

Research Article

Rural Development and Health: A Case Study of the Ganderbal Block (J&K)

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ABSTRACT

This research study evaluated the implications of rural development on health in Kashmir with special reference to the Ganderbal Block. The health status of the people in Kashmir has not been able to keep pace with the national level of achievements. The conflict situation of the last few decades has also worsened the condition. Consequently, a considerable segment of population is living below the poverty line, with poor infrastructure. The main complaints of health are headache, blurring of vision, backache, abdominal pain, limb pains and respiratory tract infection. There have been some improvements in health with respect to certain indicators. After 1990, there has been a sudden decline in the annual birth rate, which decreased to nearly 20 per million from the level of 34 per million. The annual death rate also registered a sharp decline from 7.90 in 1990 to 5.40 in 1998 in the state. A comparison of infant mortality with the rest of the country shows that the IMR in Kashmir is 45.4, far below the national average of 71.6 per thousand. This indicates a very positive signal for the state towards reducing infant deaths. The main objective of rural development has been to bring improvement in the level of living, including health, nutrition, employment, education, housing and various social services; decrease inequality of rural incomes and rural–urban differences in income; and the capacity of the rural sector to sustain and accelerate the pace of improvement in rural areas. Since rural development has been a popular programme of development in Kashmir, this study seriously intended to trace the status of health by adopting an intensive approach through a case-study method.

Keywords: Kashmir, Ganderbal Block, Rural Development, Beneficiaries, Health, Hygiene, Awareness.

INTRODUCTION

Nature, Scope and Context

Conceptually, rural development is a strategy (Sinha, 1988) and connotes a complete process of change (Munjial, 1997). Development denotes some sort of “advancement” in a positive direction (Singh, 1987). Rural development presupposes not only an integrated development of agriculture and industry but also social services (Thakur, 1988). The main objective of rural development has been to bring improvement in the level of living, including employment, education, health, nutrition, housing and various social services; decrease

inequality of rural incomes and rural–urban differences in income; and the capacity of the rural sector to sustain and accelerate the pace of improvement in rural areas. It involves systematic, scientific and integrated use of natural resources and as part of this process enabling every person to engage himself in a productive and social useful occupation (Parthasarthy, 1984). Viewed theoretically, rural development is elastic and a dynamic concept. The bottom line refers to a broad consensus putting more emphasis on those rural development activities which mainly concern the rural areas (Govt. of India, 1978). Rural development programmes comprise the following: (1) provision of basic infrastructure

facilities in rural areas, e.g., schools, health facilities, roads, drinking water, electrification, etc.; (2) improvement of agricultural productivity in rural areas; (3) provision of social services like health and education for socioeconomic development; and (4) implementing of schemes for promotion of rural industry increasing agriculture productivity, providing rural employment, etc. Rural development is not merely agricultural development but rural transformation (Munjal, 1997) and seeks to improve the quality of life in rural areas in terms of per-capita income, gainful employment, education, health, hygiene, nutrition, housing, family and gender equity; agriculture development and allied activities, viz., village and cottage industries, traditional crafts, socioeconomic infrastructure; and community services (Suramaniam, 1976; Adke, 1974). The objective is to bring poor families above the poverty line on a lasting basis by assisting them through income-generating assets and training (Dhillon, 1991). In the words of Robert Chambers (1983), 'Rural development is a strategy to enable a specific group of people, poor, rural, women and men, to gain for themselves and their children more of what they want and need. It involves helping the poorest among those who sought a livelihood in the rural areas to demand and control more of the benefits of rural development. The group includes small scale farmers, tenants and the landless.'¹ In a broader sociological framework, rural development is a comprehensive strategy providing access to application of science and technology for better utilisation of natural and physical resources of rural areas and modern means of science and technology for agriculture, forestry, crafts and industries, so that wastage of resources does not take place; full employment of poor people living in rural areas by providing them with income-generating assets, viz., loans, implements, training, subsidy, etc.; fulfilment of basic needs, viz., food, clothing, shelter, education, pure drinking water, health, hygiene, security, elimination of poverty, ignorance, diseases and inequality of opportunities and a better and higher quality of life; and local participation of people in rural developmental activities. In Kashmir, rural development has received foremost attention at the state level and sizable funds have been invested under the programme. The aim was to bring poor families above the poverty line and to ensure a social

transformation and change. However, in spite of the efforts made under the programme, the quality of rural life has not improved up to a satisfactory level. Similarly, the social implications of this programme have not been so deep and radical.

Rural Development and Health

Rural areas are mostly backward areas and lag behind in development indicators. In all spheres of life including health, sanitation, awareness, education, income and political participation, they are accorded low status. Due to limited knowledge, skills and resources at their disposal, rural people are engaged in informal and unorganised sectors where wages are very low. As a result, the income is very low, thus degrading their quality of life and lowering their standards of living. They tend to get marginalised due to their low visibility and also due to the fact that their health issues tend to be confined within the domestic sphere. In order to empower rural people, several programmes such as IRDP, ICDS, TRYSEM, DWCRA and Health and Sanitation Programmes have been implemented. In Kashmir, the aim of rural development has been social transformation and change. Despite the fact that some of these programmes have been successful, they have not achieved the anticipated impact on the overall status of rural people, particularly with reference to health. The status of health in Kashmir has not kept pace with the national level of achievements. The conflict situation has worsened the condition and consequently, the main complaints of rural people are headache, blurring of vision, backache, abdominal pain, limb pains and respiratory tract infection. The incidence of subjective and objective deviations from health was higher in people belonging to the handicraft sector than in the rest of the population. Owing to the overall problem of poverty, the people of the Ganderbal Block start work on handicrafts at an early age, despite restrictions under the Indian Factories Act. This being a tender age in the context of repercussions on health due to the postural and exhaustive working conditions, a study of this type was considered desirable as no such study had been attempted in the past in this part of the country.

THEORETICAL FRAMEWORK

This study had an explanatory research design and its purpose was to assess the social implications of rural

development in the Kashmir valley with main focus on the Ganderbal Block in District Srinagar. The theories of Sociological Dualism and Critical Minimum Effort Thesis by J.H. Broeke and Leibenstein were applicable to this study. J.H. Broeke (Singh, 1995) explained underdevelopment in terms of sociological dualism, which he defined as, 'the clashing of an imported social system with an indigenous social system of another style'². He pointed out that any effort to develop the underdeveloped countries along Western lines could only hasten their retrogression and decay.

The central idea of Harvey Leibenstein's thesis was that in order to attain sustained growth, it was essential that the stimulant to development was of a certain critical minimum size (Ibid., 1995). Socioeconomic backwardness was characterised by a set of interrelated factors, which had a certain degree of stability at their small equilibrium values. The actual values were different from the equilibrium values because the economy was always being subjected to stimulants and shocks. The stimulants had a tendency to raise per-capita income above the equilibrium level.³ However, in backward societies, long-term economic development did not take place because the magnitude of stimulants was too small. Leibenstein's thesis was more realistic because it was applicable to developing countries like India. Giving a big push to the programme of development all at once was not applicable, while a critical minimum effort could be properly timed and broken up into a series of smaller efforts for sustained development.

RESEARCH METHODOLOGY

This study was an empirical-cum-field study and based on an evaluative research design by adopting an intensive approach through case-study method. The purpose was to assess and evaluate the nature of social implications on the health status of beneficiaries of the Ganderbal Block in Kashmir.

Rationale of this Study

In the backdrop of social dimensions of rural developments, this study focused to see the social impact of rural development on health in Kashmir with special emphasis of the Ganderbal Block. This study was carried out through a micro-sociological framework, and the

main focus was to see to what extent people in the concerned block have improved their health status as a result of rural development programmes. This study will prove to be a watershed for understanding the broader sociological implications of rural development in general and that of beneficiaries of the Ganderbal Block, Srinagar District of Kashmir, in particular.

Universe of this Study

The universe of this study consisted of the Ganderbal Block in the Srinagar District of Kashmir. The Ganderbal Block was a rural area that comprised 125 villages.⁴ Census, 2001, showed the population of Ganderbal to be 1,15,654, out of which males constituted 59,913 (52 per cent) and females 55,741 (48 per cent).⁵ The Ganderbal Block was chosen for study because huge sums of money for various rural developmental activities have been invested and partly because of its geographical location and changing socioeconomic conditions. It was a developing block and the economy was developing gradually, particularly in the agriculture and handicraft sectors. People were educationally backward and the literacy rate was 44.24 per cent. People had low development indicators, particularly health, per-capita income, literacy rate, agricultural productivity, etc.

Sampling

In this study, multi-stage sampling was used. In the first stage, the regions of Ganderbal Main and Gulabagh of the Ganderbal Block in Srinagar District were selected because they were considered to be thrust areas. In the second stage, 10 per cent of the Mohallas were chosen which included two Mohallas from every cluster of the Block. All the Mohallas were arranged in serial order and thereafter every *n*th Mohalla of every cluster was tick marked. The decision of taking a 10 per cent sample of villages was decided after considering all the aspects, and it was considered to be a fairly good representative sample. In the third stage, a list of beneficiaries involved in rural development was prepared with the help of key persons, employees, NGOs, senior citizens and other knowledgeable people. The sample was drawn out of the total number of beneficiaries using a systematic sampling technique. Only 250 persons could be interviewed in all the sectors of the Ganderbal Block of Srinagar District

in Kashmir for various reasons. As per the objectives of this study, the sample includes 200 beneficiaries of rural development programmes, 40 parents and 10 government officials.

Later, the statistical sampling formula was used to obtain the sample.

Formula:

$$n = \frac{t^2 \times p(1-p)}{m^2}$$

Description: n = required sample size t = confidence level at 95% (standard value of 1.96) p = estimated prevalence of beneficiaries in the project area m = margin of error at 5% (standard value of 0.05).

CALCULATION

In the present rural development programme of Block Ganderbal in District Srinagar, it has been estimated that ~45 per cent (0.45) of people in the project area were benefited. This figure has been taken from the estimation of Rural Development Statistics, Department of Rural Development, Government of J&K. Use of the standard values listed above provides the following calculation:

$$N = \frac{1.96^2 \times .45(1-.45)}{.05^2}$$

$$n = \frac{3.8416 \times .165}{.0025}$$

$$n = \frac{.6338}{.0025}$$

$$n = 253.52 \sim 254$$

For statistical and other reasons, only 250 respondents were selected irrespective of 254.

Hypotheses of this Study

Hi - Many meaningful rural development programmes have been initiated in Kashmir for the welfare of rural people in totality, and the rural masses have benefited on the whole. It is partly because the implementing agencies were serious and had expertise in the field of rural

development, and partly because rural people do not have fatalistic and conservative attitudes and behaviour patterns. Similarly, the social implications were deep and radical.

Ho - Although many welfare programmes initiated by the government in Kashmir had introduced some meaningful programmes and schemes for rural welfare in totality, the rural masses had not benefited on the whole. It was partly because the implementing agencies were neither serious nor had any expertise in the field of rural development and partly because of the fatalistic and conservative attitudes and behaviour patterns of the large number of people living in the villages.

Objectives of this Study

In light of the above focus, the objectives of this study are as follows:

1. To assess the nature and magnitude of rural development activities in Kashmir.
2. To analyse the social implications of rural development vis-à-vis health, hygiene, sanitation, nutrition, etc.
3. To identify the felt needs of rural development beneficiaries.
4. To identify the awareness and level of participation of beneficiaries in rural development programmes.
5. To suggest measures for the benefit of rural development beneficiaries.

Techniques and Sources of Data Collection

Data were collected using the interview schedule method followed by observation. The relevant literature was reviewed and analysed to provide some direction in drafting schedule, after which the schedule was pre-tested with 25 respondents to ensure that it was understandable. The schedule was then modified (for instance, terms such as health, hygiene, sanitation, nutrition and awareness were further defined/elaborated) according to the results of the pre-test to make it more comprehensible. Structured and unstructured questions were put to respondents. The use of body language such as facial expressions and gestures were given due importance. If the answers to the questions asked were ambiguous and confusing,

supplementary questions were asked. Collateral interviews were used to supplement and corroborate the information. In this process, the researcher contacted socially notable persons, NGOs, religious heads, village heads, neighbours, as well as elderly and educated people of the village and co-workers of the respondents, and relevant information was noted down. This study involved both primary and secondary sources of data collection. For primary sources, both respondents and incidents around them were observed and information was sought through interview schedules. Secondary sources of information included books, survey scripts and material published in journals and magazines and newspaper items.

ANALYSIS AND DISCUSSION

Health Indicators of Jammu and Kashmir

The total fertility rate of the state is 2.2. The infant mortality rate is 49 and the maternal mortality ratio is NA (SRS 2004-06). The sex ratio in the state is 892 (as compared with 933 for the country). Comparative figures of major health and demographic indicators are as follows:

Health Indicators of the Ganderbal Block

The crude birth rate of the Ganderbal Block is 27 and the crude death rate is 8. The infant mortality rate is 63 and

the total fertility rate is 2.7 is (SRS 2005). The sex ratio in the block is 953 (as compared with 948 for the state). Comparative figures of major health and demographic indicators are as follows:

Health Complaints in the Ganderbal Block

The findings of this study showed that headache, blurring of vision, backache, abdominal pain, limb pains, respiratory tract infection, weakness, etc., were the major complaints among rural people. The major health complaints are shown in the table as follows:

The above table and chart indicate that 28.00 per cent of respondents were having health complaints as headache, 23.20 per cent as blurring of vision, 22.40 per cent as backache, 8.00 per cent as abdominal pain, 8.00 per cent as limb pain and 10.40 per cent as respiratory tract infection. The main reasons were excessive exposure to work, low-nutrient diet, lack of health awareness and low per-capita income. For overall development, good health of population was very essential; however, in the Ganderbal Block, people generally possess poor health in spite of the fact that they live in pure and open air and without any noise/air pollution. Rapid growth of population, poverty, illiteracy, ignorance and imbalanced diet were some of the factors that affect the conditions adversely. High fertility affects not only the socioeconomic conditions of the family but also the health

Table 1: Demographic, Socioeconomic and Health Profile of Jammu & Kashmir State as Compared with India Figures

S. No.	Item	J&K	India
1	Total population (Census 2001) (in millions)	10.14	1028.61
2	Decadal growth (Census 2001) (%)	31.42	21.54
3	Crude birth rate (SRS 2008)	18.8	22.8
4	Crude death rate (SRS 2008)	5.8	7.4
5	Total fertility rate (SRS 2008)	2.2	2.6
6	Infant mortality rate (SRS 2008)	49	53
7	Maternal mortality ratio (SRS 2004-06)	NA	254
8	Sex ratio (Census 2001)	892	933
9	Population below poverty line (%)	3.48	26.10
10	Schedule caste population (in millions)	0.77	166.64
11	Schedule tribe population (in millions)	1.11	84.33
12	Female literacy rate (Census 2001) (%)	43.0	53.7

Table 2: Health Infrastructure of Jammu & Kashmir

Particulars	Required	In position	Shortfall
Sub-centre	1666	1907	-
Primary health centre	271	375	-
Community health centre	67	85	-
Multi-purpose worker (Female)/ANM at sub-centres and PHCs	2282	1794	488
Health worker (male) MPW(M) at sub-centres	1907	-	-
Health assistant (Female)/LHV at PHCs	375	27	348
Health assistant (Male) at PHCs	375	89	286
Doctor at PHCs	375	451	-
Obstetricians and gynaecologists at CHCs	85	28	57
Physicians at CHCs	85	44	41
Paediatricians at CHCs	85	17	68
Total specialists at CHCs	340	135	205
Radiographers	85	59	26
Pharmacist	460	557	-
Laboratory technicians	460	396	64
Nurse/midwife	970	403	567

Source: RHS Bulletin, March 2008, M/O Health & F.W., GOI).

Table 3: The Other Health Institutions in the State are detailed as under:

Health institution	Number
Medical college	4
District hospitals	14
Referral hospitals	—
City family welfare centre	—
Rural dispensaries	—
Ayurvedic hospitals	2
Ayurvedic dispensaries	273
Unani hospitals	2
Unani dispensaries	235
Homeopathic hospitals	—
Homeopathic dispensary	—

Source: RHS Bulletin, March 2008, M/O Health & F.W., GOI).

of the mother and child. Repeated pregnancies cause nutritional drain of women which exposes both the mother and the child to high mortality risks. Malnutrition is directly related to deteriorating health conditions of

Table 4: Health Indicators of the Ganderbal Block

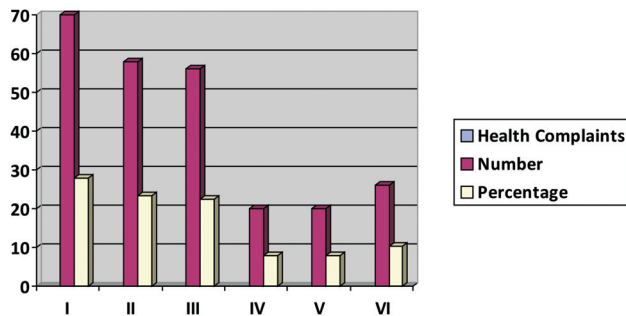
S.No.	Indicators	State	Block
1.	Crude birth rate	18.9 (SRS 2005)	27
2.	Crude death rate	5.5 (SRS 2005)	8
3.	Infant mortality rate	50 (SRS 2005)	63
4.	Total fertility rate	2.4 (SRS 2005)	2.7
5.	Couple protection rate	54 (NFHS-III)	32
6.	Sex ratio	948 (SRS 2005)	953
7.	No. of specialty hospitals	—	1
8.	No. of primary health centres	—	6
9.	No. of sub-health centres	—	14
10.	No. of private hospitals	—	02
11.	No. of anganwari centres	—	174

Source: Government of J&K, District Health Action Plan, Ganderbal (2007) and CMO Office.

the mother and the child as it does not fulfil the requirements of a balanced diet. Safe drinking water was not available to most of the villages and they depended on tanks, tube wells and ravines; the water of these was

Table 5: Major Health Complaints in the Ganderbal Block

S.No.	Health complaints	Number	Percentage
1.	Headache	70	28.00
2.	Blurring of vision	58	23.20
3.	Backache	56	22.40
4.	Pain in abdomen	20	8.00
5.	Limb pains	20	8.00
6.	Respiratory tract infection	26	10.40
	Total	250	100.00

**Chart 1:** Chart Representation of Health Complaints in the Ganderbal Block

usually polluted and unhygienic and this adversely affected their health.

Sanitation/Hygiene

The fact stands that the majority of respondents, 55.20 per cent, had been provided sanitary latrines-cum-bathrooms through rural development, whereas 44.80 per cent respondents had not been provided for. The main reasons for not possessing sanitary latrines-cum-bath rooms were because 26.79 per cent respondents were unable to pay warranted money of Rs. 1000, 19.65 per cent argued that sanitary latrines-cum-bath rooms were provided to influential people, 14.68 per cent reasoned corruption and 39.28 per cent gave the reason that they were unaware about the procedure of getting sanitary latrines-cum-bath rooms.

This study showed that although these respondents had been provided sanitary latrines-cum-bath rooms, they were only occasionally used. The respondents passed their stools in the open fields as usual. The main reason found

was that villagers worked for most of the day, and it was difficult for them to return home for ablutions. This process contaminated/polluted the surroundings and made living unhygienic, which had an immediate effect on the health of weak, aged, pregnant mothers and their children. People had not taken care of sanitation. The environment was unhygienic with no proper drainage systems. The streets were dirty and people generally took unfiltered water from the local rivers, pump sets, springs, ravines and riverlets. The use of cow dung or wood for fuel badly affected the hygiene of these people. In such a state of affairs, their health had broken down and this resulted in other problems. In spite of several programmes launched by the government to improve hygiene and health conditions and check diseases, the position still remained alarming and a matter of concern for welfare and reconstructive agencies.

Nutrition and Health

This study indicated that 9.60 per cent consumed meat, 12.80 per cent eggs, 7.20 per cent fish, 11.20 per cent milk, 20.00 per cent pulses and 39.20 per cent vegetables.

Class-wise distribution revealed that in the lower class, 3.26 per cent consumed meat, 4.35 per cent eggs, 1.08 per cent fish, 8.70 per cent milk, 21.74 per cent pulses and 60.87 per cent vegetables. Similarly in the middle class, 10.29 per cent consumed meat, 12.98 per cent eggs, 9.09 per cent fish, 11.68 per cent milk, 20.78 per cent pulses and 35.06 per cent vegetables. In the upper class, 16.04 per cent consumed meat, 22.22 per cent eggs, 12.35 per cent fish, 13.59 per cent milk, 17.28 per cent pulses and 18.52 per cent vegetables.

This study revealed that respondents in the lower and middle classes of the Ganderbal Block often take vegetables and pulses as food and seldom take meat, eggs, fish and milk. This level of diet consumption had a low calorific value and adverse effects on their health. Weak eye sight, backache and anaemia were the common diseases.

People of the Ganderbal Block had not taken care of sanitation, except a few. The environments were unhygienic with no proper drainage systems. Streets, lanes and by-lanes were dirty. People generally took unfiltered water from local rivers, ravines and pump sets.

Cow dung/wood was used for fuel and kerosene oil for lighting, which badly affected their health.

The government had provided only six PHCs, fourteen SHCs and three allopathic dispensaries in different villages of the Ganderbal Block; however, the conditions of these were very dissatisfactory. All health centres were ill-equipped with less-qualified doctors and nurses. It was observed that villagers bought medicines from retail medical shops manned by unqualified persons.

Rural Development and Reasons for Superficial Implications

This study showed that 47.20 per cent of the respondents argued non-serious implementing agencies and 52.80 per cent fatalistic and conservative attitudes of people as the main reasons behind the superficial implications of rural development programmes with the result that rural people had not benefited on the whole. It was partly because the implementing agencies were neither serious nor had any expertise in the field of rural development, and partly because of the fatalistic and conservations attitudes and behaviour patterns of the large number of people living in villages; and although huge sums of money had been invested for various rural developmental activities, the output was not deep and radical. The benefits of development have been lopsided and some monetary gains were grabbed by some politically influential and socially notable individuals and families.

Rural Development and Awareness

This study revealed that the majority of respondents, 70.00 per cent, was not aware about rural development schemes and their activities. These beneficiaries had no concept about the objectives of rural development, viz., eradication of poverty in rural areas, raising the standard of living, gainful employment, fulfilling basic needs, equality of access to opportunity, increase in production and productivity and people participation in developmental programmes. Awareness implies that rural people should have sufficient information about rural development programmes and activities, its objectives and benefits. Participation implies that rural people should participate in several rural development programmes and understand their objectives and should come to know that these programmes are for their own development. Unless rural people do not participate in development programmes, no real progress can be achieved.

This study revealed that social implications of rural development programmes in Kashmir have not been deep and radical. A significant correlation existed between rural development programmes and non-seriousness of implementing agencies/fatalistic attitudes of beneficiaries (Table 6).

For this, a statistical measure of the chi-square test was utilised and data summarised in the following 2x3 contingency Table 7.

Table 6: Reasons for Superficial Implications of Rural Development Programmes in Kashmir

S. No	Reasons	No. of respondents	Percentage
1.	Non-serious implementing agencies	118	47.20
2.	Fatalistic and conservative attitudes	132	52.80
3.	Total	250	100.00

Table 7: Relationship between Rural Development Programme in Kashmir and Non-Seriousness of Implementing Agencies/Fatalistic Attitudes of Beneficiaries

S. No.	Situation	Rural development programme			Total
		Successful	Partly successful	Unsuccessful	
1.	Non-serious implementing agencies	20	32	66	118
2.	Fatalistic attitudes of beneficiaries	18	70	44	132

Table 7 shows that observed frequencies for rural development programme and non-seriousness of implementing agencies/fatalistic attitudes of beneficiaries are 20, 18, 32, 70, 66 and 44. The expected frequencies were computed by the formula:

$E = \frac{Ct \times Rt}{N}$, where Ct stands for column total, Rt stands for row total and N for total number of frequencies.

Cell (a): Observed frequency (O) = 20

Expected frequency (E) = $118 \times 38/250 = 17.93$

Cell (b): O = 18

$E = 132 \times 38/250 = 20.06$

Cell (c): O = 32

$E = 118 \times 102/250 = 48.14$

Cell (d): O = 70

$E = 132 \times 102/250 = 53.85$

Cell (e): O = 66

$E = 118 \times 110/250 = 51.92$

Cell (f): O = 44

$E = 132 \times 110/250 = 58.08$

These results are shown in Table 8 as follows:

To test the null hypothesis, expected and observed frequencies were compared. The comparison was based on the following $\chi^2 = \frac{(O-E)^2}{E}$, where O stands for observed frequencies and E for expected frequencies (Table 9).

Level of significance = 0.05

Computing degree of freedom (df) = (r-1)(c-1) where df stands for the degree of freedom, r for the number of rows and c for the number of columns.

$df = (2-1)(3-1) = 2$

The founding value of χ^2 (table value) at a level of significance of 0.05 = 5.99 with df = 2, the inference is that since the calculated value of χ^2 (17.93) is more than the table value of χ^2 (5.99) at the 0.05 level of significance for 2dfs, and hence the null hypothesis (Ho= Many meaningful rural development programmes have benefited the rural masses in whole; and implementing agencies were serious and had expertise in the field of rural development; and rural people do not have fatalistic and conservative attitudes and behaviour patterns) is rejected. Therefore, we conclude that there is an association between rural development programmes and non-seriousness of implementing agencies/fatalistic attitudes of beneficiaries.

Table 8

S. No.	Situation	Rural development programme			Total
		Successful	Partly Successful	Unsuccessful	
1.	Non-serious implementing agencies	20.0(17.93)	32 (48.14)	66(51.92)	118
2.	Fatalistic attitude of beneficiaries	18(20.06)	70(53.85)	44(58.08)	132
	Total	38	102	110	250

Table 9: Computation of χ^2

O	E	O-E	(O-E) ²	(O-E/E) ²
20	17.936	2.07	4.28	0.2387
18	20.064	-2.06	4.24	0.2113
32	48.144	-16.14	260.49	5.4110
70	53.856	16.15	260.82	4.8434
66	51.920	14.08	198.24	3.8181
44	58.080	-14.08	198.24	3.4132
250	250		$\chi^2=17.9357$	

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