COMMUNITY HEALTH PROJECTS: AT THE CROSSROADS ?

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Any number of alternative experiments in community health have come up in the last decade. This article takes a closer look at four such projects which have today become models for others. The article is not an attempt to run down any one or other project or its founder. Rather, it raises relevant questions about the contribution of these projects to health and development, their overall perspective, and the manner in which they are organised and administered.

The early 70's was a period for a general spurt in development activities of different kinds. This was the time when some of the major community health projects were started. It is over a decade now since they have been established and their effectiveness in achieving the goals initially set up is now under review.

A careful study of these projects would reveal various conflicting aspects which deserve deeper study. All these projects have, over the years, come to revolve around the founders, while the people centred thrust they had set out to achieve has not been realised. Yet their contribution to the field of community health cannot be denied.

The focus of this article is to try and analyse what led to the present situation — the limitations inherent in such projects and the other contributory factors. I must add that this article is not an attempt to run down any one or other project or its founder. Admittedly it is far easier to be analytical in retrospect, than it must have been to have visualised the pitfalls before the event.

For the purpose of this exercise, I will take four well-known health/development projects — Gonoshasthya Kendra (GK) Bangladesh, the Jamkhed Project, Maharashtra, the Deenabandu Project, Tamil Nadu, and the Comprehensive Rural Operations Service Society (CROSS) project, Bhongir, Nalgonda District, AP. My comments are based on personal experience, literature and personal communications.

Gonoshasthya Kendra (G K): In 1971 during the Bangladesh war of liberation, a few doctors, of whom Dr. Choudhary was one, set up a hospital for the care of the wounded, which moved into a rural area after the war and started a community health project in Savar, near Dhaka. This Peoples, Health Project is now funded by foreign donors. Today they have 65 trained paramedics (mostly women), nine of whom are village based. They undertake health work, run a school, pharmaceutical factory, a women's centre and have formed agricultural cooperatives. They are today sought after by the government and international bodies, for the health training they provide. GK has "arrived" — they have further plans for expansion.

Jamkhed : The comprehensive Rural Health Project was founded by Drs. Rajnikant and Mabel Arole in 1971 in Jamkhed, Ahmednagar Dist., Maharashtra in 30 villages (covers 60 villages now). They set up a project to deliver health care in rural areas, implementing the village health worker scheme, involving community participation. They also gradually included training in agriculture, provision of safe drinking water, employment schemes, nonformal education etc. They have been receiving some support from donors abroad. The Drs. Arole were given the Magsaysay award for their work in this field.

The Deenabandu Project : Drs. Prem and Hari John started their work in Deenabandhupuram some miles from Vellore in Tamil Nadu in 1972-73. They gradually shifted their focus from "help to all" — to helping the needy. A community health programme was started and village health workers were trained. They are supported largely by the organisation called World Neighbours. Here too, the doctors realised that ill-health had to be tackled in a broad and integrated manner taking all factors leading to poverty into account. They have, for this, started several programmes — economic loans, agriculture and animal husbandry, literacy classes etc.

CROSS : Founded by M. Kurien in 1975 with the intention of "empowering the poor", they undertook the work of organising the poor to fight for their rights. Starting with less than a 100 villages with funds from donor agencies abroad, the organisation has expanded today, to reportedly, 500 villages in and around Bhongir, in Nalagonda District of Andhra Pradesh. The programmes include providing economic loans, training in agriculture and animal husbandry, health and adult literacy, to the poorer sections of the villages. Their major achievement has been the formation of sangams for men and

women, in each village, where the problems they face and the programmes offered, are discussed. CROSS is today supposedly one of the leading development groups in the country.

The founders of these projects are all doctors (except for Kurien) who had been trained within the established medical system and yet had the vision to conceive of an alternative approach to health, one for which few models were available at that time. Besides, all these groups, spoke in terms of "community participation". It was perhaps the spread of leftist ideas at that time that influenced these non-political groups with the ideals of democracy and people's rule. Kurien and Choudhary, in particular, had connections with the communist parties of their countries. One therefore assumes that their notions of people's participation was based on a relatively better understanding of the rural situation and the power structures that operated within it.

The Drs. Arole and Drs. John, on the other hand, were more influenced by the christian missionary spirit and were thus keen on doing "service to the need" (John & John, 1984). To them people's participation had a different meaning. "We started his as a total community programme for the rich and the poor alike, for we believed we had a duty to all "(John & John, 1984). Similarily Dr. Arole, talking about their selection of Jamkhed says, "At Jamkhed the leaders made arrangements to provide accomodation for the staff of approximately 20 people..... ..... The leaders also tried to understand the basic concepts of the project". (Arole 1980). When the leaders of a village are given such importance it is not likely that there could have been much participation by all sections in the village Drs. John admit that they gradually realised that their understanding was not right (John & John 1984).

Despite their differences in background and approach to start with, all of the project holders realised gradually that health was not a matter of merely delivering medical services, it was closely bound to the poverty of the people, their lack of food. Gradually the programmes expanded to improving agriculture and economic backwardness through the granting of loans, setting up of night schools and women's groups. They made attempts to tackle the problems which, as they saw it, lead to ill health.

With the loans provided — at GK it was 100 taka per person at first with a 4 percent interest to improve his agricultural production — some of the village folk did manage to improve their living conditions. All the villages that were adopted by CROSS in its initial years have at least one well today, for general use. Training in improved agricultural methods, on all projects have helped some of the poor to make the best use of the little they had. The non-formal educational classes, on all projects, taught some of the village people to read and know where to put their signature and so on. Basic arithmetic taught to the women at GK have helped them as they said, to run their small vegetable vending business more efficiently.

It is in two particular areas however — that of health (except at CROSS) and women's development that there has been a great advancement. This can be seen in the lives of the women, who have been involved in the project, particularly in Savar, but also in the other project areas. Many women who have only known oppression have now come to look on their lives with greater hope and confidence. The excitement this knowledge has generated was seen in the literacy classes at GK in the fact that a woman health worker found the courage to stand for panchayat elections at Jamkhed and in the militancy of the women at Bhongir (CROSS).

In the area of health all the areas mentioned have in the last decade registered a fall in the IMR, immunisation coverage of mother and child is high, the family planning acceptance rate is also far higher than the national average and the maternal mortality rate has fallen. The number of 'at risk' cases are provided with regular care and in case of emergencies immediate care is provided by the referal system, where operations too are conducted.

The improvement in the health status and the status of women in these areas, are more or less, directly as a result of the programmes undertaken. This has been achieved through consistent hard work over the years, the training provided to the paramedics is quite thorough and they are very conscious of the great responsibility placed on them. Today if there was to be a test of skills in dealing with rural health problems at the village level, between these paramedics and city trained doctors, the paramedics would come out in flying colours.

Inspite of the benefits these development programmes have conferred on the people of the area anyone with some understanding of developmental issues, who visits any of the four projects mentioned comes away with a feeling of disappointment and disquiet. Before visiting GK, it was, for me, from all I had read, a model project in community health

with the people directly involved in the programme. I looked forward with great anticipation to seeing the project, only to be disappointed from the first few hours itself. The project has a 100 acre campus with two large multiple-storied structures on it. As I entered the campus, I was made to wait at the gate before being taken to one of the senior paramedics I knew, just so that my reference could be cross checked. The women gate-keepers were in uniform and were there to see that all and sundry do not enter the place. This by itself was shocking—such a clearly hierarchical structure and such control did not, in my mind jell with a democratic set-up. The rest of my stay only led to confirm this impression.

Centralisation of Authority

Perhaps the other projects do not have such structures but certainly from all reports, these other projects too have a tacitly functioning hierarchy, which is fairly rigid with the sole decision maker/arbitrator on practically all issues, being those at the top, be it a Choudhary, Kurien, John or Arole. No doubt it is these few who have had both the vision and the longest exposure to the work undertaken and hence have a right to a certain amount of decision-making. But what of the others who also worked along with them over the years? There appears to be very little of sharing in the process of decision-making. This almost total authority that they wield was once defended by one project director who said, "After all I get the funds, so its for me to decide what I do with it". Perhaps the others would not put it quite so blatantly, but in essence this approach operates in their projects too. Another director is known to have sent in a proposal for a new scheme without consulting his senior colleagues, who came to know of it only when a member of the donor agency mentioned it a year later!

The major danger in such autocratic trends is that of the centralisation of power. Every major and often minor decision needs an okay from the people at the top. This becomes particularly difficult as the project expands and the work increases, as has happened in all four cases. Not only do the individuals at the top have to work harder — which any one familiar with these projects is witness to, many of the decisions get delayed and several are not followed up. Often field level coordinators do not feel confident enough to take on a responsibility they will later have to answer for. At times, issues instead of being settled at the village/cluster level, are brought by an individual directly to the chief so as to gain support for his point of view, before presenting it to the village sangam. In CROSS, for instance, the scope for such lobbying with the boss is immense. The "games of power", that eventually set in are in contradiction to the earlier vision of "community participation".

The trend described here is perhaps due to the lack of accountability the project heads enjoy. Maybe in the earlier phases of their growth they were accountable to their funders, or there might have been the danger of their funds being stopped. But as their fame and "success" increased they have now got a "carte blanche" on funding. Often no major uncomfortable questions are asked of the project holders nor are any but the barest stipulations made of them.

The project holder is theoretically not answerable to the people whom he has set out to serve. The people are not told very much about programme budgets, policies, apart from what is necessary for their day to day functioning. Yet the project directors, particularly in the early years of their work, have shown a sense of responsibility to the rural poor, perhaps because of their basic idealistic motivation. Nevertheless there is very little the people can do about changing policies, today. They are not taken into account.

As for the lay public, they could not care less about what goes on at these projects. The Government of India, had an uneasy relationship with such organisations earlier but now seems keen on formalising it. Toward this effort recently it was announced that henceforth all foreign funds to such projects would require central government clearance. Even if this is implemented strictly, the way this money is spent would be entirely decided by the project directors. Thus these directors have the field to themselves. A method of operation which does not have an inbuilt system of checks and balances is very likely to lead to absolute control by those in charge. This is not very healthy for those around them or for themselves.

The same authoritarianism also makes the project directors hypersensitive to criticism. They have received such accolades from the press, both national and international and are proud of their achievements, so much so, that they will put up with little criticism. A group of doctors wanting to do a critical evaluation of the Jamkhed project in 1980 were very specifically told that their report would have to be okayed by Dr. Arole before it went to the press. Such behaviour is but a symptom

of the malady but this too proves harmful to the project in the long run.

Cosmetic Changes, Not Structural : Why?

It is true that in all these projects, it is clearly recognised that the prevailing ill-health is due to the socio-economic backwarndness of the area. As a result the project directors have become concerned about the general betterment in the living conditions of the people apart from providing health care. Yet these efforts in the form of economic loans, agricultural inputs etc. described earlier are only superficial, cosmetic changes which do not bring about structural change. At the most they temporarily lull some people into believing that "something is being done". In the long run as we shall see, they do more harm than good. The dependency of the target population on the project increases. Worse still, those among the poor who do get benefits from the projects, are envied by those who do not — this is as true of every one of the four projects described as of other such projects. In fact, this sometimes leads to village feuds. While at GK I was told of a case where non-beneficiaries implicated a beneficiary in a police case. The conflicts in the fragmented, caste ridden village situation thus get further aggravated by these efforts.

Such a superficial approach to the solving of deeprooted rural problems is particularly difficult to understand from people like Choudhary or Kurien who, considering their background, ought to have a clearer perception of the interplay of socio-political forces in society. One is naturally led to speculate on what could be the influences which result in this deviation from their original goal. Four possible reasons could be :

(1) Constraints placed by donor agencies — despite their easy relationship with donor agencies today, these directors must have had certain conditions laid down for them in the early days of their effort. Perhaps it was tacitly made clear, that any attempt at fundamental change would not be supported. For example, in the earlier phase CROSS did try to organise the rural labourers. Gradually this activity stopped or was sporadic, over a small area, with the director being careful not to be present on such occasions. The donor agencies could perhaps have had a direct influence on the petering off of the radical approach.

(2) The reason for sticking to cosmetic change could also be that the radical approach is too demanding, too risky to be sustained over a long period. Most workers within such organisations join for "employment" and a "living wage" and not because of their 'commitment to a cause". They are, therefore, not too willing to risk their lives for the villagers they are supposed to represent. This is not to say that it has never happened. One paramedic at GK was, in 1976, murdered by the local people who were opposed to the change he was trying to bring about. Possibly there are other minor instances of acts of courage in other projects too, but, as the years go by, one gets to hear of few incidents of actual struggles with the local powers. As mentioned earlier the risk to one's life and sustainance of the project, is too great.

(3) Thus we come to the next factor in this tie-up— that of the groups gradually taking care not to antagonise the forces in power. There even appears to be an understanding among the local power groups the police and these organisations that each will leave other alone. The status-quo remains and basic change fails to occur. There is the example of a coordinator at CROSS who, with the blessings of the director, employs unpaid bonded labour on his farmlands, while he gets a salary from the organisation, for the "upliftment of the poor".

(4) These experiences have not in any way led to any deeper analysis of the problems which these projects both face and create. Or if such an analysis has been made none of the projects have acted upon it. Just as the different departments within the government have come to function independently of each other, inspite of knowing the need for inter-departmental coordination, so too on these projects the directors have had to narrow down their efforts to chiefly providing health care and superficial changes or things would become too difficult for them. All efforts at radically changing the health situation, has to remain at the verbal level. One would find that since it is so, once these directors withdraw from the area, the health situation in 5-10 years time would most probably revert to what it used to be before the doctors took over.

Models Which Are Not Replicable

The next major issue, is that of the replicability of these projects. It is not possible to replicate any of them unless one is an Arole, John or Choudhary. Sheila Zurbrigg points out that the success of the Jamkhed project led the Government to implement the Community Health Worker (CHW) scheme at the Primary Health Centre level in 1978 (Zurbrigg, 1983). And this was, as is

established today, a failure — for one thing the "essential ingredient of the 'model' project — a relationship between village level health worker and his/her community based on trust, committment and accountability to the poor village families" — was missing. This led her to ask, 'If the essential relationship of a CHW approach is therefore doomed when placed within the caste-class structure of society, what possibility is there for effective broad replication of the locally successful 'model' project?" (Zurbrigg, 1983). Similarly the present medical education does not generate, in doctors, any sense of commitment to the poor or their health problems. The medical system too, on the whole does not cater to the needs of the rural areas, much less the rural poor. Thus any question of the replicability of such projects is moot.

Related to this is the growing dependence of the people in a project area. When a project like any of these gets established its continued effectiveness over a period of time becomes heavily dependent on the presence of the individuals who started them. None of the projects functions in a manner which will enable it to carry on as before if the 'leader' were not there. The people in the project areas become dependent on them and their sustainance depends on the project. Even the health workers are rarely allowed to work independently (though some senior paramedics do so, to a certain extent, at Savar). As Prem and Hari John admit, "Of course, two independent control mechanisms do exist in the programme, more to see the effectiveness of the VHW than to "supervise" " (Zurbrigg, 1983). This inability to give up control becomes a decisive factor in determining the eventual nature of the project. This is the tragedy, that inspite of setting out to establish a people's project, even after a decade of work, the people cannot, or are not seen as being capable of running their own project.

Together with this is the notion of self-sufficiency. There has been a time in all the projects where there was some talk of making the project self-sufficient. Initially, at CROSS the idea was that the economic loans given to the poor would be returned in full and with this pool of money thus generated, fresh loans, without outside help, could be made. This could be done in several areas and gradually the economic loans programme could become self-sufficient. But this idea was not seen through and gradually the talk of self-sufficiency died down. With so much foreign funds available so easily where was the need to learn to be independent?

Here it must be said that perhaps a health project is difficult to sustain without funds — as some others have learned to their cost. But it is not impossible (Werner, 1978). Even assuming that a certain minimum of funding is necessary, surely some attempt to generate it locally could be made? It is interesting to note that this notion of self-sufficiency does bother Drs. Prem and Hari John. They however manage to side-step it, though not very convincingly, by saying "We had this problem until we realised that "Self-sufficiency" referred to the project, while what we were aiming to build at the community level was "self reliance". We were working towards building community capability in health care and hence self-reliance" (John-John). How can a people dependent on a project that is not self-sufficient, be taught to be self-reliant?

Another trend manifest in these circles today is the development of jargon and "management" techniques. Thus CROSS has a management consultant on call to tell them about "systems analysis" and "strategy planning" and so on, to help alleiviate rural poverty — the old methods having failed perhaps the new will succeed. Terms like "intersectoral integration", "integrated community" approach and so on are bandied about. They do this more, it would seem, to please the elite they interact with and the donor agencies, than to help solve any rural problem, for it is hard to believe that these founders still do not acknowledge that the essential question is one of sharing of power and its fruits by all.

What now ?

These projects have come a long way in the last 10 years — there were several points along the way where things could have changed for the better. But this was not to be. Now after having a positive impact on the health status of the people, their continued presence in the area is only likely to create fresh problems, as we have seen. It is time now that they either decided to gradually withdraw or radically change their strategy. The passing years have proved that these miniscule efforts do not really make any impact on the total health situation. They would be far more effective today if they undertake organising work among the rural poor and see that they demand that the existing government health facilities be made available to them.

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