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IDEOLOGY, ORGANIZATIONS AND COMMUNITY PARTICIPATION : A CASE STUDY OF TWO HEALTH PROJECTS IN RAJASTHAN

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CERTIFICATE

Certified that the dissertation entitled "IDEOLOGY, ORGANIZATIONS AND COMMUNITY PARTICIPATION: A CASE STUDY OF TWO HEALTH PROJECTS IN RAJASTHAN" submitted by Tasnim Partapuri for award of the Degree of Master of Philosophy (M. Phil) is her own work and has not been submitted for any other degree in this or any other University.

We recommend that this dissertation may be placed before the examiners for evaluation.

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PREFACE

Community Participation in health is one of the precepts for 'Health for All'. However, the vast literature on the subject usually fails to explain essential ingredients of the process. Though community characteristics (such as degree of community solidarity, the nature of the leadership etc.) may vary, and result in diverse styles of community participation, ideological factors are also very important in determining the overall nature of the community participation in a health project.

The present study is an attempt to study the ideological dimensions in community participation in health projects. Moreover, it seeks to understand the relative importance of organizational or managerial issues as compared to ideological factors in influencing community participation. Furthermore, it attempts to investigate ideological conflict within organizations and its effect on the involvement of the community.

The study is divided into five sections. The first chapter discusses issues of ideology, organizations and participation. The second pertains to the methodology of the study and its limitations. The next two chapters deal with the case studies of two health projects, in Rajasthan, one non-governmental and the other governmental. The final chapter includes the discussion and the conclusion.

I am not certain about the extent to which I have fulfilled the objectives of the study. However, I take this opportunity to render my acknowledgments to my 'significant others'.

I owe much to my supervisor, Prof. Imrana Qadeer, who endured my submission of drafts for correction at the eleventh

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CHAPTER I

THE PROBLEM CONTEXT

Recent years have witnessed a shift in emphasis from governmental to non-governmental organizations. The basic premise for this shift is the supposedly bureaucratic and inflexible nature of governmental organizations which make it difficult to allow communities to effectively participate in the planning, management and implementation of the programs. Non-governmental organizations, on the other hand, are characterized as smaller, more flexible and responsive to community needs and hence more likely to allow for effective community participation.

The entire issue is focussed on management of organizations. This emphasis on managerial issues seems to obscure understanding of the larger socio-political dimensions of the workings of organizations. The success of countries such as China[1], Cuba[2] and Allende's Chile[3], where community participation has been possible through state-run programs, raises the question of the importance of other issues in determining community participation. It is in this context, that the examination of ideology is meaningful.

[1]Rohde, J. "Health for all in China: Principle and relevance for other countries", in Morley, D., Rohde, Williams, G. (1983) *Practicing Health for All*, Oxford.

[2]Djukanovic, V. and Mach, E. (1975) *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*, a joint UNICEF/WHO study, WHO, Geneva.

[3]de Kadt, E. (1982) 'community Participation for health ; The Case of Latin America' in *World Development*, vol. 10, no. 7, pp. 573-584.

[1] IDEOLOGY

The concept of ideology can be generally traced back to the European Enlightenment and the French Revolution, especially to de Tracy[4], who is thought to be the first to use the term in print. However, there are earlier forms of the concept, as in Bacon's concept of 'idola' meaning 'impediment to knowledge'. In the eighteenth &century, the use of the concept is linked to the struggle against all forms of religious and otherwise traditional thought in the name of the new secular truth of science. The concept of ideology reached its florescence in the great philosophical and social scientific systems of the nineteenth century. Comte[5] criticized the French ideologists' attack on tradition and metaphysics, arguing that the forerunners of science had an important ordering function in society that would of necessity be maintained in the evolution of mental systems.

Whereas Comte confines himself to the realm of purely intellectual activity, Marx[6] generalizes this to the entirety of mental production in society. He develops his line of thought from a group of critical students of Hegel referred to as the German ideologists, and especially from Feuerbach's[7] materialist inversion of Hegel. Feuerbach's inversion of Hegel consisted in attempting to demonstrate the earthly foundations of metaphysics and religion. Marx's critique of Feuerbach stressed the historicity of the so-called material

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[4]de Tracy(1801-5) *Elements d'Idéologie*

[5]Comte, A. (1901 [1877]), *Cours de philosophie positive*, Paris.

[6]Marx, K. (1967 [1864]), *Capital*, vol I, London.

[7]Feuerbach, L. (1957) *The Essence of Christianity*, New York.

basis of ideology as well as the notion that human nature itself is a historical product just as much as its ideology. He argued further that the alienated forms of consciousness were not mere intellectual reflections but forms of human practice that play an active role in the functioning and transformation of society itself. The practical aspects of ideology were seen to be directly related with the structure of class domination.

Marx and Engels[8] generalized the question of ideology from the realm of science versus tradition to that of real versus mystified social processes, thus encompassing questions of theory and questions of political control within the same framework. In this way the function as well as the content of idea systems may be critically scrutinized.

Throughout the nineteenth and the early twentieth century, these two aspects of the concept of ideology,(namely theory and political control) were elaborated upon. The former aspect has been the formative influence in the sociology of knowledge, which has much to say about the study of ideologies. This tradition emerged in the framework of Lukacs and Mannheim, and has been developed throughout the century, its most recent advocate being Habermas. Represented most strongly in the Frankfurt School of German sociology, this approach has concentrated much of its effort on understanding the ideological bases of all forms of social knowledge. In France, Durkheim[9] and the Annee Sociologique school elaborated the analysis of the relation between social structure and the organization of collective representations

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[8]Marx, K. and Engels, F. (1970) *Selected Works*, Moscow.

[9]Durkheim, E. (1965 [1912]), *Elementary Forms of Religious Life*, New York.

(religious, intellectual etc.) that are meant to reflect the former. This had an important influence on the development of anthropology in Europe. In the work of the British Functionalists, there has been a concentration on the way in which ideology (religion and ritual) maintains social solidarity and prevents social disintegration.

Social scientists have also developed a less ambitious, positivist use of the concept. The social sciences- particularly economics, political science, sociology and social anthropology- aim to provide empirically verified statements and wider theories about the working of the social order. Different aspects of this are emphasized by the many different schools which exist. The elements that make up each of the varieties of theory are internally consistent but largely irrelevant to each other. They simply explain different things. Since it is difficult to test and falsify their propositions through empirical verifications (in contrast to the exact sciences) there are at one time few universally accepted paradigms to explain the phenomena under consideration.

All this helps to bolster the apparent persuasiveness of diverse ideologies- for these are mixtures of established fact and unsupported assertion. In terms of a simplified positivist definition, comprehensive ideologies are commitment demanding views about societies, their past histories and present operation, which contain a strong evaluative element, (sticking the label desirable/good or undesirable/bad on such views) and hence provide goals for the future. Partial ideologies 'explain' no more than certain institutional orders or spheres of activity (such as those about health and medicine).

Positivist social science regards the emergence and persistence of ideologies as a virtually universal phenomenon, certainly so in advanced societies and is open-minded about the extent to which ideologies, in fact,

misrepresent reality. Those in or more close to the Marxist tradition are more likely to emphasize the distortions which result from the operation of sectional interests: they see ideologies as weapons in the class struggle whereby, for example hegemonic groups portray reality in such a way as to make those dominated conform to their fate, which may then give rise to 'false consciousness' on the part of the latter. In the Communist Manifesto[10], itself perhaps the archetypal ideological interpretation of world history, Marx and Engels state that "the ruling ideas of each age have ever been the ideas of its ruling class".

In the more recent work of structural Marxists[11], ideological apparatuses are conceived as powerful social tools, as instruments that exist to maintain the coherence of a mode of production. This system of economic exploitation maintains itself by producing appropriate mentalities, political structures and socialized subjects who are no more than agents of the system.

The strength of ideologies -including Marxism- proves that the need for meaning is very basic to human beings, about the present as much as about the past, about health and illness and poverty and underdevelopment. So it is important to follow the lead given by Marx to enquire into the institutional mechanisms by which meanings or meaning systems become widely accepted in societies.

[1a] IDEOLOGIES AS MEANING SYSTEMS IN CLASS SOCIETIES

Men and women everywhere are faced with the need to interpret the systematic inequalities which exist in their society. Inequalities can be structured around age or

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[10]Marx, K. and Engels, F.(1955) Manifesto of the Communist Party, in *Selected Works*, vol. I, pg. 52, Foreign Languages Publishing House, Moscow.

[11]Althusser, L. (1971)'Ideology and ideological state apparatuses', in *Lenin and Philosophy*, New York.

gender, ethnicity or culture, status or class. In contemporary societies and especially in those where the economy is organized along capitalist lines, particular attention has been paid by social scientists to class-based inequalities. They have studied the different interpretations of these inequalities, as well as the socio-political movements of the disadvantaged which have challenged prevalent inequalities and their ideologies.

An example of such an analysis is **Frank Parkin's**[12] study of the interpretations of social inequality in contemporary capitalist societies. He suggests that there are three broad sets of interpretations (meaning systems) which relate to class structure. One of these is **dominant**, promotes the endorsement of existing inequality, and presents the reward system as morally just and desirable. Parkin looks at the institutional mechanism by which this dominance comes about and is maintained. Dominant ideologies are perpetuated through the institutions of civil society, such as the educational system and the mass media. Parkin concludes that "to accept Marx's proposition regarding the genesis of 'ruling ideas' is not to subscribe to a conspiracy theory of society: it is rather to acknowledge that moral and political rules hold sway not because they are self-evidently 'right' but because they are made to seem so by those who wield institutional power".

Parkin also examined what he called the **radical** value systems. This focuses on the systematic nature of class inequality, linking people's personal fate with the wider political order and presenting alternative political goals and socio-economic policies. Political movements and parties of a socialist or Marxist variety are the carriers of this set of interpretations. Parkin emphasizes the

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[12]Parkin, F. *Class Inequality and Political Order*, pg. 84, Paladin Granada, London.

crucial role of such movements or parties. In their absence, "there would be no major sources of political knowledge and information which would enable the subordinate class to make sense of their situation in radical terms".

In developing countries, presenting such an alternative meaning system has also been called *conscientization*, educational and political activities undertaken among people who have always lived surrounded by the dominant ideology. Discussion and dialogue are important means for the promotion of social consciousness. Freire[13] insists that people must be allowed to discover things for themselves, the meanings must not be imposed for them on their world. Rather than by means of the general political organization, those involved usually try to achieve their objectives through specific development activities . Such activities may be in the productive field or they may relate to non-formal education. They may also use health related projects as entry points into development, in order to create a wider critical awareness of the underlying causes of health problems. However, this shift in the nature of conscientization activities reveals the subtle manner in which Freirian ideas have been co-opted by dominant groups and their threat diminished.

Apart from the former, another ideology exists but one which does not pose much of a threat to dominant groups. The subordinate meaning system promotes accommodative responses to the structure of inequality. It is based in the community life and unlike the radical ideology, it does not promote a consciousness of class as it focuses on the inter-personal relations at the community level. It also does not yield a macro-social view that yields some understanding of the systematic nature of inequality.

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[13]Freire, P.(1968) *Pedagogy of the Oppressed*, Seabury Press, New York.

[1b] IDEOLOGIES AND ORGANIZATIONS

Ideologies are shared and logically integrated clusters of premises, assumptions, beliefs, ways of understanding relationships and interpreting reality, which reflect social experiences in a particular context at a particular time. As ideologies are used to interpret, evaluate and understand all ongoing social activities, their importance is pervasive. Indeed, ideologies are to social organizing as paradigms are to scientific practice.[14] As each organization has its own specific context , so each has its own unique ideology.

Studies of organizations in crisis show how forcefully and universally ideologies affect organizations, and life in general. Under the influence of societal and organizational shifts of ideologies, quite normal organizations undergo crises and then escape or succumb, depending on which ideologies dominate.

As ideologies provide the bases for understanding, and dominant ideologies pervade through the institutions of civil society, organizational members cannot easily doubt them. Rather, ideologies are assumed to define all possible behaviors by an organization within its environments. New stimuli and data are consistently interpreted as if they were similar and related to previously encountered events. Unexpected behaviors must somehow be interpreted as fitting into previously recognized categories, or else they cannot be accepted. This is because they would undermine members' beliefs in their ideologies capacities to provide adequate understanding and would raise questions about the organizations capacity to know its mission and to implement it successfully. Organizations avoid such ambiguity.

Organizations resource allocations reflect their ideologies and, eventually, these decisions establish

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[14] Kuhn, T. (1970) *The Structure of Scientific Revolutions*, Chicago.

organizational environments which are compatible with the existing ideologies. Members of a dominant coalition often have particularly large investments in the ideologies that are the bases for their high statuses. Resources available to the organization are likely to be used to preserve or defend the *status quo*. In addition, resources may be invested in enabling capable people to use their scientific, intellectual, technological and other talents to serve or augment the existing ideologies.

The alliance between those with ideological purity and political power, on the one hand, and those with valuable talents, on the other, creates a dilemma. In the short term, commitments to existing ideologies may allow clear goal setting and efficient resource utilization, and those in powerful positions may encourage improvement along these lines. In the long term, goals grow diffuse and new interpretive schemes become necessary. Often, changes can only occur if established ideologies are given up. High investments in the current ideologies make experimentation and discovery almost impossible. As a result, situations may be obscured rather than understood and new methods and solutions may not be considered. Organizational stagnation may result.

Organizational members must then decide whether to defend their existing ideologies, or whether to explore the confusing world they have glimpsed. Hence, changes in organizational ideology occurs either as a result of

[1] demand of objectives which are not being fulfilled by the current ideology; or

[2] intra-organizational conflict.

Usually, organizational members are likely to be divided about this issue and the leading protagonists of this conflict in ideologies in an organization are likely to be the following.

Superiors and Subordinates

Ideologies frequently portray hierarchical relationships as being necessary for effective accomplishments, and so organizations distinguish between superior and subordinate positions. Superiors supposedly define consistent ideologies , defend existing ideologies and symbolize what the ideologies have accomplished. Subordinates are told to look to superiors for guidance in ideological matters, and then to carry out the functions assigned to them.

Should subordinates question ideologies' relevance or their superior's competence, subordination becomes irrational and the existing ideologies lose credibility. Limitations that have always been there are seen by the subordinates as ridiculously narrow, serving only the superior's interests and obscuring understanding rather than facilitating it. Subordinates formulate new ideologies which may directly contradict the original ones. Adherents often agree that the new ideal can only be achieved if the existing ideologies are destroyed or transformed. The stage is thus set for severe intra-organizational conflict.

Loyal Members and Heretics

Ideologies define guidelines for task accomplishment. Within these constraints, organizational members have freedom to experiment and bring about technical changes to accommodate new facts and conditions. The ideal is for an organization to maintain a dynamic equilibrium between adhering to established routines that produce consistent accomplishments and being open to new insights arising from experience and interaction with the environment.

However, without having suffered some clearly defined losses organizations are usually unwilling to change their ideologies. Thus, as long as members behave consistently with organizational ideologies (when these ideologies are seen as satisfactorily serving objectives), organizations

generally do not change. Changes, then, may occur when behaviors contradict beliefs.

One defence of organizational ideologies is to select as new members only those who show they are eager to adopt the current organizational ideologies. The members so chosen may submerge their own personal awareness. Loyalty and consistency become virtues in their own right. Such members may believe increasingly, that the ideologies that they use to interpret the world are not only correct in some absolute sense, but that the world seen through these ideological lenses is basically so stable that no experimentation or change is necessary.

Organizations cannot choose their members solely for ideological consistency: they also recruit members with needed specialties. Even though, during their technical training they are inculcated with the dominant ideology, through personal experience such specialists may also acquire alternate ideologies, which differ from the organizational ideology. Organizational socialization processes are supposed to teach the specialists about organizational ideologies and to engender commitments to them. But organizational socialization processes often fail.

Organizations distinguish between deviance, which occurs when members do not conform to expected behaviors, and heresies, when members question social realities defined by organizational ideologies. If the selection and socialization processes were functioning perfectly, deviance would never occur, but perfection is impossible. Behaviourally deviant, ideologically critical people can come to symbolize organizational inadequacies for dissatisfied members. As a result, deviant members become notorious and controversial, loved by some and hated by others. They may be subjected to difficult trials and emotional ordeals as well as adulation. But organizations

rarely value such people. While deviant people remain members of organizations, they frighten leaders, arouse uncertainty and evoke anger. Thus, organizations tolerate them for only short times and then expel them. Most often, they depart too soon to bring about significant changes.

More difficult for organizations to handle, and hence more likely to stimulate changes are those people who behave as expected but who also hold heretical beliefs. Socio-cultural norms endorse organizations efforts to control behaviors, but organizations' attempts to control ideologies are considered illegitimate. Thus, heretical members who behave in conforming ways cannot be subjected to legitimate organizational control. Where heresies are suspected, organizations exert subtle pressures such as delays, inaction and no responses to requests; the heretics' private lives and those of family members may be investigated to see if behavioral deviance can be found there. Such steps are designed to be so frustrating and unfair that heretics will react by behaving defiantly. The organizations can then censure these deviant behaviors without appearing to infringe on ideological freedom. On the other hand, if the heretics do not succumb but continue their behavioral conformity, their ideologies retain potency. However, the probability of a heretic gaining ideological control in an organization is limited.

The ideologies within organizations, how they emerge and how they get influenced by the larger socio-economic domain is a dynamic and continuous process. One area where it has resulted in a variety of expressions, is the area of community participation, with ideologies ranging from the most radical to the most conservative.

[2] COMMUNITY PARTICIPATION

In order to understand community participation it is necessary to initially clarify perceptions of 'community'. Although it may appear to be self-evident that the proponents of community participation are referring to communities when discussing who participates, the concept of the 'community' is poorly defined in literature even though it is central to the issue. Most authorities do not seek to define the term formally and instead use it loosely to denote a socio-spatial entity. However, the United Nations pointed out that the notion of locality in these descriptions is ambiguous: it can refer simultaneously to neighborhoods, villages, districts, towns and even cities. It instead, suggests an alternative focus on the "lowest level of aggregation at which people organize for common effort".

The notion of "the lowest level of aggregation" is implicit in the way community is defined : as the smallest unit of socio-spatial organization often evoking the idea of a village, without differentiating between kinds of rural communities and rarely focusing on urban communities.

Community is a word with many meanings and use. Thus, a grouping which constitutes a community for one set of purposes may not do so for another. It is customary, however, to distinguish between three different types of communities:

a] a geographical locality where people live and the inhabitants objectively have and subjectively feel a social and functional solidarity[15]

b] a population group with similar characteristics (such as villagers or older people)

c] people drawn together by concerns for which they feel

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[15]Midgley, J.(19860 *Community Participation, Social Development and the State* (ed.)Methuen, London.

allegiance for only one aspect of their new and more complex lives (wildlife protection society) or as a concern which people share in common (such as women, or landless laborers)[16].

The definition of the community which is said to be important to health professionals is that of target populations or at risk groups. It is rooted in the epidemiological view of community[17]. It is also customary to view community in reference to social relations characterized by a face to face character, and a considerable degree of physical togetherness, if not personal intimacy, emotional depth, social cohesion, and continuity in time. Although the definitions of community vary, most authors do relate the concept of community to notions of deprivation and disadvantage. The poorest community groups, with little access to resources and power are usually identified as potential participants in social welfare programs. They are usually characterized as the 'community' and not everyone in the identifiable community, since local elites already have a strong say in the decision-making.

However, such definitions fail to recognize the fact that deprived communities are economically, socially and politically heterogenous and that differential access to resources and inequalities of one kind or another characterize most forms of social organization. Deprived rural communities and urban slums are comprised of the very poor, the poor and the not so-poor who have differential access to resources. Hence, several authors believe that the whole community should be involved. White insists that

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[16]Ugalde, A.(1985) 'Ideological Dimensions of community participation in Latin American Programs', *Soc, Sci. Med.* Vol 21, pp. 41-53

[17]Rifkin, S. (1988)'Primary Health Care: On Measuring Participation' *Soc. Sci.Med.* Vol. 26, No. 8, pp. 931-940.

community participation is not concerned with the mobilization of some individuals who should be regarded as the beneficiaries of participation; rather it involves the 'participation of the organized community as such'. On the other hand, **Hollnsteiner**[18] maintains that only those sections of the village or neighborhood that are the most disadvantaged should be mobilized for participation, since "the equity principle of PHC militates that it is to these groups who, being most in need of health care, should organize themselves for achieving it".

It is important to seek a definition of the term "participation" as it defies any single attempt at interpretation. Despite the fact that since, the 70s, there exists an enormous amount of developmental literature on participation, it has not led to increasing clarity about the concept. **Cohen and Uphoff**[19] survey the literature and find that the concept has popularity without clarity. and is subject to growing faddishness and a lot of lip service.

The growing interest in community participation in areas other than health has resulted in a number of papers which try to bring order to an increasingly confused field. The definitions of participation proposed by the participatory theorists are worth considering in this context. Some address the question by focusing on specific areas such as communication access, basic needs and decentralization. Others who have tried to capture the central issue of participation have generally related it to power (UNRISD). For participatory theorists like **Orlando**

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[18]Hollnsteiner, M. (1983) 'The Participatory Imperative in PHC' in *Assignment Children*, Vol. 59/60, pp. 35-56.

[19]Cohen, J. and Uphoff, N. (1980)'Participation's place in rural development: seeking clarity through specificity', *World Development*, Vol 8, No. 3. (March)

Fals Borda[20] and Anisur Rahman[21], the aim of participation is to achieve power "a special kind of power -people's power which belongs to the oppressed and exploited classes and groups and their organizations, and the defence of their just interests to enable them to advance towards shared goals of social change within a participatory political system. According to Susan Rifkin, "Community participation is a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs." This definition takes into account geographic, common interests and epidemiological meanings as well as active, choice and effectiveness.

Many writers quote the United Nations Economic and Social Council Resolution when discussing this issue. This résolution states that participation requires the voluntary and democratic involvement of the people in:

[a] contributing to the development effort,
[b] sharing equitably from the benefits derived therefrom and
[c] decision making in respect of setting goals, formulating policies and planning and implementing economic and social development programs'.

These three elements suggest, therefore, that a community participates in social development if the poorest groups in the community have an effective role in choosing social development programs, if they contribute together with the

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[20]Fals Borda, O.(1988) *Knowledge and People's Power*, Indian Social Institute, New Delhi.

[21]Rahman, A. (1985)'Theory and Practice of Participatory Action Research' in Orlando Fals Borda (ed.)*The challenge of Social Change*, Sage, New Delhi pp.-107-33.

rest of the community in the implementation of the decisions and if they derive equitable benefits from these programs. Most authorities stress that the involvement of this kind facilitates a more generalized involvement of the poor in the life of the community so that it is able to act democratically in its dealings with the outside world.

[2a] ANTECEDENTS OF THE COMMUNITY PARTICIPATION APPROACH

Although it is often assumed that community participation is a new idea in development studies, current community participation concepts are based on a rich legacy of ideas and practical agendas of more than half a century which have resulted in the formulation of proposals for present day involvement. The main strands can be distinguished as:

[1] the community development movement with its heyday in the early 50s and 60s and
[2] the concern with community involvement through *conscientization*, a mainly Latin American phenomenon of the 1960s and the early 1970s.

[2a.i] COMMUNITY DEVELOPMENT

The community development movement of the 1950s and the 1960s is an important source for community participation theory. Indeed the two approaches of community participation and community development have much in common. Like community participation, community development focused on small communities, proposing to establish democratic decision-making institutions at the local level. It also proposed to mobilize people to improve their social and economic circumstances through undertaking a variety of development projects.

Origins and methodology

Among the first proponents of Community development were missionary and colonial officials. As Mayo [22] pointed out, colonialism itself created the climate in which community development was to take shape. The dual task of civilizing while exploiting, the use of forced labor under the pretext that it was an indigenous institution and the need to establish durable and responsible political structures, all facilitated the evolution of early forms of community development. Gilbert and Ward [23] state that "in preparation for the eventual independence of its African and Indian colonies, the British employed community development as a method of encouraging the growth of political democracy and local initiative". The community development movement was active above all in Asia (India) and in Africa, where it was known as animation rurale in the French speaking parts of the continent. Drawing extensively on the British literature and the African and Indian experience, the United Nations and the American government contributed further to the refinement of community development ideas. Apart from active UN promotion of community development activities, the American aid program provided liberal financial support to Third World governments schemes of this kind. A particular motive for American financial aid was a desire to contain subversive influences. As Brokensha and Hodge [24] point out, it is not surprising that American community development expenditures

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[22] Mayo, M., 'Community Development: A radical Alternative' in R. Bailey and M. Brake (eds.) *Radical Social Work*, Edward Arnold, London, PP.129-143

[23] Gilbert, A. and Ward, P. (1984) 'Community Action by the Urban Poor: Democratic Involvement, Community Self-Help or a Means of Social Control', *World Development*, Vol 12, No. 8, pp. 769-782.

[24] Brokensha, D and Hodge, P.(1969) *Community Development: An Interpretation*, Chandler, San Francisco.

were the highest in countries such as Thailand and Vietnam which were considered to be most threatened by communism.

However, community development's emphasis on the importance of involving people in their own development provided a significant counterweight to the predominant development philosophy of the time, which had little thought for the social and human consequences of promoting economic growth through large-scale capital-intensive projects. Community development saw the limited effect of such projects as the inevitable consequence of outsiders imposing development schemes which did not correspond to the felt needs of the population or which tried to induce needs by attempting to get people to accept what others had already decided for them.

Community development programs comprised a wide range of development activities, including agricultural improvements, water and sanitation, infant and maternity welfare and mass education. Emphasis was placed on identifying and planning for locally felt needs; on building up local initiative through training local leaders and encouraging self-help efforts; on coordinating technical assistance in order to bring about the integrated development of local communities; and on using multi-purpose village-level workers to motivate people to improve their own living standards.

The community development approach raised a number of important issues, and developed interesting methodologies to bring out people's inherent creativity and involve them in new ways of doing things. Yet its success was distinctly limited. It was seen by many parties particularly those struggling for independence as quite explicitly an attempt to create plausibly democratic institutions without serious dislocation to the vested interests of the status quo. It disregarded the different socio-economic and political contexts, and the differences in natural endowments between

communities, which set the boundaries for possible success. Moreover it assumed not only consensus on needs and assumptions in communities but also a relative homogeneity in socio-economic terms. Community development hardly ever faced up to the differences in interest that could exist between different members of a 'community' that was to be developed, notably in terms of their control over opportunities to make a living. Neither did it consider unequal class relations prevalent within many communities. It thus failed to understand the fundamental social and political dynamics of communities in many parts of the world.

The problem of using community development as a tool of policy without a clear understanding of its own internal dynamic meant that the community development process was itself open to abuse either through co-option by privileged groups or the destruction by the same groups to whom it posed a threat. As a result community development was perceived as a form of manipulation and associated with the discredited economic development strategy of First World governments and international lending agencies known as "modernization theory"[25].

Although the aim of self-help through the development of communities appears to be similar to current ideas about participation, radical theorists are vociferous critics of community development. They suggest that in practice it more closely resembles a bureaucracy than a development strategy, with superimposed direction and limited participation in goal setting and program formulation.[26] Community development programs, thus perpetuated structures of inequality at both the local and the national levels.

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[25]De Kadt, E. (1982) 'Community Participation for Health: The Case of Latin America'. in *World Development*, vol. 10, no. 7, pp. 573-584.

[26]Gilbert, A. and Ward, P. *op. cit.*

From a situation where community development was perceived to be synonymous with community participation it has changed to one where there appears to be no clear understanding of the relation between the two.

	original linkage		new linkage
paradigm	**modernization theory**	Superseded by	**dependency theory**
Approach	**community development**		**Empowerment**

Thus, community development was superseded by a more appropriate form of community participation (de Kadt[27], 1982). This is based on the belief that the need for community participation "stems from the failure of conventional economic models of post-war years to benefit the majority of the third world's population" (Oakley and Marsden).[28] The increasing discontent with the these "modernization" economic development strategies led to a search for more appropriate styles of development fundamentally linked to what has been termed as the "dependency"theory. Thus just as the wider economic surround of the dependency paradigm superseded the modernization paradigm, so at the community level empowerment through *conscientization* superseded community development.

[27]De Kadt, (1982) *op. cit.*

[28]Oakley, P. and Marsden, D. (1984) *Approaches to Participation in Rural Development*, ILO, Geneva.

[2a ii] CONSCIENTIZATION

In contrast to the community development movement, the concept of *conscientization* rests on the belief that societies are based on conflict and inequality. It argues that the key to development lies in the creation of a critical awareness among the poor of the real causes of their oppression and their capacity to change their situation. Under this approach, which is closer to the radical definition of participation as an end in itself, the role of community-level workers is essentially political.

The interest in conscientization stemmed from the renewed search for alternatives to the increasingly criticized Western traditional model for health care delivery. This philosophy and methodology has been elucidated by the Brazilian educator, Paulo Freire.[29] [30]

Over the past several years, applications of the Freire method to the health field in the rural areas of Latin America and Africa and in inner-city communities in the United States have demonstrated the effectiveness of the method for improving health conditions while creating in the people a critical awareness of the root causes of their problems and a resultant readiness to take action based on this awareness. There are similarities between the Freire method and the fundamental principles of health education and community organization.[31] While not set forth as a panacea to the many ills confronting traditional

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[29]Freire, P. *(1973)Education for Critical Consciousness.* Seabury Press, New York.

[30]Freire, P.(1968) *Pedagogy of the Oppressed*, Seabury Press, New York.

[31]Minkler, M. and Cox, M. (1980)'Creating Critical Consciousness in Health: Applications of Freire's Philosophy and Methods to the Health Care Setting' *IJHS*, Vol. 10, No. 2, pp. 311-322.

health care approaches currently under scrutiny, Freire's philosophy and approach, have the potential to importantly supplement current movements to reexamine and refocus our energies in the health field.

Origins and methodology

In his classic theoretical work, Pedagogy of the Oppressed, Freire set forth a view of man as an incomplete being whose vocation is to become fully human, reflecting critically on the objective reality and taking action based on that reflection in order to transform his or her world. Fundamental distinctions were drawn between the oppressed and the oppressors in society, with emphasis placed on the task of the oppressed to liberate themselves and the oppressors, both of whom were seen as manifestations of the dehumanization caused by an unjust social order.

The dialogical method upon which *conscientization* or education for critical consciousness is based involves oppressed groups of individuals in a process of:

[a] reflecting upon aspects of their reality (e.g. problems of poor health etc.),
[b] looking beyond these problems to their root causes,
[c] examining the implications and consequences of these issues, and finally,
[d] developing a plan of action to deal with problems collectively identified.

While similar in many respects to more traditional approaches to organizing for change, Freire's attempted elimination of asymmetrical often paternalistic aspects of the leader's role is important.

The leader's role in facilitating *conscientization* is essentially one of asking question of the group which will help the members see the world not as a static reality but

as a 'limiting situation' which challenges them to transform. Facilitators or 'teacher-learners' utilizing the Freire approach ideally follow a series of steps which may be summarized as follows:

1] Tuning into the "vocabular universe" of the people through a process of participant observation and where possible living with the people over an extended period of time.
2] Working with small groups initially in searching for generative themes", key words suggestive of the hopes and concerns of the people.
3] Synthesizing the ideas of the people and codifying them in visual images e.g. pictures and symbols.
4] Giving these symbols and images back to the people for decoding through "cultural circles'- groups of people who in-coordinator-questioner look at the causes, consequences and possible solutions of the generative themes they have identified.

Strong similarities clearly may be seen between Freire's approach to *conscientization* and Mao Tse-tung's earlier elaboration of the mass line strategies for mobilization of the people. Expressing a similar conviction in the ability of the people to identify and effectively transform oppressive aspects of their reality, Mao thus noted that "correct" leaders should ".. take the ideas of the masses (scattered and unsystematic) and concentrate them", returning these synthesized ideas to the people who can then "translate them into action, and test the correctness of these ideas in such action."[32] Both Freire and Mao stress the full participation of the people through

[32]Mao Tse-tung (1971)'Some questions concerning methods of leadership'. In *Selected Readings from the Works of Mao Tse-tung*, Foreign Language Press, Peking,

dialoguing and similar means as essential to effective liberation and change.

The philosophy and approach of Paulo Freire appear in retrospect to share with sound health education and community organization a commitment to sharing with the concerns of the people. By focusing on the root causes of these concerns, however, and helping people, through praxis, to develop a plan of action for dealing with these fundamental issues, the methodology becomes revolutionary rather than reformist in character. It concentrates on helping people to change the structure of society rather than simply integrating them more successfully into the existing social structure. Unlike health education and community organization it greatly de-emphasizes the role and status of the leader. A paradox exists in that leadership training which Freire rejects as "alienating" is critical to the successful functioning of his teacher learners. The latter, while not designated as leaders, clearly must exhibit leadership qualities in guiding the discussion, asking appropriate questions, and helping facilitate the emergence of a realistic plan of action. Freire on deeper analysis would espouse the training of a new breed of leaders- those who remain with the people but are able to draw them out and facilitate their praxis. Where reality is confronted as a "social problem to be solved by the people" and where the latter through their praxis, are engaged in this critical confrontation, Freire's *conscientization* offers an effective education approach to major social change in the health field.

However *conscientization* is subject to a number of criticisms. It ignores the fact that, by challenging the existing order, conscientizing activities are likely to meet with confrontation. The movement has also come under attack for the paternalistic assumption that dominated groups require the intervention of outsiders before finding

out that they are being exploited. Moreover dialogue per se cannot always enable the "voiceless" and "less conscientized" to question the ideological premise and the hidden currents that define that dialogue itself.

For the conscientizers, the nature of the power and the means of achieving it are defined by the people. Secondly, they are convinced that free and genuine dialogue will undoubtedly persuade the "oppressed" to share immediately their own beliefs and ideologies. This they assume will happen automatically as a result of patient participatory exercises. Contrary to the experts, they highly praise the people's traditional knowledge, their common sense and their wisdom. Yet the same ideological certainties with which they oppose the experts lead them into behavioral patterns of the experts. Thus when common sense prompts people to disagree with a solution offered by the activists it is often perceived as a lack of co-operation due to their "primitive consciousness". These schizophrenic trends are peculiar to many intellectuals involved in grass-roots activity. On the one hand their humanistic orientations lead them to believe that populations are mature enough to organize their lives in total freedom. On the other hand, no matter what their world view may be, it is through their lenses produced by the same world view or ideology that they see and listen to the world.

Freire's theory of "historical conditioning of the levels of consciousness" stipulates that in dependant societies and in the "transitional phases" the oppressed do not have a"critical consciousness, but a "semi-transitive' or "popular consciousness". This historical cultural reality leads them "to internalize the values of the dominant groups " and thus they have a distorted perception of their own condition. Hence the necessity exists for progressive intellectuals to engage in *conscientizatio*

exercises. However, one is not sure as to whether these stages are based on reality or are influenced by positivist/evolutionist thinking. The exercise is supposed to be a learning experience for all. However it implies that the participants are not really equal and therefore the persons with a "primitive" or "semi-transitive" consciousness have to learn from the "critical consciousness".

Subsequent events, especially in Latin America, when the state intervened and either coopted or ousted radical activists, showed that the conscientizers had over-optimistic, and perhaps naive views on the political reaction which their activities were likely to provoke and on people's power to overcome them.[33]

They were however, well in advance of the current thinking in health promotion. Only recently has the importance of wider socio-economic factors come to be recognized by international organizations such as UNICEF and WHO although this is still largely framed in terms of the need for inter-sectoral collaboration: the desirability for those concerned with health to work with other government agencies whose responsibility lies in areas such as public works and water supplies, rural development and agriculture or education. As yet much less strongly emphasized is the backdrop which colors all health promotion, namely the existence of socio-economic inequalities that subsequently affects health. The conscientizers whatever their precise political ideology, did realize that community participation in health would be meaningful only if it took account of the basic issues of the political economy of health.

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[33]Muller, F. in Rohde, J., Chatterjee, M. and Morley, D. (eds) (1993) 'Participation, Poverty and Violence: Health and Survival in Latin America' in *Reaching Health for All*, Oxford, Oxford.

Community development and *conscientization* offer quite different interpretations of participation. The former involves people in development programs devised from the top; the latter empowers people to undertake development activities themselves. Yet the ideas and assumptions of both approaches were incorporated in the Alma Ata Declaration on PHC. On the one hand, the call for equity and social justice implied a politics of empowerment. On the other the goal of reforming service delivery systems led to a more limited definition of participation as a management tool. As a result the role of community participation in primary health care has become very ambiguous. Political rhetoric continues to emphasize the potentially liberating role of community involvement in health and development. In practice, however, participation is given a very limited role in project activities.

[2b] THE GLOBAL EMERGENCE OF COMMUNITY PARTICIPATION

The idea of participation is an ancient one finding expression in the cultural traditions and practices of small preliterate societies and the writings of ancient sages and philosophers. However, contemporary notions of community participation are of a comparatively recent origin. The idea that the poor and the oppressed should be mobilized by external agents and encouraged to participate in decision-making for social development at the local level has been popularized only in the last two decades or more. The notion of participation has become so popular that it is rare these days to find a document on development strategies or approaches which does not refer to participation or suggest that the strategy or approach under discussion is not participatory in nature. For instance, apart from the notion of actually participating in development activities, we have been introduced to participatory evaluation, participatory action research,

participatory field action, and more generally, participatory research.

The present emphasis on participation reflects a profound disillusionment with established developmental strategies. It forms part of a wider debate about popular participation in Third World development, when the US and other more industrialized countries became 'concerned' about problems of development following World War II. These emphasized economic growth and industrialization in the context of increasingly centralized planning and control over the distribution of resources. The orthodox ideas, in what has come to be termed as the "modernization" approach, stressed the injection of capital inputs from outside which would result in "take-off" and the eventual spread of benefits throughout the system. Newly emergent independent nations would be helped to ascend the evolutionary ladder, that had already been climbed by those nations who had gone through the stage of industrialization. Emphases were laid on providing the infrastructural facilities and institutions to facilitate this climb and on tackling the obstacles that were to be found on the way.

In this context, the rural poor within these developing countries were not seen as major resources for furthering the process of development, but rather as obstacles, and attention was turned to mobilizing them through mass education and community development programs to reach the critical "take-off" point into self-sustained growth. The rural areas were perceived as lagging behind in the national development effort; agriculture had to be improved to support the industrialization process. Projects and programs were designed by urban planners and administrators and little attention was paid to the rural populations who were regarded as traditional and, who in a paternalistic way, needed to be educated out of their ignorance. Issues of people's participation in development

were commonly framed in terms of'traditionalism' contrasted with 'modernity'.

These strategies were based on a rather one-sided view of society in which it was assumed that people could and should live in harmonious communities working for the benefit of the nation. Public emphasis was placed on nation-building and on community development. It was seldom recognized that such processes were built upon a social order that was far from democratic and that support was given to entrench already very inegalitarian systems.

Thus, for the leaders of the developing world, "development" appeared as the new "authority." While a great deal of energy was expended in order to propose solutions to "problems" defined by the developmental experts, a crisis of confidence in the effectiveness of the developmental model appeared in the early seventies. In the 70s, the naive certainties that characterized the enthusiasm of the 50s, were being renegotiated as the complexities of the development process were recognized and as the faith in the western industrialized nations' strategies was called into question.

At the same time, several successes were reported by grassroots activists who were opposed to the techno-economistic orientation of mainstream developmental efforts. They advocated the use of bottom-up, endogenous, "participatory"approaches, aimed at "achieving power and not merely growth for the grassroots populations". This challenge to the orthodox development model appeared at a time when it was already facing mounting criticism from two quarters. On the one hand, the donor countries in the West began to recognize that the developmental efforts were largely ineffective and wasteful, and on the other, the extreme right in these countries sought to bring about massive cuts in developmental assistance. Moreover, an increasing number of development analysts began to

recognize the importance of the socio-cultural dimension, especially participation. It became clear to them that when the people actively participated, more was achieved with much less. In order to reform itself of its existing drawbacks, development sought to acquire a more participatory face and the term "participation", henceforth entered the vocabulary of all developmental literature. The early efforts to address this took the form of identification of the "social" dimensions of development and of the "human factor" and efforts were made to incorporate those who had been marginalized in the development process.

It is in this confused conceptual climate that a re-think of development strategies has occurred. The United Nations has been at the forefront of these discussions and has produced a substantial literature on the subject[34][35]. It has argued that a concerted effort be made to establish and strengthen institutions for the mobilization of popular participation in developing countries. This search for more appropriate styles of development is fundamentally linked to what has been termed as the dependence theory" highlighted by Freire and "the limits to growth debate". The new philosophy holds the issue of participation is central and is primarily associated with the rural poor, not only because they are the most disadvantaged in society but also because the rural areas have been relatively neglected by previous development strategies. Though it is difficult to define who constitutes the rural poor, they may be defined as

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[34]Wolfe, Marshall. (1982) *Popular Participation in Development: A Conceptual Framework*, United Nations Department of Technical Cooperation for Development, New York.

[35]United Nations, (1981) *Popular Participation as a Strategy for Promoting Community Level Action and National Development*, New York.

"that section of the rural population whose basic minimum needs for life, and existence with human dignity, are unfulfilled. Such a condition of poverty is characterized by low incomes, widely associated with various forms of oppression under social structures through which dominant social groups are able to dictate the conditions of life of the dominated and to appropriate much of the product of the latter's labor and also the material assets the latter may initially possess."[36]

These are the great mass of people in rural areas: small farmers, tenants, share-croppers, landless laborers and also women.

Though most people agree that participation is a good thing , the tactics that one adopts will vary according to the ideology one adopts about the role of intervention. Firstly, there is what is based on the idea that there is little wrong with the development effort and what is needed is the "human factor". Secondly, as a result of the rethink there is that strategy which assumes that the direction of the development effort is fundamentally misconceived. Here, participation is seen as a strategy for the creation of opportunities to explore new, often open-ended directions with those who were traditionally the objects of development.

All this has resulted in the increasing amount of emphasis being placed on participation. It is contended that in order to bring about physical improvements, development has largely ignored people's choices and needs. It is thus argued that "development should be people-centered" and that they should be actively participants in it and not merely passive bystanders. This should be done

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[36]Rahman, Md.(1981)'Concept of an inquiry', in *Development: Seeds of Change,* SID, Rome, No.1 p. 3

in order to ensure that all developmental efforts are planned well and have popular support.

[3] COMMUNITY PARTICIPATION AND HEALTH

Our understanding of issues in the field of health is influenced, as in any area of socioeconomic reality, by the existing ideological interpretations of the social order. These interpretations simplify reality: they make it more consistent with the interests or goals of the people who do the interpreting. Community participation as a concept is especially prone to ideological affirmations.

International health planners and national health decision-makers in developing countries are latecomers in incorporating the concept of community participation in their programs, as against agricultural development projects and in the poor urban neighborhoods in the 50s and the 60s.

This interest has resulted from a realization that in spite of health development efforts for several decades, there has been little increase in the accessibility and availability of health services. This situation is exacerbated by the increasing cuts in health budgets of most developing nations in the face of international debts. Hence, a vast majority of the population has little support in its efforts to survive and stay healthy.

In the economically advanced countries, too, the emphasis on community participation is important in order to effect improvements in the quality of services as well as to enable groups and individuals to adopt healthier lifestyles and to take greater responsibility of their own health.

Traditionally, expectations about health improvements have been linked to inputs and outputs of health services and impact in terms of health status. The decades of the

60s and the 70s, which gave birth to the PHC and the "basic needs" concepts, put forward an analysis which related better health not only to health services, but also to existing socioeconomic conditions. It was argued that health improved not merely by the provision of health services, but in addition by the distribution of available resources based on the principle of equity and by the participation of the beneficiaries in decisions about care based on the principle of participation. It is contended that the involvement of the people is required, not only in the contribution of resources and in operation of programs, but also in decision-making and in determination of health priorities.

The main drive for community participation in national health programs took place in the 70s under the influence of WHO/ PAHO, AID, UNICEF and to a lesser extent the World Bank. Private foreign and national foundations also contributed to the trend with their financial support.

A rush of documents were issued in the 70s dealing with the topic of community participation. The works of **Newell**[37] and **Djukanovic and Mach**[38] reflected the concerns of the policy-makers in Geneva, and the position of the World Bank appeared in its Health Sector Policy Paper[39]. In 1977, **WHO and UNICEF**[40] published jointly the results of a nine-country study on community participation in health programs. In 1978, the official legitimation of community

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[37]Newell, K. (ed) (1975) *Health by the People*, WHO, Geneva.

[38]Djukanovic, V. and Mach, E. (1975) *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*, WHO, Geneva.

[39]World Bank (1975), *Health Sector Policy Paper*, The World Bank, Washington, D.C.

[40]UNICEF/WHO, (1977) *Community Involvement in Primary Health Care*, JC 21/ UNICEF/WHO/ 77.2, Geneva.

participation in health programs took place at the joint World Health Organization (WHO) and UNICEF conference in Alma Ata, where the principles of PHC were formally established and the linkage between PHC and community participation was formally sealed.[41] The approach has since been endorsed as the strategy to achieve "Health for All by the Year 2000". The recommendations of Alma Ata were seen as a breakthrough in official policy formulation. By highlighting inter-sectoral coordination the declaration recognized that health could not be attained by the health sector alone. The strategy called for inter-sectoral coordination that approached the broader issue of underdevelopment.

With regard to the provision of health services, the declaration argued that the centralized technological health care model of the developed world was inappropriate to the needs of developing countries. Not only were modern health care facilities geographically and financially inaccessible to a majority of Third World populations, their curative focus was of dubious benefit in countries where the majority of diseases were preventable. The solution it was argued was to achieve universal coverage of basic health services .

The architects of PHC drew inspiration from China, Cuba, Tanzania and Kerala State in India in order to demonstrate that high levels of health and social development could be achieved by a political commitment to policies based not on economic growth but on social justice and equity.

The member governments of the WHO and the UNICEF unanimously supported the conference recommendation that " governments encourage and ensure full community participation through the effective propagation of relevant

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[41]WHO-UNICEF (1978) *Report of the International Conference on Primary Health Care*, WHO, Geneva.

information, increased literacy, the development of necessary institutional arrangements through which individuals, families and communities can assume responsibility for their own well-being".

The apparent reasons for the elevation of community participation at the level of strategy for health care have been summarized below.

1. **Health care is still inaccessible.** It is now realized that "after three and a half-decades of building the physical infrastructure for health services, training and deploying manpower for various cadres, and generating the know-how and technology for health care, the government health system is still not reaching a large proportion of the sick, the needy, the remote and the vulnerable" (Chatterjee, 1988). Thus, a simple, linear growth in the physical and human components is not sufficient to ensure the proper distribution and the actual delivery of quality service in an efficient manner to all. Participation, it is hoped will increase the number of beneficiaries by bringing a greater number of people under the direct influence of health development activities.
2. **Efficiency.** With the participation of increased numbers in all the stages of development activities, there shall be a better coordination of resources and efforts. The duplication of these shall thus be avoided.
3. **Inappropriate health care model.** It is argued that the orientation of the community is urgently needed in order to change the prevalent "wholesale adoption of health manpower development policies and establishment of curative centers based on the Western models which are inappropriate and irrelevant to the real needs of our people and socio-economic conditions obtaining in the country" (NHP, 1983).

4. **Bias towards technology and the market model.** It is felt that the present health care providers are biased towards the technology oriented curative care and they respond more to the market forces than the needs of the community.
5. **Cost-effective coverage.** A community participation approach is a cost-effective way of extending a health care system to the geographical and social periphery of a country though it is far from being cost-free.
6. **Community resources.** It is believed that community participation will make it possible to generate or mobilize the community's own resources for the health care services.
7. **Pressure from below.** Since the government has failed to exercise the desired political will to bring about the necessary change in the health care service system, the pressure built up by the community can change the situation.
8. **Accountability.** The accountability of the private and the public sectors to the people is very low. The community participation would force them to be more accountable to the people's need and as a result, some kind of social orientation of the health services would take place.
9. **Self-Reliance.** Experiments carried out in the field have shown that if proper and adequate training and inputs are provided, the community is capable of taking care of its primary health care needs by using appropriate and simple technology.

The above reasons have led to the active promotion of programs for community participation in health by international development agencies and national governments. The similarity among the community participation programs have been noted by David Werner:

"Surprising similarities exist in the format and structural details of many of these different government health programs, surprising until one realizes that nearly all of them are aided and monitored by the same complex of foreign and international agencies: WHO/PAHO, AID, IDRC, IBD, UNICEF, Milibank Foundation, Rockefeller Foundation, Kellogg Foundation."[42]

A Critique

Based on the macro-social analysis in the works of **Ugalde**[43] and de **Kadt**[44], a critique, that emerges as a result, reveals the reasons as to why international and foreign assistance agencies pressure and finance programs for community participation. The creation of agencies with community representation was interpreted by these critical analysts as a less immediately apparent and more subtle way of fulfilling the agenda of these agencies.

1. International agencies with the support of U.S. academicians and consultants found in the need to change traditional values and in the inability of the poor to organize themselves, an excellent opportunity to promote community participation programs. National policy makers adopted them specially when they came with grants and loans. The real motivation for participation came not because of concern for the poor but the need to legitimize political systems

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[42]Werner, D. (1980) 'Health care and human dignity: a subjective look at community based rural health programs in Latin America.' *Contact,* Special Issue No. 3, 91-105.

[43]Ugalde, A. (1985) Ideological Dimensions of Community Participation in Latin American Health Programs' *Soc. Sci. Med.* Vol. 21, No.1, pp. 41-53.

[44]de Kadt, E., (1982) Ideology, Social Policy, Health and Health Services: A Field of Complex Interactions', *Soc. Sci. Med.* Vol.16, pp. 741-752

compatible with liberal democratic ideologies of the First World nations. This meant [1] legitimization of the accumulation of capital and [2] legitimization of inferior quality health care and health personnel with little or no training, in the name of distributive justice. Here, community participation is mostly symbolic. Communities have the power to select volunteers. Beyond that they have little say in the administrative or financial matters.

2. Community participation has been used as a vehicle to introduce the values of a consumer society, even if at times it carries the destruction of rich indigenous values and institutions. Value changes can also facilitate the transformation of peasants into industrial and rural proletarians. The developed world benefits by the export of goods and the national bourgeoisie by the exploitation of the "modern" worker.

3. Much of this community participation is sponsored with no more in mind than the alleviation of government resource constraints. Community participation is also used for the promotion of self-help programs. In their dealings with local populations, national programs are likely to emphasize the potential for health of local activities (as opposed to those nationally organized and financed) and they will make use of local community oriented traditions and interpretations. These traditions are usually divorced from a broader view of forces operating on the community. They represent the equivalent of Parkin's subordinate meaning system and tie in with the dominant ideology which provides the world view of the government itself. The result may be to let the government off the hook as this kind of approach does little or nothing to redistribute either within the health

sector or as between dominant groups and the mass of the population in the countryside. Construction through self-help (a euphemism for free labor), can free some scarce capital that can be used for some additional infrastructural works that benefit the more affluent classes.

4. Community participation by govt. agencies can and is frequently used as a mechanism of control of private organizations and mass movements by co-opting the most able leaders . The creation of such organizations was not by the citizens themselves, but what Gramsci, called "organic intellectuals", politically sensitive people from better-off neighborhoods who were willing to try out new relationships. These can be tamed and integrated into the mainstream of society by doling out favors such as funding and the calculated satisfaction of some demands.

5. For international forces, community participation is ideal to legitimize civilian liberal democracies. Radical democrats like Rousseau thought that participation had a liberating effect which would in turn help individuals to take control of their own lives and destinies. This contrasted with the ideological current of liberalism, promoted by Thomas Hobbies and John Locke, which provided the moral foundation to ensure the accumulation of capital and power and the transformation of natural rights to property rights. For liberals like Mill participation (passive rather than active) was limited to protection of the individual who participated in as much as he was the object of consideration. Thus, according to Wolf, in this kind of community participation, democracy is limited to symbolic participation, thus maintaining a facade of equality and fair play.

Majid Rahnema[45] (1990) in his well-argued critique of Participatory Action Research, identifies six reasons for the unprecedented interest in the concept of participation by government and development institutions. These are :

1. *The concept of participation is no longer perceived as a threat.* This is because governments "have also learnt to control and contain the risks germane to possible 'unholy' abuse of participation".
2. *Participation has become a politically attractive slogan.*
3. *Participation has become economically attractive by passing on costs to the poor.*
4. *Participation is perceived as an instrument of greater effectiveness as well as new source of investment.* Examples of the beneficial aspects of participation include

a. a close knowledge of the field reality which government technicians and bureaucrats do not have.
b. networks of relations essential to ongoing projects and long-term investments.
c. the cooperation on the local scene of organizations able to carry out development activities

5. *Participation is becoming a good fund-raising device.*
6. *The concept of participation is serving the private sector and its supporters in their latest drive toward the privatization of development.*

Thus we find that ironically, the emphasis on community participation in PHC literature itself has contributed to an ideological shift. First, the romantic rhetoric of people's power detracts attention from macro-scale causes of underdevelopment which lie in national and international economies. Secondly support for community

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[45]Rahnema, M. (1990) 'Participatory Action Research: The Last Temptation of Saint" Development', in *Alternatives*, vol. xv, pp. 199-226.

self-reliance is quite compatible with the neo-classical conviction that state intervention stifles initiative, engenders dependency and obstructs capitalism. Community participation is, thus, used as a means for becoming self-reliant with minimum input. As a result the concept of participation has become a double-edged sword, providing a popular language for policies which are radically different from those envisaged by earlier radical theorists.

[3a] TYPES OF COMMUNITY PARTICIPATION IN HEALTH

A review of literature reveals a wide range of key terms or expressions which essentially characterize the nature of participation in reference[46]. As pointed out earlier, reasons for promoting participation range from economic and practical concerns associated with project efficiency, relevance and cost recovery to political aims of equity and empowerment. The nature and scope of participant involvement vary accordingly. Thus, two main typologies of participation can be identified.

I.[a] Participation in Implementation/ Participation as Contribution/ Instrumental Participation

The argument for community participation in health in developing countries most widely used today is that public resources are insufficient to extend the basic health services to those at present without access to them. There is a long history in many parts of the world, of government and NGO schemes in which communities share the burden of providing health improvements through contributions in labor, materials or even money. Local health insurance schemes through which communities contribute the cost of

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[46]Oakley, P and Marsden, D. (1983) Approaches to Participation in rural development. *preliminary Paper prepared for the Inter-Agency Panel on People's Participation.* International Labour Office, Geneva.

drugs or even to the remuneration of local health workers are relevant in this context. Beyond community contributions in money, kind or labor, community participation in the implementation of health related activities frequently involves the incorporation of CHWs in voluntary agency projects or into the periphery of the health care system.

The basic theme is that as the rural and urban poor know their priority needs better than any outsider, community involvement in problem selection and program planning ensures a greater relevance and commitment to the projects. Another argument is that if people participate in the execution of projects by contributing their knowledge, skills and other untapped resources, organizations can assist a far greater number than can be reached by conventional programs.

Resource contributions can take a variety of forms, of which cash payments are the most controversial. Whereas proponents argue that community financing may the only way of overcoming the lack of funds for PHC, opponents argue that it places the burden of financing health care on the people least able to afford it.

In the definition outlined above, participation is primarily seen as a means to get something done, whether this be the enhancement of project effectiveness, project efficiency, the sharing of costs or a combination of these goals. Such predetermined objectives imply the presence of top-down planning. At best participants will be enlisted to make or shape decisions about what specific project activities should be implemented in a program, how activities will be undertaken and who will be involved in the various stages of implementation. Such involvement is better referred to as utilization. Critics argue that while this differs from 'modernization' strategies by recognizing that the benefits of growth do not necessarily trickle down

to the poor, by implementing programs within existing national and international economic orders, the approach fails to confront the structural causes of poverty.[47]

[I b] Participation in decision-making/ Participation as Empowerment/ Radical Participation

An alternative view to that which perceives participation as an instrumental means is that which regards participation as an end in itself. This perspective sees participation as a dynamic and unpredictable process which should arise from the grassroots rather than being imposed from above. Although this view is compatible with Western democratic ideals (which state that ordinary citizens have a right to share in decision-making) it is normally associated with radical theorists who argue that participation is a process of empowerment of the deprived and the excluded. Here, empowerment ranges from enabling people to manage more effectively to having a say in developmental institutions to enabling people to decide upon actions they consider essential for their development. This view is based on the differences in political and economic power among different groups and classes. Participation thus implies a struggle for redistribution of power and resources in a society.

This interpretation of community participation is gaining increasing acceptance in development rhetoric as a means to empower people. However, it has been much less widespread especially due to the class structure and medical predominance. It has thus been left largely to the personal initiatives of rather exceptional individuals to involve community members in the organization and running of health projects. Thus in most cases, community participation in decision making may mean little more than

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[47]Oakley, P. and Marsden, D. (1984) *Approaches to Participation in Rural Development*, ILO, Geneva.

that community members choose the persons who will be trained as CHWs or decide on the place where they themselves will build a health facility. In some small-scale NGO projects, however, there has been a certain amount of sustained involvement of communities in decision-making. At times this has led to a reorientation of originally exclusively medical activities to a much wider concern with other factors that influence health, agriculture, food production, education etc, with focus on the socio-economically weakest groups.

It is clear that different interpretations of participation are very much subject to political ideology. Means definitions rely on a consensus theory of society; in which the state embodies the interests of the society as a whole and is interested in ensuring that poor communities derive real benefits from national and local development efforts. Ends definitions are more closely linked to conflict accounts of society in which different interest groups struggle for control of available assets and resources. As the state is seen to act on the behalf of the ruling classes, furthering their interests, the accumulation of wealth and the concentration of power, the empowerment of the poor is the only way in which they can meaningfully benefit from the fruits of development.

Rifkin[48] offers a somewhat different typology and distinguishes between the following three approaches:

[II a] The ***medical approach*** sees health as the absence of disease brought about by medical interventions based on science and technology. Community participation in this context is a means by which medical professionals can increase the efficiency of the health services they deliver. Health

[48]Rifkin, S. (1985) *Health Planning and Community Participation, Case Studies in South-East Asia*, Croom Helm, London.

programs are planned and implemented within vertical, top-down structures and a passive, limited role is envisaged for the community, such as distribution of contraceptives by lay persons. Because community participation is restricted to specific activities or events, it tends to be temporary in duration.

[II b] The ***health planning approach*** which characterizes PHC in practice, is based on the view that health is the result of the appropriate delivery of health services. It recognizes that health care resources in many Third World countries are inequitably distributed and that the health sector must be restructured to provide the most benefits to the greatest number of people. Both ends and means objectives of participation are incorporated into this approach. Local people have a right to participate in activities that affect their lives and must be involved in all aspects of program planning if they are to be committed to the project. At the same time, emphasis is placed on the practical need to mobilize community resources in order to extend service provision. Participation is seen therefore as a form of collaboration between the development agency and the community. This generally involves training of community-level workers and the mobilization of community resources.

[II c] The ***community development approach,*** which should not be confused with the earlier community development movement believes that health improvements are not solely dependant upon direct health sector activities, but can only be achieved through better living conditions.

According to this approach, services are a tool to be used in the education of people towards their participation, and health is only one of a possible number of entry points into the development process. It stresses that programs for participation must start with awareness building and that project activities must be developed in response to felt needs and self-help. In contrast to the medical approach which harnesses local efforts to specific short-term goals, the community development approach sees participation as a long-term process in which community confidence, solidarity, responsibility and autonomy are gradually built up.

[3b] MECHANISMS FOR PROMOTING PARTICIPATION

As well as being an ideal, community participation is also a specific process involving the use of prescribed techniques and procedures. Hence, proponents of community participation in development projects are concerned with how new mechanisms for community participation can be established.

A major element of most discussions on the promotion of community participation is the notion of institution-building. Participatory projects are invariably channelled through some form of ***local organization.*** Although traditional associations based on caste exist in India, they are often condemned for representing elitist interests. In response, project planners have set up new organizational structures. This should comprise of a representative selection of community members. Typically their functions include coordinating with the implementing agency, gathering local information, selecting priority problems and solutions, assigning responsibilities for different activities and mobilizing community resources.

In practice the methods by which such committees are created and the structures and functions imposed upon them suggest that rather than being expressions of felt needs and community defined solutions, they are outcomes of bureaucratic demands.

Community workers who are entrusted with the task of institution-building are also referred to in the literature as change agents, extension workers, motivators, community organizers, animators or conscientizers. There are two types of community workers, the first being change agents who have been recruited from "outside" the community and the second being workers selected from the community and trained in community organization work.

The former have been imparted professional training in universities and colleges and they generally assume leadership roles in the project. They are skilled in understanding interpersonal relationships, fostering group activities and promoting community solidarity and in teaching local people to be resourceful in their dealings with the outside world.

These community workers are usually posted to local communities by a sponsoring agency which also funds them and provides them with other forms of support. Ideally local communities should invite community worker to live in their midst and contribute to his or her maintenance, But most community workers today are sponsored by formal organizations, such as voluntary agencies, international development agencies and, increasingly, the governments of Third World countries. Often the activities of these workers are related to the project that the sponsoring agency has developed in the community.

Workers begin by taking up residence in the community or by staying for long periods in it. They seek to establish informal contacts with the local people. Although they will probably deal with traditional leaders and local

elites they are primarily concerned with the poorest groups, attempting to organize them and seeking their full participation in the institution building process. They will also attach particular importance to the mobilization of women.

The second cadre of workers are those who belong to the local community and have been selected and given training (formal or informal) to organize and mobilize the community. In the field of health, a central role is given to the community health worker (CHW), a local resident who receives elementary training in preventive health measures, health education and simple curative care. Under the means definition of participation CHWs have a service role as extenders of PHC services. More radical definitions give CHWs a developmental role as change agents. Hence they are envisaged as catalysts who help communities to understand about ill-health and the factors causing it and to identify solutions to their situations.[49]

They are often seen as the simplest means of extending some aspects of the basic health services beyond the health units. This kind of enlistment of community members is extremely widespread throughout the Third World. In Africa and much of Asia physicians have always been in such short supply that the use of paramedical personnel for curative tasks has been widely accepted. Lower-level auxiliary personnel have had considerable degree of latitude in these areas. In addition to curative tasks, CHWS are often expected to carry out preventive and promotive activities: to help their fellow villagers maintain and improve their families' health, and to mobilize them for collective action in sanitation, water supply and communicable disease control. In practice, few

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[49]Werner, D. (1978) "The Village Health Worker- Lackey or Liberator" in Skeet, M. and Elliott, K. (eds.) *Health Auxiliaries and the Health Team,* Croom Helm, London.

community worker schemes, and especially CHW schemes have lived up to their expectations. Rather than being selected by and accountable to their communities, community leaders and professionals usually identify the workers who come to be regarded as low-level government employees. They rarely represent the poorest sections of the community and the tendency of some national CHW programs as in India, to set minimum educational requirements can result in the virtual exclusion of women.

A major priority is to raise the level of consciousness of local people regarding their life situation, why it is so and the alternatives they have to redress these deficiencies. Part of this process entails the use of confrontational tactics that create an awareness of problems and possibilities. This is a particularly important technique
for integrating the poorest and the more privileged sections of the community and for fostering community solidarity.

Mass meetings are an important element in the promotion of community participation. These meetings often promote the discussion of local issues and help foster group solidarity. Often role methods are used to sensitize people to both local and external problems. However community workers, using ideal participatory methods are not supposed to tell the community what to do. Thus they should be catalysts rather than manipulators. However, as Rahnema points out,

> "Change agents may be also gradually tele-guided into following the steps of as against the professional or expert, and the alien authority of the outsider, may the old expert. The production and dissemination of such agents on a mass level could well be prompted by generous intentions and macro-reasons. Yet this does not always happen and requires special relationships

and conditions. Couldn't they be ultimately used to carry to areas yet untouched by the conventional developers the values and biases of an alienating knowledge together with their own ideological and political conditionings."[50]

Community leadership is perhaps the most important factor influencing participation at the local level. The workers themselves cannot themselves act as leaders, and where traditional elites are reactionary and unresponsive, they cannot develop their programs around existing leadership. Nor can they appoint alternative leaders since these should emerge naturally. They are however trained to deal with problems of leadership and have various tactics at their disposal. They may succeed in isolating reactionary elements or persuade them to abide by the wishes of the majority. They may also be able to integrate the traditional and emergent leaders in the new decision-making bodies and in this way, be able to build a coalition of interests that unites the different factions. However, they are wary of placing too much responsibility on individual leaders, because though charismatic leaders may be able to mobilize people and resources effectively, the emergence of strong and collective institutions is retarded.

Many authors feel that community participation can be effectively initiated through the creation of *specific projects* that command popular support. Pearse and Steifel point out that attempts to foster community participation are often linked to the introduction of particular social development projects. However, several writers have warned of an excessive reliance on projects as a basis of promoting participation. The United Nations (1975) pointed

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[50]Rahnema, M. (1990) 'Participatory Action Research: The Last Temptation of Saint" Development', in *Alternatives*, vol. xv, pp 199-226.

out that the project can easily become an end in itself and that participation will decline once it is completed. There is also the danger that in the rush to construct facilities, community participation will be overlooked and that people's involvement will be relegated to implementation.

Training for participation is recommended for the reason that in addition to efforts of the community workers to train local people in participatory skills, more structured opportunities for training should be created within and outside the locality and specialist skills in a variety of social development activities should be provided.

A major topic in the literature on community participation is the idea of decentralization. The tendency towards centralization, it is argued, must be resisted, since ordinary people are becoming increasingly excluded from political affairs. Decentralization requires the creation of democratically elected and representative decision-making bodies with clearly defined powers to administer programs and control revenues. Once they have become firmly established, it is suggested that these bodies should be integrated into the formal administrative and planning process.

A major problem facing the proponents of decentralization and one of general relevance to community participation, is finance. True decentralization is said to occur only when local decision-making bodies have control over financial resources. This is a controversial issue on which strong opinions are held. Self-sufficiency is cited as a reaction to the indiscriminate handing out of food and drugs, which by themselves may do little to improve health. It is also based on the view that people do not value a service unless they pay for it. Again another aspect of the view is based on the fact that small scale projects cannot

be replicated if their has been a too great dependence on outside financial resources. Moreover, it is felt that since communities are unable to raise sufficient revenues to meet their own needs, they are dependant on external funds and thus subject to external control.

There are various ways in which greater self-sufficiency is sought. In some cases villages are expected to pay the stipends of the village-level workers, or the workers are expected to work for nothing. Curative treatment may be charged, and this may cover some of the costs of preventive services.

All these ways of ***mobilizing community economic resources*** are legitimate and in poor communities may be the only way of developing adequate services. But to use the goal of self-sufficiency as the main criterion is not seen as justifiable in view of the gross inequalities in income and access to services. Community poverty naturally sets limits to the practicality of sharing costs with prospective beneficiaries. Bang argues that this goal leads to losing sight of the primary objective which is to improve the health of the people. 'Self reliance of the people in their own health care should not be the objective of the health activity. The funds necessary for health care have to be generated by the economic programs'. Although, this is fine in principle, programs have to, in the meantime, struggle with a lack of resources.

[3c] THE SOCIO-ECONOMIC CONTEXT

Community participation is promoted as a global strategy. However, attitudes towards collective action vary according to socio-economic context. Here, we examine what factors promote or undermine participation within social formations (whether social, political, economic or cultural). While cultural values may be used to promote collective consciousness there is always the danger that

religious, caste or clan divisions will have a negative effect on participation. In India, for example, where members of low-castes are seen as polluting to high caste groups, promoting collective responsibility for facilities such as wells can prove difficult. In addition to cleavages based on traditional bonds, there are now class or class-like antagonisms arising significantly from the unequal distribution of the fruits of development. Thus, different interests may conflict and compete for project resources. Moreover in cultural contexts where women were seen as repositories of traditional and family values, there may be a great resistance to women's participation. Pressures also easily build up to steer benefits from the poor. Poor and especially women are the least able to afford the time required to participate in community activities.

Thus, it needs to be stressed that community involvement for health is likely to present different problems and different opportunities in relatively homogenous and in relatively segmented or unequal communities. The most significant distinctions are socio-economic. In these instances the success of community participation depends upon whether or not formal or informal leadership has developed among the poor majority. Where material resources are more equally distributed there appears to be a better basis for community activities. Nevertheless even in such circumstances, it may be difficult to involve community members if poverty and individualism prevails. These structural factors are however mediated by the wider socio-political context.

If local communities are to participate in the design and implementation of development activities, there must be a political commitment at the national level to bureaucratic reorientation. In most parts of the world however, there has been almost no decentralization of effective authority and power. Although liberal regimes

grant their citizens political representation they do not necessarily offer greater opportunities for participatory development. Because people's empowerment implies a change to the political status quo, governments may profess to support participation while deliberately maintaining a narrow power base. By creating a bureaucratic framework for channelling local demands a government will seem to be responsive to the needs of the poor. In reality however, grassroots mobilization is contained and participation routinized. Local leaders may be coopted through the practice of political patronage. Finally, governments nay be under pressure to skew their policies towards donor-led interests. Today, many governments that previously advocated collective responsibility for health care are increasingly favoring the private market which offers little scope for community involvement. Within the public health sector, the goal of participation is often undermined by the tendency to concentrate on specific medical targets rather than comprehensive social development.

[3d] COMMUNITY PARTICIPATION IN HEALTH IN INDIA

In India, a British civil servant, F.L. Brayne[51], tried to organize the people of a Punjab village in a wide-ranging effort, which included family and community welfare. The experiment did not prove successful, leading critics to comment that community participation is not possible on a durable basis by administrative directives from the top. However, even the efforts of most nationalist leaders failed in this respect and while they lasted, they

[51]Brayne, F. L. (1929) *The Remaking of Village India,* Oxford University Press, London, as mentioned in Madan, T. N. (1987) 'Community Involvement in Health Policy: Socio-structural and Dynamic Aspects of Health Beliefs' *Soc. Sci. Med.*, Vol. 25. No.6, pp. 615-620

were dependent on the charismatic appeal of leaders such as Gandhi at Sevagram.

The idea of involving people in schemes of common welfare did however gain ground. Thus, we find that, a committee appointed by the British Government of India[52] (with Sir Joseph Bhore as its chairman) in the early 1940s, to look into medical education and care problems of India, suggested that the citizen himself should contribute to his own health, and stressed the importance of community-based rather than hospital-based medical services.

After independence, the Government of India launched, in the early 1950s, a massive Community Development Program, which was intended to galvanize millions of villagers all over the country, to articulate their "felt" needs and to participate in programs of social and economic development. The efforts and resources of the state and the people were to be combined for this purpose. Health improvement was a part of the objective, though the primary stress was on enhancing the production of food. Though India's Community Development Program aroused much enthusiasm at home and world-wide attention, the drive behind it was a spent force by the early 1970s, by which time the task of covering the whole country with a massive institutional framework had been completed. This survives today, but is used by the state governments for other purposes, such as decentralization of development planning, which seeks to enhance the benefits of development activities rather than promoting community participation, an important paradigmatic shift which similarities in rhetoric cannot always conceal.

As we have already seen, the terminology of participation is expropriated to meet prescribed objectives of the dominant groups, and one such group is often the

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[52]Government of India,(1946) *Report of the Health Survey and Development Committee*, New Delhi.

state itself, which often in the name of removal of poverty, generates programs which reinforce the resource distribution patterns and superiority of professional and class structures. One such example is the decision in 1970s, to initiate schemes of Community Health Workers.

This initiative from the government, in 1977, aimed to place "people's health in people's hands," through the provision of health services at the doorsteps of the villagers. Community Health Workers, (CHWs) later called Village Health Guides, and traditional female birth attendants were to be recruited to provide a link between the PHC and the local community. These workers would belong to the community, represent it, and be answerable to it. Early assessments of the scheme by governmental and other agencies, indicated that the scheme had generally been well-received, though not properly understood. Almost one and half decades after the CHW/VHG scheme was launched, the general assessment was that it has enjoyed only limited success. Thus, according to N. H. Antia, the main problems are the inadequate preparation of the workers (who were not only not well-compensated but over-burdened) and the community, opposition from the medical profession, appropriation of the CHWs by the health bureaucracy, inadequate technical support and irregular supply of materials including drugs. Moreover, it was believed that with the CHWs, (who are the lowest in the hierarchy of health care providers) being appointed as volunteers by the community, people's participation in health care would increase. But, as Qadeer states, "it is a paradox that the well-off, who used the CHWs the least, were also the ones who were bestowed with the CHWs' attention and the poor who used them the most, had to beg plead and wait". She adds that the degree of participation or non-participation is determined by the "overall socio-economic relationships that bind a population and within which all schemes have to

function. It is the links with the larger system that decide the success or failure of a scheme".[53]

In the name of ensuring community participation, the real intention of the state seems to have been one of having a dual system of health care services; with expensive, doctor-staffed, hospitals for relatively better-off urban populations and untrained or inadequately trained CHW providing low-quality care in the rural areas.

The ideal of community participation is, however, being promoted in a big way as an alternative strategy by NGOs and"activist" groups which do not consider state agencies as capable of bringing the right kinds of development to the people. In a document prepared under the joint auspices of ICSSR and ICMR[54], it is stated that an alternative approach to health care has become imperative and that the "top-down and elite-oriented approach of the existing services" be replaced by one "based on or rooted in the community and then rises to specialized services at the district or regional levels".

While the ICSSR and ICMR are autonomous agencies, the Government of India also emphasizes community involvement in health plans. Thus in the Seventh Five Year Plan (1985-1990) it is stated that "community participation and people's involvement in the program being of critical importance, programs involving active participation of voluntary organizations and the mounting of massive health education movement would be accorded priority".

It is interesting to study the reasons behind the increasing emphasis given to NGOs. The term NGO entered mainstream developmental literature only in the 1980s

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[53]Qadeer, I. (1985)' Social Dynamics of Health Care: The Community Health Workers Scheme in Shahdol District' in *Socialist Health Review*, Vol. II, No.2, Sept.

[54]ICSSR and ICMR, *Health for All: An Alternative Strategy*, Indian Institute of Education, Pune.

Earlier this sector used to be termed as the voluntary sector. In the decades preceding and following independence, most voluntary organizations in India were largely Gandhian in orientation, based on funds generated from income-generation activities or raised from charities. The seventies witnessed the emergence of community health projects such as those in Kasa, Tilonia, Mandwa, Miraj, Jamkhed and Vadu. Most of these projects turned medical auxiliaries into multi-purpose workers and achieved notable successes in improving immunization coverage and nutritional status of mothers. Later self-help activities were extended to education, income-generation, improved water supply etc. However, most of these projects were also characterized by the leadership role exercised by certain unusually gifted individuals (urban born and highly educated). They had to do certain things to secure community participation and improve its quality. It is also they who helped the people take initiatives. Thus, as according to T.N. Madan,"participating communities are made not born"[55]. Despite these drawbacks, it cannot be these projects genuinely attempted to secure Community participation.

The mid-seventies and the eighties have been characterized by a new -breed of organizations broadly described as NGOs, "organizations differing in size, form, orientation, ideological affinity, resources and target groups"[56]. Though there is little evidence to support their claims of securing the participation of the target communities, they receive increasing amounts of funds from

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[55]Madan, T. N. (1987) 'Community Involvement in Health Policy: Socio-structural and Dynamic Aspects of Health Beliefs' *Soc. Sci. Med.*, Vol. 25. No.6, pp. 615-620

[56]Vahlhans, M., (1994)' The New Popularity of NGOs: Will the Enthusiasm Last?'

national and international donor agencies. The real reason for the new interest in this sector is a reflection of the predominance, in the eighties, of market economics, with its emphasis on private initiative in development over the earlier Keynesian thinking. In India, as well as in most parts of the developing world, the structural adjustment policies witnessed the withdrawal of the state from several sectors, especially from the service sector. This vacuum was thus sought to be filled by the NGOs, who are said to be more participatory, deliver services more efficiently and at lower costs. However, as suggested earlier, the ability of the NGOs to secure community participation is questionable, since ideological dimensions have an important role to play in this area. Hence, at this point, it shall be worthwhile to consider the interaction of organizational and ideological factors in determining community participation

[4] HEALTH ORGANIZATIONS, COMMUNITY PARTICIPATION AND IDEOLOGY

In the best of situations, participation would mean that all initiatives come from the people and include the making of proposals regarding improvements in public health, converting these proposals into concrete plans and participating in implementing and evaluating them. Governmental and non-governmental agencies would then be expected to assist the people in wide-ranging activities. In actual practice however, things are the other way round. If participation at all exists in programs run by government organizations and NGOs, it is in the form of cooperation mostly at the stage of implementation that is sought by the state and NGOs responsible for public health programs. This should not be a surprise for people in general do not have the resources, technical expertise,

power or time, nor are they organized to take initiatives mentioned above. Left to their own resources communities are not likely to change their behavior in or understanding of the world around them, though the mass media may have a catalyzing influence.

Most community participation is, thus, sponsored that is, brought about by agents external to the community. Reviews of participation programs make the distinction between the policies and outcomes of governmental, and non-governmental organizations. Several authors have stressed that " the major characteristics that differentiate the approaches to community participation are the organizational structures and procedures" (Askew[57]).

State sponsored programs are said to be characterized by a high degree of control over the programs if their policy goals are to be achieved as originally planned. Multilateral organizations such as the World Bank and the UNICEF and state agencies tend to give loans or grants to governmental agencies to implement large-scale projects. Having access to considerable financial resources, they may place significant political or bureaucratic pressures on the implementing agency to justify its policies and expenditure and to give tangible evidence of its success. Constrained by both national and international considerations, government projects are almost inevitably "top-down" in orientation. Any errors and uncertainty which may occur during implementation and thus threaten the effectiveness of the process have to be minimized. This control can be maintained through a variety of administrative procedures such as fixed quantitative targets, detailed blueprint plans and complicated evaluation methodologies and involvement of professional

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[57]Askew, I and Lenton, (1987) *Community Participation in Family Planning: Some Suggestions for Organizational Development and Management Change.* IPPF, London.

experts in program design. How and in which activities the community will be encouraged to participate need to be decided well in advance.

This need for administrative control necessarily restricts the potential for community participation and reinforces the top-down approach to project planning and implementation. It excludes meaningful input from the community members (and often the lower levels of the program hierarchy) because to include such input may introduce a level of uncertainty which these procedures are designed to remove. Thus, it is felt that though governments may pay lip-service to the principle, but in practice the implementation of it tends to be weak.

NGOs have generally been cited as successful in using community participation as the principal method of operation[58]. There are many reasons put forward for this, by governments and NGOs, quite apart from the charges against the bureaucratic machinery. These are as follows:

[1] The initiative for participation emerges as a joint activity of the NGO and the local people. The objectives of the project are more locally-oriented and concerned with meeting the development needs of the community, rather than being determined by national policy and limited to the delivery of a particular service. Hence, their actions are likely to be responsive rather than imposed. Locally placed NGOs are potentially, at least, more able to include meaningful input from the community at the planning stage of the project as well as in its implementation.

[2] Moreover, NGOs can foster overall community development rather more easily than government-

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[58]Padron, M. (1982) 'Popular participation in development projects; comparing limits and possibilities of private development associations and governmental agencies' in Galjart, B and Buijs, H. (eds.) *Participation of the Poor in Development.* Institute for Cultural and Social Studies, University of Leiden; Askew, I. (1989)'Organizing community participation in family planning projects in South Asia.'*Studies in Family Planning* 20 (4) pp. 185-202; Morley, D. *et a*, op. cit.

sponsored community health programs: the latter are more enmeshed in the web of specialized government agencies, each of which has its bureaucratically separated and maintained sectoral tasks in health, education, agriculture, public works and so on. This division of labor easily obscures the interconnections between different problems. NGOs are less hampered by this particular constraint.

[3] NGO projects are on a smaller scale, so community participation is much easier to achieve. They are more likely to employ dedicated people who are supposedly less concerned about the career prospects of their job. It is also easier for an NGO to be innovative, to test out small pilot projects.

[4] Government organizations are necessarily large-scale bureaucracies that have developed hierarchical organizational structures and inflexible administrative procedures in order to carry out their functions effectively. NGOs, on the other hand tend to be less bureaucratic and because of their smaller size are relatively more flexible. Consequently, they are less likely to utilize the organizational and procedural mechanisms discussed previously, which inhibit community participation.

Nevertheless, it has not been systematically proven that NGOs always fulfil these potential comparative advantages. The use of these organizations in community participation has a number of drawbacks which sometimes may, in fact, act against the emergence of authentic forms of community participation.

In spite of their avowedly non-bureaucratic character, many voluntary organizations and especially the larger ones function bureaucratically and use formal procedural rules to carry out their tasks. Similarly, while flexibility and innovation do characterize a great deal of voluntary endeavor in this area, NGOs are prone to ossification particularly if they are dominated by charismatic leaders. The assumption that they are politically progressive also needs to be questioned. Many are run by middle class individuals whose views are liberal and paternalistic rather than radically egalitarian.

The sustainability of NGO run health projects is greatly affected by uncertain funding sources which invariably limit the scope and the extent of the project. Funding is time-limited, project-based and limited to a small geographical area. This has led to the "colonization of the voluntary sector", because whatever their motives and ideologies, those who control the flow of funds are most likely to attach conditions to their disbursement. In this climate of insecurity, many projects struggle to survive from one round of funding to the next, or are forced to close down despite continued interest and demand. This uncertainty that has crept into participatory activities as a result of the shift in the nature of activism that we discussed in Section 3.d. i.e. the shift from small, voluntary or mass-based activities to institutionally funded NGOs.

The voluntary sector also suffers from a continuous problem of duplication of or lack of coordination with government services. In the field of health, NGOs sometimes perceive themselves as an alternative to the public health services provided by the government.

Another major drawback is the inability of the voluntary sector to redistribute resources. Though they may be able to allocate considerable resources to a deprived community they are seldom able to shift resources between groups on a sizable scale. This is not only because of the spatial localization of much of voluntary effort, but because, unlike the state, these organizations have no mandatory mechanisms for transferring resources from the wealthier sections of the society to fund programs for poorer groups. Hence, unlike the state, which has the power to mobilize and redistribute resources, they are generally dependent on charity.

Another problem is that successful NGOs tend to attract more and more resources for their own projects

resulting in a concentration of these resources in certain areas. This helps create "masterpieces of development programs" which become places of pilgrimage for international development tourists. However, excessive foreign funds disproportionately influence local development. While those living in the project benefit much more than those in the surrounding areas, the organization's programs are not expanded or replicated to reach a wider section of the population.

In general, the evidence suggests that community participation through NGOs can usually help achieve some health improvement. One problem, however, is inherent in the structure of any purely local project. Where issues beyond the locality and the health services are at the roots of ill-health and poverty, it is difficult to influence those issues from a wholly local project. If local ill-health is largely accounted for by the fact that people cannot make a living and if that in turn is caused by forces beyond the community then emphasizing community participation is unlikely to be very helpful.

Finally, in instances where the state itself is responsible for unjust distribution of services and resources, it is difficult for NGOs to organize the local people against the state, with the aim of challenging and changing existing social and economic priorities. This is because either direct state funding and state support or state regulation of funds (as in the Foreign Contribution [Regulation] Act in India) are essential to the establishment and the development of the program. Hence, when such NGOs pose fundamental challenges to the state, that support is lost or withdrawn, and they could decline or close down.

As these arguments suggest, it is questionable whether the voluntary sector, in general, is any more able to promote authentic participation than the state. It also

leads one to question the almost exclusive importance attached to organizational factors in determining the nature of community participation. This imputed emphasis on organizational factors is further weakened when one considers several instances where the state has actually been successful in promoting community participation (as in China, Cuba and Allende's Chile[59]) and where the voluntary sector has not[60].

As de Kadt[61] suggests, it is the orientation or the ideology of the sponsors as well as the nature of the organization that determines the kind of participation that will emerge. He proposes a theoretical framework based on the sponsors of participation and their ideology. According to him, the sponsors of participation or the actual implementing agencies may be closely linked to official organizations or to voluntary organizations. They may claim they want to make the community more self-reliant, more capable of influencing their own fate. Yet in reality sponsors may differ considerably in their links with the existing socio-political structure and to the extent to which they would be willing to see communities challenge certain aspects of the structure. Two dimensions are thus involved, which can be represented as follows.

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[59]See footnotes 1, 2, and 3.

[60]Jesani, A. Gupte, M., Duggal, R (1986) *NGOs in Rural Health Care,* FRCH, Bombay. This study of 45 NGOs in rural Maharashtra found that the organizational structure of most NGOs was such that it prevented community control over them.

[61]de Kadt, E. (1982) 'Community Participation for Health: The Case of Latin America'. in *World Development*, vol. 10, no. 7, pp. 573-584.

Sponsorship

Ideology/ Orientation	Part of or close to the government	Non-governmental organization
Maintenance of status quo		
Reform or fundamental challenge to the status quo		

[a] **Government sponsorship with conservative orientation**

Since Alma Ata, all governments have formally accepted the PHC approach. This implies that sooner or later some form of community participation is likely to be policy everywhere, even in the case of governments whose overall policies have little or no real concern for the disadvantaged. The state while supporting the existing social structure through its economic policies may want to avoid the potentially negative effects of great poverty and inequality. Hence community health programs may be developed, while the health sector remains heavily weighted to urban curative care which absorbs most of the country's health care resources.

If communities are being involved by official organizations, in such circumstances, participation is likely to be largely a matter of following directives from above- of compliance. The poor themselves will not contribute much to the definition of the problems and it is unlikely that their attention will be drawn to the main causes of their ill-health, their poverty and underdevelopment. Werner found that most such programs were characterized by "a maximum of handouts, paternalism and

superimposed, initiative-destroying 'norms".[62]

Moreover, in these situations, contributions in time and resources of the rural poor 'let the government off the hook' as the people's activities are neither accompanied by a redistribution of resources within the health sector itself nor by wider efforts to help the members of such communities to improve their socio-economic well-being.

[b] **Non- governmental sponsorship with conservative orientation**

Certain health projects sponsored by religious organizations or charitable trusts provide examples of this type. Such organizations are conservative in essence and are less likely to concern themselves directly with problems of the socioeconomic structure, as they take the status quo for granted.

[c] **Government sponsorship with reformist or radical orientation**

Governments with a reformist orientation are found in many countries of the world, the degree of 'reformism' varying considerably from one place to another. These are intermediate cases, neither clearly conservative nor absolutely revolutionary, and there is often wide disagreement in assessing the effects and intentions of the policies of governments in this category.

Community participation for health promoted by reformist governments may easily be dismissed as 'integrative' that is strengthening the system (of capitalism) that marginalizes. Yet they could also be seen as enabling the disadvantaged groups to relate their health

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[62]Werner, D. (1980) 'Health Care and Human Dignity', in Rifkin, S (ed.) *Health, The Human Factor: Readings in Health, Development and Community Participation*, CONTACT Special Series, No. 3, CMC, World Council of Churches, Geneva.

problems to the broader causes of underdevelopment and its perpetuation, potentially setting in motion processes of change beyond the health care system. There are many instances of government sponsored programs in which community participation has been regarded as a tool for *conscientization*.

Governments may also attempt to mobilize the masses in support of a radical change in social and productive relations. Community participation then is a part of a strategy for change: it is a weapon used by the government or the ruling party to challenge the influence of power groups and classes and to shift power and resources to those hitherto disadvantaged. This happens after a socialist revolution or in the early years of elected governments committed to a transition to socialism.

[d] **Non governmental sponsorship with reformist or radical orientation**

Werner has defined as community supportive programs as those which

> "favorably influence the long-range welfare of the community, that help it to stand on its own feet, that genuinely encourage responsibility, initiative, decision-making and self-reliance at the community level, and that build upon human dignity." [63]

Many such NGOs are community-supportive. Because of their smaller scale and more direct human involvement with the communities of such projects, their promoters are likely to listen attentively to the views of community members, sharing a concern for their 'felt' needs. However, when asked about their health needs many poor people do not place health as such very high up on the list of their priorities. More urgent are food, work and income, water

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[63]Werner, D. (1980)'Health care and human dignity' in Rifkin, *op. cit.*, p. 94.

etc. Sponsors of a NGO with a reformist orientation usually realize that poor people are not wrong to put emphasis where they do. Thus, they realize that it is incorrect to attempt to bring about health improvements in isolation from the wider social and economic context and promoted on their own without a thought for the way in which living conditions and social relations may impede their implementation or nullify their effect.

This type of project then appears particularly prone to move away from isolated health activities. It can engage in wider development activities, broadening out beyond conventional health issues- e.g. from nutrition through food production to income generation and then perhaps on to income distribution, class and power.

Sometimes the promoters of such projects start with a radical interpretation of the nature of health and development problems. NGOs may, thus, see themselves as presenting a radical challenge to the status quo but this may not always be obvious to outsiders. This ambiguity results mainly from the relationship between projects and the government. The more repressive the state, the more easily it will define projects as subversive and in the final analysis any radical project will face the decision whether or not to defy government authority outright. Before that occurs the projects activities may remain within limits acceptable to the authorities even if its orientation and hence the nature of what happens in the name of *conscientization* point in the direction of basic change. Project leaders will require a capacity for predicting the reactions of potential allies and adversaries in order to weigh possible chances for success or failure.

The success of such projects in achieving improvement for the disadvantaged, and in using health as a lever in the wider socio-economic arena, depends to a large extent

on the political context in which they operate. Thus, the projects of radical non-government sponsors are not likely to be all that different from those sponsored by reformists. Both types of projects can help sow the seeds of change. Yet only when their aims and those of the authorities are basically identical can radicals outside the government really stimulate communities to challenge those who remain powerful in the socio-economic structure.

De Kadt's analysis and the various examples he provides of Latin American health programs indicates that ideological factors have a great bearing on the kind of community participation that emerges as a result. Such a representation, though useful as a starting point, suffers from various drawbacks

[1] It oversimplifies reality and is static as it cannot take account of changes over time in the ideology and nature of organizations. Most organizations in their life-times undergo various changes in their ideologies either due to interaction with the larger environments or due to alternative ideologies offered by sections of the organizations themselves.

[2] It also confuses basic social categories of welfare and radical social change by lumping together the categories of reform and challenge to the status quo. It also combines the categories of the government and close to the government, which is not an exact antithesis to the term NGO.

[3] De Kadt's framework, while focusing on ideological differences between organizations, tends to ignore ideological differences within organizations. It is incorrect to assume that organizations are necessarily monolithic. Within any organization there are always nooks and crannies where an orientation can operate which is more radical or conservative than the dominant ideology. But there are obviously limits to

the divergence tolerated though these limits can only be known when tested.

Therefore, a framework which takes into consideration these dynamic aspects of organizational ideologies needs to be constructed. Hence, for the purposes of our study it would be fruitful to link the leads provided by de Kadt's framework to Parkin's typology of class-based ideologies. This would aid in the understanding of the differing ideologies of community participation within an organization, that of the leadership or the 'management', of the technical staff or trainers, field workers and the people within communities. This type of an analysis would also yield important insights into how these differing ideologies struggle between themselves for supremacy and how they contend with the larger socio-political context (funding, national policy, state support, community leadership). Moreover, it also takes into account, organizational changes arising out of ideological changes over time, specifically due to interaction with the larger socio-political context and with other ideologies. Hence, a modified framework would take into account:

[a] the differences within the different sections/levels of the organization;

[b] the process of evolution of ideologies through their confrontation with the larger as well as local socio-political realities and other ideologies; and

[c] the influence of ideological shifts on organizational structures.

In other words, the project planners' ideology (whether conservative or radical) influences the nature of the organization, both its structures and processes. The greater the compliance with and dependence of the project planners on the larger socio- political context, the lesser the challenge to the status quo. This will in turn

influence the organization, its structure and processes. The more conservative the ideology, the more bureaucratized the structure, and the greater the degree of centralization and administrative control. This will affect the nature of the participation which will mostly be instrumental participation. However, if organizational socialization processes fail and the planners are unable to impart their ideologies to their subordinates then there is a possibility of a more radical ideology emerging. This could lead to some challenge to the larger status quo, a resultant decentralization in the organization and more radical forms of participation. However, this deviance is not tolerated and the dominant ideology evolves methods to finally prevail.

Conversely, if the planners subscribe to a more radical ideology, then the lesser will be the compliance and dependence on the larger conservative environment and the greater will be the challenge to the status quo. This will influence the organizational structure, rendering it more decentralized and flexible. The form of community participation that will emerge as a result will be radical community participation. However, if socialization processes fail, a more conservative ideology may prevail which may not be willing to challenge the status quo. The project leadership, however, will not tolerate the deviance and it would evolve methods to allow its ideology to prevail. The above two types of ideologies are extreme possibilities and a reformist ideology may be found between these two extreme points.

We hope to show through our case studies that it is these ideological underpinnings which are much more critical than governance of the projects by governmental or non-governmental organizations.

GENERAL OBJECTIVE

1. To determine the extent to which ideological and hence organizational factors are responsible for the type of community participation being promoted in health projects through a comparative case-study of a non-governmental organization and a governmental organization.

SPECIFIC OBJECTIVES

2. To examine project planners' ideologies with regard to community participation, the importance given to the larger environment and how these have influenced the creation of the organization.

3. To study how the ideology and hence the organizational processes and structures have changed over time as a result of environmental influences and constraints and alternative ideologies offered by sections of the organizations themselves.

4. To study ideological differences within organizations, the conflicts arising from these differences and its effects on the community participation in health.

CHAPTER II

METHODOLOGY

I. RESEARCH DESIGN

To carry out an analysis based on these objectives, the comparative case study design was adopted.

As a research design, the case study contributes uniquely to our knowledge of individual, organizational, social and political phenomena. The case study allows an investigation to retain the holistic characteristics of real-life events, be they in the life of an individual or an organization or a given social process.

Since each of the research designs can be used for the purposes of exploration, description or explanation, what justifies the selection of a particular design are the three conditions discussed below. These are:

1. the type of research question posed,
2. the extent of control the investigator has over actual events, and
3. the degree of focus on contemporary as opposed to historical events.

As the study asks "how" and "why" questions (process-related), with regard to contemporary phenomena, and since the investigator has no control over the events, the case study method was considered most appropriate for the study. Moreover, because the objectives demanded an empirical enquiry into a contemporary phenomenon within its real-life context and since the boundaries between the phenomenon of community participation in health projects and the larger environmental context are not really strict, this design, using multiple sources of evidence, was selected.

The main variable categories of the study are ideologies, organizational processes and structures and

community participation. Some of these are subjective elements and can be studied only through descriptive interpretation. Accordingly, qualitative methodologies of the case study were used in order to access the meanings which participants assign to these social situations.

The case study was a comparative one because the results obtained from comparison are more compelling. The logic underlying the use of multiple case studies is that each case must be carefully selected so that it either:

[1] predicts similar results [a *literal replication*] or

[2] produces contrary results, but for predictable reasons [a *theoretical replication*].

In this study, the latter (theoretical replication) was used in the selection of cases. Two organizations were selected because they produced differing styles of community participation as a result of differences in the ideology and orientation of the planners.

II. AREA OF STUDY

i. Selection of Locations.

Two organizations in Rajasthan state, one governmental and one non-governmental, were selected. Both have been well-documented as success stories in the promotion of community involvement. For the first case, the governmental organization, namely **Women's Development Program** (in Ajmer District) and for the second case of the NGO, namely **URMUL Trust**, (Bikaner District) were chosen. These two organizations were not always comparable, especially in terms of size, (since Women's Development Programme is a state-wide program, and URMUL is confined only to one district). However, they were chosen because the objective of the study was to understand the nature of Community participation, thus requiring qualitative rather than quantitative indicators.

More specifically, the cases were selected also due to the following criteria:

a. accessibility, or the degree of access and entry given to the researcher
b. unobtrusiveness, so that the researcher could take on an unobtrusive role
c. participation, or the possibility of the researcher to participate in activities.

In this study, it was possible to meet these criteria to a great extent, especially in the non-governmental organization.

ii. The Selection of Events

The researcher in the role of the observer studied several events which were considered revelatory. Three type of events were selected:

1. Intentional, systematic and theoretically guided (such as observation of daily activities of workers).
2. Events which were fortuitous but anticipated (meetings, workshops)
3. Untoward events such as emergencies, dramatic situations and crises which are not anticipated. Here, the researcher utilized the extended case method. This focusing on events or crises brought to the fore issues which and interests which would otherwise have not been apparent. It was intended to ventilate different accounts of the same event by different actors.

iii. The Selection of People: Key Informants

The researcher selected a range of informants drawn from different status levels in organization for each of them provided a different account of the organization and about the different elements of their culture as they perceived it. They were selected for their knowledge of the particular setting which could complement the researcher's observations and point towards further investigation that

needed to be done in order to understand organizations and social processes. Informants were selected on the basis of the following sampling techniques:

a. Judgement Sampling

These forms of non-probablistic sampling involve the selection of actions, events and people. Informants were selected for the study according to a number of criteria established by the researcher such as occupation etc. This required a detailed knowledge of the universe from which to draw these individuals.

In the present study, respondents were selected from the different levels in the organization ranging from the managerial to field level staff. For the first case, i.e. the NGO (URMUL), those interviewed or observed were:

1. Secretary, URMUL Setu
2. Health Coordinator
3. Field Coordinator (Health)
4. Nirogi Sathis (10)
5. Swasthya Sathis (8)
6. Other field Level Workers.
7. Researchers

In the Governmental organization (WDP), those interviewed or observed were:

1. Project Director, Ajmer District.
2. District IDARA Coordinator
3. Former Member, Health Project, Ajmer and Jaipur, Districts, currently Secretary, Sathin's Union.
4. Former Prachetas (2), 1 is Currently Office Minister, Sathin's Union.
5. Prachetas (4)
6. Sathins (8)

b. Opportunistic Sampling

Here the researcher found respondents who provided her with data. She selected individuals who were available (in the villages, as it was peak agricultural season during the time of the fieldwork). The researcher interviewed members of the community through this procedure of sampling. Since these were selected as a result of the opportunity afforded, replication of this technique may not be possible.

c. Snowball sampling

This too relies on the researcher's knowledge of the social situation. This approach involved using a small group of informants who are asked to put the researcher into touch with a further group of informants. Thus, a chain of informants had been selected. Organizational members, who were not selected by judgement sampling, were usually approached in this manner.

III. DATA REQUIRED

* Project (especially health projects) histories
* Organizational structures and intra-organizational relations of the projects and changes over time
* Areas of work and changes over time
* Project planners' views regarding community participation
* Views of technical and field -level staff regarding community participation
* Indicators of the type of community participation.

The framework proposed by Rifkin *et al*[64] has been used. The broad indicators are:

[1] needs assessment [2] leadership
[3] organization [4] resource mobilization
[5] management [6] focus on the poor

IV. DATA COLLECTION

In order to access to the required data outlined above, a variety of techniques were employed so that leads or inferences drawn from one data source were corroborated or followed up by another. This use of multiple sources of evidence allowed the researcher to address a broader range of historical and attitudinal issues. However, the most important advantage of this was the development of converging lines of inquiry, a process of triangulation. This enabled any finding or conclusion in the case study to be much more convincing and accurate, since it was based on several different modes of information, following a corroboratory mode. In this manner potential problems of construct validity have also been addressed.

The study was characterized by flexibility. There were no set rules or procedures or fixed roles, since it predominantly involved the use of observation, unstructured interviews and examination of documentary evidence all, of which had to be applied to specific cases studied.

To undertake the analysis, data was collected using the following methods.

i. Observation

The researcher gathered data by studying the daily life of the group or the organization. She watched the people under study to see what situations they ordinarily encounter and how they behave in them. She entered into

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[64]Rifkin, S., Muller, F. and Bichmann, W. (1988) 'Primary Health Care : On Measuring Participation' in *Soc. Sci.Med.* Vol. 26, No.9, pp. 931-940.

conversation with some of the participants in these situations and discovered their interpretations of the observed events. This method facilitated the collection of data on social interaction and on situations as they occurred rather than on artificial situations (as in experimental research) or constructs of artificial situations (as in survey research). It gave her the opportunity to collect rich data based on observations in natural settings. Furthermore, the researcher could obtain accounts of situations in the participants language which gave her access to the concepts that are used in everyday life. She could, therefore, construct an account of the social situation on the basis of the various accounts that were obtained from the informants. This also afforded her the opportunity to collect the different versions of events that were available, with the aim of comparing these accounts with each other and with other observations that she had made in the field of study.

In the context of this study, the researcher was involved in a variety of situations in which she deployed this role: hanging around the organization, observing meetings, and accompanying workers as they went about their duties. This entailed the sustained involvement of the researcher in the organizations studied with a view to generating a rounded, in-depth account, although it was not possible to observe all relevant situations and processes.

ii. Unstructured interviewing

Often, this method is part of a broader program of research and draws on the knowledge that the researcher has of a social situation. It can help the researcher gain access to situations that through time, place or situation are closed. In this sense interviews might be used to gain access to a career history or situations the researcher did not witness.

This method was used as an adjunct to participant

observation. Here, the researcher provided minimal guidance and allowed considerable latitude for interviewees. Rather than using an interview schedule, it was used for a loose collection of themes which were to be covered. Interviews were carried on for more than one occasion, in order to reveal the interviewees concerns.

Three main types of questions were used. These were:

1. *Descriptive questions* which allowed informants to provide statements about their activities
2. *Structural questions* which attempted to find out how informants organize their knowledge
3. *Contrast questions* which allowed informants to discuss meanings of situations and provided an opportunity for comparisons to take place between situations and events in the informants' world.

In the course of this research, the researcher found that workers often asked her for information during interviews. She was asked about her background, about her previous work experience and her views about the organization. To have avoided these questions would have provided the "sanitized" interview demanded by the textbook writers, but would have ruined her rapport with the respondents. In addition, she also discussed situations with her respondents who invited her to comment on events that they had all observed. Though, the researcher is often advised in the name of research to avoid such situations, her participation in the organization meant that she could hardly claim that she had no knowledge of the situation in which they were all located and the events in which they were involved. The result was that some of the unstructured interviews became discussions in which some evaluation of social situations took place.

iii. Group Discussions

This is a form of unstructured interviewing but with more than one subject. The group discussions were loosely structured around a series of topics and questions to allow for a degree of flexibility. These discussions had the advantage of bringing to surface the differences among the participants and the contradictions within and between their replies. They stimulated discussions among respondents, rather than just a series of individual interviews between the researcher and the members. Responses were mostly spontaneous and not always in response to the queries of the researcher. In this study, focus group discussions were employed with respondents of a similar occupational status, such as the Sathins and the field level health workers.

iv. Examination of Documentary Evidence

This type of information can take many forms and in this study the documentary evidence used included:

* letters, memoranda and other communiques
* agendas, announcements and minutes of meetings, and other written reports of events
* administrative documents- proposals, progress reports, and other internal documents
* formal studies or evaluations of the case
* news clippings and articles in mass media or academic journals.

The usefulness of these was not based on their accuracy or lack of bias, but rather on corroboration and augmentation of evidence from other sources. The documentary evidence reflected a communication among other parties attempting to achieve other objectives. By constantly trying to interpret those conditions, the researcher was less likely to be misled in interpreting this evidence.

V. DATA ANALYSIS

Before the analysis of the data, the researcher created a case study database in order to ensure reliability of the procedures adopted. The data base included:

a. *Field Notes*: These were both

i. systematic and substantive field notes which were essentially descriptive

ii. methodological notes on interpretations, hunches and problems encountered

b. ***Transcripts*** of taped unstructured interviews and focus group discussions

c. ***Documents***

The general analytical strategy was to rely on theoretical propositions. The propositions helped to focus attention on certain data. They also helped to organize the entire case study and to define alternative explanations to be examined.

The dominant mode of analysis was **pattern matching.** Such an analysis compares an empirically based pattern with a predicted one. If the patterns coincide, the results can help a case study to strengthen its ***internal validity.*** Since this case study was explanatory, the patterns were related to the dependent and independent variables. In this analysis of rival explanations as patterns, the focus was on the different outcomes in community participation and why this outcome occurred in each case. This analysis required the development of rival theoretical propositions. The important characteristics of these rival explanations was that each involved a pattern of independent variables that are mutually exclusive. If one explanation is valid the others cannot be. In the first case the successful matching of the pattern to one of the rival explanations would be evidence for concluding that this explanation was the correct one. Then, if the same result failed to occur

in the second case due to predictably different circumstances *theoretical replication* would have been accomplished and the initial result would be proved more convincingly.

VI. LIMITATIONS

1. The major shortcoming of this study is the short time-period during which it was conducted. Due to constraints of time, the researcher could devote only about a month each of fieldwork for both the cases. It is difficult in such circumstances to study all the organizational aspects of the projects. However, some of these shortcomings were sought to be overcome with the use of documents and extensive interviews.
2. Moreover, due to the short time for field work, it was not possible to conduct interviews with many members of the community and some important respondents. As a result, the emphasis of the study is more on ideological factors in the organizations, rather than in the community.
3. The age, gender, and social status of the researcher might have created some biases in the responses. However, since the researcher conducted her study in a geographical area she was familiar with, the interaction was in some senses "natural". This was because the researcher had rapport with the subjects, sharing a similar language and socio-political context. The fear and the suspicion in the minds of the subjects and informants was usually absent.

CHAPTER III

URMUL :A NON-GOVERNMENTAL ORGANIZATION

I. THE CONTEXT

Bikaner district, (spread over an area of 27,244 sq km, in the Thar desert in north-western Rajasthan), is one of the most inhospitable areas of the country, particularly due to its climatic and topographical conditions. Apart from the 34% of the land which is cultivated, the rest of the land is mainly fallow and wasteland.

Lunkaransar Tehsil of Bikaner district is a predominantly unirrigated area. A household socio-economic survey conducted in 1986-87 revealed that 80% of the 21,000 population was completely dependent on two closely linked primary occupations- agriculture and animal husbandry. However the ownership of the two most productive assets in the area, land and livestock, was extremely skewed. 40% of the families owned 82% of the total land in the area and 25% of the families owned 65% of the cows in the area.

The introduction of the Indira Gandhi Nahar Pariyojana (IGNP) in the region has resulted in significant changes in the lives of the people. Because access to water, land productivity and income have increased, the traditional pastoral lifestyles with large herds of cattle have given way to settled agriculture. People who were traditionally not dependent on agriculture are now trying to adopt water intensive agriculture. The increased investment in lands, in addition to uncertainty in irrigated agriculture, has led to a conversion to cash crops and a disbandment of grazing lands. These crops are usually water-intensive and lead to degradation of land. Considering the precarious ecological balance in the command area of the canal, this reliance on cash crops leads to severe water-logging and

increased salinity, with their ramifications for sustainable agriculture and environmental health. Severe water-logging in many previously fertile areas has also resulted in the displacement of a large number of farmers. Further, it leads to a vicious cycle of indebtedness, due to the inability of farmers to support their investments solely from the uncertain agricultural income. As part of the colonization in the area, a large number of special allottees from Haryana and Punjab have been granted land in this region. This allotment of former grazing lands for agriculture discourages farmers from considering animal husbandry as an optional source of income.

The incomes of those who have adopted water intensive agriculture, in the irrigated area, have been raised significantly. However, all this has led to a general worsening in the life conditions of many people. The worst affected have been the marginalised, small and middle farmers, who are unable to hold on to and cultivate their lands. Disputes with regard to land and the changed lifestyles has also had social repercussions with an increase in violence and crime, and greater workloads for the womenfolk. With the settlement of farmers into dispersed hamlets, and with the 12-month farming routine, women find themselves increasingly overworked and socially isolated. Moreover, even after more than a decade since the construction of the canal, there are still many people who are not used to the agriculture.

Apart from the economic hardship, poor people's access to the government health care system, education and credit is almost non-existent. Medical facilities are scanty and both personnel and materials are in short supply. Primary schools exist only on paper. About 90% of the schools have only a single teacher in which 40% of the posts are vacant. Potable drinking water remains a problem and several villages are without their own water source and depend on

wells or reservoirs several kilometers away. Traditional water harvesting structures are destroyed and there are no community resources to build new ones. The welfare services including the relief do not reach the poorest. This is because the feudal structure has never allowed the dalits and women to participate in the decision-making process.

This is one of the most thinly populated areas in the country. The population distribution is around 44 per square km. in Bikaner. The rural settlements are very scattered. During the monsoon, part of the household moves away from the settlement to the agriculture field known as the 'dhani'. There is another pattern of migration after the monsoon around holi (March) when poor rural young men and women (15-40 years) migrate to cities in search of work. The scattered nature of the communities and the seasonal settlement patterns make it a challenge to institutionalize any form of service-delivery- whether health, education, or extension banking or agriculture-related services.

In the recent years the population density is increasing very sharply in the district town of Bikaner and some of the irrigated areas. In the decade of the 1980s, Bikaner has had a 43% increase in population- the highest in the state. The growth rate in the cities and the irrigated areas, however, is no indication of improvement in social conditions. The increase is on account of the colonization of the canal area and increased commercialization in the urban areas. Bikaner shows unfavorable indicators for women's status. It has one of the lowest sex-ratios in the state, at 885 females per 1000 males. Of the total literate population only 27.03% are females. For the rural areas the proportion drops to 17.6%, and total female literacy in the rural areas is as low as 1.5%.

The area is drought endemic. On an average, in every four years, there is one good harvest year. Each drought destroys the economic base of the poor, especially the dalits, such as the Meghwals and the Naiks. In the drought years, they sell their productive assets to buy food, fodder and seeds.

The other reason for the poverty is the increased privatization and the commercialization of the land. The common land available for grazing has disappeared. At the same time intensive tractor ploughing has destroyed the fodder resources. This has brought the poor cattle owners into the market for dry fodder. The rural artisans who have been dependent on the economy based on wool extracted from animals face extreme hardship because of difficulty in rearing animals.

II. GENESIS AND EVOLUTION

In this setting the URMUL Trust has been involved with a variety of development programs over the last 10 years. It originated as a program for delivering health care services to members of milk cooperatives in the villages of Bikaner. This milk cooperative was formed in 1972, with the objective of organizing milk producers to better returns for themselves. The cooperative was based on the Anand Pattern, an institutional form that evolved from the success of the AMUL milk cooperative in Anand, Gujrat. The cooperative is a three- tier structure. The first element is the individual milk producers who voluntarily organize themselves into a cooperative society. The cooperative is a secular body, with membership open to all milk producers and with equal voting rights to all members, regardless of the quantity of milk produced or the number of milch animals owned.

All the village milk cooperatives in the milk shed area (for administrative convenience, usually a district)

send their milk, through a network of 'chilling centers', to a central milk processing unit, which processes and markets the milk products. This is the second tier or the 'Union'. To avoid competition among sister cooperatives in the same state, the marketing is usually done by a centralized state-level federation of district unions, which forms the third tier.

As URMUL -the Uttari Rajasthan Milk Union Limited - grew, a variety of services were added on, such as mobile veterinary care, the supply of balanced cattle feed, the vaccination of cattle against common infectious diseases and even artificial insemination.

In 1984, directors of the URMUL milk union (elected from amongst the Chairmen of Village Milk Cooperatives) visited Anand, and saw there the integration of MCH services into the fabric of the milk cooperative. This was done through a milk cooperative-supported voluntary agency, the Tribhuvandas Foundation. The visit left them with an understanding of their own power for change. On their return to Bikaner, they drafted a Deed of Trust and set up a Charitable Trust- the URMUL Rural Health Research and Development Trust with a similar objective of reaching out to the under-privileged in the rural areas and to provide them, especially women and children, with access to good health care.

Keeping in view the need for close coordination with the Government machinery, the Trustees are all ex-officio, key functionaries of the District Administration, the District Health Authority, the Medical College and the District Milk Union (URMUL).

The Trust is registered under the Rajasthan Charitable Trusts Act, Bikaner, 1987 and the Ministry of Home Affairs, Government of India, under the Foreign Contribution Regulation Act, 1986.

Its objective is to lead village communities towards

self-reliance by making available to them a package of integrated development services that they themselves design and implement and eventually manage. Primary health care, education, and on- and off-farm employment have been used as entry points in the past 10 years and the attempt has been to move from service-delivery to empowering communities to manage their programs through 'sangathans', or organizations of poor men and women. These *Sangathans* have already contributed to increasing access to Government and other infrastructure and programs.

URMUL's total program covers 40 villages of Lunkaransar block, and 113 villages in the Bajju area, both in Bikaner District. These programs cover approximately 30% to 40% of the population of the Lunkaransar and Kolayat Blocks respectively.

In addition, URMUL supports groups working in Nagaur and Churu (worker education), and in Chattergadh (research on animal husbandry). URMUL also runs an Arid Zone Environmental Research center, presently located in Lunkaransar, which documents community survival strategies in desert conditions. The Lunkaransar Program has been operational since 1986. Action Aid has been the major supporter of URMUL's work since 1987. The Bajju program has been operational since 1988.

In 1988, URMUL first 'hived off' its income generation program and created the URMUL Vanasthali Bunkar Vikas Samiti, a weaver's cooperative based in Phalodi. In 1992, a similar artisans' cooperative called Vasundhara was registered in Lunkaransar, and it is hoped that once financially viable, it will also begin to function independently.

Initially the Trust was financially dependent on URMUL cooperative. Each cooperative member contributed 3p per liter of the milk they sold for the activities of the Trust. In the first year, the health program ran with a

contribution of Rs. 26, 500. Since cattle ownership is highly skewed in the favor of the rich, over the years URMUL realized that restricting their services to members of the dairy cooperatives excluded the poor. Moreover, they also felt that the program had a strong curative bias. As the activities of the project increased, the programs were made available to the entire population in the project area. Health became purely an entry point program which had to be complemented by a multi-sectoral attack on poverty. As a result, the large milk producers, who contributed more, felt that they were subsidizing the health care of the poor people. Moreover, in villages where there was more than one cooperative, it was difficult for the Trust to take any decision. As a result, in 1989, the Trust stopped taking any money from the cooperative and formulated its own goals. Presently, funds are raised from a number of funding agencies as well as from the government. Since 1986, the Trust has been financially supported by Save the Children Fund, the Aga Khan foundation, the Overseas Development Network, OXFAM, ICDS and Action Aid.

During the drought of 1987-89, the Trust worked directly with the poor on famine relief, running fodder and cattle camps and employment generation. Usually during the drought, the merchants and the landlords take advantage of the helplessness of the poor by providing loans on high interest and selling food and fodder at exorbitant prices. Often poor people make distress pawning or sell their productive assets, leaving them more economically vulnerable. Thus, after the drought was over, the Trust took the decision to work primarily with the poor. It was decided that all programs would be carried out in such a way as to empower the poor people and strengthen their institutions. Since 1989, building people's organizations like gram *Sangathans* and Mahila *Sangathans* was the focus in all the initiatives. The turn of the decade, thus, seems to

have been a turning point for the organization with a shift in emphasis on service-delivery to building up local-level organizations who would have a greater say in the planning and implementation of the programs.

Another shift in the thrust of the program seems to have occurred in 1994, when the Trust formally presented its decision to 'withdraw' from the community. As the Withdrawal Plan states:

> "Withdrawal for URMUL is important for primarily ideological reasons. We believe that if empowerment of any community is envisaged, then such a process should be accompanied by the withdrawal of the catalysts (in this case, the Trust). The concern that the communities we work with might become dependent on us, as they have been on the State, must logically lead to the alteration of the relationship in its present form. It would only be too easy to justify one's *raison d'etre* in the area but the fallout of our continued presence would only cause us to be an alternative power structure/institution that would in fact ease in some sense the pressure of the state and the other institutions of local government. The future in our opinion lies in the ability to empower communities to make decisions and to manage resources on their own. This quite obviously goes against the grain of all that is being preached or practiced at the present. The issue in a free market society is each to his or her own. But for the poor of Rajasthan the only alternative for the future (in our opinion) lies in collective action..For URMUL, 'withdrawal' does not necessarily imply our moving out from the area. The possibilities are numerous but what is clear is that within the next five years we wish to provide our *Sangathans* with the necessary skills to manage the systems that we have put into place. We could later

provide only information and training or the Trust as it exists today could spawn several smaller independent initiatives."

With effect from 1994, URMUL Trust became two organizations, SETU to cover the operations in Lunkaransar and SEEMANT to manage the program in Bajju. A need for decentralization was felt because the program had expanded to a large size, and "management time was being spread very thin across all the locations". Moreover, since the Trust was owned by the dairy and had very close institutional links with the State government, it was seen as a hindrance, especially if the organization were to play more of an advocacy role. The new boards are comprised of some local persons, and some outsiders who are development professionals. At Lunkaransar, the 'core team' would consist of an executive Coordinator and seven sector heads, each responsible for different functional areas. The areas that have been designated are:

1. Water
2. Health and sanitation
3. Women's Development
4. Agriculture
5. Training, research and documentation
6. Education
7. Accounts and administration

The major line responsibilities are, however, at the 'cluster' (or administrative division) level, managed by a coordinator, with a team of 3-4 workers. Two of these would be specialists in health and education and the other two with experience in community organization. It was planned that by 1996 the *Sangathans* and 'mahila Mandals' would take most of the decisions. Work would continue through 'sangathans' and the emphasis would shift from community organization to training. This work would be carried

forward by the sector specialists and the support staff in Lunkaransar. The new sector, women's development was put in place from early 1995. This sector would be funded by the State government (since URMUL has been identified as the District Training agency) and partly supported by Action Aid.

The eight clusters currently operational in Lunkaransar have been restructured. The new configuration of five clusters would get genuine power devolved to them. The endeavor, over the two years after 1994, was to transfer funds for each cluster directly to the coordinators, and maintain accounts locally. Earlier, plans used to be made centrally at Lunkaransar. From 1994, onwards, however, the annual plans and budgets are aggregates of budgets prepared by each cluster. There are meetings in which *Sangathan* members decide what they want to do over the next year and then in discussions with the cluster teams, they prepare a rough outline of a plan and allocate money for the different programs. Subsequently there is discussion within the organization, as well, and it is finalized. The planning exercises are initially conducted at the cluster level and the sector specialists join later. In 1996, one *Sangathan* and two Mahila Mandals from each cluster will be asked to prepare the budgets of their respective villages. Eventually, it is hoped that by 1999, all the budgets will have been prepared in the village itself. Only proposals for new projects and recruitment of staff would be managed centrally, but even that, after the first two years, would be gradually transferred. This would enable each cluster to grow as an organization, and at the same time keep the structure and staff small and accountable to the people.

Withdrawal also includes the possibility of Lunkaransar later turning into a training and resource center. This, according to project coordinators, is taking

time in achieving because the pace at which decentralization in the institution has taken place has not been matched by a similar pace of decentralization in the support team at the center. However, it is hoped that in the future there shall be decentralized field teams working with teams in Lunkaransar who provide them with backup support. Thus, all decisions are left to the *Sangathans* rather than with the central team in Lunkaransar.
The aim is to solve people's problems at the village level whenever possible. The organization would play a major role only when macro-level issues arise (such as liaison with the state), thus requiring the intervention of the organization as a whole.

III. TARGET GROUP

The URMUL target area covers 40 villages. The selection of the villages was initially based on the presence of strong and motivated milk societies. It was coupled with an assessment of the need -level of the village. The newer villages were selected primarily on the basis of contiguity. With the project headquarters in Lunkaransar, the mean distance to villages works out to be 40 km.

Until 1988, URMUL had adopted a target area approach for all its programs. Since then, however, the project has decided to target its economic and group organization programs to the poor. In the service -delivery sectors i.e. health and education, although priority is given to the poorer families, all target area families have access to the services.

Of the total population, approximately 35% has been identified as the target population. The selection of the poorer families has been done through informal wealth ranking conducted in each village. The wealth ranking exercise was carried out by the URMUL extension workers

responsible for the village and representatives from the poorer sections of the population such as Meghwals and Naiks. The final list was prepared after the extension worker spent several nights in the village and after consulting the community at large. Although several criteria were used in selecting the poorest families, based on absolute poverty, rather than relative poverty. The major indices that have been used are asset ownership [land holding (5 ha. and below) and cow ownership (2 cows and below), condition of housing, ratio of earning members and dependents and health and educational status.

IV. NATURE AND SCOPE OF ACTIVITIES

URMUL Trust has executed many programs and has changed program direction often. The program started as a welfare-service oriented health delivery program for all. But it soon realized that poor people will not gain access over their services unless they are empowered and that it is incorrect to attempt to bring about health improvements without changing the wider social and economic context. Thus in order to achieve its primary objective of empowering the communities to gain access to and control over resources, URMUL has initiated several programs and activities, ranging from health to income generation, education, water, women's development, community organization and advocacy.

i. Community Health Program

The target area is located in one of the most backward regions of India in terms of the social indicators of development, especially in the area of health. The first baseline survey, conducted in 1986, revealed a high morbidity rate caused by immunisable diseases. Pneumonia and whooping cough were reported as widely prevalent and

post-measles pneumonia accounted for 50% of infant deaths in the previous year. It also revealed a high incidence and prevalence of 'occupational' or 'environmental' diseases, namely tuberculosis and silicosis, especially among working males in the mining industry. These account for a large number of adult deaths. Moreover, amongst the adults, opium addiction was also recognized as a problem in several villages. The maternal mortality, which is the highest in the country, in turn, is caused mainly by pregnancy- related problems. Serious problems were, thus, also identified in the area of reproductive health.

The underlying causes, identified by URMUL, for these problems, are a set of complex and inter-related factors. These are:

[a] Low female literacy and lack of awareness of basic health practices including immunization and safe delivery.

[b] Certain basic causes like lack of appropriate food intake, lack of safe drinking water and drainage systems, especially in the summer months.

[c] Lack of availability of health facilities (especially curative services) due to desert terrain and scattered settlements. Even where Government facilities are available, they are under-staffed and ill-equipped. (In terms of availability of services, there is one PHC and six sub-centers catering to a population of 1,50,000 over an area of 7000 sq. km. Four of the six sub-centers were understaffed).

When the URMUL Trust started its work in 1986, the directive from the milk cooperative- the major financier- was simple : provide an effective cheap curative health cover to members of village cooperatives in the district.

The program, thus, aims to:

1. To set up a system to record the births, deaths and morbidity in a village.
2. To reduce the mortality rate to 50 per 1000 by 1992
3. To reduce the maternal mortality to less 2 per 1000 by 1992.
4. 100% monitoring and follow-up of all ANC and PNC cases.
5. Detection and follow-up of all TB cases.
6. Elimination of night blindness, anaemia and goiter.
7. 100% coverage of children eligible for immunization
8. To make the village self-sufficient in all aspects of MCH.

URMUL adopts a two-pronged strategy to achieve the stated aim:

1. In the short run, the project focuses on health education, training of village-level cadre of health workers and providing basic preventive, promotive and curative services to the community as a whole - with priority attention to the poor. Services like immunization and curative health care are provided at the doorstep. In case of serious ailments referral services are provided. The Trust also provides transport services to poor patients.
2. However, in the long-run, the project aims that financially and managerially autonomous village *Sangathans* will meet salary costs of village -level health workers. Simultaneously, the strong awareness-building being carried out will create enough demand for health services provided by the government.

Evolution of the program

Till 1989, the program was managed centrally from Lunkaransar. The key functionary in this system was a trained village-level, female health worker, the Swasthya

Saathi. Besides the Swasthya Saathi, the Trust earlier provided a support structure comprising of:

a. Health Extension Workers
b. Professional Nurses and Doctors
c. The PBM Hospital at Bikaner, the hospital in the campus of the project, with a full-fledged OPD, and the PHC in Lunkaransar.

The mobile team comprising of doctors and social workers was based in URMUL and made visits to villages to provide referral and extension services. There was a fully-trained social worker stationed at a referral hospital in Bikaner to help patients with access to good quality medical care.

After 1989, in a bid to decentralize the program, the 'cluster' (administrative division) approach was adopted. This was in contrast to the earlier centrally managed 'sector' approach. Thus, each extension worker was made a cluster coordinator and was given the responsibility of looking after *all* programs run by the Trust in a few villages. Despite the change in the program, the Trust continued its hospital activity from the campus and the hospital was the center of activity for some time. Various camps like eye camps, drug de-addiction camps and FP camps were organized on a large scale on the campus. The mobile curative health care and services (doctor route) and immunization services (immunization route) were provided to villagers from the hospital. Later, the hospital closed down its outdoor patient services. However the route continued. The full time doctor stationed at the campus hospital spent 20 days a month on the route. In September 1991, the hospital was formally closed after the doctor left the campus.

After a period of 9 months, this approach was discontinued and the program adopted the sector approach. Again in 1992, the cluster approach was adopted. Apart from

the change and shift from cluster to sector approach , most of the basic service activities remained the same. However, the project leadership felt that this was not very effective, because they found that despite having worked for 7-8 years, the health program was not very cohesive and that it was losing its focus. Hence, in a meeting in March, 1995, they decided to concentrate on moving away from the earlier service delivery mode and consciously concentrating on primary health education and preventive work. This also meant minimization of the curative aspects of health care. As a consequence they decided :

1. to centralize the team again, which would help in training of staff or village-level people; and
2. to create a new cadre of health workers or the Nirogi Saathis, who each would have a responsibility for a specific sized population, ranging from 1 to 3 villages.

It is proposed to keep the health team centralized for at least 6 months or a year and then gradually integrate them with the cluster teams. Centralization was thus preferred for the time being, in order to maintain direction in the program and to provide support to the staff in their formative years, since many of them were working on health issues for the first time. After support had been provided in a structured manner, the program would be gradually integrated with the other work being done at the cluster level.

Thus, we find that the community health program management has changed frequently and in periods where there was no person in charge of the program, it has run effectively due to the high motivational level of the staff. Moreover, due to the jumps from sectoral to cluster management there have been changes in the leadership of the program.

Over the years the program has changed to the present structure, which is managed by a three-tier system of functionaries:

* At the village level the Swasthya Saathi is the key functionary and pivotal to the health program. This worker, preferably a *dai* (Traditional Birth Attendant), is identified and strengthened to identify danger signs during pregnancy, delivery and child growth. She also motivates village women to adopt immunization and family planning.
* A team of health extension workers, or Nirogi Saathis, provide additional support, input and guidance to the Swasthya Saathi. The extension workers are the second-level functionaries. They work in close association with the Swasthya Saathis.
* The program is headed by a health coordinator (non-health) and a medical practitioner (as and when on the payroll).

Health Personnel

In consonance with the objectives of the project, the **Swasthya Saathi**, a local woman, (preferably a *dai* or traditional birth attendant) was chosen to form the first tier of the health services. She was selected by the villagers themselves among the village women. Traditional Birth Attendants were preferred because of their involvement in village health care practices. In a village where there was no *dai* or had one but who was not willing to work, any other interested woman was selected. The decision to use the *dai* as the key functionary in each village was based on the following factors:

a] Normally the village *dai* is of a low caste. In an area

b] Almost 50% of the infant mortality in Rajasthan and by extrapolation in Bikaner district, is neonatal and perinatal, resulting directly from a lack of neonatal and perinatal care. This interface is within the control of the *dai*, if she is trained in basic diagnostic skills (to recognize danger signals) and in safe delivery and after care.

The main focus of the program is on the training of the Swasthya Saathi in each village who would not only serve as a resource person for low-cost effective primary health care but would also act as a link between the professionals working for the Trust and the village community. Thus, they were given an intensive pre-service training as well as in-service training at URMUL. Initially, they were given three-months training which equipped them with a knowledge base of Primary Health Care. As part of their course, they learnt basic diagnostic and curative skills, first aid, nutrition and hygiene, midwifery and the criteria in deciding whether the patient should be referred. They further learnt to keep accurate records and how to order medicines. This training was organized with the help of other training institutions. After this, the Swasthya Saathis received two days of training every month to revise their learning.

At the end of the course, each woman received a medicine kit containing many of the drugs used in common health problems. Apart from having a simple stock of medicines with her all the time, the Swasthya Saathi propagates low-cost home remedies such as ORT (for diarrhoea) steam inhalation (for colds) and cold sponging (for fever). She is also trained to motivate pregnant women in accepting antenatal care and in having regular check-ups and also to canvass for family planning among eligible couples.

The Swasthya Saathi is paid a basic honorarium and is

given additional incentives for her work in immunization, recording of births, deaths, deliveries, managing of TB patients and motivating couples to accept family planning. In an average the volunteer can expect to earn between Rs. 250-400 per month.

When URMUL started work in 1986, the poor in the area had virtually no access to primary health care services. The Trust has made available a wide range of curative and preventive services. This has been achieved to a great extent because their traditional role, as *dais*, provides the Swasthya Saathis with social acceptance. The poor families seek all health service support including medicine from the Swasthya Saathis and they seem well-accepted by the community. However, though they did not appear to favor any particular community or caste, in most cases, the reliability of the Swasthya Saathis is low with the upper-caste and upper-class men in the village. This was because in a patriarchal feudal system, their expertise with western medicine was doubted, since they were illiterate, low caste women. Hence, in villages like Dhirdan and Nathusar, the higher castes- Brahmins, Rajputs and Jats - did not take medicines from the Swasthya Saathis, who are from the Meghwal and Naik castes. As one of them stated,'Till last year this woman used to work with cow-dung and now she aspires to be a lady-doctor'. They instead, preferred to bypass the Swasthya Saathis and visit a doctor in town or a vaid or RMP, whom they perceived as more competent with dispensing drugs, even if this involved considerable additional cost. As a result, their curative services are often under-utilized, especially after the introduction of user fees. Moreover, since their training was uneven and there was little structured supervision for a long period, the quality of work of the Swasthya Saathis was low. In spite of incentives on registration of births, deaths, detection of TB cases, the output of work is

limited. A study of the knowledge and practice conducted in 1992 found that

1. Swasthya Saathis had internalized to a degree what they had been taught about personal hygiene, health practices and social issues. The last indicator, however, was least apparent. Though most female family members of the Swasthya Saathi had accepted immunization, FP and personal hygiene was maintained, girls studied only up to primary school and marriage was still very early.

2. Though knowledge of ANC is somewhat satisfactory, her ANC work is not effective. She visits homes but is not able to overcome resistance to accepting TT and IFA .She lacks practical skills to translate theoretical knowledge, especially about spacing and early births. In most cases no risk assessment was being done.

3. RMPs were called for deliveries to administer injection to induce labor. There was over-reporting of births attended as she receives payment for these.

4. She had knowledge of sterilization but not of spacing methods.

5. The drug stock register well-maintained, except where the teacher who was supposed to enter it was uncooperative. Home visit forms were not maintained and the referral book was not being used, though several referrals were made. The diary was kept well very rarely.

As the scope of the Trust's activities has widened, over the years the role of the Swasthya Saathi has broadened. The Swasthya Saathi, by virtue of her interface

with the Trust and the outside world, has become a reference point for information on all kinds of issues; water, land rights, employment and represents a force of change. She assists women participating in the income-generation program by monitoring the quality of the products and by ensuring that they have access to raw material and production facilities wherever required. In some villages, Swasthya Saathis are taking leadership roles in the community, such as in struggles for possession of common land in Dulmera, fodder depot in Nathwana and seed loans in Rajpuria and Adsar. Their involvement in non-health issues has, however, affected their performance in health-related work. They report a constant pull between general development work and health work. In some of the villages, they have diverted out of the primary task, after the initial few years, and become more of development workers. In most cases, the only regular health-related work was done by the *dais* who did their traditional delivery work. This involvement in what are not strictly 'health' issues has emerged due to an understanding of the critical links of health status with food, education, water and employment. However, another reason is the fact that since, they are paid very little for their health work, they feel that involvement in community issues enhances their influence and acceptance.

> "I have seen that in the Swasthya Saathi program, they used to do health work and there was some regularity in that. There were routes, the workers were regular..After that, when local level workers, then health workers were combined with other organizational programs-and several other issues were raised. The Swasthya Saathi started taking an interest in these because there was greater economic help in them. So, they started leaving the health work. Health was going out of our hands"

"The whole community..does not think they are trained. Even among the Swasthya Saathis there were several problems..There were some women who were not leaving their traditional practices. After a lot of explanation a few changes occurred. They did work whenever there was an economic incentive. Where there no incentives they did not do well...We had wanted them to distribute medicines at a primary level, even that was not happening. The community had a particular view that they wouldn't be able to do it. Moreover, here we have a lot of RMPs (Registered Medical Practitioners). This too caused problems..Most curative work is done by them. Everywhere there are RMPs."

The project leadership realized that, though the Swasthya Saathi is a key health worker, her growth as a development worker is a strategic requirement in a patriarchal and feudal set-up. Thus, in the name of task-performance their leadership was not allowed to be curtailed and an alternate mechanism was developed to share their task of service -delivery.

Thus Swasthya Saathis cadre was continued but with an altered role. The organization decided to reserve them only for women's health and for traditional work conducting deliveries. It was planned that Swasthya dals or voluntary village health committees would be appointed to provide support to the Swasthya Saathi. However, this concept failed to materialize effectively and thus it was planned that the other work would be gradually taken over by the Nirogi Saathi. This functionary would be looking after more than one Swasthya Saathi's field of work. This cadre of second-line workers was chosen from the existing staff. They were either from other programs or were earlier in the health programs. Unlike the Swasthya Saathis, all of

them are literate with basic schooling and belong to a younger age group. Moreover, unlike the Swasthya Saathis, the Nirogi Saathis include both men and women. Their pay too (ranging from 1500-2200 per month) is considerably higher than that of the Swasthya Saathis. There are a total of 10 Nirogi Saathis for five clusters, (or one Nirogi Saathi at each village or between a few villages).

They were trained along the MPHW model over a three month period with 10 days every month of classroom lessons and 20 days of practical work in the field. There were three parts to the training:

1, anatomy and physiology,
2, diseases commonly encountered
3, communication.

The training laid a greater emphasis on technical skills so as to increase acceptability for health work, which the Swasthya Saathis lacked. However, for the Nirogi Saathis curative health work is seen also a means to impart health education and raise awareness levels of the community with regard to health and sanitation issues. Though Nirogi Saathis are supposed to primarily work with only health-related issues, they do get involved in other issues at the village level, such as, issues that are related to the *Sangathans*, the savings program, the water problem or the problem of education. Several of them are afraid that like the Swasthya Saathis they too might get over-involved in other issues and the program might lose focus again. The team of Nirogi Saathis, however, seems highly motivated, but since this cadre of workers is relatively new, it is difficult to comment on their success in health intervention.

The health program coordinators have generally been trained medical personnel. However, since there have been long periods when there has been no doctor in charge of the program, it has been largely run by non-medical personnel

(a field coordinator and a health coordinator). Most of the staff of this level is urban-educated whose salaries range from Rs. 2,500 to 3000 per month.

The roles of this level of functionaries range from planning, training, supervision and evaluation. The scope of activities of the doctor has lessened over the years with the closure of the hospital in the project campus and cessation of immunization work by the Trust. The primary curative work performed by the doctor is, thus, confined mostly to the treatment of TB.

Areas of Health Intervention

[a] Child survival, ante natal care

* **Growth monitoring;**

Children below two are weighed periodically by the Swasthya Saathis in the presence of the mother. This is used as a tool for imparting health and nutrition education. Children identified as malnourished are given supplementary food known as URMUL mix. In Bajju the Trust also administers the ICDS, financed through the State Government. The first time in the history of the state that such an agreement was negotiated between an NGO and the Govt.

* **introduction of better (and earlier) weaning practices;**

The base-line survey reported late weaning, sometimes 1 year and over-dependence on just breast-milk. This practice is obviously responsible for infant malnutrition. Using the Mahila Mandals, the staff educates women about different types of weaning foods.

* **prenatal, perinatal and postnatal care of both mothers and infants;**

With the mobilization of the community the Trust achieved over 80% immunization coverage for all the six diseases for children under five, in the early years of the program. Government of India schedules were followed and vaccines

were acquired from the district health authority. Immunization was carried out through a weekly village visit, known as 'route', for the initial two years. From 1989, such visits were made once a month. The Swasthya Saathis motivated the mothers of eligible children and brought them for immunization. The immunization remained 60 to 70% (grew from initial 5%) during the whole period for both female and male children. However, the figure dropped down in 1992 after the rising trend during 1989-91. It was found that mothers had no self-initiative to get their children fully immunized and only did so at the insistence of the Swasthya Saathis and extension workers. The regular availability of the immunization services by the Trust and the persistent pressure of the Swasthya Saathi was the main cause of the achievement. This was contrary to the expectation of the Trust whose objective was to make the community aware so it would demand services from the Government, when the organization withdrew. This, however, did not happen and when these services were actually withdrawn immunization reached almost a standstill. The project coordinators felt that even after carrying out immunization 20 days every month, round the year for 7 years, The investment in time and money was not yielding expected results, as there was little felt need in the community for these services. Hence, it recognized the fact that it had not been able to generate a demand for immunization in the community. So it was decided to create that demand through awareness-raising and health education since it was doubtful if the villagers would make any self-initiative if the services were discontinued. At present URMUL's role is confined to supporting the Government health administration through mobilizing and educating the community, making of transport arrangements and provision of syringes, etc.

[b] Family Planning

The Trust actively promotes family planning among both men and women and encourages temporary spacing methods for couples. Women are motivated to attend regular government sterilization centers and to the referral hospital at Bikaner for the procedure.

[c] Tuberculosis control

The Trust conducted a study with NTI, to ascertain why in a sparsely populated desert area with extreme weather conditions adverse for the bacillus, the disease is so widespread. Of all the health interventions of the Trust, this is the only curative input in which the doctor personally intervenes. Screening is carried out and patients are treated so that the disease does not spread further. The Trust provides patients with short-course chemotherapy which though more expensive is considered more reliable, with less drop-outs.

[d] Referrals

Referrals used to be a part of the health program and all referrals used to be done centrally from Lunkaransar. However, now all referrals, except for a very small percentage of cases who come there, take place directly from the village through the cluster team onwards to Lunkaransar or to Bikaner. These are done free of cost for the members of the *Sangathans* i.e. from the poorest and weakest sections of the communities. Other than that, only life and limb-saving emergencies from the villages are transferred at organizational cost. This is a thorny issue but the credibility of the workers rests to a great extent on the help they give to communities in emergency situations.

[e] Health Education

Health education is imparted through the communications team and through monthly meetings of the

Swasthya Saathis. The Nirogi Saathis are also trained in this and carry out health education activities during house- to -house visits. A Health museum has been created as a resource base for health education. It is planned to approach teachers of shikshakarmi/ Marushala/ Lok Jumbish schools and children of all village schools either on planned trips to the center or on the routes, to conduct health education programs. The Trust has also planned to have sessions with RMPs and PHC doctors and nurses for promoting rational drug therapy.

[f] Other health activities

Opium addiction is a serious problem, in some villages. Opium is traditionally used as a way to welcome guests. It is also used as a pain-killer and sometimes as an incentive to work. The Trust uses the approach of partly medical, partly spiritual group therapy to foster de-addiction. All patients are followed-up with community activities planned for the entire group.

The Trust as a part of its community health program has carried out eye camps to surgically remove cataracts. Eye specialists provide the services free and the Trust and local volunteers provide nursing care.

Resource Mobilization

When the project was initiated, treatment and especially medicines were not directly charged. As a result, it was felt that the villagers, who considered the medical services as free, had a tendency to take the medicine whether or not needed. In the second year the three paise system of contribution from dairy members was discontinued. A new system of Rs. 1 per day per patient was introduced. This was because, according to the project coordinators, only a small percentage of the people in the community were unable to cover the costs of an average illness. Thus, members of the identified target groups are

entitled to free treatment. The Trust, however, provides free treatment for the whole community in case of chronic illnesses, for severe problems or for accidents.

Despite the fact that user fees are charged the Trust recognizes the fact that in an area such as primary health care, it shall not be in a position to raise resources from communities. This is sought to be explained by the fact that since the region is so backward sustainability of programs is not feasible. Since people have had little access to these programs in the past and since health is not a priority issue, it shall take a few years of assured access to these before they realize the need for them. This holds especially true for health education and preventive health actions.

ii. Education

A situation similar to the status of health care exists in the area of education. Several villages are without schools, and numerous schools without teachers. The strategy of the Trust is:

1] to improve formal schools, through provision of training to teachers and supplementing the budget for infrastructure.

2] to set up non-formal schools run by people from within the same community to integrate dropouts and the 'outsiders' into the formal schooling system,(especially those who are deprived of access to education due to their poverty).

The Trust provides infrastructural support and training inputs to teachers in non-formal schools run by the people from within a community in an attempt to integrate dropouts and non-attenders into the formal schooling system. The education program has seen the phasing out of the non-formal education program, and its

replacement with the Anganshala program for girls who cannot attend formal schools. It is modelled on the program for girl children that is being implemented by the Shiksha karmi in other parts of the State.

iii. Income Generation

The objective of this sector is to provide sustainable livelihoods to the poorest in the villages covered by the project. A majority of the economic assistance has been in the form of farm credits, for crop loans and animal husbandry, credit programs are administered through Sangathans. However, the trend is towards identifying families and trying to find sustainable vocations outside agriculture, given the vagaries of rainfall. The main occupational rehabilitation that has been carried out has been weaving, of cloth and dhurries. Spinning, although employing a large number of families, still does not provide the amount of income necessary to make the activity a primary economic activity.

iv. Women's Organizing

According to the project planners, women's organizing is not a program, it is a perspective of the Trust. The need for building village -level people's organizations was discussed in one of the internal reflection meetings of the Trust in 1988. It was thought that the poor people and women can have access to community resources and general services if they build their internal strength by organizing. In this context, two organizations were thought of; one village- level poor people's organization called 'gram sangathan' and two, women's organization called 'mahila Mandal'.

URMUL Trust is avowedly pro-women in its approach since the beginning and hence has been nicknamed as *'lugaiyyon ka Trust'* (women's Trust). This was also the

reason for involving women workers in the health program. Through various activities particularly through the drought of 1987, the Trust found that the women are interested in doing work collectively. Thus, efforts were made to involve women in managing a fodder depot and organizing a small-scale income generating activity like spinning. the organizing process started along with drought relief work. The 600 women working on wool spinning and 500 women employed under different construction activities could see that the Trust saw them as more than workers. Women were motivated to work in groups. This approach of working in groups at one place took the shape of a Mahila Mandal. Since the Mahila Mandal came forward to work collectively on spinning or construction, the Mahila Mandal disappeared along with the closure of the work.

In the 1990, annual meeting, while analyzing the activities of the Trust, it was felt that no real women's organizing had happened yet. It was felt that greater importance should be attached to building women's organizations so that they can challenge the oppressive structures and systems of society and gain control over services and resources. After this, women were organized on more long-term issues. In Sui, women were motivated to develop a fodder farm on common land, in Sabania on the issue of water, in Krishnasar and Dulchasar on the issue of income-generation. A three- point strategy was also adopted to strengthen women' organizing.

[1] To improve the economic conditions and relations
[2] Encourage women to take up larger community issues
[3] Build awareness on their status in society.

Most project villages have Mahila Mandals with credit societies. These provide the agenda for coming together and creating a collective feeling. In some of the villages women are mobilized to take up community issues, such as demand for water supply, equal wage for the . in drought

relief work, land capturing, building community centers and income generation activities.

All the s realize [a] the advantage of a sangathana [b] how to form a sangathana [c] problems of discrimination [d] cause of drought [e] . programs for women through village meetings and women's camps.

Organizing through Mahila Mandals has raised the confidence of the women and they have been able to articulate their collective interest. They do not hesitate to demand their rights from the government as well as the URMUL Trust.

Earlier men were suspicious of women joining organizations. Those who did participate were objects of ridicule and censure. But since this was the first opportunity for women to speak for themselves and raise their own issues, a lot of women, especially the poorer women participated. Raised taboo issues such as rape.

"In the villages, people used to say that women from decent families don't roam around in a village in this manner."

"Women have achieved such things in the villages such as getting grazing land, getting water..(They've always got water in pots)..But making arrangements for water for everyone.., getting a nurse, getting employment, doing the work of a mate. then everyone stopped speaking...Those who used to oppose them earlier, now themselves came to the women and said 'Get us some work, as well'".

"And the most important thing is that the women of this place, who never left their homes, whether their mother's or their mother-in-law's, their coming to the meeting is a very big thing, coming to the meeting and raising their own issues."

v. Promotional Initiative Through Advocacy and Networking

Besides all the village -level initiatives, URMUL trust also works on promotion of people-centered, sustainable development policies through advocacy and networking.

Along with other work, URMUL is also actively involved in advocating other local issues that are affecting the poor. The Trust's main aim is to influence policy level changes in certain development programs at the state level. During the last five years the Trust has taken up a series of issues.

Advocacy to review the developmental perceptions and practices relating to the IGNP

Some of the project villages are covered under the First phase of the IGNP. While working on other issues the Trust realized some of the ill-effects of the canal on the people. Sine the second phase of the canal is in the planning stage, URMUL Trust is in interface between the people and the government. It was in a position to influence the planning of the second phase as well as to place the problems of the people before the government.

The Trust organized a workshop in February, 1991 which was attended by . officials, academicians, journalists, villagers and NGO activists. In this workshop villagers expressed their experiences on the nature of resettlement in the command area, environmental impact of the canal and the effect of changes brought about by the canal irrigation on women and children. The views expressed reflected the ground reality, but in order to gain a greater understanding the yatra was planned.

The yatra began as a purely academic exercise to understand what had happened in the earlier stages of the canal and make some people -centered suggestions for policy and practice. But soon it became a forum for people's voice to be heard, to voice their concerns and demand a fair

hearing. Over a 150 people -activists, representatives of NGOs, researchers, farmers, workers, journalists, irrigation experts and concerned citizens- from all over Rajasthan and some other states undertook a yatra along the 648 km stretch of the IGNP. Main problems related to water-logging and increased salinity, corruption in land-allotment, marginalisation of women and mismanagement in canal water supply. The principle focus of the yatra was to Suggested community collaboration rather than . dealing with people as individuals. the principle focus of the Yatra was to understand the impact of the canal on original inhabitants, later settlers, the nature of problems faced by them, the solutions offered by the state and the people, and the impact on the environment and the sustainability of the canal as also to identify the issues around which the community could be mobilized and to promote people's participation in the management of the canal. Though not opposed to the bringing of the Ravi-Beas waters to Rajasthan, it was seen as a means of having an informal debate with people on the issues, programs and policies pertaining to the canal. First collective attempt to elicit and document people's perception of the problems and solutions which helped to form an agenda for planning action locally and prioritize issues for further research.

The Nahar yatra and the subsequent actions of the Trust are an effort of advocacy for people- centered development -process in general and desert land and water management in particular. It has raised many questions before the government in planning the second phase of the canal. It has brought the issue of desert environment management into the forefront which was a neglected area till now in India.

Advocacy on safe procedures in Family Planning Camps.

During 1986- 90 the Trust organized many family planning camps with the district health and family planning

centers, due to its rapport with the village communities. in 1989, a woman developed post-operative complication possibly due to a lapse in hygiene conditions. URMUL took up this issue with the distinct administration and developed guidelines for safe family planning camps, making it clear that its responsibility as a voluntary agency was limited to providing motivation and counselling services. Instead it is the responsibility of the health and family welfare department to ensure safe camps in the villages.

Advocacy to regularize the Public Distribution System

In the project areas people do not avail of these services because of non-availability of PDS. However, according to the government there are PDS ration shops for all the villages. URMUL trust carried out a survey and made a proposal to the Prime Minister's Office to regularize the PDS. It is of the view that irregularities can be reduced if it is given to village institutions.

The Trust also conducts advocacy on resettlement, on access to basic services (water) by the villages, on the clean management of government programs and media Advocacy With the aim to create public opinion on alternate development perspectives. Moreover, the Trust networks with other institutions such as NGOs, the Government and academic institutions.

V. PROJECT PLANNERS' IDEOLOGY AND COMMUNITY PARTICIPATION

The introduction of a health program reflects judgements about the health needs of the people. In the early phase, the need for a health project had been felt by the directors of the Dairy, yet actual need identification was done on the basis of a survey conducted by the project coordinators and it is they who planned possible intervention strategies. This survey was used solely as a means of obtaining information rather than as a way of initiating discussions with the local people. The results

of this assessment led to the identification of predominantly health service needs, and a largely service-delivery mode of intervention was planned. Hence, the program initially began by emphasizing health service delivery with emphasis on routine curative care. The basic premise seems to have been that the health status of the community was low because public resources are insufficient to extend the basic health services to those at present without access to them. It was felt that the community did not have access to formal health services, either by virtue of its isolation in dispersed rural settlements or by its lack of awareness. The planners seem to have found little wrong with government health system and the only shortcoming recognized seems to have been one of coverage. This lack of coverage was not sought to be remedied by mobilizing the community to demand these services.

Thus, even though the Trust avowedly attempted to avoid replication of government services, the main thrust of the intervention was a village-level community health worker, who provided access to cheap curative care. Here, through the 3p per liter contribution by cooperative members, the community shared the burden of providing health improvements, especially for the cost of drugs and the remuneration of health workers. The Trust saw its role as one of augmentation of existing government services which is the reason the support of government functionaries was sought in the board of Trustees. This idea of collaborating had not, however, evolved from the community. In fact, a very limited role was envisaged for the community, which was merely one of passively receiving services or helping in the selection of the health workers.

This viewpoint evolved and changed over a long period, especially as a result of interaction with the community. Working with deprived communities altered the perceptions of the project leadership and helped them realize the

inter-linkages between health and the larger socio-economic context. Health was seen merely as one of the indicators of the socio-economic condition of the community and in order to improve the former, the latter had to be dealt with first. Hence, the altered ideology resulted in the introduction of interventions aimed at increasing the resource base of the community and also helping it gain control of project and if possible community resources. The scope of the Trust's activities widened to include income-generation and credit schemes. This shift in ideology is also demonstrated by the fact that for its socio-economic programs the project worked specifically with the poor rather than the whole community. The selection of the target population or the 'community' thus gave opportunity to those who were hitherto left out of the scope of development schemes and prevented its takeover by already powerful groups within the community. As they state,

> "The objectives of the organization have moved..have changed, altered over time over the last eight years. As people in the organization have grown.. in the way we think,, that's changed, that's developed in some sense..In the beginning essentially, I think the objective was to provide members of dairy co-operatives with access to primary health care and primary education. Then slowly the focus changed to working with a specific target group, not necessarily with dairy societies. That changed again and then we decided to not just work with a specific target group but to work with groups of members, to organize people into *Sangathans* or Mahila Mandals and that's been now for all our economic programs are directed through ..are channelled through the *Sangathans* and the Mahila Mandals. We continue to work with the same target group, that continues to be the emphasis of the institution. What we are essentially trying to do is

to at least put together processes by which the poor people with whom we work can start to play a greater role in decision-making about their own lives, about management of resources around them in their own villages and definitely in the management of all resources that URMUL's put into place over the last eight years.. Essentially to have poor people to manage all of this on their own so that we don't need to do it. And where, largely over a period of time just concentrate on providing them with access to more information and with access to training that can basically help them manage their own systems better. We'd like to.. we at least hope that in the.. by the time when we start to pull out from the villages that we work in very actively,, there will be at least a fair amount of food, fodder and water security in these villages and we hope that all of this will be eventually managed by the communities that we care for."

"After living in the villages, relations were formed, family relationships..So if there is hunger in the stomach and if we give them medicine for malnutrition, then it doesn't seem right. If hunger is not finished, then malnutrition will not be finished. In that health alone could not do anything."

"We did not make this program, it got made on its own.. Health alone is not anything, it is just a sign. People here are hungry, thirsty. Even in the village many people's conditions as compared to others is different. If we have to do people -centered work then we have to work with the people. Such as if I've gone to a house to see a woman, who is pregnant to give a TT injection... If after giving the injection you find

that there is no food in that house, your heart aches. What is this? This injection was not needed at all. What was needed was something else. Then all this got added..income generation, education."

Though the initial needs assessment was done without much participatory input from the project community, the constant endeavor of the Trust has been to secure greater participation of the community, whether in the *Sangathans*, (organizations), in resource mobilization or in management patterns.

Since local-level **organizations** (such as gram panchayats and jaati panchayats) were already dominated by the rich and the powerful, *Sangathans* and Mahila Mandals were formed on the behest of the Trust. However in spite of this fact, the *Sangathans* have realized strength in collective action, and take initiative, while representing the poor. The **leadership** of the *Sangathans* and Mahila Mandals comprises of men and women from the target group of the socio-economically disadvantaged. Leadership is chosen generally in a democratic manner, though there are instances where a dictatorial leader may exist who may limit participation by the various groups in a community. Since the leadership itself hails from the target community, it responds favorably to the issues concerning the poor, the unemployed and the laborers.

On the issue of **resource mobilization**, from initial mandatory contributions of 3p per liter of milk to user fees for non-target group population, the Trust has tried to raise resources from the community. But as the program managers admit it is difficult to raise resources for all health activities particularly health educational and prevention activities from an already deprived community. Resources are also mobilized from the community in the form of labor and materials especially for construction of

community assets such as schools or water storage facilities. Yet, only a small percentage of the required resources come from the community. Most of these are raised from funding agencies and the government for running projects like the ICDS, Lok Jumbish, Shiksha Karmi Etc). However, we find that mechanisms have been developed so that allocations of resources are to be decided by the communities. Though the poor make little contribution because of their poverty, they have the more important role in allocation of resources.

According to the project leadership, working for poor communities means that there is a definite limit to the extent to which resources can be raised from the community. In their own words,

> "Sustainability of the organization is not something which we're really looking at. I think sustainability in terms of covering one's own costs is not something which we're going to see. In areas where primary education and primary health care I don't think we'll be in a position to raise resources from communities. i think Bikaner is so backward that you cant look at sustainabilty of programs. People don't have access to these programs. And only when people are assured of these services over a ten-year period, are they going to be looking at qualitative aspects of it, looking at whether they make sense for them to pay for it. I don't think we've reached that stage at all. I don't see the health program being run by raising all resources from the community. Sure for treatment you can charge a fee for providing good quality service. But you cant cover all costs. Health education for example. If you think *Sangathan* members are going to pay 2 Rs. to come to a talk on health, I don't think that's going to happen. That's something you have to decide if you're certain enough they'll do it. Because

I told you that health is not really a priority. Similarly primary education is pretty close to health in terms of priority for people. The priorities for poor people are basically employment, water and then maybe fodder. I think health and education come very low-down. Quality of water, for example is not an issue."

One of the salient features of the URMUL Trust is that even though it has a formal organizational structure, the work environment is quite the opposite. As a matter of fact, given the attendant problems of a growing organization, the Trust still operates in an informal environment. The staff of the URMUL Trust does not follow the typical 5-day work-schedule or even the 9 to 5 timing with work continuing much after the sun sets. For the management of the organization, the line responsibility comprises of the professionals and staff in charge of different sectors and ex-officio government functionaries at the top with program staff below them and then finally the organizations of the beneficiaries. The program was earlier headed by a charismatic leader, who inspired a great deal of respect and awe in the organization as well as the community, and it was difficult to manage the legacy after his leaving. As one of the present project coordinators put it:

"NGOs are built around leaders . Whichever small, successful organizations there are, you will also find a very good management style and a charismatic leader.. I am yet to see somewhere , where you see village groups are being formed by one particular person and village groups in the same area formed by another person, you'll find that entire difference. ..Of how a person, how an organization has been built up, how they have been molded, how they have been challenged, how they have been inspired. The dynamics

of this are worked out by the person who started it..like ( ). You were here yesterday when she challenged this and said ' I can make any group take a decision which I want'. That's what I am trying to say. People have taken the decision, but if you were there to tell them what the pros and cons are, they accept it."

However, this has changed with increasing amount of decentralization, with *Sangathans* making plans and budgets and inclusion of beneficiaries in the board. With different clusters evolving into full-fledged voluntary organizations, and the transition of the central team in Lunkaransar into a support and training center, the process of decentralization would be complete.

"We don't want to invent reasons for staying here. We don't want to be a place where we're simply providing employment to a 100 people. We'd like village communities to be playing a greater role on the management of their own lives, playing a greater role in decision-making and we have to find ways of doing that. Provide them support but not with the intensity with which we're doing now. Whether this takes 2 or 3 or 5 years we'll have to do it. And then we can look at new areas where we can work."

Most programs have been decentralized with the exception of the health program, which is presently centralized with CHWs answerable to the program managers rather than the local-level organizations. However, program planners envisage that this process too seems possible in the future. Thus, we find that the decision-making structure has changed since the initial period to favor certain disadvantaged groups. The decision making groups have thus been broadened and the Trust has been able to

include needs which are not health service needs.

The most remarkable achievement of the Trust is the community health workers' growth of knowledge, skills and social awareness. It has evolved from work generally centered around early detection and treatment of common diseases and health education to probing deeper with people into the issues of exploitation through money-lending, prices in the village markets, bribes extracted by health officials, etc. The CHWs now play a catalytic role among the women and the community, especially in the organization of the women in Mahila Mandals, helping the community to tackle marketing and money-lending as systems of exploitation. This realization of the critical links between poor health, illiteracy, landlessness and other problems led to involvement in areas outside traditional health concerns, sometimes carrying out untraditional roles for women. Perhaps the most far-reaching was their participation in efforts in land allotment. With their knowledge of protective legislation and development schemes, they have helped in creating a new atmosphere among the people of self-confidence and critical understanding of their place in society.

Workers, especially women workers, perceive a lot of changes in themselves. They feel a broadening of vision, an increase in experience and greater self-confidence as compared to what they were earlier. They also report that they have, to a great extent, consciously and unconsciously, discarded prejudices of gender and caste.

VI. IDEOLOGICAL DIFFERENCES WITHIN THE ORGANIZATION AND INTRA-ORGANIZATIONAL CONFLICT

Staff are recruited for the skills they bring to the organization. According to the project coordinators, when they get recruited, most workers see their jobs merely as a means of securing a livelihood. However, sustained

involvement in the activities of the Trust changes their way of thinking and looking at the world and they are imbued with a mission and a purpose to effect social change. This according, to them, is evident in the way in which the staff rallies around in situations which involve conflict with powerful groups and which hold the potential of danger.

This viewpoint is contradicted by junior-level staff who feel that socialization into the predominant ideology of the Trust is neither complete nor unambiguous. They feel that unlike the staff hailing from other areas, the local staff is less committed. They feel that the project leadership has failed, firstly, in making apparent the ideology or what they term as the basic principle of the Trust and secondly, in socializing staff into that ideology. The leadership is perceived as preoccupied with the management of a rapidly growing organization, with little time for evaluating the qualitative aspects of the staff's work.

> "The earlier workers were mostly outsiders and they had a desire to do something in the villages -had a long-term vision. As more local people joined, their approach was more program-related. That is because there was never such an organization here. The people thought that they should join and if the program had more money -they showed greater interest in it..because they would benefit and the people in the village would think that they have got a lot of work done. Though there is no measure who has got more work done...social work does not have a measure."

> "The local workers work only when there is a problem. Their understanding is limited.. What sort of changes should there be, what the organization wants, what the government wants- this they haven't been able to

understand... The local workers here think that since they have to work in the organization, they will do whatever the organization asks them to do. They don't work on their own. They are dependent on orders. If the organization wants savings or construction work, they get preoccupied in these programs. They have a short-term understanding."

"They, the outsiders, couldn't give people the proper understanding. For, example, as soon as I joined I had an interest in learning, so I kept on learning. We were not taught anything in particular. If you want to learn, then learn. There is no one to teach you."

"For this the local workers should improve. They, at least, should present an example. If they live in the society and behave like the rest, then there is no effect on society... They (the project leadership) have never tried to control this. They have given them full rein. It only depends on their work. There has been no principle of URMUL- for the workers. Its only a way to earn money."

This gap in socialization is also attributed to the rapid turnover of the staff, resulting in little time for orientation of the staff. As a result, the staff is over-involved in activities which involve only economic benefits to the project communities and afford them with increased social status. However, when it comes to social issues which might entail conflict with entrenched traditions and powerful local groups, the workers are not so willing to confront them. This is especially true of issues of women's exploitation and discrimination in the community. Most workers seem wary of tackling such issues even when they are aware of their prevalence in the

community. There was fear that taking up such issue or even speaking about them might be interpreted as an interference in the affairs of others and might jeopardize whatever little progress that had been achieved in changing the patriarchal-feudal society they worked in. Hence, greater emphasis was given to income-generation activities, agriculture, fodder or water as these would bring about tangible benefits and would help win the trust of the communities. This would give them greater confidence to tackle such issues in the future.

> "You just cannot get into family matters. It is so frustrating. Sometimes, you feel that 'what are we doing here?'"

> "Its all very hunky-dory when its IGP or credit schemes, but once you get into serious things, they all want to go back."

There have been instances where the project leadership has adopted a more confrontationist stance on such issues, but where a section of the subordinate staff has preferred not to act or have actively opposed such moves. It is in such instances that ideological differences within the organization come to the fore and in such times the organization has been in the grip of severe conflict with a great deal of rumination and self-analysis.

> "I think its very easy to go into an institution and start speaking the language of the institution, because each institution, every group has its language or vocabulary that it develops over a period of time..When the institution started of there used to be 5 people, now we're talking about a 100 people. And you're not able to..now the interaction between people is much less than it used to be in the past. So now you have people who say the right things at the right

times and who do not necessarily feel the right way and that became very clear".

These ideologically and behaviorally deviant episodes on the part of the subordinates were highly emotional, confronting and long-remembered by all the members in the organization. However, no significant ideological changes were stimulated as a result. The project leadership did not question its own ideology. Instead it treated this kind of deviance as a danger signal that those who were supposed to be improving the organization based on its ideology were in fact violating that very ideology. It correctly understood that allowing the deviant behavior to continue would undermine the existing ideology.

In order to deal with the ideological differences within the organization, the leadership has developed the following mechanisms:

[1] To remove those members whose difference with organizational ideologies is perceived as too vast.

[2] Reorientation and training of staff so that the organizational ideology percolates down the various levels of the staff.

[3] Selection of staff in future with similar ideologies

[4] Increased intra- organizational communication to strengthen the socialization process into the ideology of the organization.

Only time will tell as to the success of these changes and whether the organization can socialize its members into a less conservative ideology. However, the project leadership itself is wary of tackling issues which might result in conflict with forces which would threaten the sources of monetary help and as a result the very existence of the NGO.

In spite of this, the ideology of the project leadership can be characterized as having moved from a

conservative to reformist one, in the sense that whereas earlier the community was envisaged as merely passively receiving services, it is now being given greater control over project decision-making structures and project-created resources. The leadership in URMUL may be characterized as ascribing to a reformist notion of the role communities play in managing programs and resources, especially project programs and resources. The programs introduced by the Trust, especially its economic programs have brought about tangible benefits to the community and have secured their enthusiasm and involvement.

> "They (the community people) have received so much economic help that people think the organization has a lot of money. The money has created so many misconceptions in the minds of the people, which is why we had to run some programs of this kind. People's demands have increased. These demands are always money related."

> "They only look towards money. If you find that you'll get financial aid they'll get organized. Today if URMUL stops any economic help, this kind of cooperation shall disappear- no organization will remain.

The main reason why the project community has benefitted in the first place is due to the services provided and assets created by the Trust. These resources have in turn been created by quite substantial monetary inputs from international funding agencies and the government. The donors, however, act as a constraining influence and the Trust cannot confront powerful interests such as the State or other entrenched forces which may be seen as directly and negatively affecting the community. Thus, the very reason for the project's success in this area has also been the factor which has prevented the

project from undertaking more radical activities. The Trust generally tries to avoid conflicts with powerful local groups. In the few instances where these have been challenged, whether over water, land or availability of PHC services, these conflicts have been characterized by a number of successes, with avoidance of major losses, not a few of them attributable to the contacts of the project leadership with the local administration. In the case of larger issues such as the IGNP or the Malaria epidemic, the Trust is much more careful. It has undertaken advocacy activities, yet its efforts have not been sustained and have got diffused over time.

The Trust claims that it does not intend to replicate government services, yet when immunization activities were stopped by the Trust, the understanding was that the community would create pressure on the government health services to take up from where the Trust left off. Yet no sustained campaign was carried out to force the government to provide these services. Similarly, one of the main causes identified for the poverty in this region is the impact of market forces, yet the means adopted to tackle it have been to increase the resource base of the community to withstand these forces. The way in which the resource base is sought to be increased is by introduction of off-farm based activities such as spinning and weaving products meant for the urban markets, themselves a part of the market forces which are supposed to be combatted.

> "Institutions of this kind have chosen to work within the framework which the State provides...We are working in parameters which are essentially defined by the State. There are other people who are able to also look at class problems, but who believe that the whole parameters that the State defines, themselves have to be challenged. That you won't find within this institution because there are problems- the nature of

funding, the fact that you have salaried people working here, you can't really address those issues. You can't challenge those parameters on a salary. You have to be willing to go out and go through four days of hunger if required to do that".

This case illustrates the fact that changes in an organization's ideology have expanded the role originally envisaged for communities in project decision-making structures and resulted in a greater role for them over project -created resources. However, the ideology of the project leadership still remains essentially reformist. Rather than confronting the state, and helping the community demand services, it eases, for the time being, the process of the gradual withdrawal of the state from its responsibilities. This is done by the organization attempting to provide these services, itself. However, major structural injustices are unaddressed and real empowerment of the community seems to be only a distant possibility.

CHAPTER IV

WOMEN'S DEVELOPMENT PROGRAM: A GOVERNMENTAL ORGANIZATION

I. THE CONTEXT

The state of Rajasthan covering a vast area of 342.4 thousand square km. is located in the western region of India. It comprises of 31 districts and 37890 inhabited villages. The total population of the state, according to the 1991 census, is about 44 million. One-thirds of the state (11 districts) is covered by the Thar desert, five districts are predominantly tribal and about 15 districts are drought prone.

Chronic problems include desertification, scarce and unsafe drinking water, drought and industrial backwardness. Only 57.3% households in Rajasthan have access to safe drinking water, from a pump or pipe, as compared to the all-India figure of 68.2% households.

I. a. Status of Women in Rajasthan

Rajasthan is also notable for the low status of its female population. One of the standard indices of the status of women in any society is the sex-ratio (i.e. the number of females per 1000 males). The sex-ratio has come down to 913 in 1991, as against 919 in 1981. The National family Health Survey reveals an alarming sex-ratio of 880 for Rajasthan.

The female literacy rate in Rajasthan is 11.4%, compared to the all-India figure of 22.4%. Only 2.69% of scheduled caste women and 1.2 % of scheduled tribe women are literate. In Jaipur district, which contains the state capital, less than 1% rural women are literate. Rajasthan's female literacy puts it among the six states of India having the lowest rate of female literacy (less than 20%).

According to the conventional methods of computing work participation, Rajasthan has a female work participation rate of 21.06%. Child marriage is widely prevalent, and 69.55 women currently aged 20-24 years were married before the age of 18 years. The median age at first marriage in Rajasthan is 15.9 years, while it is 17.4 years for the whole of India. Women's health is another area of concern with only 31.2% mothers receiving ante-natal care. The corresponding all-India figure is 62.3%. In Rajasthan, only 11.6% babies are delivered in a health facility.

The backwardness of women in Rajasthan can be traced to the hold of a feudal culture, which reinforced the low status of women. The geo-physical features of the area serve to compound the adverse situation of women- in terms of accessibility to health care and education, as well as the availability of water, fodder and fuel-wood.

While Rajasthan does not have a history of involvement in the freedom struggle or movements for women's emancipation, it does have a number of NGOs working among the poor and the underprivileged. In addition, as pointed out by Maitreyi Das (1992), the last two decades have seen the rise of several women's organizations involved in research, training and field work. "This, combined with the fact that Rajasthan has a strong administrative ethos, has paved the way for innovation and experiment." (Das, 1992)

II. GENESIS AND EVOLUTION

The status of women in Rajasthan has already been elaborated upon. It was apparent that even after three and a half decades of independence, there was no significant enhancement of the status of women in the state. The Sixth

five-Year Plan (1980-85), which for the first time included a chapter on women and development, states that the "improvement in the socio-economic status of women would depend to a large extent on the change in the value system, attitude and social structure, prevailing in the country". It was felt that many government schemes and projects were adversely affected due to the non-involvement of women, especially in areas such as health, education and family welfare. In addition, it was felt that even programs of animal husbandry, social forestry and rural sanitation would have greater outreach if women's participation were to be intensified. Rajasthan was the first state in India to boast of a program exclusively for the empowerment of women. The Women's Development Programme (WDP) was launched in 1984 as part of the Sixth Five Year Plan. WDP was visualized as a collaboration of three kinds of inputs, a structure which would have the inner strength and grass-root linkage of voluntaryism; the security and stability of the government; and a continuous incorporation of critical reflection from research bodies.

WDP originated as a result of rigorous exercises undertaken by the Department of Rural Development and Panchayati Raj (DRDPR) of the Government of Rajasthan from 1982 to 1984, in response to difficulties encountered in the implementation of various development schemes. The DRDPR was charged with overseeing the Government of India's 20-Point program, which included various schemes such as the emancipation of bonded labor, securing minimum wages for workers, primary education, child immunization etc. After reviewing available research, intensive field study, and interaction with voluntary agencies and social activists working in the field, the DRDPR reached the conclusion that in order for development programs to be successful, women must be given access to them through

innovative means. The consensus was to launch a program which would create a new sense of worth among poor rural women and develop new fora of communication, and understanding about social and developmental issues.

The formal beginnings of WDP can be traced to May 1983 when the Development Commissioner initiated a brief conceptual paper on the proposed program. The paper was discussed by Secretaries and heads of departments in the state administration. While these officials had no objection to the program, neither were they enthusiastic about it. Moreover, they could not commit funds for the program, in view of the financial stringency in the state. However, the Development Commissioner had already had preliminary discussion with UNICEF and the Ministry of Social Welfare at the center, regarding funding for the program. Apart from its clearance by the Rajasthan Chief Minister and the Minister in charge of Rural Development and Panchayati Raj, the proposal does not seem to have been the subject of discussion with the political leadership of the state.

In February 1984, UNICEF sponsored a two-day workshop in Udaipur, Rajasthan, to discuss the draft prepared by the DRPDR. The workshop was attended by senior officials of the Central and State Governments, leaders in the field of Women's Development from across the country and the UNICEF. The importance of the workshop lay in the fact that various components of the Project document were discussed in detail, and suggestions made by the participants.

The WDP document was finalized by DRDPR within a month after the Udaipur workshop. The financial estimates were prepared, in close consultation with the local UNICEF office. The Government of Rajasthan gave its final approval

in April 1984. The document was published in the following month.

The salient feature of the Project document is not its content, nor even the process which was followed for its development, but its declared provisionality and tentativeness. In fact, the earlier records of the meetings of WDP have statements by the Development Commissioner, that he did not attach any sanctity to the project document, and that depending on experience its parameters could be altered. The project document essentially remained a guide to the structure and financial patterns. Most other aspects of the project were altered as the implementation got underway.

The fact that WDP was initially set up under the auspices of the DRDPR itself seems illustrative of the almost complete lack of administrative and organizational infrastructure for women's development. Subsequently in 1985, WDP was shifted to the Department of Woman, Child and Nutrition, under the Department of Social Welfare. From 1991, it has been administered by the Ministry of Women and Child Development.

In 1984, WDP was set up in 6 districts of Bhilwara, Jaipur, Jodhpur, Banswara, Udaipur and Ajmer. Financial assistance for five districts as well as state level expenditure was arranged from the UNICEF. One district, Banswara, was in the tribal sub-plan area and formed part of the Tribal Development Programme.

The objectives of the program as set forth in the project document are both ambitious and ambiguous. The document stresses that no development is feasible without strong receiving mechanisms among disadvantaged groups, in

this case women. While other programs stress on strengthening delivery systems , the sole aim of the WDP is to form groups which will consolidate themselves for their own development. It is implicit that these groups once formed will initiate the action which they need and decide upon. The policy document displays a basic faith in the potential of women's groups and the "need to encourage and create agencies, groups and individuals to articulate concerns over indignities and discrimination against women .. (and to) .. empower women through communication of information, education and training and enable them to recognize and improve their social and economic status" (Government of Rajasthan, 1984).

The second important element of the document is the degree of freedom visualized for women's groups and non-government organizations (NGOs). This is what basically sets WDP apart from other innovative government programs in women's development. All such programs have stressed on the need to build awareness and confidence among women, but before WDP, there never had been a program that saw this as a paramount prerequisite for integrating women into the development process.

In order to enhance the status of women from deprived sections of the population the policy states its overall objective to consist of a "shift of attitude from one of compassion and welfare to that of the treatment of women as equal partners with men in the family, social situations and economic activity, in education and in culture". In a nutshell, the essence of WDP is the empowerment of women through information, education and training. This would enable them to improve their social and economic status

II.a. Specific Objectives of WDP

1. To identify programs of direct importance to women's development and to create mechanisms for implementing these programs for the benefit of women.
2. In implementation of women's development programs, to ensure a focus on families from poverty groups and on women who have suffered disabilities due to social oppression and physical disadvantages.
3. To train women in improved ante-natal, natal and post-natal services and child-care, since child welfare is intrinsically linked to women's development.
4. To establish centers to enable women to learn how to look after themselves and their families, and to improve their economic status.
5. To support a number of NGOs already taking up women's issues financially and with material.
6. To develop administrative machinery and support networks with other agencies and institutions to ensure a creative functioning of WDP.

II. b.The Organizational Structure

The management structure of the WDP is an unusual combination of conventional departmental functioning along with direct and continuous involvement of local NGOs through an apex level Information and Development Resource Agency (IDARA) and an NGO assigned with the responsibility of concurrent evaluation, the Institute of Development Studies (IDS). In a somewhat unique manner, WDP permitted the initiative for decision making to be taken over by women's organizations, rather than resting with the conventional administrative hierarchy. The following chart will aid in the understanding of the various levels of the organization and functions.

Level	Organization/Worker	Function
STATE	Department of Women and Child Development	Overall Coordination/ Administration
	State Information and Resource Development Agency (IDARA) non-governmental	Information, training, staff selection, newsletter
	Institute of Development Studies (IDS) non-governmental body	Monitoring, evaluation
DISTRICT	District Women's Development Agency	Administration
	District Information Development and Resource Agency	Information, training, district newsletter
BLOCK	Pracheta Block-level worker	Supervision of 10 Sathins, training, liaison
VILLAGE (for every 10 villages)	Sathin	Main field functionary Organizing, animation of groups

State Level

Originally WDP was intended to be a part of the Department of Rural Development and Panchayati Raj (DRDPR). It was expected that a Joint Development Commissioner would be in charge of the program with some support staff. Over

the years, however, the administrative responsibility of WDP has shifted to the Department of Social Welfare, more specifically the Directorate of Women and Child Development. The Secretary of Social Welfare is assisted by a Director of Women and Child Development, who in addition to WDP is also responsible for several other important schemes such as the ICDS. He is assisted by an Additional Director who is exclusively in charge of WDP. The persons responsible for WDP are generally officers from the Indian Administrative Service.

The Department of Social Welfare is responsible for staff recruitment, monitoring, selection of districts, and identification of a voluntary agency to serve as district Information Development and Resource Agency (IDARA).

There is also at the state level, the apex technical support agency or the State IDARA . In this program, training and provision of need-based information were identified as necessary inputs. The concept of the State IDARA was based on the fact that a substantial portion of the work involved in group formation is related to information needs of the group. Hence appropriate learning material has to be created and made available to the popular idiom. Also the dissemination of information has to be conducted with skill. The responsibility of the IDARAs has been entrusted to voluntary agencies based in the area, working in the sphere of education and women's development. The State IDARA is the coordinator of the district IDARAs and its role is fulfilled by the Women's Studies wing of the Rajasthan Adult Education Association.

The third organization at the State level is the Institute of Development Studies , Jaipur (IDS), an institute for social science research. It was originally envisaged as an evaluation agency, but has over the years been critically involved in the management of WDP

District Level

Each WDP district has a District Women's Development Agency (DWDA). DWDA is an autonomous body (registered under the Societies Registration Act) with financial and administrative powers. The District Collector is the Chairman of the DWDA and its membership comprises a few officials, and some women who may be researchers or social activists. The guidelines issued by the State government also specify representation of the District IDARA and a few block and village-level WDP workers on the DWDA. The Member-Secretary of the DWDA is the District Project Director (PD). The project Director is a key functionary in the WDP. Her selection is made under special selection rules, and through group meetings. Apart from handling administrative responsibilities, she has the task of drawing upon the strength of the governmental and non-governmental segments of the program and building a relationship of equality and partnership with the IDARA. Her other functions range from selection of block -level WDP functionaries, the supervision of their work, to working with the other government departments.

The other component of the WDP at the district level is the District IDARA. Each IDARA has two professionals and supporting staff. The IDARA was visualized as working closely with the DWDA, and it was to assist in the planning and implementation of activities, as well as in making available the necessary resource personnel and other inputs. It was also visualized as a link between the grass-roots and the wider women's movement. It drew upon activists from the movement to serve both as functionaries as well as consultants. The other functions of the IDARA include training of Sathins, participation in Sathin meetings, publication of monthly newsletter -'*Sathin Ro Kagad*'' and dissemination of information about schemes and programs relating to women.

Block Level

Prachetas (literally animator or initiator) supervise ten Sathins or village level workers. The Pracheta represents the departmental support to the Sathin at the field level. It is she who is initially responsible for the selection of the gram panchayats and the Sathins through meetings with the local community. She functions as the guide and motivator to the Sathin. She helps the Sathin in identification of needs, issues and problems, helps organize collective discussions and provides inputs in terms of information and possibilities for problem resolution. She also helps the Sathin liaison with other government functionaries and departments at the village and block levels, as well as the village leadership (caste, panchayat).

Officially, the Pracheta is referred to as the Field Supervisor. She has the responsibility of supervision, documentation and reporting the activities of the Sathins. Most Prachetas come from urban backgrounds with a minimum educational qualification of Higher Secondary.

Village Level

The criteria for the selection of a Sathin are:

- preferably a woman from the lowest socio-economic strata,
- a woman with the support of her own community,
- a woman with empathy for the condition of village women and flexible ideas,
- a woman for whom monetary gain is not the only motivation.

For the selection of a Sathin officials of the WDP spend several days and nights in each village. The low levels of community solidarity and relative lack of social interaction make it important that women be contacted individually by staff members who explain the proposed

program. These personal contacts are supplemented by evening community meetings, during which village people are asked to nominate women whom they feel would be effective as workers. Nominees are subsequently interviewed by the staff, who select them for training.

The Sathins today are a heterogenous group of about 650 women from different castes, educational levels and economic groups, marital statuses and age-groups. There can only be one Sathin in a Gram Panchayat. Therefore, there is on, an average, one Sathin to a population of 5000 persons, (or 4 villages) in each WDP district.

A Sathin who completes her training was initially given a monthly remuneration of Rs. 200 p.m., which was later raised to Rs. 250 p.m. In the course of her training, a Sathin is given a sense of worth, self-confidence and capacity to communicate. She begins to understand that she has to play a leadership role in enabling the women of her village to understand their predicament and to move towards securing a better status for themselves. Some basic information is given to the Sathins during training regarding laws relating to women's work, marital and social issues, women's physiology and hygiene, selected government programs etc. A Sathin is expected to organize groups in her village and is the core link in the program.

The WDP document sets forth certain directions for Sathins, She is to "begin her work on a low key...familiarize herself with the village institutions...and the people working in them" and "establish rapport with some village women". Essentially functions of the Sathin include:

- initiating discussions on problems of the women
- reporting to the Pracheta and the DWDA the problems of women and the possible solutions, including giving feedback to them about development programs.

- sharing information about development programs and laws
- organizing action on issues of concern for the women in consultation with the DWDA and the Pracheta
- reading out and initiating discussion on '*Sathin Ro Kagad*'
- preparing reports of her activities either in writing or pictorially.

II.c. Changes in the Program and the Organizational Structure

Since its inception, the program has changed in content as well as in the functions performed by its various components. It has also witnessed increasing amount of dissent and intolerance of deviance within the program.

The WDP document aims at formation of autonomous women's groups. Yet when women from Kekri (a Pracheta and some Sathins) organized an independent group and participated in the fourth National Women's Conference in Calicut, 1990, with local resources, conflict came to the fore on this issue of women asserting their independent identity. They were punished for their independent action and five Sathins' services were terminated on their return. The disapproval of the authorities was clear when reinstatement of the Sathins did not ensue even after a high court order to this effect.

Expectations from the Sathins have also greatly increased over the years. Community demands range from a small matter related to the seeking of information or the understanding of procedures to the issue of rights of women, caste and social issues or developmental needs ranging from the availability of employment to distribution of rations to repair of hand-pumps. While increase in

quantum of tasks and range of work is evident, there is also a change in the nature of expectations on the part of the government. In some spheres such as family planning, where earlier targets had been opposed in favor of awareness raising, the focus was now on fulfilling of targets. Work progress is increasingly being assessed in terms of quantifiable targets. As compared to earlier years, there is greater emphasis on implementing government -determined programs, as opposed to responding to community-based needs. Sathins are being increasingly used to participate in predetermined programs of the government and other international agencies such as campaigns for AIDS control, in training in modern agricultural methods organized by international agencies. This shift from village -level issues to implementing programs of the government has also thus added to the workload of the Sathins. Since, they have been identified as a resource person in the community and have taken leadership roles in many struggles in the past (payment for minimum wages in drought relief work, fighting for removal of liquor dens, land issues), the community continues to expect support from them. The demands from the government have added to these responsibilities.

This increase in the work-load and the predetermined nature of the work led to the Sathins' questioning of their status as voluntary workers and their insignificant honorarium. As a result, in 1990, when Sathins from eight districts gathered in Padampura to share their experiences in a mela, they had an opportunity to discuss their exploitative service conditions. They raised a demand for increase in salaries and regularization as government workers. Support from the autonomous women's movement has helped unionize the Sathins and, in 1993, an independent union of the Sathins was registered at the state level. A demand has been raised for basic worker's rights, for

giving priority to the needs of the community and protection of workers within the program.

The reaction of the authorities to the union has been hostile. While they have attempted to dismantle the union, the activists of the women's movement, now a part of WDP (who form the influence base and determine the direction of the program) are also its loudest opponents. The limited strength of the union in terms of numbers, resources and easy dispensibility of workers gives it very limited bargaining powers.

One of the ways in which the authorities responded to the unionization of the Sathins was by trying to do away with the post of the Sathin. This was first announced in the governing council meeting in Bara district in 1993, where it was reported in the minutes that the Sathin's post had been abandoned. It was proposed that from then onwards groups of women .i.e. Mahila Samoohs would be set up in each village and instead of one Sathin now the group would receive the Sathin's honorarium. The post of the Sathin exists in 13 districts while the program has expanded to 21 districts. In districts where there are Sathins, the required number of 100 Sathins is not being met. Instead Mahila Samoohs are being set up. Districts like Bara and Dausa have just six Sathins each. Newer districts like Bikaner and Churu do not have a single Sathin.

This is also due to the expressed concerns of the officials within WDP regarding the limited outreach of the program. It is felt that even after more than a decade, the area covered remains considerably small. It is contended that the Sathin's impact is confined to her village and other villages in her Gram Panchayat. Two remedial measures have been prescribed

[1] the fast expansion in other areas and districts; and
[2] the adoption of the Mahila Samooh model.

The Mahila Samooh model envisages the formation of a women's group, who collectively executes the tasks of the Sathin. This model, it is argued is a collective model, unlike the 'lone crusader' Sathin model, whose weaknesses have been demonstrated by the Bhanwari Bhateri incident[65]. The argument continues that the processes of WDP have resulted in a visible upgrading in the status of the Sathin, in contrast to the village women, and resulted in the creation of a '*jati*' of empowered Sathins. Some other arguments put in favor of the Mahila Samooh model are that Sathins get into social conflict because of their own caste and economic positions, whereas the Mahila Samooh bypasses it as it incorporates women across caste and class.

However, another group among the officials of WDP strongly support the Sathin model. They feel that the process of empowerment of the Sathin has had a direct effect on creating an entire community of empowered women. They also contend that the initial outreach of the program was limited because the geographical coverage was relatively small. In the rare instances when the target of a 100 Sathins per district is almost fulfilled, it, in effect, covers only 5-10 % of the total district. In the newer districts, the number of Sathins is less than 30. Thus the total spread of the impact of the Sathin's work across the district is thin. Moreover, this group expresses doubts about the rapid expansion to other districts and the adoption of the Mahila Samooh model.

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[65] A Sathin from Bhateri village, in Jaipur District was gang-raped by some men in her village, on September 22, 1992, for her role in preventing a child-marriage

III NATURE AND SCOPE OF ACTIVITIES

III. a. The Support Activities

District and state-level activities are planned to provide support to the Sathins and the village women. Some of the planned activities are as follows.

Training

After their initial selection, Sathins and Prachetas receive an initial training in groups comprising of approximately 25-30 women, for a period of time varying from 15 days to a month. Even though each training has had its specific characteristics, the training is essentially a period of experiential learning, where through a process of community living and personal sharing, an atmosphere of mutual trust, empathy and an understanding of the commonalty of women's suffering is created. Experiences are generated to facilitate altered perceptions of self-image as well as the social image of women. The essential component of the training is value-based. However, information is also provided regarding the existing governmental schemes, the concerned departments and procedures, village and block-level functionaries and legal and other rights of women. Experiences of women's struggles in the past are also shared. Skills are imparted in handling the various forms of communication. The training also serves as a process for final selection as well as for evaluation and review of the processes adopted.

Jajam

This is the term used to denote the village level meeting. The nature and frequency of the *Jajam* varies. As a rule, there is at least one *Jajam* per cluster (i.e. every 10 Sathins) in a month. Usually the monthly *Jajam* combines two or three clusters and every three or four months, the Sathins meet in what is called the *Samuhik Jajam*. Meetings of Sathin from one cluster are also termed as cluster meetings or *chhoti jajams*.

The *Jajam* has been visualized as a village level platform, where village level issues are discussed and analyzed. It provides a platform for village women to articulate their needs and problems in an atmosphere of trust and solidarity. The Pracheta is the main facilitator and depending on the need, the other officials of the DWDA or IDARA and IDS also attend the *Jajam*. It can also serve as a meeting place of village women and other government functionaries and officials and a two-way flow of information takes place. The monthly *Jajam* is also a time for administrative functions such as the payment of the Sathin's honorarium and reporting and documentation of the activities at the village-level. An important aspect of the *Jajam* is that it is the Sathins who plan the venue, date and issues to be discussed. the decisions taken by the Sathin is communicated by the Pracheta to the DWDA, during the Pracheta monthly meeting.

The major issues discussed at the *Jajam* depend on the particular problems of the area. The commonly discussed issues at the *Jajam* in the past have been drought relief works, and the access of women to them. Other development problems discussed have been: accessibility of water, health, pensions, disbursement of loans and subsidies, fodder and fuel-wood. Social issues like rape, child marriage dowry, desertion, the status of widows and a range of legal issues are also featured.

There are occasions when the *Jajam* has been used as a show of strength, particularly in situations where the Sathin along with a group of women in her village is facing opposition. When the Sathin begins work, she often has to challenge existing norms for women and practice a new set of values. She faces opposition from the community and it requires courage and perseverance to win its confidence. This process occurs gradually and there are times when the Sathin is extremely vulnerable. The role of

the *Jajam*, in such times, is to provide support and make the village community realize that the Sathin is not alone.

Sathins from other villages show their solidarity, and depending on the gravity of the situation, Sathins from other parts of the district, and occasionally, from other districts, also participate. A major portion of the time of Jajams is devoted to the discussion of individual issues as they affect the lives of particular women. The Sathins rally around the wronged woman and systematically plan action to seek redress.

The *Jajam* emerges in the WDP as an important mechanism for feedback not only about WDP but also the other development programs. It is also a forum for retraining of Sathins and Prachetas, who attend the jajams. The attendance of IDS staff in *Jajams* assists them in the task of evaluation.

The form of the *Jajam* continues to evolve. At present, the pattern is generally as follows. During the day, a meeting takes place of the Sathins and the Pracheta, with or without other WDP officials. It is a time for reviewing and evaluating. Strengths and shortcomings are discussed and analyzed and the required inputs identified. Village women may or may not participate. At night, there is invariably a village level meeting where both men and women participate. It is an attempt to discuss village level issues jointly and incorporate women's participation into the planning and decision-making process.

Pracheta Monthly Meeting

In the first week of the month, all the Prachetas in the district meet in the DWDA. The PD and the IDARA representatives also attend these meetings. The representatives of the IDS may or may not.

It is a monthly stock-taking where the activities of the past month are reported, processes analyzed, and reflected upon and progress evaluated. Needs and inputs are

identified and any specific information required is made available. It is also an occasion for the direct exposure of the Prachetas to the governmental and non-governmental elements of the program. An attempt is made to keep track of existing governmental policies and developmental programs for women. The focus is on processes and it is through these that impact and change is evaluated.

Shivir

The concept of the 'Shivir' or camp, evolved, when over a period of time common issues began to be identified across different parts of a district. It was realized that the extensive nature of these issues required an in-depth understanding in order to plan concerted action on a larger scale. Often these issues related to the existing situation of drought, famine and unemployment. Other issues which came up were related to health, population control, Panchayati Raj, child marriage etc.

The process of deciding the topic around which the Shivir was to be organized is usually lengthy and spread over many months, during which the Pracheta has several meetings with the Sathins and the village women, and identifies problem areas requiring clarification and additional information. Some of the meetings are attended by the IDARA, the IDS or the PD.

Campaigns or Abhiyans

Usually campaigns are organized around social and other issues requiring awareness -raising and public education. The decision to organize a campaign could come from the state or district level administration, as part of the larger policies of the state for women and weaker sections, or public education campaigns. The decision could also be due to a need identified during the course of routine work by Prachetas or the IDARAs etc. Some of the campaigns that have been conducted are on literacy, child marriage, AIDS and the girl child. These usually last for

a week or a fortnight. The forms of communication used in the campaigns vary from local folk forms to traditional communication media. Yatras, meetings and discussions are the usual components.

Melas

District and state-level Melas or gathering of Sathins along with village women are regularly organized. These are accessions for interacting in an informal manner, dancing, singing and being together for two or three days. There is an input of awareness -raising, education and information using the different cultural forms. Some of the Melas relate to the celebration of specific days, such as 8 March, the International Women's Day.

Sathin Ro Kagad

In an attempt at establishing links between WDP villages, two monthly newsletters are brought out, one by the state IDARA and the other by the district IDARA in the local dialect. The state level newsletter provides information on activities related to the different districts. District-based 'Kagads' are based on letters from Sathins and village women which are received by IDARAs and the reports on Shivirs, jajams workshops and other activities. Generally, however, they focus on a particular issue like alcoholism, famine works, water and fair-price shops. The 'Kagad' is read out by the Sathin to women of her village and discussion is initiated on its contents.

Other Activities

State and district level workshops are organized by IDARA or IDS, from time to time, on specific need based issues. Apart from this there is also direct communication between the Sathins and the PDs or the IDARA through letters.

III. b. Areas of Work

The National Commission for Women's [66] study, of the work of the Sathins, provides an exhaustive lists the impact of the WDP and its areas of work. These can be broadly categorized as:

1. **Physical**

Sathins help in identification of community needs and with their knowledge of schemes such as the Jawahar Rozgar Yojna and the IRDP, they are instrumental in the installation of hand-pumps, construction of roads etc.

2. **Establishment of Village-Level Forums**

By establishing village-level women's groups and activating jajams, Sathins aid in awareness-raising and dissemination of information. They also help in breaking gender barriers by bringing about an attitudinal shift in the village community's perception of women as well as in changing self-perceptions of women.

3. **Liaison with government functionaries such and the building of lateral and vertical linkages**

The Sathin seeks to establish credibility as a link agent between the government departments and functionaries such as the patwari, gram sevak, teacher etc and the community, thus helping government functionaries in extension work.

4. **Attitudinal Shifts within villages**

These are shifts in perceptions of gender, caste, health literacy and education development schemes which have occurred due to the Sathin's role as a source of information at the grass-roots level.

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[66] National Commission for Women, (1996) *The Sathin as an Agent of Women's Development*, Government of India, New Delhi.

5. **Awareness of legal social and constitutional rights of women:**

Some of the most significant achievement in this area is the obtaining of land pattas in women's names, combatting dowry and bigamy, initiating and enrolling women in employment schemes and in payment of equal wages.

6. **Combatting social evils / practices**

By raising public awareness and organizing collective resistance in the form of local struggles, Sathins have sought to combat social evils such as lavish death-feasts, alcoholism, dowry etc.

7. **Leadership, Community mobilization and participation in political processes.**

Areas where WDP is operational have succeeded, more easily than others, in ensuring women's participation in Panchayati Raj institutions. This is due to the continued support provided to rural women in these institutions, in the form of training and information.

8. **Development of skills**

Sathins have also been instrumental in imparting skills to rural women, especially those which were traditionally considered unsuitable for women. These are skills in planning, and decision-making, in training and in communication and public speaking.

<u>Health Project</u>

The health project lasted only for a year. A description of the project by members of the health team follows:

> "Two years after the inception of the program, in response to the needs of women at the grass-root level, a health project was formulated and supported

as part of the WDP, by the State IDARA for a period of one year, from April 1986 to April 1987. Working in close coordination with the functionaries of WDP in Ajmer, Jaipur and Jodhpur districts, the project made an attempt to evolve an understanding of women's health in the larger socio-economic context.....

Following the success of Shivir focussing on famine as its theme in February, 1986, the WDP authorities in Ajmer decided to make the Shivir an annual feature, to address the problems and needs of the time.

Two work areas were identified- land and health. The former, being overtly political and thus more sensitive, was dropped and, towards the end of 1986, it was decided to focus on women's health and organize a Shivir on this issue.

The health Shivir held in Ajmer district in February 1987, was the starting point of a year-long health project. Based on a survey of the prevailing health problems among rural women conducted by the Sathins and the Prachetas, it was revealed that a significantly large number suffered from menstrual disorders, vaginal discharges and problems related to child birth. The Shivir focussed on these three areas. Information was shared in the context of personal beliefs, practice and experiences. The local language and idiom was used along with visuals and models. Existing beliefs were explored and myths exploded. For instance, a pregnant woman was not allowed to eat curds and butter-milk as it was supposedly deposited on the foetus; menstrual blood was considered impure; conception during the waxing phase of the lunar cycle was said to result in the birth of a son and in the waning phase in the birth of a daughter. An insight into bodily functions, particularly those related to fertility and sexuality, resulted in the expression of a feeling of liberation, of clarity of being strengthened and being in control. A need for carrying forward the information to the respective villages was expressed by the Sathins and culminated in the formation of a year-long health project.

Since it is the woman's body which is used against her as a weapon of repression, a struggle for improvement necessarily needed to begin by identifying the origins of these repressions and forms of control that are being used. Bodily function such as fertility and sexuality were seen from a point of view which accounted for social attitudes to women as expressed in relations within the family and society, including the attitude of the medical establishment and the state. Health problems were often related to food intake which was determined by the position of the woman within the family, her economic class and the

existing famine situation. The process of dialogue, information-sharing and feedback was the basis on which the health project was run. This was seen as a step towards an understanding of the situation most poor rural women find themselves in.

The development of visual material like booklets was central to the evolution of this understanding. Shareer ki Jankari: book 1 and an incomplete Japa ki Kitab were the products of the year-long process, the former dealing with fertility and sexuality and the latter with child-birth. Realization of the essential issues involved paying attention to two major attitude shifts. Information given had to integrate itself with the life situation, beliefs and practices of the women who were receiving it..Secondly, the health project could no longer retain a separate identity and had to integrate itself into the larger reality: the overall famine situation, employment payment of wages and family planning excesses.

Open discussions on fertility and sexuality, and delinking the two, provoked strong responses. For some it was the starting point of increasing control over their life situations. The questioning of some of their existing beliefs and practices led to a feeling of liberation. ..On the other hand there were also those who refused to share much of the new insights as age-old beliefs were being challenged and questioned..By and large most Sathins and younger women took a keen interest onto their sexuality as well as observing their fertility cycles...

After about six months, the health project evoked disapproval of the authorities within WDP as well as the medical establishment. The project was accused of instigating the Sathins and corrupting rural women; of preventing the Sathins and Prachetas from performing their duties; of not motivating cases for family planning and thus of working against national interests. Women controlling their fertility by increasing awareness of their fertility cycle was not approved of. There was a great deal of pressure being applied to accept the contraception in the population control strategies being promoted by the state.

Other than a few exceptional years, the eighties was a period of severe drought in Rajasthan. From 1985 to 1988, Ajmer district was witness to the failure of rainfall and subsequent crop failure of over 88%. With other employment opportunities being scarce, the government famine-relief works became the major source of livelihood...

During these years, the state conducted a vigorous campaign for population control. The experience in

Rajasthan was that the state linked sterilizations to labor eligibility on the sanctioned famine relief works (like road construction, deepening of ponds in villages). In Ajmer district there was a direct linking up of provision of employment in famine works to having to adopt sterilization. A certificate of having undergone sterilization was required for obtaining wage employment on the famine relief works. Coercive measures, excesses and inhuman conditions of the sterilization camps raised a widespread protest at the grass-root. The pressure from the local administration to meet targets resulted in forcible sterilizations in many districts of Rajasthan, caused large-scale morbidity and in certain cases even post-operative deaths.

For a time because of opposition from the people and a section of the WDP, Sathins were exempt from meeting targets. But with the exit from WDP of people critical to the program, targets were reintroduced. Questions were raised in the Vidhan Sabha about the dissent within WDP against the FP program and soon it became an issue on which the WDP's survival rested. The initial five years of the UNICEF funding were to be replaced by state funding. Authorities within WDP withdrew their support. and took a stand in favor of population control. When questioned, it was explained as a necessary move as the very existence of the program was otherwise threatened. The health team responded to the overall situation and:

> "..It was decided to carry out a survey focussing on post-sterilization health problems in women and the process of decision making which led them to accept sterilization. The objective of the survey was not merely the collection of information, but to use it as an agenda of discussion in the villages. The authorities within WDP and the state administration strongly disapproved of work of this nature. They forbade Prachetas from holding meetings with the members of the health team. The Sathins were also put under pressure and subjected to restrictions. As a consequence team-work became increasingly difficult.

It was also not possible to finally analyze and report on the information collected during the survey. The hostility of the authorities to the health project work and the health team members grew and finally the decision was taken to withdraw the book on sexuality and fertility awareness.

Over a period of time, the clash of interests at the grassroots and the higher level of the program became more pronounced. Empowerment at the grassroots level, which was the prime objective of the program, when it commenced- was now being viewed as a threat by the state. Any attempt to change the power balance began to meet resistance from the authorities. the emphasis began to shift from fulfilling community needs to implementing state policies from the top.

One year of the health project was drawing to a close. A decision had to be taken about its future. From the very beginning, demand from the grass-root. had been the guiding factor of the health project and was the basis on which issues were taken up or dropped. activities were evaluated on their basis of having helped strengthen village level processes.

Information was collected, keeping these principles in mind so that information from the grassroots was fed back and analyzed to deepen understanding.

The objective of the health project now seemed to be at variance with the direction and policies being pushed by the state authorities. Awareness raising, empowerment, mobilization and internal growth were no longer indicators of development. Development now began to be measured in terms of achieving targets. Sathins and Prachetas were now caught between catering to community needs on the one hand and succumbing to pressures from the above on the other.

Thus when the decision to further the health project was to be taken at a *Samuhik Jajam* in village Devlia in April 1988, the atmosphere was surcharged with tension. the PD and the health officials were openly hostile to the project and accused it of being disruptive, of instigating the people and working against programs of national importance such as the Family Planning Program. The Sathins, despite threats, were firm on the opinion that the health project had helped strengthen processes at the grass-root level and that work had gained momentum and needed to be supported. The PD thus came under pressure and finally agreed to inform the state authorities of the Sathin's views, adding however, a personal note of reservation.

To take a final decision on the health project, a meeting was called in My, 1988, in Jaipur. This was represented by representatives from the State

Directorate, UNICEF, State IDARA, District IDARA, IDS and the PDs of Ajmer, Jaipur and Jodhpur Districts. The detailed health project report was presented. The work of the project came in for praise, it was decided to keep the project internal as a part of WDP. It was now to be integrated with the overall program and budgets received from various districts.

Funds for the health project stopped flowing from April 1988, even as work continued. Proposals for further work were drafted along with the concerned authorities in the different districts as part of the annual proposals and were submitted in May 1988. Till the end of September, not a word was heard in response, at which point the members of the health team took the decision of continuing work, while officially disassociating themselves from the WDP.

The health project team, however, continued work outside the WDP. *Shareer ki Jankari: Book I* was published with the help of well-wishers and was well-received. It has now been translated and is being used in many parts of the country as well as abroad. it was only much later, on seeing the response in other parts of the country, the authorities within WDP decided to distribute the book to the Sathins."[67]

IV. PROJECT PLANNERS IDEOLOGY AND COMMUNITY PARTICIPATION

The above account of the program reveals interesting insights into ideology, dissent within organizations, attempts to control dissent and its effect on the nature of community participation that emerges.

Women are viewed increasingly as one of the most stable and potentially powerful elements of society- and the most oppressed. Campaigns for female literacy, women's awareness and empowerment; and focussing on gender concerns are being looked upon as crucial inputs for overall development or as ways to handle the crises of increasing burden on the poor. The inaccessible, invisible woman of feudal society had remained out of reach of government

[67]Sawhney, A. (1994)'Women's Empowerment and Health Experiences from Rajasthan',*Social Scientist*, Sep-Dec, pp. 137-146.

development schemes. As women's issues increasingly found space, the state too realized that its developmental efforts required the participation of women. Studies conducted confirmed that for furthering market interests, as well as for controlling the population, it was necessary that women break out of the rigid controls of the feudal and patriarchal structures and asserted their independent decision-making. The state realized that in order to gain acceptance for its existing development programs, particularly the population control program and other 'rational' plans, it was necessary to draw rural women into its so-called 'modern development' fold. According to the state, minimal literacy promotes consumerism and lesser defiance of the small family norm. This along with the campaign against child marriage suits the objectives of the fertility control program, (whose sole aim objective is shifting focus from the political-economic features of poverty to over-population). Promotion of modern agricultural technology like hybrid seeds, pesticides, fertilizers, etc., serves the interest of the international monetary agencies, the multinational companies and modern capitalist farming.

It was, thus, not surprising that the Government of Rajasthan launched the WDP using the tone and the tenor of the women's movement and drawing on a large number of activists from the movement and from the NGOs. This collaboration lent legitimacy and credibility to the state's real objectives. The slogans and methods of progressive movements, thus, got co-opted. Women now militated with state support and development was defined in terms of creating a positive perception of women's own identity in the larger social context. Through programs like the WDP, the state built a progressive image- of encouraging awareness building, organization and mobilization of women for struggle rather than for

executing state-run development schemes. The emphasis of women's development was on awareness-raising as opposed to reallocation of resources, thus glossing over the basic conflict of the state's real intent, with the women's situation.

The state's ideology, at this time can, at best, be described as liberal. Community participation was envisaged in terms of imparting certain skills and confidence in rural women, so that demand or "receiving mechanisms" for government programs could be created. The progressive nature of the rhetoric used, the structure of the organization, the initial disavowal of all targets and the experiential nature of the training, all contributed to creating an image of the state actually responding to the women's and the community's demands. This image was transmitted to the rural women who participated in the program, through the mechanism of training, the intra-organizational relations and the activities and issues taken up in the initial years. Ironically, however, these women internalized the declared ideology of the state, regarding women's participation, when the state's real manipulative intent was quite at variance with it.

In the form of the IDARA, women joined this exercise of awareness and confidence -building among the rural women and managed to bring a large number of them out of the confines of an oppressive family structure. Most women who participated in the training course were functionally illiterate and few had held positions of responsibility outside their homes. They were trained to provide conditions for rural women to re-discover themselves as active participants of the development process. By generating experiences which facilitated altered perceptions of self-image as well as the social image of women, it helped them to rediscover faith and confidence and discover collective strength. Conceptually development

was thought in terms of internal growth rather than handing out of schemes. The Sathins were also taught how to facilitate dialogues such as what kind of questions to ask and how to lead the dialogue in such a way that the others would begin to critically analyze their reality looking at root causes and consequences of problems and searching for solutions.

The result of their work was impressive, with the first and most dramatic change occurring in the workers themselves. Early discussion of the role of women for example had revealed very low self-images. In the process of dialogue, they began to question the legitimacy of their inferior position in relation to men. Their changing self-concepts were reinforced, as they experienced success in their work. With few exceptions, the women saw their role as one of service to the community and helping to bring about a more just social order. The nature of the training, (which Freire describes as creating 'teacher-learners' rather than dominating and elitist leaders alienated from their communities), was successful in preventing the development of distance between the Sathins and the village women with whom they worked.

Thus, WDP helped them to challenge, to a certain extent, the feudal and patriarchal structures. It questioned medieval practices like sati and child marriage and helped them to challenge to a certain extent the traditional social image of women. The program also succeeded in linking women from remote and backward villages of Rajasthan to the developmental schemes of the government. The initial few years of the program witnessed a great deal of enthusiasm. Articulate and dynamic, the Sathins now actively participated in the development of their communities and acquired leadership positions in sporadic and spontaneous struggles. These struggles varied from fighting domestic and sexual violence to demanding

minimum wages; from demanding employment opportunities to agitating for fulfillment of basic needs like drinking water, education and medical care. "Women's forums sprang up in many villages, and it appeared that women had found space to articulate their oppression and had begun to organize themselves to recognize their own power. The existing cultural forms began to be used as a means of expression and women became increasingly visible."[68] The Sathins were the link between the community and the petty officials and administration. Local issues were sought to be resolved by the intervention of higher authorities. The 'Jajam' became the meeting ground for village women and officials, with the seemingly informal and friendly atmosphere blurring the otherwise hierarchical structure.

In the beginning of the program, the Sathins worked actively on several issues and campaigns. Initially, village-level issues and problems were the moving force behind the community getting organized, (demanding minimum wages for famine-relief programs, resisting the harassment of the lower level functionaries like the patwaris, highlighting and demanding justice through organizing the women). This meant confronting government functionaries in the administrative and development sectors. However, where organized spontaneous protests, led by the Sathins, have occurred, they have been localized , against the petty officials or the local vested interests. Moreover, in these instances, the solution is sought through the links of the WDP officials with the state administration. The government bureaucracy is helpful since some amount of such confidence-building is deemed as necessary for increasing the outreach of governmental policies. However, when questions, which bring major social contradictions under

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[68]Sawhney, A. (1994)'Women's Empowerment and Health Experiences from Rajasthan',*Social Scientist*, Sep-Dec, pp. 137-146.

scrutiny or those which challenge state policies of development, are raised, they are dubbed as 'political' in the former instance, and out of the WDP charter in the latter.

The past few years have also seen a steady shift to government determined priorities of development. The campaign against child marriage, adult literacy for women and promoting the state's family planning program have now become the major concerns. Recently, trainings were also being organized in modern methods of agriculture. Clearly, the interests of international monetary agencies, multi-nationals and the national capital are being promoted. Having made inroads into the rural areas, the state no longer seems to require a facade of empowering women.

V. IDEOLOGICAL DIFFERENCES WITHIN THE ORGANIZATION AND INTRA-ORGANIZATIONAL CONFLICT

Hence, it is evident that the state desires to see women as isolated individuals and as social beings only in the context of marriage, family and traditional social structures. Women's oppression is seen only in terms of gender, negating its caste and class reality. In a limited way, struggle for rights within the family and marriage, for redefinitions of gender -roles and against sexual violence and abuse, have been supported. Interventions have taken place within the traditional as well as established justice dispensing systems. However, support was ceased when gender was related to its class and caste reality,(for instance where land issues were taken up or when workers asserted their rights).

In its project document, the WDP purportedly aims at empowerment and facilitating the collective strength of women. It stresses on "the formulation of appropriate

organizations for women in order to facilitate communication, learning and organized action". Yet, the dismissal of the Sathins and the Pracheta from Kekri, when they independently participated National Women's Conference in Calicut, reveals the actual disapproval of the project authorities when women assert their independent identity. It also reveals, that the state in this instance, did not tolerate the collectivisation of women, be it formation of autonomous women's groups or workers' unions.

Women's economic role as workers, even in state-run programs, be they famine relief works or development programs, is also not recognized. This helps preempt any unionization of women, as in WDP, and thereby denies them basic rights as workers in a government -sponsored program -including protection and for redress in cases of sexual assault.

The disparity in the working status of the functionaries within WDP and the exploitative service conditions, however, have forced the Sathins to organize themselves into a union, despite stiff opposition. The Sathin who is the backbone of the program is termed a volunteer and paid an inadequate, (to say the least), honorarium of Rs. 250 a month. This is in contrast to the administrative and supervisory staff who get salaries between 3-7000 per month. With no rules for hiring and firing the Sathins are at the mercy of the authorities .The question raised by them, therefore is that how can a program whose prime objective is the empowerment of poor and backward rural women, under value, underpay and exploit its women workers by defining their work as non-work. More so when historically women's work has been defined as non-work.

In this instance of intra-organizational ideological conflict, as well, the project authorities, did not

reflect upon or make explicit their own ideologies. Instead, they perceived the demands of the Sathins as a threat, and realized correctly that allowing the threat to grow would undermine its own ideology and defeat its real intention. Consequently, the authorities within WDP have reacted strongly against any kind of ideological deviance as symbolized by the Sathin union, with responses varying from threats to emotional appeals to organizing meetings to explain the concept of unionizing.

The program leadership have thus tried to combat this kind of ideological deviance in several ways. These can be broadly identified as:

[1] Attempting to dismantle or discredit the union. This was especially apparent at the time of the Sathin sammelan, in 1993, when a thorough effort was made, in some districts, to prevent the Sathins from participating. A concept of a management supported union was floated The concept of voluntaryism was played upon and a fear was inculcated that the demand for regularization would lead to the closure of the program. Most of the activists from the IDARA and the IDS defended the state and played an active role in breaking the strike.

[2] An increased effort to build personal and emotional bonds. Any attempt at organizing the local women outside the government -run WDP is seen by the authorities as dividing the 'unity of women'. The message sent to the Sathins was that since this was a government-aided program, the Sathins were accountable to the state while at the same time keeping the facade of voluntaryism which was used to justify their measly salaries- as has been the experience in other state-run programs like the ICDS.

[3] Decreasing the numerical strength of the Sathins. The

major response of the WDP authorities has been changing the structure of the program. This was first announced in the governing council meeting in Bara district in 1993, where it was reported in the minutes that the Sathin's post had been abandoned and from then on groups of women .i.e. Mahila Samoohs would be set up in each village and instead of one Sathin now the group would receive the Sathin's honorarium. Opposition from the Sathins defeated such a move, but Sathins are not being recruited in any of the new districts. The post of the Sathin exists in 13 districts while the program has expanded to 21 districts. Districts like Dausa and Bara have just six Sathins each. Newer districts like Bikaner and Churu do not have a single Sathin. In districts where there are Sathins, the required number of 100 Sathins is not being met. Instead Mahila Samoohs are being set up. Strong militant Sathins in leadership positions are being absorbed into other programs such as the Lok Jumbish.

As a result, many Sathins hesitate to assert outside or independent of WDP or support from the higher authorities. The politics of gender have, thus, been effectively used as a trap. An atmosphere of informality, personal sharing that effectively blur the clash of interests between the authorities and the workers. Thus, despite the realization of their pivotal role in the program, the feeling of powerlessness remains.

The case of the health project is also an example which provides insight into the ideological conflict within the organization. From its onset, the project had a strong participatory principle. According to the health project coordinators, consistent attempts were made to adhere to principles which were seen as fundamental to the process of

working with oppressed people. These were that a specific activity would be undertaken only if it was the expressed felt need of the Sathins and the village women. Since the aim was to strengthen the women's struggles in these villages, all information collected and analyses would be fed back to the village so that a concrete action could emerge. Thus, though the needs assessment was done by project authorities through a survey of prevailing health problems among village women in Ajmer district, the Sathins and the Prachetas themselves has voiced the demand for the project, as they had expressed a desire "to understand the causes of such (reproductive health) problems so that women with these complaints could be helped in some way." Future needs assessment, (such as the one on post-sterilization complications), was done by the Sathins and the Prachetas, but was not only meant to collect information but to also to initiate discussions at the village level on the subject on which information was being sought. The interventions that emerged as a result, in the form of the books on women's anatomy and physiology, on reproduction and the work on post-sterilization complications were thus for meant for both collecting, as well as, imparting information.

Though the basic focus of the project was on health problems faced by women, especially during pregnancy and child-birth, the understanding that emerged was that a woman's health problems are not limited to her reproductive years alone but is a part of her life-cycle, where different social situations and the various stages of her life interact to create ill-health. More specifically, her health is the outcome of her energy expenditure in carrying out the various tasks within and outside her home and the rewards in terms of access to food, medical care and other services that she gets. It was seen as essential that women see their role and the place of health in relation to the

total social structure. The realization of the critical links between poor health, illiteracy, landlessness and other problems led to involvement in areas outside traditional health concerns, such as the overall famine situation in the district and people's demands for work and excesses by the authorities in order to bring in cases for sterilization.

The management of the project was by health professionals appointed by WDP authorities and line responsibilities were as described in the earlier section on the organizational structure. However, the issues taken up and the areas of intervention as well as the mechanisms for feedback which altered the program to suit community needs, ensured that generally community demands dictated the nature of the program. The organizations used for implementing the project were the informal women's groups established by the Sathin at the village level, the jajams and the Shivirs. These provided a platform for free dialogue and a place where village women found an opportunity to express themselves. The leadership of these groups generally comprised of the Sathin who had emerged as a resource person for the community as well as a leader in collective struggles at the village-level in the past. With the above factors and the projects strong emphasis on the poor, the health project seemed to have ensured wide participation of the community, during the year in which it lasted.

The health project had initially received the full support of the WDP authorities as they had wanted to respond to the health-related demands of women. These needs were seen in terms of medical information or the health education that the project would provide. However, since the health project raised issues such as famine-relief works or related family planning excesses they perceived the health project as encroaching upon areas they perceived

as non-health and furthermore, areas which were seen as outside the scope of WDP. Hence, when the project sought to help women to control their fertility without resorting to sterilization or to express their sexuality, the authorities realized that there were strong ideological differences between the health project and the stated objectives of the WDP, which were to increase demand for government programs and services. As a result, it provoked the hostility of the WDP authorities and there was subsequent discontinuation of the health project.

Official curtailment of the project is important to examine because it illuminates some of the critical dilemmas facing conscientization and other change efforts. The state may be characterized as harboring what Freire terms as "false generosity"of the oppressors, giving the oppressed too little to alter the material well-being but enough to suggest that those in power are taking positive action on behalf of the poor. In the initial years of the project, a great deal of effort was made to ensure the participation of the community in government programs and, especially in creating a demand for them. These years witnessed many successes of collective struggles at the grass-root level. As long as the issues raised remained confined to their gender dimensions, the \WDP structure was supportive. The state focussed solely on women's issues and sought to subsume the class questions under gender concerns, thus attempting to ignore major structural contradictions in society. However, when contentious issues such as those of land or worker's rights, (especially within the program) were raised,the state lost its liberalism and even became repressive. The health project, which questioned some of the policies of the state, was seen as ideologically deviant and viewed with suspicion in the WDP power structure and to eliminate this deviance, the project was not renewed.

The experience of the Women's Development Programme, thus, brings to light the fact that a considerable amount of community participation is possible even within a state-run program. But, it also reveals that community participation is not a phenomenon which cannot be easily controlled once it is initiated, nor does it adhere to the parameters set by project planners. It is a dynamic process and as communities realize collective strength, their demands increase accordingly. This sets the stage for conflict, since in most instances planners had not envisaged the arising of such demands, while they were planning such participatory activities. The consequent subversion of such attempts on the part of the community, by the state, and the resultant disappearance of community-based initiatives is, hence, not a reflection of the failure of managerial processes but a deliberate tactic, a manifestation of the ideology of the planners.

CHAPTER V

CONCLUSION

Community participation is a complex phenomenon. Non-governmental projects are popularly characterized as ensuring greater participation of communities, unlike the state, which is described as unresponsive and inflexible, and hence less able to effectively allow communities to participate. However, our contention has been that though managerial or organizational issues have usually been portrayed as relatively more important in determining the nature of community participation that occurs in a health project, it is the ideological issues which are the actual determinants.

The two cases studied here have validated the above claim. The first study of the non-governmental organization delineated the process by which the project planners initiated the project with a conservative ideology. This ideology was reflected in the earlier centralized decision-making processes in the organization. As a result, it envisaged the participation of the community in solely instrumental terms, as passive receivers of services, especially of health services.

Interaction with the community and an increased understanding of the problems of the area, made them realize the inter-linkages between health and the larger socio-economic context. This altered ideology led to a subsequent change in the structure of the organization and in the nature of project activities, which allowed for a greater say of the community in the organization and for greater community control over project resources.

The organization seeks to better the conditions of the project communities by activities aimed at increasing their resource base. Though, these activities have helped to improve their socio-economic conditions, to a certain extent, it is the larger socio-political features of the area which continue to influence people's lives and be responsible for their poverty. Nevertheless, in most instances, the organization is itself wary of antagonizing, larger powerful groups, such as the state, whose policies may be known to negatively affect the community. Since the organization is largely dependant on the government and the donors, it does not challenge any of the structural causes of poverty and exploitation. It instead, manages its activities around acceptable and predefined agendas. This reformist notion of community participation, thus, precludes any real empowerment of the community.

This emphasis on income-generation and service-delivery has also affected the socialization of its members into the ideology of the project leadership. With their preoccupation with such activities, some of the staff in many instances, are even less prepared than the leadership, in challenging powerful forces. These ideological differences within the organization, thus, lead to situations of intra-organizational conflict.

In the second case, of the governmental organization, the program was initiated with a somewhat liberal ideology on the part of the project planners and several mechanisms were incorporated in the organizational structure for ensuring community participation. Participation of the community, and especially of women, was encouraged in demanding and utilizing government services.

However, the processes of participation that were initiated at the grassroots level also resulted in challenge to the vested interests and in many instances were unacceptable to the state. The unionization of the workers, the challenge to the authorities posed by the health project, were all perceived as threats to its basic motives. The state responded by attempting to change the structure of the program and thus effectively subvert any real participation by the community. An important lesson to be drawn from this experience is that the state, with its power to override certain kinds of local constraints, can provide enabling conditions for communities to mobilize around their own self-defined priorities and ensure community participation to the extent it suits its interests. But where such activity conflicts with other interests of the state, it tries to subvert them.

Hence, claims about participation being an exclusive preserve of NGOs appear unfounded. Participation of the community is possible, as much in government programs as in NGOs, as long as it confines itself to parameters acceptable to the project leadership. Participation by poor communities in their own development is determined by the extent to which they are able to challenge the social and economical situation they are located in. It is the degree to which organizations are willing to encourage and support communities in this effort, which determine the extent of their participation, and not the management of these organizations by the government or the voluntary sector.

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