Chapter-III

METHODOLOGY

The previous chapter has given an overview on relevant literature. This chapter provides details regarding the methodology that has been adopted to carry out the present study. It encompasses rationale of the study, specific objectives, research design, sources of data, construction of tools, sampling, process of data collection, nature of analysis and so on.

The actual limitations, those the study admits, are also included here. It should be noted that there is no specific methodology for research on NGOs in health care. It depends on the topic, the purpose of investigation, the data available and the experience as well as capability of the researcher. The present work is an empirical study and has shown a new methodology using a few methods together.

Rationale of the study

Review of studies on NGOs, in the previous chapter, shows diversity among the research initiatives. For instance, a few are individual case studies, few are related to programme activities, few deal with the organizational structure and the remaining studies relate to the beneficiaries. These studies are largely from a management or a sociological perspective. A public health perspective, which has an interdisciplinary approach and can examine the social basis of these NGOs, their growth & distribution, their contribution, etc. is lacking in this area of research. It is also found that there are only two state level studies on NGOs in health care. Those were conducted in Maharashtra.
(Duggal, Gupta, Jesani, 1986) and Andhra Pradesh (Baru, 1987). No other state level work on NGO's health effort is undertaken. Hence, the present study is a state level study of NGOs in health care in West Bengal having considered the perspective & research gap mentioned above. The reason for selecting West Bengal is its unique socio-political environment. For instance, it has history of series of movements, more than twenty-five years rule of the Left Front Government and at present more importance is being given on industrialization and work culture.

Again, a few studies on NGOs express that NGOs are not reliable for social planning due to their variations. For instance the above-mentioned studies conducted in Maharashtra (Duggal, Gupta & Jesani, 1986) and Andhra Pradesh (Baru, 1987) show, NGOs are skewed in favour of socio-economically developed areas in their distribution. The study of NGOs in Assam (Sarkar, 1998) shows, NGOs are varied in size, ideology, organization structure, programme and the population that they serve. These raise an important issue regarding to what extent NGOs actually serve the poorer areas and under privileged sections. In this context, the present study tries to examine the case of West Bengal with regard to NGOs in health care.

During the last two decades, there has been a shift towards greater reliance on the market and NGOs for provision of services in the social sector. The private sector and NGOs are seen as more efficient, less bureaucratic and effective as compared to the government. With this understanding, the National Health Policy document 2001 also envisages a greater role for private sector and NGOs. The NGOs represent plurality in
terms of size, services provided and inter as well as intra state distribution. Given these variations, the present study has decided to examine the social basis, growth, distribution and contribution of NGOs working with health care in West Bengal. Ultimate aim is to locate the relative position of NGOs in providing health care vis-à-vis the state in West Bengal.

**Objectives**

The specific objectives of the study are as follows:

(i) To develop an understanding of the socio-political factors influencing the rise of NGOs in West Bengal after independence and examine their role in health services.

(ii) To analyse the trends in growth and distribution of NGOs in health care in West Bengal with special focus from the early seventies.

(iii) To do an indepth study of a selected NGOs by focusing on historical background, organizational set up, present activities, nature of programme sustainability, level of job satisfaction of the staff members and beneficiary's perception towards the working of NGOs to explore how far NGOs can contribute in health care.

**Research Design**

There was paucity of data in the research area. It was necessary to explore different aspects and establish facts related to socio-political factors influenced the rise of NGOs in West Bengal, growth and distribution of NGOs in health care in West Bengal, these NGO's historical background, organizational set up, programme sustainability, staff member’s job satisfaction, beneficiary’s perception and so on. Hence,
researcher had to do literature review, experience survey and case studies of some NGOs. Literature scanning and experience survey were done to understand the socio-political factors influencing the rise of NGOs. Experience survey was made through informal interviews and mailed questionnaires. Informal interviews were conducted among the key persons and mailed questionnaires were sent to the Directors of NGOs. Case study was initiated in selected NGOs to observe and reveal various aspects pertinent to past history, programme, staff and beneficiaries. Thus, the present study has used exploratory design.

Types of Data Required

In order to carry out this exploratory study, the following types of data were required.

(i) For the first objective, data related to the social and political factors those led to from NGOs in WB were essential. Each factor was explored and discussed clearly. It was to examine whether there was any factor related to health.

(ii) To carry out the second objective, researcher required following data: (A) Growth of NGOs (number of organizations emerged periodically i.e. 1945 to 1950, 1951 to 1955, 1956 to 1960, 1961 to 1965, 1966 to 1970, 1971 to 1975, 1976 to 1980, 1981 to 1985, 1986 to 1990, 1991 to 1995, 1996 to 2000) in health care in West Bengal in terms of (a) operational area (urban, rural, tribal, etc.), (b) type of organization (religious organization, service organization, development organization, research & consultancy agency, action group, etc.), (c) type of service (institutionalized or community based
or both), (d) nature of starting programme (awareness or service
oriented or both ) (e) promoter’s background ( medical practitioner,
school teacher, retired government official, political leader, freedom
fighter, activist of any movement, group of young enthusiastic
friends, businessman, untrained dedicated social worker, college or
university teacher, etc.), (f) year of starting health programme, (g)
nature of starting health programme (awareness generation,
occasional health camp, regular mobile dispensary, permanent clinic,
permanent hospital and training of health workers), (h) full time
separate health staff ( have or do not have), and (i) health budget (nil,
upto Rs. 10000, Rs. 10001 to 50000, Rs. 50001 to 100000, Rs.
100001 to 200000, Rs. 200001 to 500000, Rs. 500001 to 1000000
and above Rs. 1000000 ). (B) Distribution of NGOs (as per the area
of operation i.e. Urban area, rural area, tribal area, urban & rural area
/all the areas) in health care in West Bengal in terms of location,
affiliation (yes or no), type of organization , type of service, total
number of full time paid staff (nil, one to five , six to ten, eleven to
twenty, twenty one to fifty, fifty one to eighty, eighty one to hundred,
above hundred), annual budget ( upto Rs. 500000, Rs. 500001 to
1000000, Rs. 1000001 to 2500000, Rs. 2500001 to 5000000, Rs.
5000001 to 10000000, Rs. 10000001 to 20000000, Rs. 20000001 to
40000000), promoter’s background, present health programmes
(awareness generation, occasional health camp, regular mobile
dispensary, permanent clinic, permanent hospital, training of health
workers and RCH), separate health staff, types of health staff
(trained doctors, non-trained doctors, nurses, trained health workers, non-trained health workers and administrative staff), health budget, etc.

(iii) In order to fulfill the third objective, three NGOs were selected for case study. Types of required data were: NGO’s (a) historical background, (b) organizational set up & present activities, (c) programme sustainability: programme’s name, objectives, target group, various component, programme execution process, duration, area of operation, service cost, nature of infrastructure and resources required, alternative arrangement for resources after the project duration, beneficiary’s needs & participation, people’s organization and its link with the programme, use of volunteers, staff mobility, staff selection, staff related difficulties, innovative aspect, political intervention, integration with other programme, programme monitoring, evaluation, etc., (d) staff member’s job satisfaction: satisfaction for the facilities available at the job, satisfaction from the relationship with the boss, satisfaction for physical condition of working place, satisfaction for career advancement scheme, satisfaction for job security, etc., (e) beneficiary’s perception towards the working of NGO: health care programme of the locality, necessity of the NGO’s health care programme, service cost & quality of the NGO’s health care programme, NGO’s health service in difficult situation, staff co-operation, beneficiary’s participation, etc.
Sources of Data

Keeping in view the objectives of the study, researcher collected data from secondary as well as primary sources. First part of data requirement was collected using both the sources i.e. through literature (secondary source: Government’s report, NGO’s report, Books, Newspaper, reports of the State Level Society Registration Office, etc.), informal interviews (primary source), and mailed questionnaires (primary source). Second part of the data requirement was collected by means of mailed questionnaires (primary source). Same mailed questionnaire was used for first two objectives. Last part of the required data was explore using only primary source, i.e. from selected NGOs. In this connection, five separate tools were developed i.e. Information Proforma for NGOs, Interview Schedule in understanding nature of programme sustainability, Information Proforma for health care staff, Job Satisfaction Scale for full time paid health care staff & Interview Schedule for beneficiary’s perception.

The Techniques and Tools

It is understood from the above paragraph that altogether one technique and six tools were used. Informal interview was the only technique used among the key persons, such as, activists, politicians, academicians, bureaucrats and NGO promoters, to know the socio-political factors influencing the rise of NGOs. There was no specific question but main thirst was to explore the roots of NGOs through a fruitful discussion.
Regarding tools, mailed questionnaire was used at first to make a survey of NGOs in health care at the state level. It carried nineteen questions, which covered NGO’s origin & trends in growth as well as distribution. Director or secretary of NGO was respondent. In order to examine the reliability of this questionnaire, it was administered twice in one-month interval among the seventy NGOs of West Bengal. Ninety eight percent of the responses were found similar between the two tests.

The remaining five tools such as two information proforma, two interview schedules & one job satisfaction scale were used during case study. Information proforma of NGO was necessary to collect the history as well as basic information (name, address, objectives, operational area, organizational structure, programmes, staffing pattern, financial aspect, monitoring and evaluation, etc.). Information proforma of health care staff was required to know various types of staff and their number as well as characteristics. Both the proforma were filled up with the help of Office Superintendent or Office Incharge. Interview Schedule in understanding nature of programme sustainability encompassed total thirty three questions pertaining to programme, beneficiaries, infrastructure (organizational & local), volunteers, funding agencies, etc. Programme Coordinator or Programme Incharge was the respondent. Interview Schedule to understand the perception of beneficiaries included twenty six questions pertinent to local health care facilities, nature & necessity of NGO’s health care programme, staff co-operation, beneficiary’s participation, etc. Beneficiaries under a particular group were considered as respondents for this tool. With a view to standardize these two
proformas and two interview schedules, researcher selected an NGO named Seva Sangha (situated at Kanthalfully of South 24 parganas district) where he spent one week and tried out these tools. After the test, a few changes were made in various tools by putting appropriate word for the question, simplifying the complex question and correcting the question with the concerned problem.

In respect of job satisfaction scale, which was developed for full time paid health care staff, researcher had to work very extensively. It was fact that a few job satisfaction scales were available in literature for the employees of private industries, autonomous organizations, government agencies, etc., but there was no scale for the staff of NGOs specially located in West Bengal. Hence, this scale was constructed. It followed Likert’s method. At the very outset, five dimensions (from where satisfaction came) were identified. Those were: (a) Facilities available at the job, (b) Relationship with the boss, (c) Physical condition of working place, (d) Career and self-improvement scheme and (e) Job security. Hundred statements were framed and gathered with the help of experts and relevant reading giving emphasis over all the five dimensions mentioned above. The draft comprises of hundred statements was sent to few experts for cross verification of the items. After the verification, eighty statements were retained. Researcher revised this draft several times and at last the list contained seventy items, both favourable and unfavourable equal in number, under all the five dimensions. All these seventy statements were shuffled, systematically arranged and finally draft scale was developed. The score of the favourable items were decided as
5, 4, 3, 2, 1 for the responses Strongly Agree (SA), Agree (A), Undecided (U), Disagree (D) and Strongly Disagree (SD) respectively. The scores were reversed (i.e. 1, 2, 3, 4, 5) for the unfavourable items. The following table 3.1 shows the scoring key at a glance:

<table>
<thead>
<tr>
<th>Degree of choice</th>
<th>Scores for items</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Favourable</td>
</tr>
<tr>
<td>SA</td>
<td>5</td>
</tr>
<tr>
<td>A</td>
<td>4</td>
</tr>
<tr>
<td>U</td>
<td>3</td>
</tr>
<tr>
<td>D</td>
<td>2</td>
</tr>
<tr>
<td>SD</td>
<td>1</td>
</tr>
</tbody>
</table>

This five-point job satisfaction scale with seventy items was tried out on a group of fifty-four employees of Seva Sangha (located at south 24 parganas district). Having collected fifty-four filled up scales from the respondents, scoring was made. The filled up scales were arranged in the ascending order on the basis of total scores obtained by the respondents. Then, one-third scales from the top as well as one-third scales from the bottom were taken and middle one third were put aside. Thus, two scoring groups i.e. higher & lower scoring groups were formed. Then each item was taken and calculated discriminating value (D), using the percentages of correct and incorrect responses of both the groups, with the help of following formula:

\[
D = \sqrt{\frac{P_1Q_1}{N_1} + \frac{P_2Q_2}{N_2}}
\]

Where P1 and P2 were percentages of staff respectively in higher and lower scoring groups who solved the item correctly; and Q1 and Q2 were
percentages of respondents who solved the item incorrectly. N1 and N2 were number of staff members in higher and lower scoring groups respectively. In this regard, researcher made it clear that 'correct' answer meant reply to the positive or favourable item as 'Strongly Agree' and getting five marks against such response. Similarly, a reply to a negative, or unfavourable item as 'Strongly Disagree' was considered as 'correct' answer and five marks were awarded to such response. Thus, the researcher gave the award of five marks against each correct answer irrespective of upper and lower group.

It is known to us (Asthana, B and Agarwal, R.N., 1995), if the value of D is 1.96 or more, then the item is discriminating. Having calculated D value of all the seventy items, through above formula, best thirty-eight items were selected whose discriminating values were more than four. These thirty-eight items were mixed up irrespective of their specific dimensions, arranged logically and gave the shape of final job satisfaction scale. The dimension wise distribution of the items in the final scale was as follows:

**Table 3.2: Dimension wise distribution of the items**

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Nature of statement</th>
<th>Serial number of the statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities available at the job</td>
<td>Positive (+)</td>
<td>20,21,24,30,32,36,38</td>
</tr>
<tr>
<td></td>
<td>Negative (-)</td>
<td>2,14,19,34</td>
</tr>
<tr>
<td>Relationship with the boss</td>
<td>Positive (+)</td>
<td>4,8,9,15</td>
</tr>
<tr>
<td></td>
<td>Negative (-)</td>
<td>25,31</td>
</tr>
<tr>
<td>Physical condition of working place</td>
<td>Positive (+)</td>
<td>5,26,37</td>
</tr>
<tr>
<td></td>
<td>Negative (-)</td>
<td>11,12,16,27</td>
</tr>
<tr>
<td>Career and self improvement scheme</td>
<td>Positive (+)</td>
<td>1,6,10,17,22</td>
</tr>
<tr>
<td></td>
<td>Negative (-)</td>
<td>28,33,35</td>
</tr>
<tr>
<td>Job security</td>
<td>Negative (-)</td>
<td>3,7,13,18,23,29</td>
</tr>
</tbody>
</table>
In order to determine the reliability co-efficient of this tool, split half method (Rulon) was used. The final job satisfaction scale comprises of thirty-eight items was administered once again among the thirty staff members of Seva Sangha (located at south 24 parganas). Researcher divided the scale into two equal halves by separating the odd and even items. Each halves contained nineteen items. The scores for both the halves were given separately. Each respondent had a score on first half and a score on second half. Having used these scores, reliability co-efficient was calculated by applying Rulon’s formula. The process of calculation was as follows:

Table – 3.3: Score distribution of the two halves

<table>
<thead>
<tr>
<th>Sl no. of the respondent</th>
<th>Score of first half (A)</th>
<th>Score of second half (B)</th>
<th>Difference (D) [D = A - B]</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>70</td>
<td>70</td>
<td>0</td>
<td>140</td>
</tr>
<tr>
<td>2</td>
<td>70</td>
<td>64</td>
<td>6</td>
<td>134</td>
</tr>
<tr>
<td>3</td>
<td>59</td>
<td>53</td>
<td>6</td>
<td>112</td>
</tr>
<tr>
<td>4</td>
<td>66</td>
<td>75</td>
<td>-9</td>
<td>141</td>
</tr>
<tr>
<td>5</td>
<td>66</td>
<td>62</td>
<td>4</td>
<td>128</td>
</tr>
<tr>
<td>6</td>
<td>83</td>
<td>75</td>
<td>8</td>
<td>158</td>
</tr>
<tr>
<td>7</td>
<td>59</td>
<td>57</td>
<td>2</td>
<td>116</td>
</tr>
<tr>
<td>8</td>
<td>69</td>
<td>71</td>
<td>-2</td>
<td>140</td>
</tr>
<tr>
<td>9</td>
<td>68</td>
<td>72</td>
<td>-4</td>
<td>140</td>
</tr>
<tr>
<td>10</td>
<td>59</td>
<td>59</td>
<td>0</td>
<td>118</td>
</tr>
<tr>
<td>11</td>
<td>50</td>
<td>62</td>
<td>-12</td>
<td>112</td>
</tr>
<tr>
<td>12</td>
<td>65</td>
<td>70</td>
<td>-5</td>
<td>135</td>
</tr>
<tr>
<td>13</td>
<td>78</td>
<td>81</td>
<td>-3</td>
<td>159</td>
</tr>
<tr>
<td>14</td>
<td>78</td>
<td>80</td>
<td>-2</td>
<td>158</td>
</tr>
<tr>
<td>15</td>
<td>76</td>
<td>83</td>
<td>-7</td>
<td>159</td>
</tr>
<tr>
<td>16</td>
<td>63</td>
<td>67</td>
<td>-4</td>
<td>130</td>
</tr>
<tr>
<td>17</td>
<td>46</td>
<td>55</td>
<td>-9</td>
<td>101</td>
</tr>
</tbody>
</table>
\[
\begin{array}{cccccc}
18 & 53 & 66 & -13 & 119 \\
19 & 67 & 69 & -2 & 136 \\
20 & 51 & 66 & -15 & 117 \\
21 & 51 & 64 & -13 & 115 \\
22 & 57 & 68 & -11 & 125 \\
23 & 70 & 72 & -2 & 142 \\
24 & 74 & 66 & 8 & 140 \\
25 & 74 & 66 & 8 & 140 \\
26 & 58 & 58 & 0 & 116 \\
27 & 60 & 59 & 1 & 119 \\
28 & 63 & 69 & -6 & 132 \\
29 & 65 & 76 & -11 & 141 \\
30 & 64 & 65 & -1 & 129 \\
\end{array}
\]

\( r_{tt} \) = Reliability coefficient of the whole test

\( \sigma^2d = \text{Variance of } D = 45.0298 \)

\( \sigma^2t = \text{Variance of total score} = 235.0989 \)

\[
\begin{align*}
\frac{r_{tt}}{\sigma^2t} &= 1 - \frac{\sigma^2d}{\sigma^2t} \\
&= 1 - \frac{45.0298}{235.0989} \\
&= 1 - 0.1915 \\
&= 0.8085
\end{align*}
\]

Thus, it was proved that the job satisfaction scale was reliable.

With regard to validity of this scale, content validity as well as face validity was ensured. Researcher took care of it while he selected the statements by undergoing statistical technique and experts opinion.
Field of Study

The present study has covered the entire West Bengal. This state is situated in the east part of India stretching from the Himalayas in the north to the Bay of Bengal in the south. Geographically it locates between 85°50’ east longitude to 89°50’ east longitude and 21°38’ north latitude to 27°10’ north latitude. As per census 2001, West Bengal is 88756 sq. km and having 80221171 population. Its literacy rate is 69.22% and sex ratio, i.e. number of female per thousand male, is 934 (Manorama Year Book, 2002). Seventy percent of West Bengal’s population are engaged in agriculture. Out of total land of the state, 62.63% are cultivable area and it contributes around thirty percent of the states income. Jute, textile, coal, steel, tea, silk, etc. are the major industries. In 1995, this state had 10236 registered as well as functioning factories and 453831 small scale industrial units (Manorama Year Book, 1999). Regarding health, infrastructure and manpower development are not upto mark in W.B. But, overall health status of the state is better than the national picture. For instance, in India, in 1999, birth rate, infant mortality rate and death rate were respectively 26.1, 70 and 8.7 whereas in West Bengal it was respectively 20.7, 52 and 7.1 (Economic Survey 2000-2001).

It should be noted that administratively West Bengal is divided into three divisions i.e. Presidency division, Burdwan division and Jalpaiguri division. Jalpaiguri division is called as North Bengal. Since this division is very far from the state capital, West Bengal government has the step
motherly attitude towards the socio-economic development of it. In order to know more regarding West Bengal, chapter IV has given the details.

Process of Data Collection

Under the study, data were collected in five phases. In the first phase, secondary data related to the socio-political factors influenced the rise of NGOs in West Bengal specially after independence were gathered through literature review. In this regard, National Library of Kolkata, Jadavpur University Library, Calcutta University Library, American Information Centre, British High Commission Library (Kolkata), Library of Indian Institute of Management Calcutta, Indian Institute of Social Welfare and Business Management Library, West Bengal Voluntary Health Association Library, etc. were visited by the researcher. In the second phase, addresses of NGOs(registered) in health care were collected from various umbrella organizations (i.e. from Child in Need Institute, Lok Kalyan Parishad, LIONS International, Rotary International, and West Bengal Voluntary Health Association), various national or regional institutes (i.e. National Institute of Orthopaedically Handicapped, Regional Institute of Speech and Hearing Handicapped, Regional Institute of Mentally Handicapped and All India Institute of Public Health and Hygiene) and various directories of NGOs(published by Indian Institute of Management Calcutta, Family Planning Association of India, etc.). Having put all the addresses together, a comprehensive list of 705 NGOs of West Bengal was prepared.
In the third phase questionnaires were mailed to all the 705 NGOs whose addresses were collected. Having given three reminders there was a total of 216 responses, which worked out around thirty one percent response rate. This was done to know various socio-political factors influenced the rise of NGOs and to get required data for understanding trends in growth and distribution of NGOs in health care in West Bengal. In the fourth phase, fifteen key informants (such as activists, politicians, academicians, bureaucrats and NGO promoters) were interviewed informally to know socio-political factors influenced the rise of NGOs.

At the last phase, case studies were made only in three NGOs (i.e. Southern Health Improvement Samity, CINI Moyna Rural Health Development Centre, & Rural Health Development Centre), selecting one organization from each division (i.e. Presidency division Burdwan division and Jalpaiguri division). In each NGO, researcher spent minimum twenty-five days. He collected information related to the organization, programme and staff from the campus and information pertinent to the beneficiaries from the field by forming four groups. The criteria for group formation were as under: (a) one nearby and one distant villages would be selected under each organization, (b) in each village, one male and one female group should be formed, (c) members of the group should fall within the age group of 20 to 40 years, (d) each group should contain 10 to 20 members, (e) group members (beneficiaries) should be Scheduled Caste/Scheduled Tribe/Backward Class/Minority people and fall below poverty line & (f) members (beneficiaries) should be permanent residents.
for last three years in the respective villages and should get health care benefit.

Sampling

As per the information of Society Registration Office, in the year of 2000 in West Bengal, total numbers of registered NGOs were over 100000. It was also known from the same office that nearly thirty per cent of them existed only in papers and the remaining seventy per cent really operated who would prepare annual report and audited statement of account in every year. According to experts, seven to ten per cent of the existing NGOs had health care programmes. Thus, over seven thousands NGOs would carry out health activities in West Bengal and those were considered as Universe of the present study.

Sampling was not required in the first phase of data collection. In the second phase, a list of 705 NGOs was developed from the Universe. Thus, sample size was 705. The unit of sample was selected by applying snowball sampling technique based on the following criteria: (a) NGO must be located within the territory of West Bengal, (b) NGO must be registered, alive and should submit annual report as well as audited statement of account regularly in the society registration office & (c) NGO should have at least one health care programme.

During the third phase of data collection, questionnaires were mailed to all the 705 NGOs. Therefore, no specific sampling technique or criterion was used to handle questionnaires. In the fourth phase, purposive sampling technique was used to select fifteen key informants. It was done
based on the following criteria: (a) Minimum qualification of the respondent should be Bachelor Degree, (b) Respondent should be either activist or politician or academician or bureaucrat or promoter of NGO & (c) respondent must have minimum fifteen years experience in the field of NGO.

In the last phase of data collection, three NGOs were chosen purposively (purposive sampling), for case studies, based on the following criteria: (a) NGO may be in urban or semi-urban or rural area but should locate within the territory of West Bengal, (b) Only one NGO should be selected from one division (i.e. Presidency division, Burdwan division & Jalpaiguri division), (c) NGO must be registered, non-profit and welfare organization, (d) NGO should have at least twenty full time paid staff and yearly turnover of Rs. 50,00,000/-, (e) NGO must be having at least one full fledged health programme which has specific project proposal, budget allocation and full time paid employees. In this phase, five separate tools were used. Sampling was necessary in handling job satisfaction scale (for staff members) and interview schedule (to understand nature of programme sustainability). For job satisfaction scale, thirty staff members were selected purposively (purposive sampling) from each NGO. Efforts were made to include all types of staff (lower level, middle level & higher level) as per their availability, age, sex, marital status, educational qualification, etc. For interview schedule, four main programmes were identified purposively (purposive sampling) from each NGO based on certain criteria, such as, (a) At first, preference should be given to include health care related programme. If four health care programmes are not
found, other programmes can be undertaken. (b) Each programme should have specific project proposal, budget allocation as well as full time paid employees. And, (c) Coverage of each programme should be at least three villages. No sampling technique was required to handle interview schedule for beneficiaries. Because, all the beneficiaries of each group were interviewed.

**Analysis of Data**

In the present study, qualitative and quantitative both kind of analysis were done. For first objective, data were discussed qualitatively. For second objective, quantitative analysis was made. At fast available data were reorganized to develop a common framework for examining the same. The data, those were possible to code, were identified and grouped from each questionnaire. Then simple cross tabulation was done to understand the aspect mentioned in the objective.

In the third objective, data related to NGO's history and existing activities were presented having followed qualitative method. To understand the nature of programme sustainability, data were also discussed qualitatively. In this regard, programmes of each NGO were analyzed on the basis of following twelve factors:

(a) Capacity of the organization: Whether organization has-

- appropriate policy (as per constitution),
- infrastructural capacity,
- democratic decision making procedure,
- will power & united approach.
(b) Continuity in funding:

- Whether organization can arrange funds continuously to carry out the programme.
- If not, whether any alternative arrangement has been made.

(c) Need fulfillment and ensuring qualitative services:

- Whether needs are fulfilled properly.
- Whether qualitative services are ensured.

(d) Intention of the beneficiaries:

- Whether beneficiaries understand that those services are meant for them.
- Whether beneficiaries show their interest and fight judiciously to utilize this service.

(e) Nature of people's participation: Whether people participate in –

- beneficiaries selection,
- need identification,
- resource contribution or collection,
- programme planning,
- monitoring & evaluation.

(f) Recognition of people's participation:

- Whether people's participation is recognized.

(g) Use of volunteers and continuous liaison with them

- Scope of use of volunteers to carry out programmes.
- Continuous liaison with volunteers.

(h) Nature of staff mobility:
• How frequently staff members leave a particular programme and what reasons are found for it.

(i) Innovative component:
• Whether there is any innovative component, which helps the programme to be executed in an effective way.

(j) Local co-operation:
• Whether local people, influential persons and other organizations of the community co-operate in the programme.
• Whether problems or barriers or inconvenient issues are created by political parties or opponent groups as threat for the programme.

(k) Integrated with other programmes & multi-sectoral activities:
• Whether this programme is integrated with other programmes for its better existence.
• Whether the programme is having multi-sectoral activities. For instance, health programme can have a component of income generation since both are inter-related. If people are advised to boil water for drinking or to use soap for maintaining personal hygiene, they can not follow these instructions if they do not have money to buy fuel or soap.

(l) Regular monitoring:
• Whether various aspects of the programme i.e. staff, finance, and activities are monitored regularly.
If a programme was in favour of all the above-enumerated factors, it was treated as more sustainable. If any programme was lacking one or few of the above-mentioned factors, that programme was understood as comparatively less sustainable. If any one did not relate most of the factors, that indicated unsustainability of the programme.

Under the third objective, qualitative analysis was also made for the data pertinent to the perception of the beneficiaries. Information collected from each group were discussed under six separate dimensions such as (a) health care institution of the locality and their nature of services, (b) necessity of the NGO’s health care programmes, (c) cost and quality of the NGO’s health care services, (d) NGO’s health care services at difficult situation, (e) staff co-operation and (f) scope of beneficiary’s participation. Under this objective, quantitative analysis was done only for the data related to the job satisfaction of the staff members. Simple cross tables were used to highlight profile of the staff. As per the obtained score (in the scale) of each staff, levels of satisfaction were identified on the basis of following rules:

**Table 3.4: Rules to identify levels of satisfaction**

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>Very low satisfaction (score)</th>
<th>Low satisfaction (score)</th>
<th>Moderate satisfaction (score)</th>
<th>High satisfaction (score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable-1</td>
<td>11-21</td>
<td>22-32</td>
<td>33-43</td>
<td>44 and above</td>
</tr>
<tr>
<td>Variable-2</td>
<td>6-11</td>
<td>12-17</td>
<td>18-23</td>
<td>24 and above</td>
</tr>
<tr>
<td>Variable-3</td>
<td>7-13</td>
<td>14-20</td>
<td>21-27</td>
<td>28 and above</td>
</tr>
<tr>
<td>Variable-4</td>
<td>8-15</td>
<td>16-23</td>
<td>24-31</td>
<td>32 and above</td>
</tr>
<tr>
<td>Variable-5</td>
<td>6-11</td>
<td>12-17</td>
<td>18-23</td>
<td>24 and above</td>
</tr>
<tr>
<td>Total Score</td>
<td>38-75</td>
<td>76-113</td>
<td>114-151</td>
<td>152 and above</td>
</tr>
</tbody>
</table>
In order to understand the association between nature of staff & level of satisfaction, chi-square ($\chi^2$) test was used.

**Operational Definitions**

**NGO:** It is voluntarily formed and registered organization working towards development and amelioration of suffering with non-self serving aims and free from the state control in managing day to day affairs. Study has considered those NGOs who execute at least one health care programme.

**Public Health:** In a narrow sense, public health refers to the health of a population, the longevity of its individual members and the extent to which they are free from disease. Alternatively, public health can be seen as a philosophy of intervention aimed at protecting and promoting the health of the population. According to Winslow, in a broader sense, "Public health is the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health” (Baggott, 2001). It is found that state has an active role in providing public health services. Under the study, public health perspective is considered as an interdisciplinary approach which includes various aspects like health
services, availability of food, nutrition, safe drinking water, sanitation, improvement of wages, education, etc. to ensure every individual in the community an adequate standard of living for the maintenance of health. Universality (reaching service to all the sections or age groups of the society), equality (services are accessible and available to all the people irrespective of caste or class) and comprehensiveness (includes all sorts of services like preventive, curative, promotive, rehabilitative, etc.) are the three main principles of this perspective.

**Health care:** It is defined as “Multitude of services regarded to individuals, families or communities by the agents of the health services or professions, for the purpose of promoting, maintaining, monitoring or restoring health.” Such services might be staffed, organized, administered and financed in every imaginable way, but they all have one thing in common: people are being ‘Served’, that is, diagnosed, helped, cured, educated and rehabilitated by health personnel (Park, 1995). In the present study, health care refers to NGO’s service or intervention those are provided by the health personnel in order to promote, maintain and restore health.

**Social basis of NGO:** According to *Webster's New World Dictionary* (1991), the word ‘Basis’ refers to the base or foundation or chief supporting factor of anything. It may be the fundamental principle or theory, as of a system of knowledge. As per the *Cambridge International Dictionary of English* (1997), ‘Basis’ means the most important facts, ideas, etc. from which something is developed. A basis is also a way or method of doing something. Under the study, ‘Social Basis of NGO’
refers to the important facts or social phenomena or ideas from which NGOs are developed in West Bengal. Social basis of NGO basically indicates to various socio-political factors those lead to promote NGOs.

Socio-political factor: The term ‘Social’ refers to attribute which is related to people and community or which is influenced by people’s common problems, life styles, customs, welfare and reforms or which is pertaining to society. It does not talk about only one or individual; it encompasses more than one. The word ‘Political’ indicates to the matter, which is related, to state or government or public affairs in general (rights or liberties). It may be something related to conflict or rivalry between two or more parties. It can also imply to the people interested in or active in politics. Under the study, Socio-Political Factors refer to the aspects like people’s common problems, customs, welfare, reforms and state affairs or public affairs those have influenced the rise of NGOs in West Bengal.

Rise: As per The Oxford Dictionary for International Business (1998), ‘Rise’ means to appear or to be visible above the horizon. It may be getting up from lying, sitting, kneeling or from bed. Sometimes, ‘Rise’ indicates increase in amount, degree, quantity, price, etc. It may also refer origin or begin or spring up. Under the study, the word ‘Rise’ is used to understand the increase of NGOs in numbers or quantity.

Growth and distribution: The term ‘Growth’ is generally used to indicate changes of a quantitative nature, such as change in weight, height, number, etc. (Dandekar, 1995). It may be increase in economic activity or profitability. It is sometimes abnormal or diseased formation in the body
(eg. a tumor or cancer). The word 'Distribution' is meant to understand an instance of giving some items among several people (eg. prize distribution, form distribution, etc.). It may be positioning or location of items, features, etc. within an area. Thus, the words 'Growth' and 'Distribution' are used in the study to understand trends of NGO's increase in numbers and its positioning or location within the West Bengal state.

**Programme:** Under the study, the programme of an NGO refers to activities having specific project proposal, programme staff and budget allocation.

**Sustainability:** It refers ability to bear something without breaking or falling. It is also considered as ability to keep somebody or something alive or in existence. Present study uses the word 'Sustainability' to know nature of programme continuation i.e. whether one programme will exist for long time (more sustainable) or for short time (less sustainable) or will be stopped (unsustainable) when project duration will be over or organization will withdraw its programme from the operational area.

**Job satisfaction:** According to Herbert Simon (1966), 'Satisfying' means picking a course of action that is satisfactory or good enough under the circumstances. Koontz H. & Weihrich H. (1990) feel, 'Satisfaction' refers to the contentment experienced when a want is satisfied. 'Job satisfaction' is a result of employees' perception of how well their job provides those things that are viewed as important (Luthans, 1998). Locke (1976) gives a comprehensive definition of job satisfaction as 'a pleasurable or positive emotional state resulting from the appraisal of
one's job or job experience'. Smith, Kendall and Hulin (1969) have suggested five factors that influence job satisfaction. These are: (a) The work itself i.e. the extent to which the job provides the individual with interesting tasks, opportunities for learning and the chance to accept responsibility; (b) Pay which as equal as in other organizations; (c) Promotion opportunities i.e. the chances for advancement in the organization; (d) Supervision- the abilities of the supervisor to provide technical assistance as well as behavioural support; and (e) Coworkers- Whether fellow workers are technically proficient and socially supportive.

In the present study, job satisfaction refers to the emotional responses and several related attitudes of the staff members under an NGO as a result of job situation or job experience.

Perception: According to the Encyclopedia Americana (1992), the core meaning of perception is immediate awareness. To perceive something is to become directly or immediately aware of it. For example, by means of our senses, we perceive, or become aware of, the objects, events, and persons in our environment. As per the New Encyclopedia Britannica (2002), perception is the process whereby sensory stimulation is translated into organized or meaningful experience. Mc Grow-Hill Encyclopedia of Science and Technology (1987) defines perception as the subjective experiences of objects or events that ordinarily result from stimulation of the receptor organs of the body. According to A.F. Witting, perception would be the set of mental experiences arising when the Brain processes sensory data (Ray, 2000). Under the study, perception refers to
the way of seeing or awareness of beneficiaries towards the working of NGO.

**Contribution:** Under the study, contribution refers to NGO’s activities or support or help towards development in general and health care in particular.

**Data Presentation**

This study has presented its data in the following chapters: (i) Introduction (Chapter-I), (ii) Overview of NGOs: A Review of Relevant Literature (Chapter-II), (iii) Methodology (Chapter-III), (iv) West Bengal and Its Milieu (Chapter-IV), (v) Socio-Political Factors Influencing the Rise of NGOs in West Bengal (Chapter- V), (vi) Growth and Distribution of NGOs in Health Care in West Bengal (Chapter-VI), (vii) Case Studies of Health Care NGOs in West Bengal (Chapter-VII) and (viii) Discussion and Conclusion (Chapter-VIII).

**Limitations of the study**

(i) This study is limited only in West Bengal. As roots of NGOs are influenced by the socio-political factors of the state, entire findings of the study may not be applicable in case of other state.

(ii) In the second phase of data collection, when a list of NGOs in health care was compiled, few umbrella organizations and directories of NGOs were consulted. It was not possible to collect all the addresses (over seven thousands) of NGOs in health care in West Bengal.
(iii) At the last phase of the study, case studies (of three NGOs) have been done. It is important to note that outcome of case study may not be generalized everywhere in West Bengal.

So far we have understood the methodology of the study. Now the following chapter will try to give an overview of West Bengal and its milieu.

References


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