Chapter-VIII

DISCUSSION AND CONCLUSION

The emphasis on the concept of 'Welfare State' was a post Second World War phenomenon in the developed and developing countries in order to mitigate social and economic crisis in terms of mass unemployment, fall in production, political unrest, etc. As per the provisions of the Welfare State, the state invested in health care, education and other welfare programmes for enhancing productivity of labour and also reducing social inequalities. The growth period for the welfare state in the developed and developing countries was upto the early nineteen seventies. In the wake of three decades of growth of welfare state after the second world war both the developed and developing countries faced fiscal crisis. In order to overcome this crisis, many countries cut-back on spending in the welfare sectors.

Thus during the late nineteen seventies and beginning of the eighties, many developed and developing countries decided to introduce privatization, liberalization and limited the role of the state in social sector programmes. Several Third World countries who were in a crisis due to the balance of payment, cut down their budgets in the social sectors and started taking loans from International Monetary Fund (IMF) and World Bank (WB) for tiding over the fiscal crisis. The assumption that was implicit in this process was that the public sector was inefficient and markets tended to be more responsive to people’s needs. Therefore, the IMF and World Bank emphasised the role of both markets and the NGOs for financing and provisioning of services. NGOs were seen as important because of their special characteristics like small size, being more
participatory, less bureaucratic, more flexible, cost effective, and capable to reach vulnerable population. The World Development Report 1993, 'Investing in Health', in fact reiterated this view globally.

It is true that there is a long history of NGO activities in India. But the growth of NGOs is a phenomenon of the late nineteen seventies and eighties. This was due to a number of factors those have been discussed in greater detail in chapter-II. Apart from certain national factors, there was an important influence of the international NGOs as well. Thus the inability of the state to invest coupled with support from donor agencies and other international NGOs provided the impetus for the expansion of this sector in India. The emphasis on the NGO sector in India was expressed through various government documents (1).

These NGOs are varied both in terms of size, levels of operation and services provided. Studies indicate that these NGOs encounter a number of problems due to lack of trained manpower and finance. In the process of development, they carry out various programmes pertaining to health, education, income generation, training, welfare of the handicapped and so on. Especially in the field of health, NGOs perform different roles. They provide clinical service, health awareness, health care training and at the same time conduct research. In India, some of the health care NGOs include the 'Parivar Seva Sanstha' in Delhi; 'Institute of Health Management-Pachod' and 'Streehitakarini' in Maharashtra; 'Society for Education Welfare and Action Rural' in Gujarat; 'Rural Unit for Health and Social Affairs' in Tamil Nadu; 'Banwasi Sewa Ashram' in UP; 'Child in Need Institute' & 'Tagore Society for Rural Development – Rangabelia
Project’ in West Bengal; etc. These are the larger NGOs but there are several who work at the grass root levels. There is little information on the characteristics and distribution of NGOs at the all India and state levels. Inorder to get some insights into these aspects, this study has been conducted on NGOs in health care in West Bengal. The reason for selecting West Bengal is that it is a middle ranking state with a history of a left front government that has tried to initiate policies for equity. According to experts, in West Bengal, nearly 7000 NGOs carry out health care programmes. Review of available literature suggests that there are very few studies done on NGOs at the state level and these include Maharashtra, Andhra Pradesh and Assam (Duggal, Gupta, Jesani, 1986; Baru, 1987; and Sarkar, 1996) These studies show that NGOs are skewed in favour of socio-economically developed areas in their distribution. The study of NGOs in Assam (Sarkar, 1998) shows, there is heterogeneity among the NGOs in terms of size, ideology, organizational structure, programme and the population that they serve. These studies raise an important issue regarding to what extent NGOs actually serve the poorer areas & under privileged sections.

However, similar studies have not been initiated in West Bengal from a public health perspective on NGOs in health care. In this context, the present study has tried to examine the case of West Bengal with regard to NGOs in health care. It has made effort to understand the social basis of NGOs, their growth & distribution, contribution, etc. Ultimate aim is to locate the relative position of NGOs vis a vis the state in providing health care in West Bengal.
An exploratory design has been used in the present study. The study has been carried out in five phases. In the first phase, secondary data pertaining to socio-political factors influenced the rise of NGOs in West Bengal specially after independence were gathered through literature review. In the second phase, addresses of NGOs in health care were collected based on certain criteria by using the snow ball sampling technique and a comprehensive list of 705 NGOs of West Bengal was prepared. District wise distribution of NGOs was analysed from this list. In the third phase, questionnaires were mailed to all the 705 NGOs and after three reminders were sent, there was a total of 216 responses. This was done to collect the necessary data in order to analyse the ideological motivations, the growth, distribution and characteristics of NGOs in health care in West Bengal. In the fourth phase, fifteen key informants were interviewed purposively to collect much more information on the influence of socio-political factors on the rise of NGOs. In the last phase, three NGOs (i.e. Southern Health Improvement Samity, CINI Moyna Rural Health Development Centre, & Rural Health Development Centre) were selected purposively based on certain criteria and studied in details. In each NGO, emphasis was given on historical background, administrative set up, present activities, nature of programme sustainability, staff members & their job satisfaction, beneficiaries perception towards the working of NGOs, etc. to understand how far an NGO could contribute to health care.

Now, the important issues, those have been observed in this study, are being discussed below.
(i) **Distinction between VO & NGO:** Chapter II, while articulated the relevant literature, has discussed the distinction between VO and NGO. VOs are non-profit organizations, have voluntary service, depend on self-managing source of funding and registration is not essential for them. But, NGOs are a later phenomenon. They are non-profit organizations and provide welfare services sometimes as a part of or at the behest of government and sometimes outside it. NGOs require registration, depend on external funding and try to use professionals (where voluntarism is not entertained) for rapid & massive social development. The present study has been conducted only among the NGOs. It is found that all the NGOs under the study do not follow public health perspective i.e. do not have an integrated approach with various programmes like health care, education, nutrition, safe drinking water, sanitation, etc.

(ii) **Typology of NGOs:** There are different ways in which NGOs can be classified. They can be classified according to types of activities and levels of operations. In order to avoid the complexity, the present study has classified NGOs in terms of types of activities and grouped the NGOs of West Bengal into five categories such as religious organizations, service organizations, development organizations, research and consultancy agencies, and action groups. It is found that health care programmes are carried out, in most of the times, by development organizations and service organizations.
(iii) **Factors influencing the rise of NGOs:** The various socio-political factors that have led to the rise of NGOs in West Bengal have been discussed in Chapter-V. In the pre-independence period, Christian missionaries, movements against casteism, Scouts and Guides movement, LIONS movement, Gandhian movement, Women’s movement, etc influenced the rise of NGOs. After independence, along with these factors, there were the Tebhaga movement and the Naxalite movement that played influential role in West Bengal. Apart from these, natural disaster like devastating flood and concerns regarding enviornmental issues, poverty, matters pertaining to the youth, handicapped, minorities, etc were also important motivations for the growth of NGOs. As discussed in Chapter-V, except the Tebhaga movement, movement against casteism and concern regarding the reduction of poverty, all other socio-political factors contributed in initiating health care activities. Health care programme was found as a part of entire activities under most of the NGOs. It is interesting to note that some of the results found in the present study have similarity with the study conducted in Andhra Pradesh (Baru, 1987). For instance, the study of Andhra Pradesh (Baru, 1987) shows that several factors like Christian missionaries, natural disaster, etc led the development of NGOs in Krishna & Guntur districts.

(iv) **Relationship between socio-political factors and nature of programmes of NGOs:** There is a relation between socio-political root and nature of programme of NGOs. For example, women
organizations run development activities for women. Similarly, environmental organizations, those came into existence during the environmental movement, carry out mainly environment upgradation programmes. The action oriented groups, those originated from tebhaga movement or naxalite movement, have programmes pertaining to mass mobilizations or meetings or processions against social or political or economic oppression. Apart from the influence of the ideological motivations of the NGO, other factors such as financial situation or competition among NGOs compel them to initiate programmes that is contrary to their objectives. Hence, sometimes, women organizations initiate environment upgradation activities or youth organizations start aged welfare programmes because of the availability of funds. Given this incremental nature of funding and programming, very often NGOs are unable to pursue their objectives. This undermines a holistic approach to programme planning and also creates uncertainty for continuity. This clearly goes against the principles of a public health approach.

(v) Growth of NGOs: It is discussed in the Chapter-VI that NGOs have grown more in numbers in West Bengal during 1980s. Majorities of these NGOs have followed developmental approach and initiated community-based activities. It is also found that growth of NGOs, during 1980s, was reinforced by awareness generation programme and there were only few promoters like medical practitioners, school teachers and untrained dedicated social
workers. These raise three important questions i.e. (a) What as the reason for rapid growth of NGOs during 1980s? (b) Why did awareness programme get importance? (c) What was the reason for more involvement of medical practitioners, school teachers and untrained social workers in NGO sector? Answers are also found in the present study. Since various documents of the Government (like National Health Policy 1983, CAARD Report-1985, Sixth Five Year Plan Report, Seventh Five Year Plan Report, etc) expressed the need of greater involvement of NGOs in development work, there was a growth of NGOs in 1980s. The reason for focusing more on awareness programme during 1980s was mainly because of more importance on human resource development in the Sixth and Seventh Five Year Plan. Apart from that, also a paradigm shift was taking place from welfare approach to development approach in that period. With regard to promoters of NGOs, involvement of medical practitioners was more since there was availability of funds with the government for initiating health care programme in NGOs; involvement of school teachers was more as they had extra time, humanitarian attitude and efficiency for negotiation with the government as well as mobilization of Community resources; and more involvement of dedicated untrained social workers was found due to their unemployment.

(vi) **Health services provided by government and private sectors are complementary for the NGOs:** The Chapter-VI also shows that half of the total NGOs (who sent back mailed questionnaires)
started health care activity during the year 1985 to 2000. In that period, health awareness programme was visible more in NGOs. It raises two basic questions i.e. (a) what was the reason for more importance on health care programme after 1985? (b) Where did people go for curative services, after getting awareness from the NGOs? In fact, more involvement of NGOs in health care activity was due to favourable policy of the government (i.e. National Health Policy 1983). The answer for the second question is found in the case studies, made in three divisions (one NGO from each division) of West Bengal. After awareness, in order to get the service, people at first would go to village quake doctors; the PHC (if it was located in the nearby area) or local NGOs (if services were go to government and private institutions for curative services. But, the quality of service that people would receive from both the public available) were their second preference; and district hospital or urban hospital or private nursing homes were only their last option. Thus, health services provided by the government institutions and private nursing homes were very important and complementary for the NGOs under the study.

The fact is that having received awareness from NGOs, people would go to government and private institutions for curative services. But, the quality of service that people would receive from both the public and private sectors was uneven. Uplekar’s (1998) study on ‘Tuberculosis Patients and Practitioners in Private Clinics in India’ shows that there was lack of awareness regarding treatment
procedures among the doctors who treated TB patients in their own clinics. Phadke et al (1995) conducted a study on supply & use of pharmaceuticals in Satara district of Maharashtra. They found that there was a very high proportion of use of unnecessary, irrational, hazardous drugs and injections specially in the private sector. Public sector prescriptions were more rational than private sector prescriptions. Thus, we can assume from the present study that merely providing health awareness (by the NGOs) without adequate and responsive health services has serious consequences for the community.

(vii) **District wise distribution of NGOs:** In the Chapter-VI, district wise distribution of NGOs in health care in West Bengal has been analysed. This chapter has clearly brought out the fact that 72.19% of the total NGOs are situated in Kolkata and its adjacent area [i.e. Howrah, 24 Parganas (South & North) and Hoogly]. It means, NGOs prefer to work in socio-economically developed areas. This kind of trend has an implication for the principle of universality, accessability and availability. In other words, as a result of this trend, health services do not reach to all areas and sections of society. This trend also suggests that the common assumption is that NGOs work in poorer areas but the present study questions that assumption. A similar trend was observed in the study of Maharashtra, Andhra Pradesh and Assam (Duggal, Gupta & Jesani, 1986; Baru, 1987; Sarkar, 1998). In Maharashtra, NGOs are centralized in Konkan and Pune regions; in Andhra Pradesh, NGOs
are skewed in favour of well developed districts like Krishna, Guntur, etc; and in Assam, more number of NGOs (63.49%) are situated in Kamrup and its adjacent districts (Barpeta, Nalbari, Marigaon, Nagaon & Darrang).

(viii) **Distribution of NGOs as per the area of operation:** It is discussed in the chapter-VI that, except 11.1% NGOs, all other NGOs (who replied to mailed questionnaires) have either partly or fully rural based programmes. Over one-third (35.6%) of the total NGOs operate only in rural areas. Almost half (47.2%) of the total NGOs (who replied) are development organizations and majority of them (except 4.9%) have rural based activity. Institutionalized services or community based services or both are found more among the rural NGOs. Again, these rural based NGOs are identified as very active organizations for preventive as well as temporary health facilities, use of separate health staff and for giving appointment to different kinds of professional or para-professional health staff. Hence, it can be assumed that rural based NGOs of West Bengal have achieved very good reputation for development initiative and have significantly contributed to preventive health care. But, it should be noted that these rural based NGOs are situated more in the well-developed districts. Very few NGOs serve in remote rural area or backward districts. For instance, Cooch Behar, Dinajpur (South & North), Darjeeling, Purulia, Birbhum, etc have very few NGOs. This kind of trend has serious
consequences for availability and accessibility of services from public health perspective.

(ix) **Organizational set up:** Case Studies, in Chapter VII, bring to our notice that there is variation in organizational structures of NGOs. For instance, RHDC & CINI Moyna RHDC have very simple or flat type organizational structure. They have very limited coverage. But SHIS has very complex or hierarchical organizational set up. It has very wider coverage. It tries to reach all sections of the community. As a result of this kind of plurality, it is understood that all NGOs do not contribute equally. But in public sector, there is standardisation and uniformity in the organizational set up. For instance, district health care system (i.e. District Hospital → Community Health Centre → Primary Health Centre → Sub-Centre) is same in all the districts.

(x) **Present activities of NGOs:** Case studies, in the Chapter-VII, also show that most of the on going programmes of NGOs are targeted or issue based. Each programme is designed with some specific objectives. Many a time, programmes are initiated for a particular section of the people i.e. socio-economically backward class. It may be for children or mother or adolescent girls or youth or aged or so on. As a result of this trend, the principle of universality of public health approach gets undermined – since the needs of the entire population are not being addressed.

(xi) **Nature of programme sustainability:** In the Chapter-VII, nature of programme sustainability of the NGOs has been discussed on the
basis of twelve requisite criteria. These criteria are (details are mentioned in the methodology chapter): (a) Capacity of the organization, (b) continuity in funding, (c) need fulfillment and ensuring qualitative services, (d) intention of the beneficiaries, (e) nature of people's participation, (f) recognition of people's participation, (g) use of volunteers and continuous liaison with them, (h) nature of staff mobility, (i) innovative component, (j) local co-operation, (k) integrated with other programmes as well as multi-sectoral activities and (l) regular monitoring. The chapter has shown negative results with regard to programme sustainability in all the three NGOs. In RHDC, none of the four programmes under the study fulfils all the twelve requisite criteria. Each programme suffers from one or more problems and thus they are less sustainable. In CINI Moyna RHDC, only Women Empowerment Programme is more sustainable. Other three programmes do not fulfill the necessary requirement and hence they are treated as less sustainable. SHIS has the same performance like RHDC. Its all the programmes are less sustainable. In fact, it has been observed in Chapter-VII that ultimately sustainability of a programme depends on funding. If NGOs want to continue their programmes (after the project duration is over), they have to depend on beneficiaries contribution or need to integrate the programme activity with some other on going project. As a result, felt needs of the beneficiaries will not be fulfilled appropriately. This kind of trend expresses that NGOs cannot contribute in the community for long time.
(xii) **Staff and their satisfaction:** In the Chapter-VII, case studies show, most of the staff members (84.44%) are moderately satisfied with their job. The main reason is that the terms & conditions of the job & salary structure of the staff of NGOs under the study are almost same like public sector. NGOs also provide many facilities (like public sector) to the staff members. It is also found that the association between salary & level of job satisfaction is statistically significant and salary is a vital part. In fact, this understanding has been qualitatively proved. In NGOs under Caste study, in terms of salary structure, a large gap has been noticed between upper level staff and lower level staff. Upper level staffs are satisfied with salary but lower level staff are not. Hence, staff mobility is mainly found among the lower level staff. This kind of trend shows that staff mobility or staff related problem is no longer a problem in NGOs if salary structure is designed properly. NGOs can contribute well if staff salary is taken care of.

(xiii) **Sources of funding:** It is observed in the Chapter-VI that there is plurality in sources of funding. Self generated source, state government, central government and foreign funding agencies are the main sources. Data show that almost 90% of the total NGOs generate more than half (54.17%) of their required funds by their own effort (self generated). Those NGOs depend on state government & central government, respectively 26.12% and 29.74% of their total budget come from state government and central government. Similarly, one- third of the total NGOs depend
on foreign funds and each one receives almost 44% of their total budget. This trend indicates two important aspects. (a) Since most of the NGOs depend on internal sources, their existence in West Bengal cannot be ignored. They will survive in long run. (b) Who receive foreign funds, their activeness is doubtful and they have every possibility to become 'sick'. Again, it should be noted that the reason for less dependency on the state government funding or central government funding is harassment. Government officers have more queries for funding, reject proposal without any enquiry, release funds through so many offices, ask bribe and after one installment show reluctance in fund delivery.

(xiv) Extent of people's participation: The Chapter-VII shows, community participation in programme planning is very limited. People can neither be involved in fund management nor have right to know the financial status of a programme nor can intervene in top-level decision. Their view is not considered (except a few felt needs) while a project is designed. Participation of the people is sought only during programme execution or monitoring or evaluation. For instance, during health awareness camp, topic is chosen in consultation with the beneficiaries; spot, date as well as time is decided by the beneficiaries; etc. People ensure their involvement by attending the programme, providing physical infrastructure (i.e. table, chair, bench, etc), controlling public gathering, arranging refreshment for the trainers, etc. But people have no right to sanction a health awareness camp, which is
management level affair. It is also observed that people participate in few programmes by contributing resources or providing information to the evaluation team that comes from the funding agency. This kind of trend cannot challenge the top-down approach for planning, that is a criticism levelled against the public sector. It is found that government approach is replicated in NGOs.

(xv) **Perception of beneficiaries towards the working of NGOs:** By and large, beneficiaries have better perception towards the working of NGOs. They express that they need intervention of an NGO more because of community development activities (village infrastructure improvement), income generation, educational improvement, disaster relief, etc. than the health services. The health services of the respective NGOs under the case study are not very satisfactory to the beneficiaries. But, beneficiaries perceive that NGO’s various health awareness camps, mobile clinics, outdoor health services, etc contributed in improving health status during last few years. In fact, they would like to have facilities of twenty-four hours curative services with all technological facilities of modern medicine than the temporary facilities only during office hours. A few of the beneficiaries are in favour of using these NGOs as stepping-stone for better referral health services.

The present study has given many new insights. It has confirmed following two hypotheses. The first hypothesis was assumed in the study of Andhra Pradesh (Baru, 1987). The second hypothesis was developed
for first time in the study of Maharashtra (Duggal, Gupta & Jesoni, 1986) and was confirmed once by the study of Andhra Pradesh (Baru, 1987).

i. Socio-political factors influence the emergence & growth of NGOs in a state.

ii. There is an association between socio-economically developed areas & location of NGOs.

The present study has also developed two new hypotheses. These are:

i. Contribution of NGO varies with the nature of financial sustainability of the programmes.

ii. There is a significant relation between contribution of NGO & salary structure of the staff.

In conclusion, it is important to note that there is plurality among the NGOs in health care in West Bengal in terms of their emergence, basis of initiating programme, approach, type of service, promoter’s background, source of funding, organizational set up, nature of activity, etc. In West Bengal, NGOs prefer to work in socio-economically developed areas and cannot continue work in the community for long time due to financial unsustainability. NGOs also cannot contribute much in providing health services. They are found as suitable means to provide preventive, community based and temporary health care facilities. Ultimately people, having received the awareness from NGOs & understanding the need of health care, go to public & private sectors for better curative services. This kind of trend proves that health services provided by the government and private sectors are complementary for NGOs of West Bengal. There is a need of integration of services of
government, private & NGO sectors in providing better health care. It is also important to note that the major findings of the present study will be worth for government in making plan for health care and useful for the funding agencies & NGOs to be careful in designing, implementing and monitoring various health care projects. The present study suggests that there is a need to initiate further research in the following areas: (a) Nature & extent of preventive health care of NGOs in West Bengal, (b) Extent of the requirement of public sector health care in relation to private sector considering the role of NGOs in preventive care in West Bengal, (c) Interface between Government & NGOs with regard to health care in West Bengal, etc.

Notes and References

1. These government documents include the Foreign Contribution Regulation Act (1976), the National Health Policy (1983), the CAARD Report (1985) [Report of the Committee to Review the Existing Administrative Arrangements for Rural Development], the Seventh Five Year Plan (1985-1990), etc.


