

**National Health Programme**

During these plans, the Indian government has implemented a number of health programmes to improve the health status of the people. These programmes are:

1. **National Malaria Eradication Programme:**

   In the year 1953, National Malaria Control Programme was launched in order to reduce malaria which was changed to National Malaria Eradication Programme which meant completely wiping out the disease of malaria from the country. The main objectives of this programme were: (i) elimination of deaths from malaria; (ii) reduction in suffering from malaria; (iii) maintaining the gains achieved earlier by reducing transmission whenever possible.

2. **National Filariasis Control Programme:**

   Filariasis is a term given to include a rage of acute and chronic conditions comprising of fever, elephantiasis of arms, legs and genitals and involvement of lymph channels. The programme to control this disease was started in 1955. The main objectives of this programme were:

   (i) Finding of the extent of the problems in areas where it had not been done so far.

   (ii) Control measures in urban areas by killing mosquito larva and treatment of cases.

   (iii) Control measures in rural areas by detection and treat.
National Tuberculosis Control Programme:

Tuberculosis is still a major disease in India. It is a chronic disease which may affect the lungs and almost all other organs. Classically, it is characterized by cough associated with blood in sputum, chest pain, low grade fever and loss of weight. In order to fight this disease a national T.B. Control Programme was launched in 1962. The short term objectives of this programme were to:

1. Detect active cases in an early stage by sputum examination and their treatment.
2. Protect health personnel especially the age group below 20 years by BCG vaccination. The long term objective is to reduce the problem of T.B. in the community sufficiently quickly to the level where it cases to be a public health problem.

National Leprosy Eradication Programme:

Leprosy is quite common in our country with about 4 million cases estimated. Leprosy is characterized by the presence of light coloured patches on the body, partial or total loss of sensation in various parts of the body and thickening of nerves. The national Leprosy Control Programme has been in operation since, 1955 and was redesignated as National Leprosy Eradication Programme in 1983. The programme is implemented through the establishment of Leprosy Control Units/Centre, Survey "Education" Treatment (SET) Centres, Urban Leprosy Centres, Temporary Hospitalization Wards, Reconstructive Surgery Units etc.

National Programme for Prevention of Visual Impairment and Control of Blindness

This programme was launched in 1976. Before this it was known as Trachoma Control Programme and Vitamin A Prophylaxis Scheme. Since 1982, it has been included in the new 20-Point Programme. The Control Strategy of the Programme include:
(i) Health education
(ii) Establishment of mobile eye clinics
(iii) Creation of permanent infrastructure for eye care at all levels.

6. National Diarrhoeal Disease Control Programme

Acute diarrhoea is one of the main causes of death and sickness in our country especially among infants and children below 5 years of age. Under this programme following strategy is being promoted:

(i) Treatment of acute diarrhoea as early as possible in the course of illness with oral dehydration therapy (ORT) accompanied by education of mothers on appropriate feeding of children.

(ii) Encouragement of practices like uninterrupted breast feeding, preparations of safe wearing food, good domestic and personal hygiene etc.

7. National Goitre Control Programme:

Iodine deficiency is one of the nutritional problem in our country. Its most common and visible manifestation is goitre which presents as an enlargement of the thyroid gland in the neck region. It also leads to cretinism which may present with sub-normal intelligence, lack of muscular coordination, deaf mutism, squint, abnormal and short stature. National Goitre Control Programme of government of India came into existence in 1962 with the following objectives:

(i) Survey of areas where goitre is detected.

(ii) Production and supply of iodized salt to endemic areas to control endemic goitre.

(iii) Re-survey after five years to assess the impact of iodized salt on prevalence of endemic goitre. The government has made a commitment to iodize the entire edible salt by 1992. The programme has been included in the new 20 Point Programme
8. **Universal Immunization Programme:**

As part of an overall strategy for improving the child survival rate the Expanded Programme on Immunization (EPI) was started in 1978. EPI focused on six childhood diseases and coverage of expectant mothers with tetanus toxoid vaccine. The disease covered under EPI are:

- (i) Tuberculosis
- (ii) Diphtheria
- (iii) Pertusis (whooping cough)
- (iv) Tetanus
- (v) Polio
- (vi) Measles

The programme was renamed Universal Immunization Programme in 1985 with more inputs.

9. **National Guinea Worm Eradication Programmes:**

This was initiated in 1983-84. The disease is present in some rural pockets in six states namely Andhra Pradesh, Gujarat, Karnataka, Madhya Pradesh, Maharashtra and Rajasthan. Tamil Nadu which was previously infested is now free from the disease. Following activities are being taken up under this programme:

1. Active care research twice a year by visiting every village in the endemic districts.
2. Chemical treatment of unsafe water sources periodically before and during peak transmission.
3. Personal protection e.g. boiling of water and sieving of water.
4. Health education of the community.
5. Management of cares by occlusive bandaging of ulcers.
6. Provision of safe water supplies.
National Family Welfare Programmes:

India was the first country in the world to have a state sponsored population control programme which was launched way back in 1952. Even before this the All India Women’s Conference had set up birth control clinics in 1932. In the earlier stages the programme took off slowly with the establishment of a few clinics and distribution of educational material, training and research. In the third five year plan, the objective of stabilizing the growth of population was posited as at the very centre of planned development. The emphasis was shifted from the purely clinic approach to the more vigorous extension education approach for motivating the people to accept small family norms. In the mid sixties again there was substantial expansion of the programme with the introduction of Intra-Uterice Devices (IUD). When the IUD programme proved inadequate then a target oriented time bound programme adopting the cafeteria approach was adopted. This involved:

1. Offer of monetary incentives to doctors, motivators and acceptors.
2. Mobilization of government functionaries belonging to all departments including revenue collection staff for family planning work.
3. Exerting administrative pressure on field workers.

This again proved inadequate and then recourse was taken in the early seventies, to the Mass Vasectomy Camp approach. This involved extensive use of the district administrative machinery, along with enhanced incentives and a massive publicity drive.

In April 1976, the country framed its first “National Population Policy”. There was a steady escalation in the use of pressure and forcible sterilization campaign during the emergency period. This led to the Congress defeat. The government that replaced it categorically ruled out use of coercion
of any kind in implementing the family welfare programme. Although the performance of the programme was low during 1977-78 it was a good year in as much as giving the directions. The 42nd Amendment of the Constitution has made “Population Control and Family Planning” a concurrent subject and this provision has been made effective from January 1977. The acceptance of the programme is now purely on voluntary basis. The launching of Rural Health Scheme in 1977 and involved of village Health guides, dais and local people were aimed at accelerating the pace of progress of the programme. The Family Welfare Programme is included in the 20 point programme. The restructured 20 point programme calls for promotion of the 92 child family.

(11) National Water Supply and Sanitation Programme:

It was initiated in 1954 with the object of providing safe water supply and adequate sanitation arrangements for the entire urban and rural population of the country. A Central Public Health and Environmental Engineering Organization (CPHEEO) was set up in 1954 to provide technical guidance and advice to state governments in preparation and execution of their scheme. According to an assessment made in 1980 by CPHEEO only 30 percent of rural population had been provided with safe drinking water and 2 percent have basic sanitation facilities. In the urban areas about 82 percent had safe water supply and 27 percent sanitation facilities out of 5.76 lakh villages about 2.31 lakh villages were identified as problem villages i.e. where drinking water was not available within a distance of 1.6 kms. or below the depth of 15 meters or where available source was unhygienic.

India had committed to providing safe water and adequate sanitation to all by 1990.

12. Minimum Needs Programme:

This programme was introduced in the first year of the 5th five year plan. The objective of this programme was to establish a network of basic services and facilities by social consumption in the areas upto nationally
accepted norms, within a specified time frame. The programme was designed to assist in raising living standards in reducing the rational disparities in development. The programme was essentially an investment in human resources. The basic needs of the people identified for this programme were:

1. Elementary Education
2. Adult Education
3. Rural Health
4. Rural Water Supply
5. Rural Roads
6. Rural Electrification
7. Rural Housing
8. Nutrition

13. **Sexually Transmitted Diseases Control Programme:**

   Sexually transmitted diseases are diseases which are spread from person to person by sexual contact. The programme began in 1949 as a pilot project for control of venereal diseases. In 1955, the planning commission recommended the establishment of at least one STD clinic in every district and one headquarter clinic and laboratory in every state. The strategy focused on training, teaching and research in various aspects of STD. It was envisaged to establish 5 Regional Training Centres, Regional Laboratories and Regional Survey cum education centres, development of health education with regard to STD and establishment of VDRL testing at district hospitals and PHC’s (Goel: 2004).

14. **National Rural Health Mission:**

   The government of India launched a National Rural Health Mission on 12th April 2005. The mission covered the entire country with special focus on 18 states where the challenge of strengthening weak public health system and improving key health indicators was the highest. These states include Uttar
Pradesh, Madhya Pradesh, Bihar, Rajasthan, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Jammu & Kashmir and Himachal Pradesh. The mission aimed at provision of integrated comprehensive and effective primary health care to the poor and vulnerable and marginalized sections of the society, especially women and children by improving access, availability, quality and accountability of public health services. The duration of the mission is 7 years from 2005-12 (Singh: 2005).

15. Urban Family Welfare Schemes

This Scheme was introduced following the recommendation of the Kirshnan Committee in 1983. The main focus was to provide services through setting up of Health Posts mainly in slum areas. The services provided were mainly outreach of RCH services, preventive services, First Aid and referral services including distribution of contraceptives.

16. Sterilization Beds Scheme

A Scheme for reservation of Sterilization beds in Hospital run by Government, Local Bodies and Voluntary Organisations was introduced as early as in the year 1964 in order to provide immediate facilities for tubectomy operations in hospitals where such cases could not be admitted due to lack of beds etc. But later with the introduction of the Post Partum Programme some of the beds were transferred to Post Partum Programme and thereafter the beds were only sanctioned to hospitals run by Local Bodies and Voluntary Organisations.

17. Reproductive and Child Health Programme

The Reproductive and Child Health Programme was launched in October 1997 incorporating new approach to population and development issues, as exposed in the International Conference in Population and Development held at Cairo in 1994. The programme integrated and strengthened in services/ interventions under the child survival and safe
motherhood programme and family planning services and added to the basket of services, new areas on Reproductive Tract/ Sexually Transmitted Infections (RTI/STI).

Apart from this, the Ministry of Health and Family Welfare has a number of schemes to cover the under-privileged sections of society and help them with maternity, post and neo-natal healthcare and family planning. These include the Janani Suraksha Yojana, Rehabilitation of Polio Victims and several financial assistance schemes for surgery and other health problems. Counselling centres are also available across the country as part of the government sponsored family welfare schemes.

**Health Policy in India:**

The aim of health policy is to secure a fundamental change in health status of people to help break the circle of poverty encircling the masses in the developing world and liberate the population to secure the change that they have chosen and in which they participate. It includes the decisions on medical education, health facilities, health coverage, medical research, choice of systems of medicine etc. It also includes the decisions as regards the relative role of the government, the private and voluntary agencies in the promotion of health care. The health policy must be made with relevance to the time dimension. It can be a long-term policy, e.g., provision of comprehensive health care to all by the year 2000, or a medium term, e.g. providing elementary care to all by 1990, or immediate, i.e. covering half the population by 1985 and so on.

A statement on the “National Health Policy” was laid on the table of both the house of parliament on the second November 1982. The National Health Policy was discussed at length at both houses and was approved by the Rajya Sabha on 4th August 1983, and the Lok Sabha on 22nd December 1983. The policy laid stress on the preventive, primitive, public health and rehabilitative aspects of health care services to reach the population in the
remotest areas of the country, the need to view health and human
development as a vital component of overall integrated national socio-
economic development, decentralized system of health and care delivery with
the maximum community and individual self reliance and participation. The
policy also laid stress on ensuring adequate nutrition, safe drinking water
supply and improved sanitation for all segments of the population (Goel:
2005).

National Health Policy-2002

The main objective of the policy was to achieve an acceptable standard
of good health amongst the general population of the country and increase
access to the decentralized public health system by establishing new
infrastructure in deficient areas, and by upgrading the infrastructure in the
existing institutions. Salient features of the policy were as follows:

1. Increase health sector expenditure to 6 percent of GDP with 2
   percent of GDP being contributed as public health investment by
   the year 2000.

2. Increased allocation of 55 percent of the total public health
   investment of the primary health sector, the secondary and tertiary
   health sectors being targeted for 35 percent and 10 percent
   respectively.

3. Apart from the exclusive staff in a vertical structure for the disease
   control programmes, all rural health staff would be available for the
   entire Gamut of public health activities at the decentralized level.

4. Revival of primary health system by providing some essential drugs
   under central Government funding through the decentralized health
   system. Provisioning of essential drugs at the public health service
   centre would create a demand for other professional services also
   from the local population.

5. More frequent in service training of public health medical
personnel at the level of medical officers as well as paramedics.

6. Expand the pool of medical practitioners to include a cadre of licentials of medical practice, as also practitioners of Indian systems of medicine and homoeopathy.

7. Implementation of public health programmes through local self government institutions and decentralize the implementation of the programmes to such institutions by 2005.

8. Minimal statutory norms for the deployment of doctors and nurses in medical institutions.

9. Setting up a Medical Grants Commissions for funding new government medical and dental colleges in different parts of the country.

10. Modify the existing curriculum.

11. Enable fresh graduates to contribute effectively to the providing of primary health services as the physician of first contact.

12. Raise the proportion of post graduate seats in public health and family medicine discipline in medial training institutions to 114th of the earmarked seats.

13. Improvement in the ratio of nurses vis-à-vis doctors/beds.

14. Improving the skill level of nurses and increasing the ratio of degree holding nurses vis-à-vis diploma holding nurses.

15. Need for basing treatment regimens, in both the public and private domain on a limited number of essential drugs of a generic nature.

16. Setting up of an organized urban primary health care structure.

17. Funding for the urban primary health system to be jointly borne by the local self government institutions and state and central governments.

18. Establishing of fully equipped ‘hub spoke’ trauma care networks in large urban agglomerations to reduce accident mortality.
19. Inter-personal communication of information and folk and other traditional media to bring about behavioural change.

20. Association of PRIs/NGOs/trusts in IEC activities.

21. Increase in government funded health research to a level of 1 percent of the total health spending by 2005, and their after, upto 2 percent by 2010.


23. Encourage setting up of private insurance instrument for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages.

24. Disease control programmes should earmark at least 10% of the budget in respect of identified programme components to be exclusively implemented through NGO’s (Goel: 2004)

Due to these efforts the health status of people increased. The Table 1.1 indicates the selected health indicators of India 2001.

**Table 1.1**

*Health Indicators of India, 2001*

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Health Indicators</th>
<th>India (in Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Crude Birth Rate</td>
<td>26.1</td>
</tr>
<tr>
<td>2.</td>
<td>Crude Death Rate</td>
<td>8.7</td>
</tr>
<tr>
<td>3.</td>
<td>Total Fertility Rate</td>
<td>3.2</td>
</tr>
<tr>
<td>4.</td>
<td>Maternal Mortality Rate</td>
<td>40.7</td>
</tr>
<tr>
<td>5.</td>
<td>Infant Mortality Rate</td>
<td>70.0</td>
</tr>
<tr>
<td>6.</td>
<td>Child Mortality Rate</td>
<td>22.5</td>
</tr>
<tr>
<td>7.</td>
<td>Couple Protection Rate</td>
<td>46.22</td>
</tr>
<tr>
<td>8.</td>
<td>Life Expectancy at Birth</td>
<td>60.4</td>
</tr>
</tbody>
</table>

In the year 2001, in India there was 26.1 percent crude birth rate, 8.7 percent crude death rate, 3.2 percent total fertility rate, 40.7 percent maternal mortality rate, 70 percent infant mortality rate, 22.5 percent child mortality rate, 46.22 percent couple protection rate and 60.4 percent life expectancy at birth.

This shows that India made considerable progress in health. A number of diseases like smallpox and plague were eradicated. The death rate is showing downward trend and life expectancy has increased due to improved health care facilities and augmentation of public health services. Despite this, people are still suffering from a number of communicable and disabling diseases. This situation is thwarting the physical, mental and social well-being of the people and thereby affecting the economic progress of the country. The vicious circle of disease not only creates a problem of health and sanitation but also of social welfare and social justice.

Still various diseases affect the health and hygiene of the people. Malaria continues to be a major public health problem with 19 million cases being reported during 2000. Tuberculosis (TB) is a major problem and nearly one third of global T.B. incidence in India. Leprosy is now at one incidence of one per 1000 population in 13 states. HIV/AIDS emerged as a serious problem besides other like Kalazar and blindness (Gautam of India, 2001). Thus the government could not achieve the objective of health for all in 2000 A.D.

Health Situation in Haryana

The process of globalization has led to a situation where richest 20% of the population command 86% of the world GDP while the poorest 20% command merely 1%. In other words this model of development and market oriented system, has divided the world in to "Shining World" and "Suffering World", Similarly we can say that there are two Indias, "Shining India" and "Suffering India." Haryana cannot be an exception," Shining Haryana and
suffering Haryana are very obvious now. On one side of the road there is "Shining Gurgaon" and on the other side of the same road is "Suffering Gurgaon." It can be said about every town or village also.

Public Health is an obvious causality of this process. There is a clear contradiction between the principles of public health and neoliberal economic theory. Public health is a "public good" i.e. its benefits cannot be individually enjoyed or computed, but have to be seen in the context of benefits that are enjoyed by the public. Thus public health outcomes are shared and their accumulation lead to better living conditions. It does not mechanically transfer into visible economic determinants, viz. income levels or rates of growth. Kerala, for example, has one of the lowest per capita incomes in India but its public health indicators as such approach the levels in many developed countries. Infant mortality rate in Kerala is less than a third of any other large state in the country including Haryana. An important consequence of globalization has been commonly described as the "Feminisation of poverty" as women increasingly had to strive to hold families together in various ways in the face of increasing pressures, main among them are increasing poverty, insecurity and ill-health. According to one estimate less than 10% of the $ 5.6 billion spent each year globally on medical research is aimed at the health problems affecting 90% of the world’s population.

The results of National Family Health Survey-III, about Haryana need an in-depth analysis but seeing it on random basis it can be said that a state which is "Shining on one side is also suffering on the other side. Economically very much advanced but socially lagging behind, Haryana is well known on the map of the world regarding declining sex ratio. The under weight children under age 3 percentage is 42 in NFHS-II where as it was 35 and 35 in first and second NFHS surveys. The wasted group has 6, 5, and 17% respectively in I, II and III NFHS. The percentage of Women whose body mass index is below normal is 27% in NFHS-III where as it was 25.9%
in NFHS-II. Also the percentage of women who are overweight or obese had increased from 16.6 to 21.0. The percentage of anaemic in married women age 15-49 has increased from 47.0 (NFHS-II) to 56.5 (NFHS-III).

Similarly the percentage of pregnant women are 15-49 who are anaemic has increased from 55.5 (NFHS-II) to 69.7 (NFHS-III). This has been shown in the table 1.2.

### Table 1.2
**Comparison of Health Situation of People in Haryana with reference to NFHS-II and NFHS-III**

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Health Situation</th>
<th>NFHS-II</th>
<th>NFHS-III</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Under weight children under age 3</td>
<td>35</td>
<td>42</td>
</tr>
<tr>
<td>2.</td>
<td>Wasted Group</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>3.</td>
<td>Malnutrition</td>
<td>25.9</td>
<td>27</td>
</tr>
<tr>
<td>4.</td>
<td>Anaemia in Pregnant Women Under age 15-49</td>
<td>55.5</td>
<td>69.7</td>
</tr>
<tr>
<td>5.</td>
<td>Any Anaemia in Women</td>
<td>47</td>
<td>56.1</td>
</tr>
</tbody>
</table>

The percentage of women who want 2 sons has also increased from 95.2% (NFHS-II) to 97.4% (NFHS-III). Paradox is that per capita expenditure on health has increased from Rest. 175.02 in 1998-99 to 243.27 in 2006-07, though it may still be less, a very challenging situation is emerging on health front in Haryana. The medical fraternity and paramedics have to rise upto the occasion and decide whether they are for “Shining India” only or are for “Suffering India” first and then “Shining India.” The primary and secondary level health care is virtually collapsing in Haryana. In Rohtak district there are 5 CHC’s – Meham, Kalanaur, Chiri, Sample and Kiloi. As per the norms there should be a surgeon, Physician, Paediatrician and gynaecologist in each CHC. Unfortunately there is not a single specialist in any of the above CHC’s.
Thus, the government has failed to provide basic health facilities to the people and involved Non Government Organisations in health care programmes. These NGOs are also called civil society institutions.

Civil Society Institution

The resurgence of civil society is one of the most distinguishing features of the post-liberalized world. The world has gained vast currency in developing and undeveloped countries, especially in relation to resistance against state actions on/ in relation to development aid. While there is much controversy (Chandhoke: 1995) regarding the definition of civil society institution the most operational definition is that of London School of Economics (LSE) centre of Civil Society. It defines Civil Society thus:

"The area of uncovered collective action around shared interest, purpose and values. In thereby, its institution forms are district from those of the state, family and market, though in practice the boundaries between state, Civil Society, family and market are often complex, blurred and negotiated. Civil society commonly embraces a diversity of spaces, actors and institutional forms varying in their degree of family, autonomy and power. Civil societies are often populated by organization such as registered charities developments non- governmental organizations, community groups, women’s organization, faith-bare organization professional association, trade-unions, self-help groups, social movements, business association, coalition and advocacy groups.

Although civil society has gained currency in the globalized world its idea is not new, In fact the idea of Civil society was found in the writing of the western classical writers like Aristotle and Cicero, In India, Asokan inscriptions also refer to various types of Samjas, (meaning Community groups in Hindi) as a form of society organization. Most likely the organization existed independent of the state and parallel to the state, and therefore, Asoka exhorted against Samaj. Kautilya’s Arthasastra prescribed
active vigil on the past of rajukas (road officers) against there Samajos (Thapar: 1985).

The notion of civil society, however, become popular in the 19th century Europe. A host of political theorists, from Thomes Paine to George Hegel, developed the notion of civil society as a domain parallel to but separated from the state — a realm where citizens associate according to their own interests and wishes. This new thinking reflected Changing economic realities: the side of private property, market competition, and the emergence of two classes namely the bourgeoisie and the proletariat. It also grows out of the mounting popular demand for liberty, as manifested in the American and French Revolution. However, the term fell in to disuse in much of the 19th and first half of the 20th countries only to be revived by Antonio Gramsci. Although Gramsci was concerned about Fascisms of Italy, his Prison house Notebooks was a source of inspiration for people fighting communist dictatorship in Europe (Gramsci: 1971).

Suddenly in 1990s, civil society institutions became the new mantra. The global trend towards democracy opened up space for NGO’s in East Europe. In Europe and America, Citizen, fatigued by two party systems and consumerist individualism began to find meaning in activities like going to church which provided space for social renewal, in developing countries, privatization and other market reforms offered civil society to step in as Governments retracted their reach. And the death of distance through Information technology revaluation provided new tools for citizens to converge and work beyond the narrow confines of nation-state. The civil society institutions are also working for the health care of the people.

**Resurgence of Civil Society**

Organized Social action was not a novelty in the late seventies and early eighties. In fact, its existence can be traced back to pre-colonial times. In this regard, the Societies Registration Act was enacted during the colonial rule
in 1860. During the course of freedom struggle, numerous socio-political organizations came up in the domain of civil society that challenged the discourses on colonialism and its model of progress. In this context, Gandhian movement had specific component of rural construction, with emphasis on volunteerism. What made the resurgence of civil society movements in the eighties different from the earlier ones were to be located in the scale, structure and forms of these civil society institutions. New forms of movements - ecological and environmental, human rights including gender rights emerged during this period, which challenged the authority of the state. Civil society institutions became more organized and networked. Access to funds leapfrogged and big NGOS soon acquired corporate identity. The NGOS were considered to be portions and/or pressure groups in the formulation and implementations of various government schemes of the government.

In the development discourse, the notion of civil society gained ascendancy in the 80s. This was in the wake of a town syndrome-development of fatigue in consumerist capitalism on the one hand and the failure of the democratic state to address the problem of the disadvantaged on the other, it was being argued that civil society provided a third leg to the 'trinity' model of development (Tandon and Mohany: 2000). The 'trinity' consisted of the public sector model of development with its emphasis on public welfare, the private sector model of economic development with the predominant theme of 'profit motive' and the third model of development in the form of civil society as a non-profit associational life. As the third element of comprehensive reaction against the 'dirigisme' of development states .........civil society is a sociological counterpart to the market. In the economic sphere and to democratic capitalism in the political sphere (White: 1996). The civil society in its discourse has traced its role to identify social forces that have participated in struggle against the overwhelming state power.
(Chandhoke: 1995). Some argue that civil society strictly refers to the social components with its emphasis on the authority of society. Its differences from the state and the political class have been elucidated for the purpose of explaining some specific developments. But in the broader sense, it refers to a segment of society populated by voluntary associations (intermediary bodies social movement, intent groups, political parties, ideological grouping), which pursue their own particular interests including the assertion of their identities and their own version of the general interest (Perez-diaz: 1995). Broadly, it refers to the arena of uncoerced collective action around shared interests, purposes and values. In theory, its institutional forms are distinct from those of the state, family and market though in practice, the boundaries between state, civil society, family and market are often complex blurred and negotiated. Civil society commonly embraces a diversity of spaces, actions and institutional forms, varying in their degree for formality, autonomy and power. Civil societies are often populated by organizations such as registered charities, development non-governmental organizations community groups, women's groups, faith-based organizations, professional associations, trade unions, self-help groups, social movement business associations, coalitions and advocacy groups.

It is an intermediate sphere of social organizations or association between the basic units of society, families and firms and the state (White: 1996). In a sense, this can indulge 'uncivil' entities like the mafia, 'primordial' nationalist, ethnic or religious fundamentalist. Organization and 'modern' entities such as trade unions, champs of commerce and profession associations.

Faced with this social farrago, some authors have tried to give the term a more precise meaning. Some argue that civil society could not be independent from the state. For instance, civil society restricts it to organizations that interact with the state. Seligaman (1992) expressed that
civil society is an ethical ideal, which holds the public and the private in a balance. The concept of civil society is considered as an ideal character that covers political component (limited government) as well as social components (market, associations and public sphere).

In identifying civil society as a distinct but broadly desired sphere of immediate social institutions, it is necessary to desire its relationship to the state on the one hand and society on the other. The conventional dichotomy between the state and society, even though important, is not realistic. Civil society in a strictly independent sense is more an ideal type concept, which embodies and qualities of separation, autonym and voluntary association in their pure form and the real world of civil societies compared of associations, which embody these principles of varying degree. The term 'civil society' has also been used in various developments on political projects, each with its own preferred associational life. Neo-populist development theorists and partitions extol the virtues of grassroots non-governmental organizations as paradigms of social participation, alternative developmental agencies and potential building blocks of democracy.

In contemporary times, the boundaries between the state and civil society are blurred. Society may play an important role in shaping civil society and vice versa, the two organizational sphere may overlap to varying degrees; individuals may play roles in both sectors, and the principle of voluntary association may be infringed through political pressure on legal regulation. In particular, the autonomy of civil society organizations is highly variable – a question of degree rather than either/or (White: 1996). For instance, Tocqueville and more recently Putnam see civil society as a network of associations and applications which safeguards democratic spaces between the state and the family (Tocqueville: 1900; Putnam: 1999 and Keane : 1988) for a discussion of the role of civil society in reforming and transforming the state.
Types of Civil Society Institutions:

In modern discourse, civil society emphasizes several intermediary institutions. Edmund Burke called these as little platoons (Heywood: 2000). Every society has a number of mediating institutions that link individuals to each and negotiate between the citizen and the state (Bettille: 1996). They became important in the backdrop of modern life, which is atomized, alienated and fragmental simply because individualism as the hallmark of the modern world breeds self-interested action (Chandhoke: 1995).

It may be necessary to distinguish between different types or sections of civil society, for example, between (modern interest groups such as trade unions on professional associations and traditional organizational based on kinship, ethnicity, culture on religion, between formal and informal organizational and informal social network based on prim or dial on clientelastic allegiances between those institutions which specifically prefer political roles as pressure on advocacy groups and those whose activities remain largely outside the political systems; between legal or open associations and secret or illegal organizations such as the free masons, the mafia or the triads; between associations which accept the political status quo or those which seek to transform it by changing the political regime (such as a guerrilla movement or a reactionary religious organization or redefining the nation (as in the former Yugoslavice) (White: 1996).

The components of civil society are based on the classification of intermediary institutions. Tandon and Mohanty (2000) categorized civil societies into five types such as; Traditional association, Religious association social movement, membership association and intermediary.

These intermediary institutions of civil society in India associated with voluntary bodies in the social arena, allow individuals to participate directly and manage their own affairs. These organizations, independent of the government have witnessed the emergence of non-governmental organizations
NGOs as a major collective actor in developmental activities and in the sphere of public space in general. This occupation of the public space by NGOs, according to Bebbington and Farrington (1993) is the most important role of NGOs.

**Non Government Organizations (NGOs)**

People's agencies make up the gamut of associational relationship that translates community aspirations, duties and functions into actions. They also create that necessary linkage between the state and its people in various capacities. While this linkage is governed by the nature of associations and its ability to influence decisions, a lot also depends on the nature of relationship as institutions. In developing countries, for instance, the relationship is defied by a top-down, highly centralized approach with local level involvement raving mainly as an aid to implement such programmes instead of being a part and parcel of system itself. Institutionalised people's agencies created to respond to such crisis situations have been unable to function in an efficient manner mainly due to their isolation from decision making in most of the cases.

In recent decades, there has been move to distinctly democrat people's activism from the state's rigid structures. Non-governmental organizations have come to play a vital role not only in acting as intermediaries but also by directly managing tasks, which traditionally have been functions of the state. There has been an enormous growth of these organizations within the independent sector, these indulge everything from strictly civil associations, such as athletic teams, to organizations that are trying to develop their communities or promote social change.

NGOs constitute the primary vehicle for individual citizens to articulate their views, to participate in the policy, process and implementations and to contribute to the progress and well being of all state of society. NGOs are the life force for civil society. Civil society, when not
used as a synonym for society in general, is used to refer to 'that segment of society that interacts with the state, influences the state and yet is distinct from the state' (Chazan: 1992).

NGOs have been involved in a variety of activities from implementing grassroots/sustainable development, prompting human rights and social justice, protesting against environments degradation to many other similar tasks. On the basis of objectives and methodology there are two different types of NGOs. First, there are NGOs which concerns supporting, in various forms, social movements and for initiatives of development that and the expressions of the free civil of groups that are formed to confront certain essential questions of life (common needs and common aspirations). These support the strengthening of civil society and the conflictive dynamic of 'individuals' and group aspiration, as they try to build a collective society in which every individual becomes a citizen. Second, there are NGOs, which are in the nature of social movements and represent a certain degree of their institutionalization (Frantz: 1987).

NEED OF NGOs

In the beginning of the 1980s, several developed and developing countries started thinking of privatization, liberalization and withdrawal of state from the social sector programmes like education, health, nutrition etc. Because there was a movement that the state was incapable of tackling the problems of neglected and vulnerable groups of society (Bhambhri: 1987). Many third world countries, who were facing balance of payment problems, reduced their budget from social sector and started taking loan from International Monitory Fund (IMF) and world bank for the survival of the country's economy. During the implementation of IMF and World Bank programme, an under standing was developed that investment in public sector was wasteful and therefore the emphasis on non government organization was better. It was assumed that where government failed to reach out the
marginalized sections and created gap, NGOs could bridge the same (Sarkar: 2004).

In order to perform the task at the international level, NGOs have also been given importance. They are recognized as highly organised and most influential networking groups. Because, in 1990s, they helped, in the preparatory phase of almost every major U.N. Conference, such as, conference of environment and development in Rio in 1992, Human right conference in Vienna in 1993, the Population Conference in Cairo in 1994, conference on social development in Copenhagen in 1995, conference on women’s development in Beijing in 1995 etc. NGO is one of the few means that manages to maintain a common identity and an agenda from one UN conference to another. It has become customary now that every official global conference will be flanked by an NGO forum (Seth: 1997).

Cumper (1986) describes NGOs, as organizations not mainly financed by governments and not under the control of governments. It stresses on the sense of distance from the state.

Duggal (1988) defines NGOs in a broader sense. According to him,

(A) NGOs are registered as public trusts or societies.
(B) Programmes adopted by NGOs are welfare programmes.
(C) NGOs as a rule do not generate their own funds completely but rely on external financial assistance from government agencies, both national and international.
(D) NGOs are private organizations, but their nature makes them different from what one gradually refers to the private sector. Thus they are not supposed to make any profit.

This definition makes them different from voluntary organizations i.e. voluntary organization may or may not be registered societies.

According to Smith (1989), NGOs are having legal independence from government, a non profit status and a voluntary decision making structure.
Rajasekhar (2000) examines the term NGO that undertakes voluntary actions, social action and social movement. According to him, four characteristics voluntary formation, working towards development self serving aims and relative independence. He admits that these NGOs work within the parameters of government legislations and policies formulated for them.

The credible institution like the World Bank defines NGOs as private organizations that pursue activities to relieve suffering, promote interests of the poor, protect environment, provide basic social services, or undertake community development.

In wider usage, the term NGO can be applied to any non-profit organizations, which is independent from government. These are voluntarily formed and registered organizations working towards development and amelioration of suffering with non-self serving aims and free from the state control in managing day to day affairs.

We may perceive NGOs as outfits that are generally formed by a group of like minded people committed to an idea often weaved around social change or development. As the term suggests, NGOs work outside the government, but they usually have to get approved by, and are sometimes funded by government. They are not-for-profit, have a board and can comprise any number of people. These organizations are registered either under Society Registration Act of 1860 or India Trust Act of 1882. They are registered in the concerned district or at the registrar of societies at the state or at the central level.

**Characteristics**

Since the beginning of 1980s, the activities of NGOs have been growing worldwide in terms of size and scope, their number and volume of aid. The popularity of NGOs is due to their specific characteristics. These are:
1. Flexible and experimental interventions due to their small size and learning process approaches.

2. Their low costs and effective work at the grass root level especially in remote areas.

3. Their relationship with the beneficiaries is based on voluntarism which is the main factor allowing NGOs to achieve meaningful participations.

4. Furthermore, NGOs recruit highly qualified and motivated staff on the basis of shared value and a belief in the social mission of the NGOs (Baru: 1998; Rajasekhar: 2000).

Types of NGO

Various types of classification of NGOs found in literature.

Sethi (1991) categorized voluntary organizations in four types namely:

1. Those having characteristics derived from the independence movement
2. Those based on Gandhian movement
3. Missionary organizations
4. And professional organizations created for economic and social development.

Nandekar (1987) classifies NGOs into ten categories:

1. Individual practice of Dharma – This covers individual’s services to the needy.
2. Religious Institutions – This category includes temples/ churches or similar institutions engaged in activities – development in nature.
3. Individual based philanthropic activities – These cover a vital sector of social and cultural life.
4. Social service and cultural associations – These are non-political in nature and work though the socio cultural ethos of the system.
5. Professional and consultancy associations – They extend advice, guidance and help in their specialized fields.
6. Functional Associations – These express in unambiguous terms the interests of their members and endeavours to protect the same.

7. Front line associations – Political parties look to these associations as recruitment grounds, e.g., Kisan Sabha, Khedut Samaj etc.

8. Action Groups – these groups are involved in mobilization and socialization of unorganized sections of society.

9. Protest Groups – These groups are like action group, with or without political affiliation.

10. Citizen Groups – These associations develop secular interest with community life and encourage interaction with administration. For instance, Grahak Panchayat, consumers education canters, citizens council etc.

Rajashekhar (2000), Classified NGOs in four categories, such as,

1. **Operational or grassroots NGOs** – These NGOs directly work with the oppressed sections of society.

2. **Support NGOs** – These NGOs provide services that would strengthen the capacities of grassroots NGOs, Panchayati Raj Institutions, co-operatives and others to function more effectively e.g. of this types of NGOs are SOSVA, SEA RCH etc.

3. **Network NGOs** – these are formal associations or informal groups of grassroots and/or support NGOs which meet periodically on particular concerns, an example of this is FEVORD-K (Federation of Voluntary Organisation in Karnataka).

4. **Funding NGOs** - Funding NGOs are those who extend financial assistance to the grassroots NGOs support NGOs or people’s organization. For e.g. CRY, Dorabji Tata Trust, Aga Khan Foundation etc.

**Functions of NGOs**

In describing the functions of NGOs, Korton (1990) distinguish three
generations of NGOs. The first is committed to relief and welfare, which predominate in the developing world. These often have close ties with political activities. The second attends to small scale, local development projects, which organizes, individuals locally to address issues like public health and agricultural development. These groups frequently help their constituent to overcome structural constraints and to challenge local and regional deities. And the third consist of community organizations interested in building coalitions explicitly targeting political constraints and engaged in mobilization and ‘concretization’ Their focus is on coordinating communications and linkages among people’s organizations.

Generally the functions of NGOs are as follows:

1. **Helping/ Assisting Government:**
   Whenever government institutions are not able to do their work and are insufficient in their men, the NGOs are leading a helping hand to these institutions. This is also beneficial in areas where government machineries are bound in their own limitations of rule and regulations and therefore NGOs have an advantageous position.

2. **Innovative Experiments**
   NGOs are today in such a state where they can experiment on new-things. Research is also under purview of some of the voluntary organizations and these organizations are doing quite a good job of it. When those innovative experiments become successful at the micro level then based on these, even the government tries to incorporate then in their functioning. The live example is this regard is the example of National Family Welfare Programme which was started by NGOs.

3. **New Kind of Techniques**
   Today NGOs are famous for the new kind of techniques and methods which they have adopted in managing themselves. Working in these organizations gives an independent environment and freedom of work. Today
more and more doctors and other professionals are attracted towards the voluntary work.

4. **Importing education of people**
   
   In this field of providing education to people NGOs are very actively engaged. But whatever effort they do shall always be a drop in the ocean because it is a vast area. If the government alone does this task, they will not be successful and therefore, NGOs have an added duty to assist in this task.

5. **Raising important health issues**
   
   Health non-governmental organizations are today creating awareness on various health issues. They are forming effective network, running campaigns in association with consumer units, social activists, health workers social workers and national and international organizations. It is important to realize in this context the issue of rational use of therapeutics is being popularized by Voluntary Health Association of India and has come a long way since it was started.

6. **Playing a role of “Pressure Groups” on government**
   
   Today numbers of NGOs are engaged in the task of keeping an eye on the government work and seeing to it that the functionaries who have been assigned the use of public money are really using it for public. This is a potential area where lot of efforts needs to be put together.

7. **Striving for social justice in the field of health**
   
   This area has become an area of utmost importance and is being taken as a long term goal by many NGOs.

8. **Facilitating communication**
   
   NGOs can facilitate communication upward from people to the government and downward from the government to the people. Communication upward involves informing government about what local people are thinking, doing and feeling: While communication downwards
involves informing local people about what the government is planning and doing.

9. **Advocacy for and with the poor**

In some cases, NGOs become spokespersons for the poor and attempt to influence government policies and programmes on their behalf. This may be done through a variety of means ranging from demonstration and pilot projects to participation in public plans, to publishing research results and case studies of the poor.

**Theories of Origin of Voluntary Associations**

Western scholars have put forward several theories regarding the origin of the voluntary sector. The disciplines from which they emanate range from economics and political economy to sociology, political science and anthropology. The theories are partial in that they are not incompatible with one another.

The contract failure theory, an economic theory, explains why particular kinds of goods are produced by voluntary rather than by the private sector. It argues that when consumers are unable to evolve accurately and adequately the quality of the goods, they choose voluntary organizations as supplier rather than profit making firms. This theory is not applicable to the Indian situation since in India most voluntary organizations are set up to meet the needs of the vulnerable and those who cannot protect their interests, and to deliver merit goods. A modern state is expected to provide them, but India has failed to do so. The reasons for failure are:

1. The state lacks resources. Therefore, voluntary associations frequently supplement the supply of such goods e.g. health care.
2. Often, negligent public servants fail to perform their duty, even when they have no material gains to derive from this. Of course, there are corrupt officials who can and do subvert enacted policies and reap unauthorized profits from them. In either case, those who
are too weak to assert their rights are left out.

3. The weak and the vulnerable often do not know how to access merit goods.

A vast majority of Indian voluntary associations are set up by the organizers to address this shortcoming of the public system.

The second economic theory, the subsidy theory, agrees that non-profit organizations benefit from a variety of implicit and explicit subsidies, such as exemptions from taxes. Thus, once set up, a part of the financial burden shifts to the government, a prospect which acts as an incentive for setting up a voluntary association. This theory seems particularly applicable to the Indian situation since voluntary organizations here often obtain even their initial funds either from the government or foreign funding agencies. This theory explains the phenomenal growth in the number of voluntary organizations as a result of the abundant availability of funds, both foreign and domestic (mainly government), which began to characterize the voluntary scene from the late 1960s onwards.

The exchange theory offers yet another way of understanding voluntary associations. It views a voluntary association as a benefit exchange. The group organizer offers a set of benefit to the members and receive benefits in return. To join and continue as a member, one may have to pay a subscription, attend meetings etc. These are the costs a member has to bear to receive the benefits. The organizer, on his part, has to devote time and energy to recruit members and to obtain and deliver benefits may take the form of fulfilment of much cherished goals or more compensation (Patel: 2000).

The Rise of NGOS in India

The rise of NGOS is one of the central processes in the sphere of development since the 1980s. The period coincides with the demise of developmentalism as a project of the nation-state and the rise of post-developmentalist neo-liberal political economy. This is often described as a
move from inefficient states to efficient markets, which facilitate the free play of market forces and enable decentralized institutions to practice 'participatory management'. This has been a new mantra for the provision of services through community based organizations and social municipalities as panchayats. It is the sphere of natural resources management functions where NGOs are seen as 'civil society' actors that are more accountable, responsive and committed to bringing about social change. The state is seen as consisting of entered interests and styles of functioning that make it unwilling and unable to work with the people, a role that NGOs are supposed to be good at. Thus NGOs have emerged to perform roles with greater efficiency, motivation and transparency. Increasingly, the state itself accepts the presence of NGOs and in fact expects them to take over certain tasks. Given the profound implications of NGO-involvement in development, there is a great need to examine the performance of NGOs and the changing relations between NGOs the state agencies, multilateral and bilateral funding institutions, and social groups.

Rise of NGOs in India may be discussed in two phases i.e. before independence and after independence.

**NGOs — Before Independence**

The efforts and initiatives towards welfare and developmental activities, which originated outside the state structure and within society come into prominence during the colonial period. The agents of these activities would be called ‘voluntary organizations’ and today we them as ‘non government organizations’ with regards to rise of these organizations; three major landmark are found before independence. (Sarkar: 2004)

During the early British rule i.e. in the 18th century (1707 A.D. to 1800 A.D.), the Christian Churches initiated welfare activities by establishing educational institutions, hospitals, dispensaries to serve the non-convert majorities both among the Hindus and Muslims. English educated natives,
In 19th century during the social reform movement, Raja Ram Mohan Roy (1772-1833), Ishwar Chandra Vidhyasagar (1820-91), Sasipada Banarjee (1842-1925), Keshab Chandra Sen (1838-84), Pandit Ramabai (1856-1902), Mahatma Phule (1827-88), Sir Sayyad Ahmad Khan (1817-1898) are the persons brought about social change in India through voluntary agencies.

Raja Ram Mohan Roy began ‘Brahma Samaj’ in 1828 to shake the belief of orthodox Hindus by opposing child marriage and propagating widow remarriage. Keshab Chandra Sen advocated inter-caste marriage, widow remarriage and removal of the purdah system. He campaigned against untouchability and founded ‘The God Will Fraternity Society’ and ‘The Calcutta Evening School’. Mahatma Phule established ‘Satya Shathak Samaj’ in 1873 to fight against untouchability. Swami Dayananda Saraswati formed ‘Arya Samaj’ in 1875 to work against idd worship, child marriage and caste discrimination. “The Indian National Congress” was established in 1885 keeping in view the objectives of National development. Sasipada Banerjee founded ‘The Home for Hindu Widows’ in 1887 to reduce women sufferings and to perform a number of widows’ remarriages. Pandit Ramabai opened ‘Sarda Sadan’ a home for Hindu widows in 1889 at Bombay. Maharshi Karve started ‘The Hindu widows Home’ at Poona in 1896 at Calcutta in order to provide food and famine relief; health and educational facility; etc. Bahramji Malbari started ‘Seva Sadan Society’ in Bombay to look after destitute women and children. (Lalitha: 1975)

The enactment of the Societies Registration Act of 1860 was a landmark in the history of voluntary organization in India. The act is still operative with minor amendments and adoption by the central and state governments. It was during the period 1858-60, that the need for registration of societies on the pattern of a similar act in the United Kingdom was felt on
the receipt of an application from Calcutta public library. The first known voluntary organization according to the records maintained in the national archives of India was the “Friend-in-need society” of Madras (Lawani: 1999).

The Christian missionaries had played a significant role in the growth of voluntary organizations in India. Some of the educational and medical institutions particularly in the south were started by foreign and Indian Christian missionaries, who demonstrated a good deal of commitment to the cause they were striving to serve (Lawani: 1999).

They also took interest in spreading education among the Tribals and improving their health and living conditions. In the Tribal belt of Orissa, Madhya Pradesh, Andhra Pradesh and the north-east, they carried on humanitarian activities on a considerable scale (Prasad: 1987).

Another trend emerged during the days of the national movement (from 1905 to 46). As a result of this movement, patriotism, nationalism, Swadeshi Sprit, a deep faith in power and widow of the common people come into existence and the same led to form a few organizations. For instance, Gokhale formed ‘The Servants of Indian Society’ in 1905. The approach of the society was secular and it sought to solve the national and social problems on a rational basis. It engaged itself in improving the condition of women, problems of untouchability, establishing cooperative enterprises and rendering relief work Mahatma Gandhi founded the ‘Harijan Sevek Sangh’ and ‘All India Village Industries Association’ to uplift the Harijans and economically poor people. As a result of Gandhiji’s effort a number of voluntary agencies like ‘All India Women’s Conference’, Indian Adult Education Association, ‘Balken-ji-Beri, ‘Bharatiya Depressed Classes League’ came into existence. (Lalitha: 1975). The ashrams formed by Gandhiji can be considered as the first generation of modern NGOs in India (Bhatia: 2000).
NGO — During Post Independence Period

After independence India was declared to be a “Welfare State”. The government undertook welfare schemes under various plans and policies. Besides, it has encouraged voluntary organization to undertake social welfare programmes under the grant-in-aid programme and set up autonomous bodies like Central Social Welfare Board, Indian Council of Social Welfare etc.

Some of the institutions started by Mahatma Gandhi and by the wives of officers with the support of the British Government and those started by the Indian Philanthropists, Christian missionaries, Rama Krishna Mission etc. continued to function although national organizations like Indian Red Cross Society, Young Men’s Christian Association (YMCA) Young Women Christian Association (YWCA), Harijan Sevek Sangh etc. were functioning. It was around this time that several all India level voluntary organizations such as Kasturba Gandhi National Memorial Trust, Indian Council of Social Welfare, Indian Council of Child Welfare, Youth Hostel Association, Association of Social Health etc. were set up (Lawani: 1999)

The decade that followed India’s independence marked a phenomenal increase in the number of voluntary agencies in the country; they expanded their activities to over practically every field of social welfare. They not only undertook programmes with their own resources, but also organized projects sponsored by the state and voluntary organizations. The planners in India have all along emphasized the role of voluntary agencies and have recognized services rendered by them in various fields (Lawani: 1999)

The First Plan said, “A major responsibility for organizing activities in different fields of social welfare like the welfare of women and children, social education, community organization etc. falls naturally on private voluntary agencies. Any plan for social and economic generation should take into account the services rendered by these agencies and the state should give them maximum co-operation in strengthening their efforts. Public cooperation
through these voluntary social service organizations is capable of yielding valuable results in canalizing private efforts for the promotion of social welfare.”

Having recognized the importance of voluntary organizations the government took concrete steps to assist voluntary agencies. The setting up of the Central Social Welfare Board (1953) proved to be a milestone in the history of voluntary action. One of its main functions was to provide financial assistance to voluntary organisations in order to develop them. Besides, up to 1960, it also provided financial support for setting up new voluntary organisations. As a result, there was a rapid increase in the number of voluntary organisations during 1950s. The number of voluntary organisations rose by 117 percent during 1953-61 (Lalitha and Kohli: 1982).

In order to reach out to the local NGOs and to release funds in time, the central social welfare board established state level Social Welfare Advisory Boards (Lalitha: 1975). During that time National Institute of Public Co-operation and Child Development (NIPCCD) was established to promote NGOs in the country.

NIPCCD concentrated in the area of training voluntary workers supporting NGO activities and promoting lien between government and NGOs (Garain, 1994). First Five Year Plan allocated four crores of rupees for the voluntary sector.

During the Third Five Plan NGO action was considered as an aspect of public co-operation. The National Advisory Committee for Public Cooperation (NACPC), which came into existence in 1952, has representatives during Third Plan mostly from national NGOs. As the public co-operation get institutionalized, NACPC gradually lost its credibility in the eyes of small and comparatively new NGOs (Roy: 1987). During this period, an autonomous institution called People’s Action for Development India (PADI) was also created to promote voluntary efforts in rural development.
During these years several prominent voluntary organisations made their mark in different fields among those engaged in the area of education were the Lok Bharti, Gujrat; Mauni Vidyapeeth, Maharashtra, Banasthali Vidyapeeth, Rajasthan and Jamia Milia Islamia, New Delhi. The Indian Council of Child Welfare, New Delhi and Balakanji Bari, Bombay were the prominent organizations in the field of child welfare. PADI was associated with several rural development programmes in the field of horticulture, dairy, faulty and village industries (Reddy: 1987). In the field of tribal welfare and development, commendable work was done by the Bhartiya Adimjati Sevek Sangha, New Delhi and the Bharatiya Lok Kala Mandir, Rajasthan (Bhatia: 2000).

In the Sixth Five Year Plan, National Institute of Public Cooperation and Child Development (NIPCCD), which came into existence during the first plan, drastically changed its focus and had become the apex body for training functionaries and to coordinate, monitor, valuate the integrated child development services scheme of government of India Involvement of NIPCCD in the area of public cooperation and NGOs had become minimum at that time (Garian: 1994). From the middle of the Sixth Plan, there was a number of initiatives at the government of India level to establish consultative group of voluntary agencies in each state under the chairmanship of either the Chief Secretary or the Development Commissioner. But it could not be successful and the move of creating consultating committees of NGOs at the state level met a natural death (Garain: 1994). In 1983, a new organization Council for the Advancement of Rural Technology (CART) was set up to improve conditions in rural areas through diffusion and innovation of technology with the help of voluntary organisations; In 1986 CART was merged with PADI to form the Council for Advancement of People’s Action and Rural Technology (CAPART) to catalyze the development work of voluntary agencies country wide. The main thrust of CAPART is in the area
of employment, income generation, creation of community assets and fulfillment of basic needs like housing and drinking water. The government continued to increase the plan allocation for the voluntary sector with each five year plan. For the first time in the history of Indian planning, the Seventh Five Year Plan (1985) document contained a chapter on voluntary agencies. The plan attempted to involve the voluntary organisations in planning and implementing the programmes of rural development of the government in a big way. Stressing the need of professionalism voluntarism by introducing professional competence, management expertise and accountability in the working of these organizations, the plan emphasized the need to give greater attention to the mobilization of locally available human and financial resources, identifying people in the poorer and vulnerable occupations, upgrading their skills and giving them the task to make them economically self-sufficient as well as productive (Seventh Five Year Plan: 1985). Regarding health, in the seventh plan, union ministry of health and family welfare considered following schemes for releasing funds to the voluntary organizations:

1. Schemes for improvement of medical services for expansion/improvement of hospitals under voluntary organization/associations those are operating in rural or urban areas.
2. Promotion and development of voluntary blood donation programmes.
3. Special health schemes for setting up of small hospitals/ dispensaries in rural area only.

During 1989-90, grants amounting to Rs. 35.83 lakhs were granted to 27 institutions under scheme one and two above. For the third scheme, grants of Rs. 10.75 lakhs were given to four institutions.

The Eighth Plan Document (1992) placed a still greater emphasis on voluntary organisations. It stated that people's initiative and participation
must become the key element in the whole process of development. Therefore, the focus of attention will be on developing multiple institutional options for improving the delivery systems by using the vast potential of the voluntary sector (Eighth Five Year Plan: 1992-97). In the eighth five year plan, it was proposed that grants-in-aid would be given to the voluntary sector for innovative experimental schemes. In the field of the health and family welfare, NGOs were expected to help in raising and promoting the small family norm by means of motivation and education of women, provision of antenatal and postnatal care etc.

During the Ninth plan, it has been realized that NGOs, are actually complementary in nature. Both the sectors (Government and NGO) have their own strategy and strong points. Both the sectors are to work on reciprocal basis.

Apart from the five year plans, many government committees pertinent to development recognized the necessity of NGOs. The Balvant Ray Mehta Committee (1957), the architect of Panchayati Raj administration, emphasized the need for close co-operation and collaboration between statutory organizations and the NGOs. The rural urban relationship committee (1966) focused on the role of NGOs in mobilizing community support for local level development activities. It identified NGOs as linking organizations to keep constant and close contact with the people. The Committee of Administrative Arrangement for Rural Development (CAARD) (1985) had emphasized the need for the involvement of NGOs in rural development activities (Garain: 1994).

There are also a few acts and social policies that have been passed after independence and have extended avenues to the voluntary sector. For instance, the Income Tax Act, 1965 the Foreign Contribution Regulation Act 1976, The National Health Policy, 1983 etc. (Sarkar: 2004)
During the past few years, several voluntary organisations have left their imprint on the sands of development. A majority of them have concentrated on providing Livelihood, Employment and Income Generation (LEIG) activities. Among the prominent names are the Self-Employed Women’s Association (SEWA) and Anands Niketan Ashram in Gujarat, Bharatiya Agro Industries Foundation (BAIF) and Sarvegnin Vikas Sanstha in Maharashtra, Social Work and Research Centre (SWRC) in Rajasthan, The Gandhigram Trust and Working Women’s Forum in Tamil Nadu, The Comprehensive Rural Operation Service Society (CROSS) in Andhra Pradesh, The Tagore Society for Rural Development in West Bengal, Mahila Vikas Samiti, Banwasi Sewa Ashram and the Dasholi Gram Swarajya Mandal in Uttar Pradesh and Manipal Trust in Karnataka, The Nagaland Gandhi Asharam in Nagaland and Rama Krishna Ashram in Meghalaya.

Changing Nature of NGOs:

Marxists view civil society as an unequal terrain of oppression structured by power and class. In this context, critiques point out that though many NGOs and their donors have recognized their role in strengthening the structure of civil society, it does not mean that they have adopted a commitment to social justice (Laura: 1994). In fact, role focus on strengthening the role of NGOs may contribute in obscuring many of the power equations involved. In particular it ignores the extensive ties between NGOs and the state and the other forms of power relations which shape and restrict NGOs action.

Wood (1986) took up the aid – giving as a form of gift-giving by the state and asserts that the donor – recipient relations between state and NGOs reflect a basic asymmetry of power and status that lies at the core of the aid process. The same can be said of the relationship between Northern aid giver and Southern recipient. “Paradoxically international NGOs have more freedom to impose their models than their official – and for wealthier –
counterparts: they are subject to little control by the state apparatus and they can look out a clientele which all accept, their own conception of the right way to development. Having done that, they can then engender a relation of dependence by making local institution and group dependent on short grants for their survival – for these organizations rarely provide funding beyond a year or two. The terms so soft that they are, in effect, grants, but though they sound generous it hampers the development of autonomous sustainability (Wood: 1986).

What is the effect of patron client relationship on the nature of civil society institutions? The shift from the government to NGOs is built on the growing criticism of the state in delivering development as well as on the distrust of government among the United Nations and donor agencies in reaching out to the target population. The irony, Kothari observes, is that by hijacking the whole concept of voluntary and NGO effort as a preferred mode of organizing civil society as against the State Bureaucracy, the new look will also be able to marginalise and be ruthless on these elements in the voluntary space that refuse to fall in line, are too political and are unwilling to accept the disciplines imposed by a capitalist corporate state.

One fundamental change that occurred in non-governmental organization is the pattern of resource mobilization. Earlier resource generation from within the host community was the most dominant pattern, now it is more in the form of aid, grant and donations. It is true that many of the interventionists tasks requires huge funds that require resources mobilization beyond the host community and four-anna membership of the Gandhian type in the process. But, it is also fundamentally altered the structure of the organization. Earlier, the NGO was a more amorphous and lordly structured body. Now with the mobilization of resources contributing the key to growth as the foci of power and as the most powerful autocrat within the organization.
Another important change occurred in staff pattern. The new NGOs have become more corporatised and formal. While the NGOs themselves advocate Participating Learning Appraised (PLA) for project identification and execution, within the organization there is large degree of opacity and non-linearity in decision making and communication, especially in financial matter.

The other aspect is in respect of the nature of relation between state and the NGOs. While there are many NGOs who work in opposition to states like Narmada Bachao Andolan and have access to international funding, a vast majority of around two million NGOs in India depend on government funding. A form of dependency develops which severely restricts the independence of the NGOs. Moreover, given the still pervasive nature of the state, the tool of blacklisting by Government severely restricts the space for action by small and medium level NGOs. Therefore, it is only the large-scale NGOs with access to international funding who take a position other than that of Government.

At present, therefore most of the NGOs in India are Service delivery institutions rather than policy advocates. Only the large NGOs with independent where withal are into policy advocacy that, at times is in conflict with state’s position.

**NGOs and Health Care in India:**

The state accepted responsibility for public health in the mid 19th Century, early efforts were almost entirely urban-oriented with a strong emphases on curative services. Rural areas received attention mostly in times of epidemics. Only in 1946 was the concept of community based primary health care for both rural and urban areas brought to the forefront of government attention by the Bhore Committee on public health. (Government of India: 1946)
After independence, the state took on the primary role in reiterating and implementing development activities including provision of health care and the recommendations of the Bhore Committee as well as those of the several other committees subsequently appointed by the government on various aspects of community health were incorporated in the five year plans and implemented through different government programmes. Though the health situation improved considerably as a result of these efforts, it was still far from satisfactory as late as 1980 (Sunder: 1994).

Mortality rates among women and children were still distressingly high and though many diseases like smallpox and cholera had been eliminated or curbed, in other respects the morbidity pattern had not changed much. Diseases arising from poverty, ignorance, malnutrition, bad sanitation, lack of safe water supply and drainage, inadequate housing and low levels of immunity were still among the most common. The family planning programme was far from being a success and health education was woefully inadequate. There were large variations in both mortality and morbidity, not only from state to state, but within states and between urban and rural areas.

For though a vast network of health care centres had been built up, there were critical problems within the infrastructure and gross deficiencies in the health care system provided by the government. There was also a gap between the planning and execution. No cadre of managerial physicians had been built up to shoulder the new type of responsibilities. Instead, generalists, administrators and insular health services cadres ruled in the field. As a result, participation in most health programmes was minimal and service were delivered to a passive population. People often lacked awareness of government facilities and had limited expectations from health workers. So there was a little interest in the community in the programme offered. Consequently, and changes that were introduced proved short lived.
The recognition of by the government of the role of NGOs has two aspects:

1. Incorporation of various elements of NGO approaches in to government policy.

2. The use of NGOs for various aspects of government programming because they are more effective than governmental organization and address themselves directly to the problems. Through trial and research over a period, they evolved an approach to community health which worked. It is an approach combining commitment and close investment with the community at the grassroots.

In the field of health there has been a significant growth of NGOs in the country over the past two decades. The 1970s witnessed the emergence of new form of NGOs, several of whom took on the challenge of translating the concepts of equity, social justice, community participation, and integrated development embodied within the primary health care concept through community based, people created programmes targeted to the poor. NGOs were able to demonstrate the feasibility and effectiveness of alternative health care models that were successful in reaching the unreached and servicing the un-served (Pachauri: 1994).

The 1980s were characterized by three significant changes in the NGO sector. First, since it had become abundantly clear that fundamental changes in attitudes, values, social structure and perhaps political thinking were necessary to address questions of social change, empowerment, sensitization and participation became important NGO strategies. Second, a growing constituency of women NGOs began to incorporate the gender factor along with caste, class and economic concerns in their grassroots initiatives by combining twin strategies of struggle and development to address the problems of poor women. And third, professionalization of the NGOs sector in this period resulted in the development of intermediary organizations that
began to undertake several support functions including training, advocacy, research, publication and documentation. There has since been a growing professionalization of voluntarism.

Through these processes, the NGOs sector built up a body of knowledge and practice on how to identify the poorest in the community and how to involve them in the process of development. (Sunder: 1994)

The successful experience of NGOs in reducing mortality and fertility resulted in their developing credibility with government, and NGOs leaders began to increasingly interact with policy advocacy. In recent years and particularly since the seventh five year plan period, the government has increasingly consulted NGOs in policy formulation. (Pachauri: 1994). In contrast to government programmes, NGOs have implemented health delivery strategies that specifically aim to reach the poor and to stimulate a demand for services personnel who deliver these services have played an important role. NGOs have recruited field workers from within the community and have made special efforts to involve women. Training of workers has been geared to problem solving. They have been well supported and supervised and have been accountable to the programme as well as to the community. NGOs have also instituted effective community based monitoring and surveillance systems to estimate workloads, enable planning of realistic schedules for workers, facilitate monitoring of programmes.

The success of NGOs implementing maternal and child health services to the three tiered approach that they have effectively implemented. First, level of care is provided by village workers, generally by women who can best deal with health problems of woman and child. Second, level care is usually provided through mobile health teams that visit villages at fixed schedules. At the third level, in most cases, there is a hospital. Critical problems encountered at the first and second levels are referred to. This
strategic lends itself to continuing education, supervision and monitoring and ensures equitable access to health care. (Ghosh: 1994)

**NGOs in Health Care in Haryana**

Especially in the field of health care, NGOs have acquired a considerable importance in India since, 1978 (Pattaniak: 1988). In that year, the Alma-Ala conference, held under the joint auspices of the WHO and the UNICEF, gave birth to a new approach in health care i.e. Primary Health care Approach, which fixed a goal of a Health. For all by 2000 A.D., that conference was proceeded by a joint study of the WHO and UNICEF of finding out alternative approaches to meet the basic health needs of the third world people. The study examined some of the voluntary health projects in the third world countries like India. The conclusion drawn went strongly in favour of Voluntary Organisations/NGOs. At the same time, some assumptions went against the government health services i.e. government health sector lacks infrastructural facilities, trained manpower, committed medical and para-medical personnel, and thus cannot be trusted to execute any goal oriented programme. In 1983, the National Health policy also recognized the need for greater reliance on the voluntary and private sector for achieving the goals of “Health for all by 2000 A.D. (Duggal: 1988). In 1985, the ministry of health and family welfare was in full agreement with the planning commission on the issue of greater involvement of NGOs in the field of health care (Duggal, Gupta & Jasani: 1986). National Population Policy (2000) which aims to bring down the fertility rate of replacement level by 2010 and to achieve a stable population by the year 2040, also focused on the voluntary and non profit sectors for population control (Nampudakan: 2000).

This shows how NGOs have been getting preference in health care in India. In fact during last two and half decades many NGOs have come into focus for their remarkable contribution in health care. For instance, ‘Institute of Health management Pachod’ and ‘Strahitakarini in Maharashtra’, ‘Banwasi
Sewa Ashram in UP; Parivar Seva Sanstha in Delhi, child in Need Institute in West Bengal, each of these organizations is considered as medal health care NGO and has multi-dimensional activities like health awareness, clinical service, health care training, health research etc. More or less every state possesses this kind of NGO and also many grassroots level organizations who have limited health care activities (Sarkar: 2004).

The present study was conducted in Rohtak in Haryana state to examine how these NGOs provide health care facilities to the people with their limited sources. Tikku (2004) found in his study that there were 36 NGOs in Haryana working on health care.

Here, we present, the brief discussion of some of the selected NGOs in Rohtak:

1. **Manav Seva Sangh**
   This NGO started its working in 1999 in Rohtak. The main objective of this NGO is service of the poor and needy persons. It has almost 15-16 staff members who patiently listen, counsel and provide care at the dispensary. It is totally donation based NGO and does not get any aid from the government. This NGO provides X-ray, ultrasound, testing, ambulance facilities to needy patients at 1/3 rate than other Private Institutions. This NGO organizes occasional camp.

2. **Haryana Nav Yuvak Kala Sangam**
   It is a state level NGO that works is close association with the government of Haryana. This NGO has 8-9 staff members in its dispensary who prove healthcare facilities to the people. The main areas of working of this NGO are disadvantaged communities, sustainable development, environment and women’s issues (including health also). It is a research and consultancy type organization and gets aid from the government. This NGO also organizes the occasional camps to motivate the people towards their health care.
3. **Indian Red Cross Society, Rohtak**

This NGO is one of the well-known NGOs of Rohtak working on health care. It does not provide any medicine to the people but organizes blood donation camps and provides artificial body parts to the needy people. This NGO gets its financial aid from both Indian and foreign funding agencies. The main area of working of this organization is health and disability.

4. **Hari OM Sevadal**

It is one of the NGOs working on health care in Rohtak. The main aim of this NGO is service of the people. It has its Ayurvedic dispensary in Gandinagar Camp, Rohtak. This NGO organizes occasional health camp but most of these camps are related to regular health checkups. Like Manav Seva Sangh, it is also provides health care facilities i.e. wheelchair, stretcher etc. to the needy patients in Health University, Rohtak also and does not get any aid from the Government.

5. **Disha**

This NGO was registered in the year 2001. It has its ayurvedic dispensary named Giriraj. Manav Seva Sansthan in Janta colony, Rohtak. It is also a donation based NGO and does not get any aid from the government. It is a service organization.

The other NGOs selected in the present study are Bharat Vikas Parishad, Baba Banda Bahadur Seva Samiti, Maharaja Agrasen Seva Samiti, Shri Baba Lakshmanpuri ji Seva Samiti and Sati Bhai Sai Das Seva Samiti.