CHAPTER -2

THEORETICAL FRAMEWORK AND REVIEW OF LITERATURE
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Part – A
2.1. THEORETICAL FRAMEWORK:

Human development approach – which has become a powerful element of the current development discourse – is rooted in a vision of development that sees equality and justice as essential values that must be built into processes of economic growth if they are to be sustainable. Gender equality is therefore integral to human development. As has been said by Mahbub-ul Haq, 'Development if not engendered is endangered'. No society can be called developed if one half of community remains voiceless, invisible and undervalued. Equally, economic growth – regardless of the approach adopted - has been amply demonstrated to be uneven and unsustainable in the long run if it is sought to be realised in a situation where there are significant gender inequalities.

Human development approach, in terms of social welfare theory, is based on the concept of capabilities that Amartya Sen has so eloquently advocated. Capabilities are defined as a bundle of functionings, which encompass the range of ‘doings and beings of people’. Development is defined as the process of enhancing these capabilities for all members of a society. The capabilities approach marks a distinct break from other approaches in that it treats human beings as ends in themselves, rather than instruments for other ends. This approach is therefore highly compatible with the human development framework since it enables us to deal with gender issues in a more holistic manner as men and women are considered valuable in themselves.

The capabilities approach is also useful in gender analysis as it focuses on the non-monetary, non-market dimensions of human activity and well-being. It enables one to focus on strategic gender needs as against only practical gender needs. Besides it gives importance to opportunities rather than mere attainments and hence opens up the discussion to various dimensions that lead to empowerment of men and women. It accords primacy to human beings - commodities and resources being considered only a means to attaining human well-being. While focusing on individual capabilities the paradigm recognizes societal features, social norms and the like.
Human development report was first launched in 1990 by the Pakistani economist Mahbub-ul-Haq and Indian Nobel laureate Amartya Sen. Its goal was to place people at the center of the development process in terms of economic debate, policy and advocacy. Development was characterized by the provision of choices and freedoms resulting in widespread outcomes. “People are the real wealth of a nation,” Haq wrote in the opening lines of the first report in 1990. “The basic objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives. This may appear to be a simple truth. But it is often forgotten in the immediate concern with the accumulation of commodities and financial wealth.”

The United Nations General Assembly has formally recognized the report as “an independent intellectual exercise” and “an important tool for raising awareness about human development around the world.”

The Human Development Report is an independent report, commissioned by the United Nations Development Programme (UNDP), and is the product of a selected team of leading scholars, development practitioners and members of the Human Development Report Office of UNDP. It is a report independent of the Administrator of the UNDP, as suggested by Ul Haq. It is translated into numerous languages and launched in more than 100 countries annually.

Since 1990, more than 140 countries have published some 600 National Human Development Reports, with UNDP support. UNDP has also sponsored scores of regional reports, such as the ten-volume Arab Human Development Report series, which have made internationally recognized contributions to the global dialogue on democracy, women’s rights, inequality, poverty eradication and other critical issues.

The 2010 Human Development Report—The Real Wealth of Nations: Pathways to Human Development — showed through a detailed new analysis of long-term Human Development Index (HDI) trends that most developing countries made dramatic yet often underestimated progress in health, education and basic living standards in recent decades, with many of the poorest countries posting the greatest gains.

Yet patterns of achievement vary greatly, with some countries losing ground since 1970, the 2010 Human Development Report shows. Introducing three new
indices, the 20th anniversary edition of the report documented wide inequalities within and among countries, deep disparities between women and men on a wide range of development indicators, and the prevalence of extreme multidimensional poverty in South Asia and sub-Saharan Africa. The new report also included a change in the methodology used to calculate the indexes using better statistical methods, as well as new parameters for judging the growth and development.

The first Human Development Report introduced its pioneering HDI and analyzed previous decades of development indicators, concluding that "there is no automatic link between economic growth and human progress." The 2010 Report's rigorous review of longer-term trends—looking back at HDI indicators for most countries from 1970—showed there is no consistent correlation between national economic performance and achievement in the non-income HDI areas of health and education.

Overall, as shown in the report's analysis of all countries for which complete HDI data are available for the past 40 years, life expectancy climbed from 59 years in 1970 to 70 in 2010, school enrollment rose from just 55 per cent of all primary and secondary school-age children to 70 per cent, and per capita GDP doubled to more than US$10,000. People in all regions shared in this progress, though to varying degrees. Life expectancy, for example, rose by 18 years in the Arab states between 1970 and 2010, compared to eight years in sub-Saharan Africa. The 135 countries studied include 92 per cent of the world's population.

India's ranking in the United Nation's Human Development Index (HDI) remained unchanged at 135 in 2013, reflecting little improvement in the living standard of its people, according to the 2014 Human Development Report, Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. Between 1980 and 2013, India's HDI value increased from 0.369 to 0.586. As in the previous years, the top category of "very high" human development was dominated by the OECD countries (Human Development Report 2010, Wikipedia, encyclopedia).

Improvement in human development measures has slowed down in the past few years, according to 2014 Human Development Report (HDR) released on 24 July in Tokyo. The human development index (HDI), a measure derived from life
expectancy, education levels, barely grew from 0.700 in 2012 to 0.702 in 2013. Even that small improvement could be at risk of getting reversed given the bleak picture of the vulnerabilities facing people across the world.

The planning Commission of India said there were inconsistencies in the study presented in the Human Development Report released by UNDP. Speaking at the launching of the report, planning commission deputy chairman K. C. Pant said, "These inconsistencies can create united impressions, which are better avoided.

Twenty years after the first Human Development Report said the, “the link between economic progress and human development is not automatic”. India is one of the world top – 10 performers in terms of income growth over the last 40 years, but is far outperformed by much poorer countries. The HDI is a composite index measuring progress towards a healthy life, access to knowledge and a decent standard of living.

Part - B

2.2. REVIEW OF LITERATURE:

A number of studies have been conducted in India and abroad on various aspects of health. An attempt has been made to provide a brief review of the studies on health care.

Raja. K. C. K. E (1956) in his study found out rural health development as undoubtedly great. The authors made a point of a total population of 356.7 million enumerated at the 1951 census in which about 82.7 per cent were living in rural areas. The total number of villages in which they lived was 5,58,089 giving an average density of inhabitants in a village of about 529 persons. Of the total, 75 per cent of the villages in India contain less than 2000 inhabitants and this fact adds considerably to the difficulty of organizing and maintaining adequate health services for the people. In all countries where the provision of services for an improvement of the health and welfare of the people has reached a high level of development, a substantial part of the cost involved is borne by the local community. The study concludes that human effort in all forms is motivated partly by utilitarian considerations and partly by the urge for an outward expression of the creative spirit that animates man. Both these types of forces have their influence on the health worker.
Ashok Kumar Sarkar (1971) in his study found that the NGO’s have been described as more responsive and accountable than the state which was characterized as bureaucratic and tortuous to the needs of people. The present study is a state level study of NGO’s in health care in West Bengal having considered the perspective and research gap mentioned above. This study describes that only a few programmes are found which indicates 61.7 per cent of the NGO’s. The 20.8 per cent NGO’s work only in urban area, maximum of them have only permanent clinic. NGO’s who operate only in rural area, i.e. 18 percent of them have only awareness programme, 16 per cent have awareness as well as occasional health camp, and 9.1 per cent have awareness, occasional camp and training of health workers respectively. Those NGO’s carry out programmes both in urban as well as rural areas, thirty percent of them continue awareness and occasional camp oriented programmes. This study suggests that there is a need to intimate further research in the nature and extent of preventive health care of NGO’s, extent of the requirement of public sector health care in relation to private sector considering the role of NGO’s in preventive care, and interface between Government and NGO’s with regard to health care.

Mathews C. M. E. and Benjamin V. (1981) study attempts that the health education programmes should be evaluated by assessing the change in behaviour obtained, as this is the final goal of such programmes however, it is often useful to evaluate also the intermediate stages, and to assess knowledge and attitude as well as practices. In this study every attempt was made to obtain an interview with the sample person, but there were some refusals, some had moved out since the households were listed and a few were never available or had died. When asked whether the disease can be cured, the percent who said ‘yes’ was 54 to 72 in the different area for Raththam Illadha, 63 to 81 per cent for Udhukamalai, 81 to 91 per cent for Mouth sore, 26-65 per cent for tuberculosis and 16-38 per cent for leprosy. For the first three of these diseases and malnutrition diseases, most of the respondents did not know whether the diseases could be cured, and for tuberculosis and leprosy some said it could not be cured and some did not know about it at all. The study was integrated and included not only promotive, preventive and curative health measures, including health education, but also methods to improve peoples economic status. The latter can include employment schemes, handicrafts, agricultural improvements, animal husbandry, etc. The interaction between poverty and ignorance has already been
discussed and these two factors have to be tackled simultaneously for the project to be effective.

Mach E. P and Abel Smith (1983) found out financing of health services as an important step, in such an undertaking finance and expenditure are included to use figures for expenditure actually incurred, rather than finance budgeted, and to avoid any double counting of money transferred from one source of finance to another before it is spent, which thus appears in more than one account. Further, this study highlights that, methods have been added for estimating the value of transactions in the private health sector, assessing the level and sources of forcing assistance, estimating the expenditure on safe drinking water supply, sanitation and nutrition programmes, and classifying cost and finance of primary health care. Lastly, it also suggests how this information might be utilized in policy formulation to make a master plan for the future use of all financial and material resources.

Shiv R. Mehta (1984) conducted a study on rural development policies and programmes. The author highlights that economic and educational development may encourage family planning, family planning improves nutrition, nutrition improves health, health can improve attitudes towards family planning and reduce absenteeism, increase labour availability and productivity and facilitate exploitation of natural resources. The study brings out that the Rural Health Services were very poorly developed before independence. The villagers were mostly served by folk medicine – men and indigenous doctors who after the popularity of the allopathic systems of medicine started practicing it along with their own system. As the study suggested, the other striking problems in the rural areas are demographic factors, malnutrition, insanitary conditions, housing and lack of a safe drinking water supply, which are all responsible for poor health.

Rameshwaram G. (1989) has examined the medical and health administration in rural India. This study covers the most important aspects of medical and health administration and throws light on the national health policy. Various health centres which are located in and around Mahabubad to understand the organization, staffing, performance and the associated problems thereof. The researcher has administered unstructured questionnaire and followed participant observation technique wherever necessary. The study underlines the important facts that the health care units which have the primary responsibility to educate the masses
on the importance of sanitation and hygienic conditions, should not lag behind to put them into practice. The government should meet the challenges with determination and dedication and thus identify itself with the suffering masses and not those who have attained sufficiently in all fronts. The objective and efforts should be in the direction of "Health for All" and not for only the privileged.

Rajammal P. Devadas's (1990) study described the role of voluntary agencies and international organizations for implementation of rural health and immunization programmes. The author states that health planners in India have conceived primary health care as the minimum infrastructure for the delivery of health to the people in the rural areas. In order to bring health services closer to the rural people, sub-centers have been established under the primary health centers of community development blocks, located at suitable places. These sub-centers are the peripheral and points of health care delivery system each catering to approximately 5,000 population.

Further, the study pointed out that each of the international as well as the national voluntary organizations work towards the health and welfare of mankind. This study reviews the role of a few organizations in improving the rural health and the contributions of the Avinashilingam Institute for Home Science and Higher Education for women. The study concluded that the national and international voluntary and government organizations possess abundant good will and intentions to bring about positive changes to benefit the unfortunate population in the world.

Agrawal A. K. (1990) presents an analysis of the performance of the existing health infrastructure both rural and urban and identifies the issues related to quality assurance in health services. The study is based on the personal experiences and observations of the author in different regions of the country as well as discussion with the community health experts at those places. The main objectives of study are to provide reasonable preventive, promotive, curative and rehabilitative health services to the people close to where they live and work. The utilization of government health services is for below the desired level only 37 per cent, people utilize government health facility whenever they need. The health education activities have not been very good, only 50 per cent respondents reported that somebody from the government health department had contacted them for educational purposes in the last one year. The programme services are being utilised and people do feel satisfied with them. The
study concluded that the supervisors must be trained to view their role as guides and educators and not to do inspection or bossism. The study ensured that quality of health services delivered by the field staff was not sacrificed for merely achieving numerical targets.

**Rupert Samuel G. E, et.al., (1992)** tried to analyse the satisfaction and utilisation of primary health care service facilities in Karnataka. The study focused to estimate the morbidity rate, the pattern of utilisation of services from the primary health care services network, and the reasons for not using the services. As far as the curative services were concerned it has generally been accepted that most of the health service seekers at the health institution were those who come from within 5 kms radius from the area having very good transport facilities. In general, about, two thirds of the community prefers to seek redresser of their health problems from the Government health institutions through their satisfaction level fell for below.

The study result shows that the all 17,672 households were registered for the study in 80 village units. Of these 3200 households were sampled for the study as per the design. The main respondents in about 67 per cent of the households were female members. In 33 per cent of the households the head of the households was chosen as respondent. At the time of interview, only 46.8 per cent of the non dependent age group persons were available at home. The study has observed 1.1 per cent point prevalence rate of handicapped persons, 6.8 percent point prevalence of sickness and 11.4 per cent 30 days period prevalence of sickness. In a period of one year, 1.2 per cent of the persons had hospitalization for sickness. House to house service provided by the health workers were yet another dimension of the system services in connection with health programmes which were carried out through them at the doorsteps of the people. Further, the people are dissatisfied with their services since health workers do not visit regularly.

**Elsa Dawson (1993)** emphasized on Mobilisation and Advocacy in the Health Sector in Peru. The health project in Villa El Salvador provides an example of scaling-up impact via the exploitation of these comparative advantages and also by uniting the efforts of different NGO's around a similar adjective health improvement in the district of Villa El Salvador. The project is based on two concepts first primary health care the installation of a basic range of health services, with voluntary health workers from the community viewed as the lowest range in the health system,
hierarchy, preventive health and education and democratic control of health system by beneficiaries, in order to ensure that they are appropriate to real needs. This study points out that the previous Government's Social Assistance Programme of temporary employment on public works, which by offering immediate material benefits tended to take community health workers away from participating in the UHP. However, it has already served to encourage greater co-ordination of health resources at the district level in Lima by demonstrating the feasibility of alternative structures for this purpose. It has also demonstrated workable mechanisms for the decent radiations of decision making in health down to the level of community leaders.

Howard Barnum and Joseph Kutzin's (1993) study throws light on the Public Hospital in Developing Countries Resource Use, Cost and financing. This study examines economic and financial issues of hospital resource allocation with the objective of contributing to policies that will improve the use of public sector funds by hospitals. More specifically, the study concerns, the allocation of health sector resources between hospitals and non-hospital alternatives, the internal efficiency of hospital operations and effective and equitable cost – recovery policies for hospitals. Hospitals in developing countries absorb more resources than any other kind of recurrent government spending on health. This study advocates drawing hospitals in developing countries into the policy dialogue on the use of public resources in the health sector. The authors recommend principles for pricing hospital services and health insurance. Study suggests the co-ordination between hospital and non hospital forms of treatment and some hospital procedures could be equally well performed in other settings but at less cost.

Manisha Gupta (1993) has presented the Health Delivery at the village level. The study highlights the perceptions that are determined by the social and economic reality of a person's life and it is quite possible for two persons from varied background to perceive an identical situation quite differently. It is now generally accepted that rural people, especially the working class, have low access to health care, whether to private or public health care services. The earlier doctor in one PHC was "inefficient" according to villagers. During the last quarter of the financial year, namely January to March, the activity around family planning reaches hysterical levels. Normally during monthly meetings in the PHCs, around 60-70 per cent of the time was spent in discussing family planning. By January the proportion reached on
alarming 80-90 per cent. Pressures on health workers to complete targets sometimes doubled and those who were defaulters were humiliated. The study concluded that in fact unless our programmes are decided by popular demand in the community, one cannot speak of community control. It will always be a case of manipulating the community, albeit because of our naïve belief that we are working in the best interests of the community.

Kavita Bhatia (1993) has conducted a study on the NGO Movement in Health. Author revealed that there are several alternatives to the present mode of development, but those who bear the onus of influencing development policies do not seem to pay sufficient attention to the models already developed by scores of NGOs, based on their grassroot experiences. The contribution of the NGO sector is hence often unrecognized in evolving policy, whereas it could provide a most useful basis for evolving more effective alternatives. Further the study reveals that NGO's in India function in both rural and urban areas, in one or more development areas like health, education and employment, with activities ranging from providing services to advocacy and having charity, welfare, religious, political or corporate affiliations. In health, the charity orientation gave way to emphasis on self-reliance and peoples involvement in their own development. While the early initiatives were in setting up hospitals, giving free services, or distributing free medicines, the emphasis, particularly from early seventies, was on health care at the doorsteps of the rural workers. The new approach made several innovative experiments in primary health care. The method of using village health workers for delivery of health care as demonstrated by NGO’s was accepted by the government, NGO’s, with demonstrated capabilities for continuous training of village health workers were involved in training programmes of the government cadres of health workers.

Rajnikant Arole’s (1993) study focused on “the comprehensive rural health project, Jamkhed”. Health care is the primary focus, but the scope of the project today encompasses not only the curative, promotive and preventive aspects of health care, but also the overall socio-economic development of the area. The most important tool of the project is the participation of the people. A survey conducted by project staff in December 1989, revealed that currently there are 53 villages with a total population of 60,870 people in Jamkhed and Karjat talukas, where all the health activities are being actively implemented. However, the project has a TB and leprosy detection and
treatment programme, for a total 150 villages covering about 2 lakh population and selected health and socio-economic activities are being carried out in all these villages. A quick counting thorough OPD and hospital registers to see the number of patients shows that in December 1989, there were 102 in patients. About 15 per cent to 20 per cent of these in-patients were from the 53 project villages. At the OPD, the monthly patient load was 2205 of which about 12 per cent of out patients were from project villages. Thus, most of the patients availing of the third tier of the health system were not from the project villages.

Cherian T. K. (1993) has described rural development through total health care. The study presented a model for health care services for 100,000 population, the scope of discussion here is confined to the facilities available for the 100,000 Munnar population only. The company philosophy includes commitment for their worker’s and family’s health, education and welfare facilities. This is the responsibility of the medical department. Each permanent worker and his family has proper housing, smokeless chulhas, attached toilets and potable water supply and have all the preventive and promotive functions in addition to excellent curative facilities. Study findings show that the ratio of manpower for 1,00,000 population is 1 doctor for every 2860, 1 nurse for every 1040, 1 welfare officer for every 6250 and they have 8 beds for every 1000 population. Study monitored the cost of health care very closely. At Munnar about 45 per cent is spent on infrastructure establishment, about 25 per cent on drugs about 8 per cent on transport and the rest of the expenditure is on miscellaneous activities from health information to specialist services. The study concludes that it is not easy at all to establish a viable medical centre in rural India unless there is a will on the part of the management to provide adequate infrastructure and sustain the same.

Sewa Rural Team (1993) studied the Voluntary Effort in Community Health Sewa in Rural Jhagadia. This voluntary organization was established to serve rural and tribal areas of south Gujarat, with an encompassing Health, Education and Women’s Development. The population of the area that is covered by SEWA Rural Services is entirely rural, economically poor and sixty percent tribal. It is almost entirely agricultural with 60 per cent being landless labourers. The literacy rate is as low as 29 per cent among females and 53 per cent among males. Every third family is living below the poverty line. The health status of the community was poor when the
organization commenced its activities. Ignorance, poverty and lack of time for child care on the part of parents, along with superstitious belief, led to dangerous diseases and deaths. The utilization of health services was as low as less than 10 per cent for immunization and maternal care. Since the initial group comprised mainly of doctors, beginning was made with health in 1980. SEWA Rural converted a maternity home donated by a local trust into a 30 bed hospital which has been gradually expended to 75 at beds present. The organization has felt very strongly that with proper training the village based workers and paramedical staff can take care of most of the health needs of the community in the area of preventive, promotive and curative care. There are both advantages and disadvantages of taking over total health care responsibility being provided by the government.

James Allman's (1993) study has emphasized on "Primary Health Care in Vietnam". In this study Vietnam's approach to health for the people was viewed positively in the late 1970 and 1980s by international observers. During its heroic 30 year struggle for independence beginning in 1945, Vietnam focused on providing low-cost, basic coverage for all, using local resources including traditional medicine and considerable mobilization and education of community members through mass organizations. Vietnam has developed an extensive network of health facilities reaching into all areas of the country. The lowest rung in the health system is the commune health station which serves a population of between 2000 and 20,000. The 9383 health stations are supposed to provide the usual broad range of primary health care services including health, education, maternal and child health and family planning, immunization, hygiene and sanitation, prevention of locally endemic diseases, drug supply curative service and referral. These health stations should be staffed by an assistant doctor, a nurse and a pharmacist and specialist in traditional medicine. Study further opined that the government is beginning to support NGO efforts in PHC. Several NGO's are beginning in new ideas, particularly focusing on community participation, income generation and multi-sectoral activities, and are setting up pilot and demonstration projects. Some relatively inexpensive, useful activities such as translating 'where there is No Doctor and Helping Health Worker's Learn' into Vietnamese, holding workshops and seminars, and providing training for key people can contribute to opening new directions in PHC in Vietnam.
Anita N. H. and Kavita Bhatia's (1993) study underlined the NGO’s Experiences for Health Services at the Community Level. The study operating the targeted different populations, such as the tribal rural, poor, backward castes, urban poor and women, and have utilized varying methodology. An important lesson from most of these NGO’s experiences is that contrary to common belief many, if not most of the health problems of the community, can be talked by members of the community itself, if provided with the necessary knowledge, encouragement, training of local workers and support. The NGO’s experiences also teach that village level health services require adequate back – up and a referral system. Further, the study emphasizes that these NGO’s have demonstrated in a variety of setting, the ability of community members to take up successively complex health responsibilities, with the passage of time. The study has linkages between health and other areas of development, like education, environment, economic and political factors have been integral in NGO’s experiences. Health related NGO’s, have also taken up various economic and political issues. Infrastructure, employment and income generation, environment, agriculture, and their linkages with health are emphasized by these NGO’s experiences. Indeed the struggle for health is part of the larger struggle for equitable distribution of the nations and the earth’s resources.

Paula A. Braveman and Tarimo E. (1994) dealt with the "screening in primary health care, setting priorities with limited resources". According to the author the world health organization is a specialized agency of the united nations with primary responsibility for international health matters and public health. Through this organization which was created in 1948, the health professions of some 190 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Further, the study findings indicate that means of direct technical co-operation with its member states and by stimulating such co-operation among them. WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of human resources for health, the co-ordination and development of biomedical and health services research, and the planning and implementation of health programmes. These broad fields of
endeavor encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of member countries.

Kopparty S. N. M. (1994) examined the Social Inequality and Health Care – A study in Health Behaviour in Rural Andhra Pradesh. According to the author health and illness are universal phenomena. Health is an indicator of the way of the financing of the functioning of the biological system. This study is based on intensive field work conducted in a village Rangapeta, in East Godavari District of Andhra Pradesh. It explores the relationship between social stratification and patterns of morbidity health action, utilization of health resources and observance of health practices in the community. There were 1050 households in the study village. The high caste and high class groups had reported more favorable experience of PHC than the low caste and low class groups. When it comes to preference for PHC, only 50 per cent of the respondents expressed their preference for PHC in the high caste and high class groups, while nearly 75 per cent of the respondents expressed their preference in the low caste and low class groups. Thus, improvement in health status in a community class for a closer integration of health sectors with other sectors of rural development such as education, employment communications, agriculture and health facilities.

Andrew Creese and David Parker (1994) conducted a study on “cost analysis in primary health care- A training manual for programme managers”. This study focused if primary health care is to be implemented effectively and efficiently, it is essential for programme managers to know how resources are being used and what results are being obtained. A firm understanding of these issues at the primary health care level represents an important step towards more equitable provision of services. The long term sustainability of primary health care services is also dependent on the comprehensive application of cost analysis and cost effectiveness tools and methods. An alternative approach is first to select a sample of districts and then to look at the health centre, this is called cluster sampling. This study explains how cost analysis can be used to strengthen health programmers and improve decision-making. It is aimed primarily at programme managers at national, regional and district levels, but almost any health professional should find something here of use and interest.
Neera Kuckreja Sohoni (1994) conducted a study on "rural unit for health and social affairs". This unit is a creation of the Christian Medical College and Hospital Vellore reflects a holistic approach to health. It aims at reaching integrated health and development services to the people living in the Kilvayattanan Kuppam (KVK) block in Tamil Nadu, considered to be one of the more socio-economically backward regions in that state. Since it’s inception, RUHSA's programmes has led to interventions that encompass a wide range of health, education and socio-economic development activities and utilize strengthened community awareness to upgrade the level of life of the people in the KVK block. The impact of such concentrated and determined activity has slowly and surely but perhaps selectively, permeated the target population with which RUHSA aligned its objectives in the first instance. There are statistics to support RUHSA's positive impact. In a sample survey of the KVK block community, 37 per cent of the families contacted felt that their income had grown, 29 per cent found their employment had improved, and 22 per cent sensed that there was a change for the better in their total level of life. The analysis RUHSA's strength as people whether as beneficiaries participants or workers, it is the human element which is RUHSA's principal asset and the keystone of its success. As one of the few programmes where health and development have been emphasized equally from the start RUHSA has won recognition among nationally known successful experiments in integrated rural health and development. But it is extraordinary man management that makes the RUHSA’s effort unique.

Shanti Ghosh (1994), carried out a study on "Health Delivery Strategies Lessons from the NGO Experience". According to the study over a period of four decades India has developed an extensive health infrastructure. Today there are more than 100,000 Sub-Centre's (SCs) and about 15,000 primary health centre (PHCs) in the country. However, the utilization of services provided by this infrastructure has been found to be deplorably low, various estimates suggest figures between 10 and 20 per cent. This study stated that the establishment of health infrastructure is costly but relatively easy. However, many health programmes, despite considerable expenditure in terms of money, staff and other inputs, have failed to make a substantial impact. Further, the study highlighted that the inadequate health coverage of maternal and child health services is reflected in the high mortality rate in India. Maternal mortality continues to be around 500 per 100,000, and infant mortality is 80 per 1,000
live births (1985-86), with vast variations between urban and rural areas and between states. There is reason to believe that simple health interventions and access to health care could prevent 50 to 60 per cent of infant and child mortality even without social and economic development. This study also examines the strategies employed by the Anubhav projects for community involvement and mobilization, for awareness creation and for developing health information systems. The innovation of a three-tiered structure of health services and the emphasis on comprehensive health care rather than an vertically targeted programme are some of the factors behind the success of these NGO projects.

Pushpa Sundar (1994) had shown NGO Experience in Health – An Overview. This study is in the nature of a background piece which places the experience of the Anubhav projects in context of the non-governmental health sector in India. It highlights the distinct approach to primary health care adopted by non-government organizations in contrast to that of the government as the predominant factor on the health scene. It recommended the provision of primary health care through a three-tier system with a primary health unit for a population of 20,000; emphasis on preventive health care through various health care programme and reoriented medical education to cater to rural needs. The objectives could be fulfilled more effectively if there are established mechanisms for interaction, exchange of information and representation of NGO’s interests serving either a geographical area or functional areas such as health. The NGO’s experience is then evaluated for its successes and failures in meeting the challenge of community health, keeping in mind the advantage and constraints experienced by NGO’s. The study finally pointed out the relevance of the NGO experience, as typified by the Anubhav projects, in improving primary health care in India, and considers the measures necessary to maximize NGO impact.

Neera Kuckreja Sohoni (1994) attempted to study on “Mini health centre programmes of voluntary health services”. The main objective of the MHC was to provide a reasonable level of primary health care to all members of the community irrespective of their economic status or geographic domicile. In the traditional PHC bound health care system, the remoter, peripheral population was invariably left outside of its purview. The study found that operating as a health unit for a population of about 5000 the MHC is staffed by four LFAs, one male and one female MPW, and
a medical officer. In addition, two health supervisors are provided to oversee the running of four MHCs. Improvement of health delivery services in rural areas where 60 per cent of the Indian population resides has received considerable attention in recent years. There is a growing recognition that national health services should be developed with the community as a central focus. Alongside it is perceived that health care cannot be delivered but is essentially a ‘do it your self proposition’. Together these perceptions necessitate reliance on a health worker drawn from the community itself, one who is close to the people, lives with them and is able to carry out promotive and preventive health services. To support this worker a reliable and competent referral system must function somewhat like a fail safe mechanism.

Peter Berman and Priti Dave’s (1994) study revised experiences in paying for Health Care in India’s Voluntary Sector. The NGO’s have a long and proud history of contributing to improving the health of India’s poor with early efforts beginning in the 19th century. In 1989 it was estimated that NGO’s were serving the health needs of approximately 5 per cent of India’s population in rural and urban areas. The study evidents that the Government and donars providing support for those organization should also be prepared to include capital depreciation costs in their grant. In the voluntary health services hospital, 57 per cent of revenue was collected from patients. The study findings show that the experiences of the smaller, rural based NGO’s are quite different from voluntary health service. SEWA Rural is located in poor tribal area. In the early years of the project some effort was made to acquire payment for services from hospital patients. Informal assessment of the ability of hospital patient’s fees are fully or partially waived. Patient collections account for about 20 per cent of hospital revenue. NGO’s are increasingly recognized as important contributors to health development in India. The study concludes that the Government funds play a major role in supporting these voluntary health activities with less significant roles played by foreign donations user charges per-paid. Cost studies of the NGO’s health schemes indicate that they operate at least as efficiently as public services and may primarily supplement rather than substitute for such services. Suggestions for further development of voluntary sector financing are put forward.

Veena Soni Raleigh (1994) has focused on Banwasi Sewa Ashram’s Services -“An Integrated Rural Development Programme”. This Ashram is a rural
development organization in Sonbhadra district in eastern Uttar Pradesh, one of the least developed regions in India. Study focus to the combine economic growth with health care and social justice for over 3,50,000 people who are socially and economically depressed or belong to tribal communities. The Ashram has campaigned vigorously against systems that exploit the poor. The Ashram now has a three-tiered primary health programme built through years of hard, patient work. One clinic 10 village health posts with doctors and 250 village health workers reach 250 villages with 20,000 families who previously had little or no access to medical services. In comparison with the 1974-75 baseline survey, a survey in 1979 showed that families were better fed with cloth and house; 41 per cent had poor meals through out the year as 3 per cent in 1974-75 against. There was little awareness of preventer health and a strong version to the mention of family planning. Although the need for health services was more than manifest, it was also clear that health was conditioned by many factors other than accessibility to drudgers or doctors.

Veena Soni Raleigh (1994) conducted a study on “King Edward Memorial Hospital Rural Health Project”. This project is an unusual example of co-operation between the government and a voluntary agency, with the aim of delivering rural health services. Operating in a rural community outside Pune city in Maharashtra, the King Edward Memorial Hospital has attempted to innovate and experiment within existing public health policies. It's objective has been to develop a system of comprehensive primary health care with community participation. King Edward Memorial is among the pioneering agencies to use trained village people as health workers with convincing results. Since it came into existence in 1977 KEM has achieved a significant decline in infant mortality and has contributed impressively to progress in various health parameters amongst the population it serves. The project aims to improve services within a health system that conforms closely to government policies and directives so that the lessons learned can be transferred elsewhere. Further, the study explores that KEM has demonstrated a substantial decline in infant mortality, the single most sensitive indicator of community health. Adding to a large scale government health programme, numerous voluntary organizations make a substantial and specific contribution to the task of upgrading health care. KEM represents an attempt to incorporate the particular skills of a voluntary agency into the official programme.
Sheela Rangan, Adit Iyer and Sushma Jhaveri's (1995) study stressed the non government organizations in Tuberculosis control in Western India. Study attempted with the global realization of the need to re-examine approaches to tuberculosis control; several countries have undertaken to revitalize their existing national tuberculosis programmes. The focus of these revitalized programmes is to detect at least 70 per cent of the incident cases and to cure 85 per cent of the detected cases. Definite plans are also under way to involve the non-governmental sector the voluntary sector and the for-profit private sector in these revitalized programmes. This study of NGO's in TB control based in Maharashtra and Gujarat the two large states in western India, is a step towards plugging these information gaps. It was undertaken with the aim of assessing the extent and the type of contribution of NGO's to TB control and determining ways by which it can be strengthened. It presents the analysis of responses to a mailed questionnaire by 77 NGO's in Maharashtra and 57 from Gujarat. Though the involvement of these non-governmental sectors in diagnosis and treatment of tuberculosis cases is well known and acknowledged there have been hardly any organized efforts to understand the extent and nature of their role in tuberculosis control so far.

Amar Jesai, Ravi Duggal and Manisha Gupta (1996) attempted to study on NGO's in Rural Health care. This study was under taken by the foundation for research in community health (FRCH) at the behest of the Indian council of Medical Research (ICMR) to gain a deeper insight into the role and functioning of the many different types of NGO's in the field of health located in Maharashtra, a state having the largest number of agencies. This study is based on data collected directly from households in both the NGO area and the comparative area, which for study purpose labeled as the PHC area. There were two quasi-structured interview schedules to be canvassed in each sample household. The study findings highlight that, out of the 738 that were selected from these four districts a total of 711 household have been covered. Out of these 711 household 391 were those that were part of the NGO’s project areas that authors have studied and 320 were from an area which was not covered by the NGO. Of all those who sought treatment, 25 per cent in the NGO area and 36 per cent in the PHC area used public facility. Another major difference in the two areas was that concerning self care, 8.2 per cent in the PHC area as compared with only 4.8 per cent in the NGO area used self care to treat themselves.
Alex George (1997) has revealed the Household Health Expenditure in Two States – A Comparative Study of Districts in Maharashtra and Madhya Pradesh. This study concerns household health expenditure in rural and urban areas. The overall tendency to resort to the private sector for out-patient health care, despite the greater costs involved, is a significant of our public health care system. The sample households in each district were selected on the basis of multi-stage sampling. PHCs in each district were identified on the basis of out-patient attendance and from these two sets of PHCs in each district one each was randomly selected. Further, the study stressed that dependence on the private sector for health care needs was found to a greater extent in rural Maharashtra i.e. 79.8 per cent as compared to its urban areas i.e., 73.45 and in Madhya Pradesh where private sector utilization was around 70 per cent for rural as well as urban areas. The utilization of public health care facilities was found to be relatively more in Urban areas (16.00 per cent) of Maharashtra than in rural areas. The overall prevalence rate was observed marginally higher in the rural areas in Maharashtra. A further break of the Madhya Pradesh data revealed the acute morbidity was reported more in urban areas while chronic morbidity prevailed more in rural areas.

Durgaprasad P. and Srinivasan S. (1998) evaluated the "Inter sectoral Co-ordination in Rural Health Care". The study pressing need for furthering active co-ordination between the health sector and other related development sectors such as education, social welfare, rural development, agriculture, water supply and sanitation, environment, energy transport housing, communication food and civil supplies, public works, insurance, co-operatives, voluntary agencies is increasingly being regarded critical more than ever before. Further, the study revealed that the National and State Governments have not formulated policies and programmes towards forging functional linkages between the above sectors. Additionally there exist standing committees for co-ordination of these programmes under various Ministries, Government Departments, and NGO's are expected to lend further through their own initiatives. The sample respondents of the study comprise ten medical officers, two medical development officers, five other development officers, ten health workers, and one hundred health user beneficiaries. Consequently, this seems to have distanced the staff and users, and as a result, the field staff carried a low image in the eyes of the people. It is perhaps for this reason that even those 38 per cent respondents who said
that they have utilized the services, did not make use of either the SC or MPWS services on a regular basis, only 27 per cent reported regular utilization of the SC, PHC and the referral services. Further, the study concluded the intersect oral co-ordination at the grassroots level for effective and efficient delivery of health, in a holistic sense.

Deshpande R. V. and Kulkarni A. S. (1999) studied the "Evaluation of Mahila Swasthya Sangh in Karnataka". The special scheme of mahila swasthya sangh (MSS) was introduced in 1990, with an objective of involvement by rural women in the promotion of IEC activities related to health and family welfare. The scheme aimed to establish an organized link between the community and health service providers. Additionally the scheme intended to provide an opportunity to women in villages to discuss health problems and to promote knowledge on safe motherhood, child survival, nutrition, hygiene and family planning. The MSS are established in villages having more than 1000 population and the scheme is implemented throughout rural areas since 1991. This evaluation of MSS in Karnataka suggest that the scheme has great potentials to be tapped for the success of the new RCH programme, it provides a forum for community needs assessment, it provides an opportunity to discuss the accessibility and quality issues related to RCH and most of all, ensure greater community participation in the programme.

Andrew Green (1999) emphasized on 'An Introduction to Health Planning in Developing Countries'. This study was found on the Principles of Primary Health Care (PHC) which, for many countries, was the major policy paradigm of the 1980s. Author believes strongly that these principles still should form the bedrock of health systems, though recognized this is seen in some quarters as an old fashioned view. This study begins by explaining the importance of health, planning stressing the balanced combination of techniques and judgments necessary for successful planning. This study introduced key concepts and techniques. The study ends with an analysis of why planning has not always been successful and discusses how it can be strengthened. There is an overall focus on public sector planning but also a stress on the need for an approach to planning that looks at all the sectors and organizations involved in health care.

Prakash Sharma (2000) has highlighted issues on 'Rural Health and Medical Care in India'. In this study an attempt has been made to examine the health needs of
different socio-economic strata of the community and also investigate the type of health care services available to the community and to differential health care services on the basis of socio-economic status of population. Aligarh district has been selected on a random basis out of 83 districts in Uttar Pradesh. Out of 6 tehsils in Aligarh district, two tehsils have been selected on a random sampling basis. These two tehsils are Khair and Sikandra Rao. These selected tehsils have 510 villages and 8 towns consisting of 1,13,839 households. For the purposes of this study, a total number of 426 households from rural areas have been selected through multi-stage random sampling method. The study findings revealed that nearly 19 per cent respondents felt that treatment is not satisfactory, more than 20 per cent respondents expressed their opinion that nursing care is not good and nearly about 22 per cent respondents expressed their views that medical and health facilities are far away from their houses. This study concluded that due to sharing these factors the respondents are unable to properly use medical and health facilities in the sample area. In the context of socio-economic and health situation of the people the status of health system should include provision of at least a minimum package of health care services to all the segments of the population giving property to the under privileged sectors of the society.

Rajneesh Goel (2002) has conducted a study on “Community Health Care”. Author stated that the Health and Education are the most important factors influencing the overall quality of life enjoyed by the people in an area, region and country. The objectives was to study the problems and prospects affecting Health Administration in a district / state, through comparative analysis, case studies, observation, interview method, activity analysis, etc. The study with a special focus on the women’s development use appropriate and cost-effic...
Raj Mani Tripathi (2002) carried out a study on “Health problems and health care of rural elderly”. WHO reported that the first priority of the future should be care of the aged. This study was designed to investigate in detail various dimensions of the lives of the aged and also their implication for a society with an increasing ageing population. It also attempts to assess the various strategies adopted by the aged to solve their health problems. The data for the study was collected through a sample survey conducted in February 2001 in the villages of Allahabad district. A structured questionnaire was used for data collection. Random technique was used to select 200 elderly persons in the villages as a whole. Almost all the rural respondents i.e. 97.54 per cent and those who suffered from major ailment had gone for allopathic treatment were selected. Only 1.97 per cent of the rural aged took homeopathic medicines while 0.49 per cent ayurvedic treatment. The study clearly demonstrates the decisive role of the family in elderly care. An overwhelming proportion of respondents accounting for 91.05 per cent did receive nursing from their family in which the contribution of sons and their wives appears maximum. A sizeable proportion of respondents were nursed and cured by their spouses. Married daughters also came to volunteer the tasks. Such respondents constitute one-tenth of the total.

Srinivasan S. (2002) conducted a study on “Primary health care services in rural India, current status and future challenges”. In this study author said health is an essential input for the development of human resources and the quality of life and in turn the social and economic development of the nation. Provision of basic health care services to rural community is the primary objective of the government as well as non-governmental organizations (NGO’s) in the context of rural development. Therefore, the primary goal of any health care delivery system is to organize the health services in such a manner as to optimally utilize the available resources, knowledge and technology, with a view to preventing and alleviating diseases, disabilities and sufferings of the people. It is expected that local self-governments will provide a better set of administrative arrangements for the implementation of the scheme as well as a streamlined health delivery system. Further, significant progress has been recorded in reduction of birth rates and control of communicable diseases in the last five decades, the general health scenario is, however, less than encouraging. Though 70 per cent of the rural population is aware of the existence of PHCs and SCs,
only a third of them utilize the same and are dissatisfied with the quality of inputs and services.

Selvaraju V. (2003) has focused on the "Health-care Expenditure in Rural India". This study is an attempt to estimate and analyse the level of health-care expenditure incurred by the state governments and households in the rural sector of the major states in India. It studies the interlinkage between public spending and household spending on health care. The household expenditure on health accounts for a major share of about 70 to 80 per cent of the total health expenditure in India. As a percentage of income, households spend about 5.40 per cent while the government spends only about 1.09 per cent in rural India, according to 1993-94 data. The structure of spending reveals that the state governments spend largely on personnel in terms of salaries and wages, and households spend primarily on medicines, clinical charges, etc. Further, this highlights that a substantial proportion of poorer households in rural India depend on public health facilities for the treatment of short-duration and major morbidity. However, patients depend on private health facilities at higher levels of income. Similarly, dependency on indigenous practitioners is also found to decline at higher levels of income. Thus, any move to levy user charges or attempts to recover cost from public health facilities would impose a heavy financial burden on the poorer households and may discourage them from seeking any medical care.

Mutharayappa R and Prabhuswamy P. (2003) pointed out the "Factors and Consequences of Home Deliveries: A study in Rural Karnataka". The study focused on the factors influencing the place of delivery, and why women prefer home deliveries in rural areas though there are a large number of health institutions. To highlight these issues, the study relies mainly on primary data. The criteria for selection of sub-centers in each PHC and villages in each sub-center were similar to that of selection of PHCs. Altogether 37 villages were selected for the study. The respondents for the study were currently married women between the age group of 15 and 49 years, who had at least one child during the last three years at the time of survey. In all 606 eligible women were randomly selected for interviews and necessary information from them was collected through structured questionnaires. The study finds among the deliveries that took place at home, about one fourth were attended by untrained dais, 15 per cent by mothers, grand mothers, sisters and other relatives, 39 per cent by ANMs and 20 per cent by trained dais. The proportion of
deliveries conducted at home by ANMs was slightly higher in non - health facility villages and PHC Villages than in Sub-Centre Villages. Moreover most health centers do not have lady medical officers in position and there is a scarcity of staff as well as inadequate facilities at sub-centers and hospitals.

Debasish Sarkar, et.al, (2003) arrived to highlight the Health Care Expenditure of Coalmine Workers. In this study the focus is on the coal industry. The nature of coal mining is such that one would expect that the workers engaged in the mining process suffer from various ailments. The study seeks to examine the magnitude of the burden in terms of health care expenditure caused by such hazards. This study was based on primary data collected directly from the mines using structured semi closed questionnaires. The survey was carried out in the last quarter of 1999. Using the random sampling without replacement methods, 15 per cent of the workforce in three mines were surveyed data was collected on the demographic composition of the family of the coal mine workers, their levels of income, education and health care expenditure incurred by them. Information was also obtained on the diseases suffered by the respondents and the members of their family. The analysis has established three facts. First, mining does pose significant health hazards on mine workers. Second, this health hazards increases with exposure to the mining environment, it also depends upon socio- economic parameters like income, family size and educational standards of the respondent. Finally the nature of the technology used in the extraction of coal is an important determinant of the health hazards. The episodes of diseases increase when the technology becomes more labour intensive.

Maathai K, Mathiyazhagan (2003) has discussed the “Peoples Choice of Health Care Provided Policy Options for Rural Karnataka in India”. The study explores the beuristic approach through observation and informal discussion with rural people about their opinion on existing health care services. This study covered 27,028 inhabited villages spread over 20 administrative districts. The talukas in each district were classified in to two strata in terms of their high and low accessibility to health care services, as expressed in the form of hospital beds per 1000 population and doctors per 1000 population. Even among the selected from each of 12 talukas were selected. In the third stage one village having a primary health care and private/Non Government Organization (NGO) hospital services was identified.
The results of the qualitative indicators on organizational aspects of the health care services show that private health care sources recorded the highest mean score of 3 as compared to 2 claimed by each of the other health care providers such as Government, Non-Government Organization and others. The people expressed the opinion that treatment in the private hospitals was good and they got relief faster. The descriptive results of the household survey suggest that community financing through an insurance scheme could provide the base for private health care providers and NGO's to emerge as media for the provision of curative care services in rural areas.

Vikram Patel and Thara R. (2003) studied the role of NGO's in mental health care. Author intended to study the mental health needs of developing countries and NGO innovations in India. The health concerns of a population are multi-factorial in a etiology presentation and their impact on peoples lives. It is therefore not surprising that health issues require multiple and varied sources of concern and care. No single health provider in any society can, in isolation assume the responsibility of dealing with health problems. NGO's in India have evolved from being amorphous unstructured organizations to well establish and professionally managed institutions. However, as there has been total lack of any such initiative in the specific area of mental health particularly in the context of the present global concern about the issue in developing counties where formal mental health services are often very inadequate. Further, a critical analysis of the strengths, innovations and limitations of these NGO's programmes is presented in this study. At this point, it would be best for readers to themselves to evaluate the activities of the organization profiled.

Thara R. and Vikram Patel's (2003) study examined the NGO's in mental health meeting the need ? This study started out as means to focus on NGO action in the field of mental health with the explicit objectives of documenting their sucess and viability. In this study an attempt is made to provide an overview of the rest of the study, with specific focus on generating a consensus on the role contributions and future strategies of NGO's working in mental health and allied field. According to this study mental health is arguably the least developed and most neglected area of our public health services. This is also apparent in the non-governmental and private sectors of health care hence our efforts to identify NGO’s working in the area of mental health threw up only 40 to 50 initiatives in the entire country. Out of 19 districts in Karnataka 1 district namely Tumkur district was selected for the present
study because of its easy accessibility and availability of some basic data. Out of 2454 inhabited villages of Tumkur district, 20 villages constituting around 0.8 percent of the total village were selected at random from 10 Talukas of Tumkur district. The study results justified that raising awareness on various aspects of mental health and disease providing information on facilities such as care treatment and rehabilitation is another area of NGO activity. This not only aids early detection and reduction of disability, but also helps demystify and designative, mental disorders. While most NGO's are working towards this goal the programmes are often adhoc tentative and India's population is living in rural area as against 23 per cent in urban areas.

Goel S. L. (2004) has recorded “Health care policies and programmes (Health care system and Management)”. The development of health and medical services has been promoted greatly by advances made in professional skills and technical proficiencies, but it seems apparent that the parallel advance has not been made in the art and science of health care administration. The concern for better public health care is universal. At the G-8 Summit in Japan (July 2000) major powers pledged to improve health care system of the developing, underdeveloped and poor countries. The leaders vowed to reduce by the year 2010 the number of HIV-infected people by 25 per cent, tuberculosis deaths by 50 per cent the burden of diseases associated with malaria by 50 percent. AIDS will leave 44 million orphans in the next decade. The goal is to encourage initiatives to properly manage the public health care system to solve the myriad problems. Promotion of health is basic to national progress. Nothing could be of greater significance than the health of the people in terms of resources of socio-economic development. In spite of this realization, the people living in the developing world and especially 80 per cent of them who live in rural areas have little or no access to modern medicine and health care. Inevitably this results in morbidity and high rate of mortality from preventable diseases. This state of hopelessness and frustration among the people is not because of the lack of professional knowledge or competence but due to poor administration of health services.

Tekhre Y. L, Tiwari V. K. and Khan A. M (2004) attempted to study the 'NGO-Government' partnership for promoting primary health services. As study results highlights large number of NGO's may be allowed to take the responsibility of managing SCs and PHCs even in the remote rural areas initially under the guidance of the department of health and family welfare. NGO's further expressed that while
giving the responsibility to run these PHCs and SCs, government should not impose and interfere in the day-to-day functioning. NGO's also pointed out that they could manage government health infrastructure. They were confident of providing better and cost effective services. While discussing with community members leaders and representatives from NGO's, it was pointed out that indigenous system of medicine including herbal traditional practices may be documented; indigenous health practitioners should be recognized and financially supported by the government. Thus NGO's could become permanent partners of the government in health sector reforms. NGO's suggested simplifying the funding procedures in order to avoid delay leading to de-motivation. NGO's were of the opinion that they would prefer to work in partnership with the government rather than as an alternative to the government set-up within the given from works.

**Bhalla S, et. al., (2004)** studied the awareness regarding pulmonary tuberculosis in a rural population of Gujarat. Awareness on unhealthy practices leading to tuberculosis (TB) is crucial in bringing down the incidence of the disease in the general population. The study was conducted in the rural area of Navagam, Jamnagar having a population of approximately 40,000 distributed among 8000 households. In this study, knowledge and awareness about TB were assessed among 257 randomly selected rural people in the study area. After random selection of first household every 31st household was included in the study. Though all the subjects had heard of TB weakness and breathlessness, as a symptom of TB, it was known only to 71.9 per cent of the study population 89 per cent of the people had the knowledge that TB can be transmitted from one person to another and only 38.1 percent provided the correct etiology of TB as an infective organism. A very high i.e. 91.82 per cent proportion of sample populace preferred the government allopathic health facilities for the treatment of TB and equally a large number i.e. 90.00 per cent were aware of the existence of the District Tuberculosis Centre (DTC) close to the village, 70.5 per cent knew that anti TB drugs are available free of cost at the government health centre. But misconceptions on the mode of transmission of TB through food and utensils and cure of TB through non-vegetarian diet were very much prevalent which need to be removed from the minds of the rural folk through adequate awareness campaigns.
Kusum Chopra and Neelam Makol (2004) revealed the "Common Health Problems Encountered by the Tribal Community in Bastar District". Four Tehsils named Jagalpur, Kanker, Dantewara and Narainpur were selected for data collection. 1548 tribal women in the reproductive age group and 129 health professionals were interviewed in details regarding the health problems affecting the tribal community. The types of illnesses prevailing at the time of survey in 105 households were again found to be fever i.e. 25.7 per cent, cough and cold 13.3 per cent and diarrheal diseases 11.4 per cent. 776 mothers who delivered during the last 2 years of the study presented that their children suffered mostly from fever (50.5 per cent), cough and cold (49.5 per cent) skin problem (13.2 per cent) and diarrheal diseases. Common illness among mother and children were anemia, malnutrition, diarrheal disease and skin infection. This study concluded that few health problems are common to all tribal communities and can be solved to a great extent by utilizing low-cost technologies and developing local need based health infrastructure. Involvement of practitioners of alternative system of medicine will help in reducing the disease burden of the tribal community.

Laura L. Murphy, et.al. (2005) their study has discussed How Do We Know What We Know about the Impact of AIDS on Food and Livelihood Insecurity? A Review of Empirical Research from Rural Sub-Saharan Africa. This study reviews nearly 40 selected empirical studies of AIDS impacts on rural livelihoods in Sub-Saharan Africa, highlighting how study design, analytical units and other research choices contribute to our understanding of the problem and of appropriate responses. This analysis further focuses on selected accessible reports and articles which capture a range of research approaches and of aid, biomedical studies, and other important studies of AIDS impact beyond the scope of this review. Geographically Sub-Saharan Africa as the care of the HIV/AIDS pandemic is the priority region but the methodological implications are pertinent elsewhere. This study opines that efforts to promote human development can accommodate to the potential impacts of AIDS without presuming that a specific trajectory will befall all, and agencies can resist to target homogeneous AIDS effected population with pre-packaged efforts. An HIV/AIDS represent a major emergency for nations and regions chronic poverty, lack of water, unemployment and other diseases remain major threats to livelihood security throughout rural Sub-Saharan Africa.
Thaneswar Bir (2006) has studied the "health sector reform in India perspective and issues" study focuses the role of NGO's in Health service development in India. This part takes care of the issue of non-government organization involvement in health care service which is a very important feature of health sector reform. The scope and development of NGO's in health sector has been discussed and deliberated in detail. Some implications in relation to health sector reform in India have been observed and noted here. Consequently, the perception of strengthening linkages between the government and NGO's has become very crucial for India's health sector reform especially for the decision making, planning and management procedures. Policy shifts away from the previous hegemony of health care provision by the public sector towards greater involvement and recognition of the organization outside government should not imply a reduction in the role of the state in development and implementation of policy. For the health sector reform, the role of NGO's is directed towards the most vital components of health and family welfare programmes especially population stabilization and primary health care. The existence of NGO's should be viewed as a means to an end rather is often seen as funding. The development of strong managerial and technical capacity may also be equally important.

Mutharayappa R. (2006) has revealed some aspects on the Reproductive Morbidity Women in Karnataka. The study highlight to the extent of reproductive health problems, the factors responsible for increasing RTI cases and to suggest appropriate strategies. The study collected information from the National Health Family Survey-2 (NFHS-2). The percentage of women who suffered pregnancy related health problems has show that among pregnancy-related problems of the women surveyed over one-fourth pertained to excessive fatigue, one-fifth to anaemia, little less than one-fifth swelling of hands and feet, one tenth to convulsions and 7 per cent to blurrevision. Details of prevalence of gynaecological health problems have been presented in this study. Data shows that reproductive morbidity is linked with higher education. Higher percentage of educated women reported obstetric and gynaecological problems than illiterate women. Reproductive morbidity can be reduced by raising community awareness regarding age at marriage and pregnancy and reducing the disparity in feeding practices for adolescent girls, and
also by improving quality availability and access to health care services at their doorstep.

Rakhee Thimothy, et.al. (2006) has focused on “Viability of Providing HIV/ADIS Care in Public Sector”. The study was conducted in a clinic managed in a Government hospital of Thrissur district of Kerala as part of a concept named Thrissur model HIV care facility. The clinic is conducted once a week with the active support of all the departments functioning at the medical college and aims to provide comprehensive care to HIV infected individuals. In the first two years this clinic registered 434 patients and provided PPTCT (Prevention of Parent to Child Transmission) prophylaxis to 25 pregnant women. During the study period out of the 275 admission in the hospital with server illness, only 39 resulted in the death of the patients. The number of patients that were given pre-test counselling was 170, and 434 were given post-test counselling. About 52 per cent of the HIV infected among the rescue-group did not access any desired health-care system because of their financial constraint or because of the absence of care taker to take them to the health-facility, as some of them were bed ridden. The study clearly reinforces the feasibility of providing quality HIV care to the infected within the Government system. With limited funds and facilities, providing treatment for opportunities infections goes a long way to make the infection more manageable as well as bringing the infected back to normal life.

Rajesh Sagar and Jugal Kishore’s (2007) study examined rural health services in India. Author states that the department of health and family welfare is striving for people through wide network of the Government health care delivery system. Because of poor health status of a large rural population due to inequality of distribution of health in the country and various challenges the union Government on April 21, 2005 launched a National Rural Health Mission (NRHM). It seeks to provide effective health care to the entire rural population in the country with special focus on 18 states which have weak public health indicators. In our country, the mental health care for the rural population is primarily provided through the community approach with the basic premise of integrating the mental health care with the general health services. In this regard the significant initiative was the National Mental Health Programme by the Ministry of Health and Family Welfare in 1982. The study suggests that to improve further the 11th plan should lay emphasis on integrated district health plans and on block level specifies health plans. These plans
will ensure involvement of all health related sectors and emphasize partnership with Non-Government Organizations (NGO’s).

Pranab Barua and Jiten Hazarika (2008) have pointed out views on Health Awareness in Chars of Assam. The situation of health awareness was conducted among the inhabitants of Chars of Nalbari, Borpeta and Jorhat districts of Assam. The health awareness is measured by health expenditure. The factors considered here are caste residence compound status, primary occupation of the family, family structure, economic status of the family and educational attainment of the family. The average proportion percentage of health expenditure per family for non farming primary occupation, families has been observed more than that for farming primary occupation families, that is the non farming primary occupation families may be considered as more health aware than families with farming as primary occupation.

Swarnlata Sakuja (2008) study was based on “importance of the medical and health care of women, a sociological study of rural and tribal hilly areas in Uttaranchal Pradesh”, who are the deprived classes of the society. The study adopted two techniques for data collection, on the basis of individual intensive interviews with same respondents, doctors, ANMs and NGO’s a few case studies have been prepared which are mentioned in the report. This study had been concerned with the health problems of women living in remote hilly and tribal village of Dehradun and Almora Districts, specifically from poor and downtrodden classes. It came to be noted that none of these studies had taken interest in finding out women’s health problems in hilly areas of Uttaranchal Pradesh. In the initial stage, out of 13 districts of Uttaranchal Pradesh, 2 Districts Dehradum and Almora were selected purposely as mentioned as the specifically in the heading area of the study. On the next stage, 2 Tehsils from each District, again 2 Blocks one from each Tehsil, were selected. At the last stage of sampling process the selection of villages and households was on random basis. The study suggests as data regarding the health care facilities revels that every where there is shortage of staff in already existing PHCs in the villages, as much as 38 per cent of all public health centre have the acute shortage of staff.

Esther Duflo, et.al. (2008) carried out a study on Cooking stoves, Indoor Air Pollution and Respiratory Health in Rural Orissa. This study found a strong negative correlation between using a clean stove and having high reading. Using a clean stove is associated with a 7 percentage point decrease in the probability of having a co
reading greater than 6. Given that about 44 per cent of women have a co-reading over 6, this corresponds to a 15 per cent difference. The results are larger for children under 14, with an 8 percentage point or 23 per cent deference but this difference is not statistically significant. Using a clean stove as the primary stove reduces the probability that a child has a co-reading above 10 by 8 percentage points. Given that 18 per cent of kind has a co-reading over 10, this corresponds to 45 per cent difference. The study found a high incidence of respiratory illness about one third of all adults and half of all children experienced symptoms of respiratory illness in the 30 days prior to the survey, with 10 per cent of adults and 20 per cent of children experiencing serious cough. This study provided more information on the consequences of indoor air pollution exposure. Further it provided insights into improved cooking stove programmes that can help guide the activities of NGO’s working in rural India and elsewhere.

**Rama V. Baru (2008)** the author revealed the school health services and the prevailing health status of school children. On the one hand, poor nutritional status is related to inadequate food intake and poverty that results in a variety of illnesses and on the other repeated illnesses have a negative impact on nutritional status, thus highlighting the complex association between then children with poor nutritional status have been seen to suffer form a variety of deficiency diseases like protein – calorie malnutrition, anemia, bitot spots and morbidity among children are a group of disease conditions like diarrhea, pneumonia and fever that are related to poor living conditions and lack of access to basic needs. Strengthening School Health Services is essential for addressing minor and major morbidities among school children over a period of time. The National Curriculum Framework reiterates the importance of a comprehensive approach to health and its integration with the school curriculum. These are initiatives that could provide for revisiting and strengthening school health in future.

**Abdullah H. Bquiy, et.al., (2008)** in their study highlighted the NGO facilitation of a government community based maternal and neonatal health programme in rural India: improvements in equity. This study examines whether NGO facilitation of the government's community based health in rural Uttar-Pradesh, India is successful one or not. A quasi – experimental study design included one
intervenation district and one comparison district of rural Uttar Pradesh. A household survey conducted between January and June 2003 established baseline rates of programme coverage, maternal and newborn care practices, and health care utilization during 2001-02. Improvements in equity in the NGO facilitated district compared with the government only district were likely due to the inputs from the NGO, including training for workers, effort to improve planning, supervision and monitoring, and design of tools to support these aspects of the programme. Conclusion of this study was the programmes may be able to reach the poor effectively by strengthening their community base and outreach components, especially in rural areas. NGO facilitation of government programmes can help to improve coverage in an equitable way, though the ability to change government functioning may be limited.

Collins Chansa, et. al., (2008) have conducted a study on "Exploring SWAP's contribution to the efficient allocation and use of resources in the health sector in Zambia". This study explores whether the envisaged improvements have been achieved by studying developments in administrative technical and allocative efficiency in the Zambia health sector from 1990-2006. The allocations to district are meant to cover operational costs and exclude personnel emoluments and drugs which are procured centrally. An attempt was made to measure whether the government and the donors managed to fulfill this ambition. There are a few indications pointing to improvements in administrative efficiency even though there was limited data available. Technical efficiency decreased while allocate efficiency improved to some extent during the SWAP implementations period. This can either mean that the SWAP is not yet fully developed or that it has not been adequately implemented as not all partners have completely embraced it. It is concluded that our findings do not rule out the SWAP as a co-ordination model, but its current setup in Zambia has not proved fully effective.

Jannie Jacobs Kronenfield (2009) conducted a study on “Social Policy and Health Care”. The study revealed that the detailed federal involvement in health is fairly new occurrence in United States history. This study focuses on health care in the United States and first reviews the history of federal government involvement in
health care and health concerns, and surveys some of the major pieces of legislation that link to health describing both their historical development and their current features. This study presents some current statistics on health insurance trends and health care costs. Finally this study discusses current controversies in the health care system about how to restructure health care delivery. The study differ on how likely they think it is that the United States will enact major health care reform or on whether changes will need to come with small steps such as the recent measures that added coverage for some children and improved drug cover age for the elderly. Massachusetts has just passed legislation supposed to guarantee coverage for virtually all residents of Massachusetts.

Nandita Kapadia, Kundu and Rama Tupe (2009) carried out a study on "Decentralize Health Care for the Urban Poor Role of Policy Advocacy and Implementation ". The key focus of this study is on emphasizing the role of community based services in improving the health status of women and children living in urban slums. Maharashtra faces the challenge of ensuring such a system in all its urban areas. This study examines urban health policies and public health infrastructure in India. The impact of a community based health intervention implemented in one health post in Pune has been presented. This study was conducted in 1985 in Maharashtra covering 11 municipal corporations and 18 towns. In 2004, 20 years later, the number of health posts in Maharashtra was only 280. The impetus given to urban primary care by the urban Revamping Scheme in 1983 has experienced a 20 year hiatus. The study shows the primary health infrastructure available to the urban poor in Maharashtra. The urban poor in 15 districts in Maharashtra do not have any primary health from 7 per cent to 26 per cent. The study also indicates that despite a large increase in urban population these have been no increase in urban infrastructure since the initiation of the urban revamping scheme 1984. The author suggested of local bodies as well as NGO's to enable the provision of community based services. NGO's are increasingly being involved by municipal corporations and council towns to reach the most vulnerable groups in urban areas. These NGO’s face tremendous challenges when working at the slum level.
Umamani K. S. (2009) has conducted a study on the awareness of HIV/AIDS in Karnataka: A analysis of RCH-II Data. The study focus to understand the level and differentials in the knowledge on HIV/AIDS among women in Karnataka. Present study using initially two way tables generated to understand the awareness level of the sample women by the background characteristic. In RCH 2002-04 round –II 28,167 households in Karnataka were covered. A total of 22,656 women who were currently married aged 15-44 years were interviewed. In the present study though 68 per cent of the women said they have heard about HIV/ AIDS for the subsequent questions put forth to check the completeness of their knowledge, majority could not give correct answer. Even a small group of individuals with partial knowledge or no knowledge on the disease, can damage the whole social system by exposing themselves to the disease. Spreading right knowledge and complete Knowledge on HIV/AIDS is what is required in the current situation to combat further spread of the disease and also bring behavioural change towards the infected individuals.

Jocelyn DeJong (1991) has highlighted the role of non governmental organizations in health delivery in Sub-Saharan Africa. This study attempts to set out the distinctive characteristics both positive and negative of NGO’s as institutions for providing health care. It reviews the historical role of NGO’s as vital contributors to health care delivery in Africa and looks at the current environment which has brought NGO’s to the fore front. It analyses the implications of the trend among donors to channel resources to developing countries through NGO’s and discusses various policy options governments have employed in relation to NGO’s. This study draws on limited information in several countries that have institutionalized co-operative relationships between the government and NGO health services. It considers Malawi, Ghana, Kenya and Swaziland as case studies. The study shows together disparate estimates of proportions of health services provided by NGO’s, although because of obvious methodological difficulties in making such comparisons, this study has given only a very rough idea. Given the volume of NGO involvement therefore, the major policy consideration lies first in how this existing resource can be integrated more within national health priorities and second whether or not there is potential for expansion of the NGO role.
2.3. Conclusions:

This chapter deals with the theoretical background and review of literature of the study area and it shows the health problems and prospectus of the rural citizen through the support from NGO’s. Health sector is the most important aspect to the development of human resource and a economy. The literature shows that there are so many health problems and Government as well as NGO’s role is important are in the eradication of health problems in the society. But, NGO’s and governments health services are not satisfactory about the eradication of these health problems. Hence, Government should give the priority to remove health problems and grow the health status of the citizens.