Chapter-I

INTRODUCTION

The term ‘Welfare State’ evokes images of people receiving handouts from the public dole. Sometimes, it gives impression of wasteful government programmes and undeserving recipients who are content to accept public alms rather than work for their livelihood. K.V. Narayana (1991) writes, ‘Welfare State’ would control social and economic crisis in terms of mass unemployment, fall in production, political unrest, etc., through investment in infrastructural development, health care, education and other programmes for social integration. In fact, the ‘Welfare State’ commits itself to ensuring, within the framework of a mixed economy, a minimum level of welfare for its citizens by enacting employment, social insurance and public assistance policies (Rudolph, 1997).

It is difficult to pinpoint when the modern welfare state first began to emerge. Otto Von Bismarck introduced workman’s compensation programmes in Germany during the eighteen seventies. Sweden embarked on its path toward a social welfare system during World War I. However, in most democratic and capitalist countries, the movement toward welfare capitalism received its impetus from the hardships of the Great Depression during the nineteen thirties. In United States, Presidents like Franklin D Roosevelt, Lyndon B Johnson, etc wanted to follow this path through war on poverty. The War on Poverty included few policies such as Project Head Start for educationally deprived youth, the establishment of a domestic Peace Corps for poverty zones in the inner cites and Appalachia,
a retraining programme for the unskilled, a Medicare programme to
guarantee health care for the elderly, and a Medicaid system to make
health care more available to the poor. The United States, indeed, tended
to develop its welfare state on a highly incrementalist and piecemeal basis.
Conversely, most European countries embraced the concept of an
integrated social welfare state that was committed to a comprehensive
attack on inequality and inequities through a wide range of services that
were universally available to all citizens. Perhaps the most famous
blueprint of this kind was the Beveridge Plan that was developed in Great
Britain in 1942 in order to combat the basic hardships of poverty, squalor,
and disease in British society (Brown, 1995).

In the Western world, since the nineteen thirties, the question has
not been whether a welfare state should be established but how extensive
the welfare state should be and how direct the government should work in
ensuring the welfare of its citizens. There was a great difference among
the welfare states in the west in structuring programmes (Rudolph, 1997).

As in Western countries, India believed in the same philosophy and
was declared as 'Welfare State' after independence and its constitution
laid down the obligations of the state in the Directive Principles of the
State Policy. Welfare of the people became the responsibility of the state.
Institutionalization of social services became the hallmark of Welfare
State and investments were made in a number of the state sponsored
welfare programmes for the weaker and vulnerable sections of the society.
The state monopolized the social service sector and was largely its sole
patron (Srivastava, 1999).
The first three decades after World War II, the concept of Welfare State was implemented in many countries for postwar recovery and full employment economies. The Welfare State became concerned with relative deprivation as well as absolute poverty in their efforts to create more egalitarian societies. By the late nineteen seventies, there was a growing acceptance that the Welfare State was on the decline. For instance, in Great Britain, the contradiction of national insurance and the widening scope of means tested benefits clearly indicated that Beveridge's universalism was under considerable strain. The failures of economic management raised the question of ability of any government to secure the stable growth in the economy that seemed necessary to fund adequate health and social services. Answer, in order to save the economic illness, was rolling back of the state. In Britain, some of the policies such as the privatization of public utilities or the reduction of local government responsibilities seemed an attack on the State (Brown, 1995).

In the beginning of the nineteen eighties, 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 Work Bank (WB) for the survival of the country's economy. During the implementation of IMF and WB's programme, an understanding was
developed that investment in public sector was wasteful and therefore the emphasis on Non-Governmental Organizations (NGOs) was better. It was assumed, where government failed to reach out to the marginalized sections and created gap, NGOs could bridge the same.

Since the beginning of nineteen eighties, the activities of NGOs have been growing world wide in terms of their size and scope, their number and volume of aid. It has often been argued that this new popularity of NGOs is due to their specific characteristics such as: (a) flexible and experimental interventions due to their small size and learning process approaches, (b) their low costs and effective work at the grass roots level especially in remote areas, (c) their relationship with the beneficiaries is based on voluntarism which is the main factor allowing NGOs to achieve meaningful participation, (d) furthermore, NGOs recruit highly qualified and motivated staff on the basis of shared values and a belief in the social mission of the NGOs (Vahlhans, 1994; Baru, 1998; Rajasekhar, 2000).

In order to perform the task at the international level, NGOs have also been given importance. They are recognized as highly organized and most influential networking groups. Because, in nineteen nineties, they have helped, in the preparatory phase of almost every major U.N. Conference, such as, Conference on Environment and Development in Rio in 1992. Human Rights 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).

In India, Voluntary Organizations (VOs) or Non-Governmental Organizations (NGOs) have a long history. In the nineteen & early twentieth century, on the one hand, the para-state organizations, mainly of the Christian Churches, came into existence to intervene in the social and religious life of the indigenous population through improvement of health, social welfare and social reform. On the other hand, as part of anti-colonial resistance, numerous indigenous organizations emerged to accelerate social & religious reform (Sheth & Sethi, 1996). In fact, more involvement and initiatives of NGOs have been occurring in India since late nineteen seventies. For instance, The Foreign Contribution Regulation Act (1976), 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. motivated the NGO sector for country’s all round development (Garain, 1994). At present, NGOs have become very crucial in the process of decentralization of power and development (Mathew, 1999). NGOs encourage the elected representatives to strengthen panchayats financially by collecting taxes, fees, etc from the villages and educate the poor in attending the Gram Sabha meeting to make vibrant bodies [Rajasekhar (ed), 2000].

It is evident from the above discussion, in India today, NGOs have significant role in Development. Now it essential to know how or at what level NGOs are associated with ‘Development’.
Development, being multifarious and multi-dimensional concept, is considered as a loaded term (Apter, 1981). It is a process of advancement in totality. An integrative view of development (Chart:1A) highlights that it includes all the socio-economic, politico moral and environmental aspects (Kaur, 1997). In other words, a minimum and balanced level of social security, health, education, employment, people’s participation in political process, and economic advancement manifest the true notion of development whose ultimate goal is to attain a human society imbibing the social values of dignity, moral & civic character, social justice, democracy and cultural freedom.

The process of this development involves different sectors in a society. According to P.D. Kulkarni (1984), there are four sectors: (a) the non-formal sector comprising of family, kith and kin and neighbourhood, (b) the market mechanism consisting of organized economy and the traditional unorganized segments of the economy, (c) the public sector includes civic and political institutions at local, state and national levels, and (d) the community sector which encompasses direct service, co-ordinating agencies and special interest groups. The community sector has the bulk of Voluntary Action.

The development process has three steps: (a) Formative – Aims & objectives of development are laid down or programmes are chalked out. (b) Distributive – To implement programmes in such a way that the services will be distributed among the people equally. (c) Sustainability – To ensure the longevity and regeneration of services.
Chart: 1A

DEVELOPMENT: AN INTEGRATED VIEW

Public Administrative System

- Development
  - Governmental
  - Non-Governmental

Instrument

Levels

Operators
- Legislature
- Political Executive
- Judiciary
- Public Admin/Bureaucracy
- Political Parties/Pressure groups
- People

Social Security
- Health
- Education
- Economic Security
- Participatory Govt.
- Economic Growth
- Sustainable Environment

Good Society

Levels

Local
- Individual Dignity
- Social Justice
- Democracy
- Cultural Freedom
- Moral & Civic Character

National

International
The necessary ingredients of the successful development process in all the three steps are people’s participation, commitment and dutifulness at work, economical use of resources and sharing liabilities as well as benefits on equitable basis. It is an assumption that unless a suitable ground is prepared for developmental process, any attempt to development will lead to contradictory situation (Kaur, 1997). Hence, there were so many conflicts in development process during 55 years of independence in India. It is believed, Voluntary Organizations or Non-Government Organizations can facilitate all the sectors in every step of development process by promoting the necessary ingredients.

In India, in the process of development, these NGOs play role carrying out various programmes, which are designed by their own or government, related to formal education, non-formal education, adult education, health care, social awareness, income generation training, low cost sanitation, safe drinking water, rural entrepreneurship development, computer training, agro-based training, green house, sustainable agriculture, plantation, mini saving, family counselling, legal aid for women, mahila mandal, khadi training & production, child labour, welfare for the handicapped, games & sports, aged welfare and so on (Sarkar, 2001).

Especially in the field of health care, NGOs have acquired a considerable importance in India since 1978 (Pattanaik, 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 ‘Health For All By 2000
A.D.’ That conference was proceeded by a joint study of the WHO and UNICEF for finding out alternative approaches to meet the basic health needs of the third world people. The study examined some of the isolated voluntary health projects in the third world countries like the Jamkhed in India. The conclusion drawn went strongly in favour of VOs / NGOs. At the same time, some assumptions went against the government health services i.e. the government health sector lacks infrastructural facilities, trained manpower, committed medical and para-medical personnel, and thus can not 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 & Jesani, 1986). That time in a published document (Collaboration with NGOs in implementing the national strategy for health for all, GOI, New Delhi, 1985), it was categorically stated that the government had envisaged a very prominent role of VOs / NGOs in the implementation of health, family planning and 20 point programmes. In this regard, the World Development Report 1993 – Investing in Health, which made a positive view regarding NGOs (The World Bank, 1993), cannot be ignored. It did influence the NGO sector of India for better provisioning of health services. National Population Policy (2000), which aims to bring down the fertility rate to replacement level by 2010 and to achieve a stable population by the year 2040, also focused on the
Voluntary & Non-profit sectors for population control (Nampudakam, 2000).

We have discussed in the preceding paragraph 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 ‘Streehitakarini’ in Maharastra; ‘Banwasi Sewa Ashram’ in UP; ‘Parivar Seva Sanstha’ in Delhi; ‘Society for Education Welfare and Action Rural’ in Gujarat; ‘Rural Unit for Health and Social Affairs’ in Tamil Nadu; ‘Child in Need Institute’ and ‘Tagore Society for Rural Development – Rangabelia Project’ in West Bengal; etc. Each of these organizations is considered as model 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.

The present study has been conducted to understand the NGOs in health care in West Bengal. The main reason for selecting West Bengal is its unique socio-political background, which is unlike other states. West Bengal has history of series of movements, such as, freedom movement, movement against social evils, tebhaga movement, naxalite movement, land reform of the Left Front Government, environmental movement, women’s movement, etc. These movements led to form a large number of NGOs. At present, there are over 100000 registered NGOs in West Bengal (as per the information of Society Registration Office, in the year
According to experts, roughly over thirty per cent (i.e. over 30000) NGOs exist only in papers and the remaining seventy per cent (i.e. 70000) really operate in the field. Many experts are of the opinion that nearly ten per cent of these working NGOs (i.e. around 7000 NGOs) carry out health care programmes in West Bengal. Nature of health care activity of a few NGOs can be mentioned in this regard.

*Child in Need Institute (CINI)*, situated at South 24 Parganas District, was established in 1974. It aims at sustainable health and nutrition development for women and children. CINI has almost 350 workers who patiently listen, counsel, and provide care at the clinics, educational centers, and other outreach programmes. Workers are dedicated and ranging from semi-literate to highly qualified professional in medicine, nutrition, sociology, education and other allied fields. It initiates efforts for decentralization and community involvement with the formation and facilitation of women's groups around health issues. CINI works in close co-operation with NGOs like Voluntary Action Network India (VANI), Sishu Vikash Prachesta (SVP) and government body such as State Committee on Voluntary Action Training for NGO under Department of Health and Family Welfare, WB (CINI, 1998).

*West Bengal Voluntary Health Association (WBVHA)* came into being in 1974. It is a state level NGO federation that works in close association with the Government of West Bengal and other Non-Government Organizations, National and International Agencies in the field of health. More than 1000 NGOs are connected with WBVHA. It caters services through campaigns, policy research, press and assembly
advocacy; through need based training and documentation services; through production and distribution of innovative health education materials in the form of print and audio-visuals, for a wide spectrum of users both urban and rural. WBVHA is committed to make health a reality for the distressed and under privileged people of WB on the principle of prevention, curative, promotive and rehabilitative aspects of health care (WBVHA, 1997).

Tagore Society for Rural Development – Rangabelia Project was initiated in 1975 to improve income level of the poor people, to ameliorate the women status and to reduce people’s health hazardous in Sundarban area of South 24 Parganas district. It is working in 9 blocks including 339 villages. It collects funds from state government, central government, foreign funding agencies, and internal sources. Its health programme is remarkable and provides service through 50 health workers frequent training programme, occasional awareness increasing camp at remote villages, mobile clinic, several sub centres and rural hospital. Hospital is having modern treatment facility (X-ray & surgery opportunity) with medical professional and trained health manpower. Organization’s preventive approach is highly appreciated. It could reduce water born disease in Sundarban area from 65% in 1978 to 12% in 1988 (Tagore Society for Rural Development – Rangabelia, 1995).

Ramkrishna Mission Lokasiksha Parishad (RKLSP) began its work in 1952 at Jadulal Mullick Road of North Calcutta. Later, in 1956-57, organization was shifted to its present campus Narendrapur of South 24 Parganas district. It has been working in 13 districts including 26 slums
and 3000 villages for agriculture development, health improvement, environment upgradation and income generation. Health improvement is done through environmental sanitation, family welfare and smokeless chullah programme. Environmental sanitation programme includes provision of safe drinking water; construction of low cost latrine and use of oral rehydration solution. From 1990 to 1998, RKLSP provided 245167 low cost latrines, 21535 smokeless chullahs, and 110919 ORS packets. Family welfare is done through medical unit, which provides services like first aid, immunization, health check up, and medical advocacy (RKLSP, 1998).

*Ananda Niketan*, situated at Howrah district, was established in 1961 for social reconstruction and rural upliftment. At present, it has health, education, income generation training and savings programme. Health programme includes health unit and sanitary mart scheme. Health unit is made of one co-ordinator and 12 health workers who provided general medical treatment to 14,000 people, advice to 300 pregnant mothers, immunization to 280 children and 275 mothers in 1997-98. Sanitary mart scheme brings awareness and provides equipments for construction of latrine to bring a massive decline of water borne disease (Ananda Niketan, 1998).

*Gram Seva Sangha (GSS)* began its work in 1949 under the leadership of late Sachindra Lal Kargupta and Hatthuba village of North 24 Parganas district. Mr. Kargupta was in jail for 16 years and on return from jail, he founded this organization for rural development and financial rehabilitation of the refugees from East Pakistan. Now GSS works in 520
villages through various programmes like mass education, community centre, health service and family welfare, training programme, low cost housing, family counselling centre, working women’s hostel and so on. Health and family welfare programme has different wings, such as, allopathic charitable dispensary, maternity home, immunization centre and first aid booth through which respectively 504, 61, 1547 and 1465 people were benefited in 1997-98 (GSS, 1998).

*Society for Equitable Voluntary Action (SEVA)* has been working since 1985 in North 24 Parganas though village level groups or clubs. It operates in 40 villages under 4 blocks where only group or club members get benefit. It has a health unit with Homoeopathic and Allopathic intervention for mother and childcare. Popularization of indigenous systems of medicine, smokeless oven making, low cost toilet construction, etc. are some other aspects of health intervention. “Prevention is better than cure” is the basic philosophy of SEVA’s all the health programmes. In 1993-94, SEVA provided health benefit to 5775 people through Homoeo clinic and 456 people through Allopathic clinic (SEVA, 1994).

*Tajmohol Gram Vikash Kendra* situated at Howrah district, is working with 31 villages. It has a well known Mother and Child Care centre. It is also associated with clinics, awareness generation, immunization programme, eye operation, and blood donation camp.

*Ashurali Gram Unnayan Parishad*, of South 24 Parganas, established in 1975, is dedicated for exploited neglected and poor rural women. It works in 27 villages with almost 39000 people. This organization celebrates Mother’s day once in a month where discussion is
initiated on child health. It runs immunization programme and clinic in six villages.

*Gospel Home* started working in Hoogly district in the year 1976. It covers 3 blocks including 200 villages where about 30000 to 40000 people are benefited both directly or indirectly through its services. It has mother and child health clinic, dental clinic and eye clinic. MCH clinic is run on every Monday and Friday for ante-natal care and post-natal care. In 1993, 13438 children and 6313 mothers were benefited from the MCH clinic. Dental clinic and eye clinic is respectively run on every Friday and Tuesday. In 1993, total 765 patients were benefited from dental clinic (Gospel Home, 1993).

We, from the above discussion, understand that many NGOs in West Bengal assist in health status development through rural hospital, regular health clinic, occasional health camp at remote area, awareness programme regarding prevention of disease, training of health workers, etc. Hence, initiating indepth study to understand the relative position of NGOs in providing health care vis-à-vis state in West Bengal is meaningful and realistic. In this regard, the next chapter will illuminate the relevant literature related to the research area.

**Reference**


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