Empowering Communities Through Health: Lessons from the Comprehensive Rural Health Project in Jamkhed, India

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Abstract

The Comprehensive Rural Health Project (CRHP) in Jamkhed, India is a globally renowned community health and development program that has aimed to achieve community empowerment as its ultimate goal. Though community empowerment is a goal of many community health programs, few studies have explored the true value of community empowerment and effective strategies to achieve community empowerment within the context of health programs. This paper aims to address this gap in the literature by presenting a brief review of the literature on community empowerment, the Primary health care model of CRHP, the empowerment philosophy of CRHP, and key findings of several studies that have analyzed aspects of community empowerment through CRHP’s model. Among several key practices that contributed to community empowerment, it was found that training community-elected village health workers in positive human values and locally-relevant health knowledge and skills was the main facilitator of community empowerment.

MPH Goals Analysis

As stated in my MPH goals analysis, I sought to learn how to improve the effectiveness, ethics, and sustainability of public health programs by promoting horizontal and community-centered approaches. Through this Capstone project, I have had the rare opportunity to study the model of one of the world’s most successful community-based health programs, and to understand not only how this program has improved community health, but empowered communities as a whole. As empowerment is an indicator that encompasses a program’s effectiveness, ethics and sustainability, by studying CRHP’s model in detail, I have gained an in-depth understanding of the best practices of CRHP’s model in promoting community health and empowerment, and have described them in this paper. Thus, I have achieved my goal as set out in my MPH Goals Analysis through this Capstone project.
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Glossary

**Comprehensive Rural Health Project (CRHP):** A nonprofit, non-governmental organization located in Jamkhed, Maharashtra, India. CRHP works with rural communities to provide community-based primary healthcare and improve quality of life through a variety of community-led development programs. CRHP was founded in 1970 by Drs. Raj and Mabelle Arole. The work of CRHP has been recognized by the World Health Organization and UNICEF, and has been introduced to 178 countries across the world.

**Village Health Worker (VHW):** Women elected by their villages to provide basic curative services, screening, referral, health education and community development support. They are often illiterate and low-caste women, who become the key agents of change in community health and development.

**Mobile Health Team (MHT):** A group of healthcare professionals and social workers who travel to villages that have limited access to healthcare. The MHT to provide healthcare services, health education, and community development and capacity building support.

**Farmers Club:** Men’s community group organized around the priority issue of agriculture in CRHP’s project villages.

**Mahila Mandal:** Women’s community group in CRHP’s project villages that works to address community priorities, often organized around income-generating activities.

**Casteism:** Discrimination based on caste, a system of social hierarchy in India which has strong ties to the Hindu religion.

**Primary Health Care (PHC):** An approach to health beyond the traditional medical model; includes all areas that play a role in health, such as access to health services, environment, and lifestyle.

**Community-based Primary Health Care (CBPHC):** A model of healthcare that includes the provision of services and programs outside of physical health facilities, with emphasis on enabling and empowering people and communities to take health into their own hands.
Introduction

A primary goal of many community health programs is the empowerment of individuals and communities (Kasmel, 2011; Tsey, 2009; Laverack & Wallerstein, 2001). However, few studies have analyzed successful health programs to identify effective methods of community empowerment (Laverack, 2006; Laverack, 2009). This paper aims to address this gap in the literature by presenting a brief review of the literature on community empowerment, describing the model of a highly successful community health and development program - the Comprehensive Rural Health Project (CRHP) in Jamkhed, India - and discussing the findings of several studies that have analyzed empowerment as a result of CRHP’s work.

What is Empowerment?

Firstly, it is important to understand what empowerment is, and its relationship to health. There is an ongoing debate in the literature as to what empowerment means. The study of empowerment is undertaken by numerous academic disciplines, including psychology, community development, social work, management science, and public health resulting in hundreds of varied definitions of empowerment (Page & Czuba, 1999; Oladipo, 2008; Menon, 1999; Sadan, 1997; Rawat, 2011; Ibrahim & Alkire, 2007; Alsop & Heinsohn, 2005; Narayan, 2002; Lee, 2001). Ibrahim and Alkire (2007) provide a detailed list of definitions of empowerment in the literature. The concept of empowerment ranges from an internal, subjective experience of realizing one’s own innate power, to an external experience where structural, environmental, cultural, and political factors that prevent an individual or group from realizing their power are the main focus (Oladipo, 2008). The most useful definitions of empowerment recognize that for maximal empowerment to be achieved, both internal and external factors must be addressed. Definitions of empowerment often focus on an increase in control over one’s life
and circumstances, gaining power over resources and decision making, and overcoming structural barriers that prevent marginalized groups from exercising autonomy and self-determination (Ibrahim & Alkire, 2007; Page & Czuba, 1999; Alsop & Heinsohn, 2005; Jupp, Ibn Ali, & Barahona, 2010; Israel, Checkoway, Schultz, & Zimmerman, 1994). One way of classifying these various perspectives is to view empowerment as an ecological construct involving three distinct but closely related dimensions: personal or psychological empowerment, organizational or group empowerment, and community or structural empowerment (Tsey, 2009).

**Community Empowerment**

Though there is no single definition of community empowerment, it is generally agreed upon as a process through which people gain control and influence over the issues and factors that affect their lives (WHO, n.d.; Tsey, 2009). Increased control is gained as people are able to increase their assets and build capacities to gain access, partners, networks, and a voice (WHO, n.d.). People must also assert and claim their rights and accept and willingly discharge responsibilities toward oneself, others and society (Tsey, 2009). Community empowerment is much more than the involvement, participation or engagement of communities; it implies community ownership and action that explicitly aims at social and political change (WHO, n.d.). It also requires the wider society to work consciously towards creating social environments and relationships that bring the best out of people (Tsey, 2009)

Community empowerment includes psychological empowerment, organizational empowerment and broader social and political actions (Laverack, 2009). Therefore, it includes both individual and group empowerment. It can be viewed as both a process and an outcome that is specific to the individual, group or community involved. The outcomes of community empowerment often take many years to manifest (Laverack, 2009).
Importance of Community Empowerment in Health Programs

It is accepted in the health literature that there is a link between empowerment and improvement in health (Laverack, 2006, 2009; Laverack & Wallerstein, 2001; Gregson & Court, 2010). Empowerment can be viewed as both a means to improved health, as well as an end in itself. The relationship between health and empowerment is not unidirectional, as the improvement of health is also empowering.

As stated by the World Health Organization (n.d.), community empowerment is important to the success of health programs because it “necessarily addresses the social, cultural, political and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions.” Community empowerment helps to promote health and well-being in a way that is relevant, meaningful and sustainable for the program’s intended beneficiaries (Tsey, 2009; IRED, n.d.). Moreover, Wallerstein (1992) states that at the individual level, gaining control is an important enhancer of health. Thus, empowerment that increases one’s control is likely to have a positive impact on one’s health.

Community empowerment has often been overshadowed in the literature by other related concepts such as community capacity and social capital (Laverack, 2009). What these concepts lack is the emphasis on transforming power relations, which is so crucial to improving community health. Empowerment challenges the structural factors that prevent communities from achieving optimal health status (Laverack, 2009). While the literature supports the link between community empowerment and health, the main challenge is that community empowerment is difficult to operationalize in a program context because it is difficult to measure and implement as a part of health promotion programs (Laverack & Wallerstein, 2001).
**Challenges in Measuring Community Empowerment**

The problems with measuring empowerment are two-fold. The first challenge is defining empowerment, while the second challenge is to make this definition operational enough to be able to use it to measure empowerment (Laverack & Wallerstein, 2001). Empowerment is a construct that can only be measured through other indicators depending on the specific definition of empowerment that is selected (Rappaport, 1984). Empowerment is context-specific, and has different meanings in different social, cultural and political contexts, and is a concept that does not translate easily into all languages. Depending on the specific definition of empowerment for a particular context, empowerment can be measured by assessing psychological indicators such as level of self-efficacy, control, self-confidence, self-reliance, control over decision-making, and autonomy, or external indicators such as the ability to have one’s voice heard, access to information, inclusion in decision-making, accountability of organizations, local organizational capacity, and ability to influence other people and institutions (Oladipo, 2008; Narayan, 2002). Thus, to measure empowerment, we need to know specifically what empowerment means in the context in which we are measuring it by developing a definition of empowerment that can be operationalized.

Primary Health Care and Community Empowerment

One model of health promotion and health service provision that supports community empowerment is Primary health care (PHC). PHC was defined by the World Health Organization (WHO) in 1978 as:

“Essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.” (p. 15)

PHC aims to meet the essential health needs of as many people as possible at the lowest possible cost by developing comprehensive health services in a collaborative fashion with communities (Arole, 2007b). It is a holistic approach to healthcare that is founded on the true spirit behind the World Health Organization’s definition of health as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity; a fundamental human right and the attainment of the highest possible level of health is a most important worldwide social goal” (WHO, 1978, p. 2).

PHC is about processes and outcomes, be it medical, social or political. It is a radical shift from a disease-based model that is dictated by the medical profession to one that views health from a broad perspective and where programs and priorities are defined and articulated by the community (Arole, 2007b). Thus, PHC is really a guiding framework to achieve the empowerment of people by maximizing their health status. PHC achieves empowerment both through the outcome of improved health status, as well as by enabling the community to participate in the process of improving its health status.

The goal of the Alma Ata Declaration, from which the WHO definition of PHC is taken, was to reform provision of health care services to follow a primary health care model that would
close the gap between the ‘haves’ and ‘have-nots’, achieve a more equitable distribution of health resources, and attain a level of health for all citizens of the world that would permit them to lead a socially and economically productive life (WHO, 1978). Moreover, the Declaration conveyed an acute understanding that the health sector alone could not achieve health for the world; that collaboration and integration of multiple sectors including agriculture, food, industry, education, employment, housing, public works, communication and others is essential (WHO, 1978). Thus, the holistic empowerment of individuals and communities is a part of the domain of primary health care (Perry, 2013). It is therefore essential for organizations employing the PHC model to assess empowerment as an outcome of their work, and to have a clear understanding of the process through which empowerment is achieved.

Thus, there is a need to study successful community health programs that have facilitated community empowerment in order to identify effective practices that have achieved community empowerment both as a means to better health, and as an end in itself. The aim of this paper is to contribute to the literature by describing the PHC model of CRHP, a highly successful community health and development program, and summarize the key findings of several studies that have analyzed aspects of empowerment that have occurred as a result of CRHP’s work. This paper will conclude by highlighting key practices at CRHP that have facilitated community empowerment within the context of a community health program.

The Comprehensive Rural Health Project (CRHP)

History and the Mission of CRHP

CRHP was founded by Drs. Raj and Mabelle Arole in 1970 in a rural, drought prone area of Western India. The Aroles came to the village of Jamkhed with a mission to serve the poorest of the poor. Trained in medicine and public health, they felt that a narrowly-focused, charity-
based approach to health and socioeconomic development was unsustainable, inefficient and counterproductive in truly improving the health and quality of life of people. Thus, they developed a new model based on PHC principles grounded in the values of trust, compassion and respect, with a focus on utilizing local people and resources to their fullest potential (Arole & Arole, 1994; CRHP, 2014).

CRHP’s mission is to empower individuals and communities, emphasizing poor and marginalized people, especially women, to attain health and social well-being in its totality. CRHP aims to empower both individuals and communities as it is believed that empowered individuals collectively lead to an empowered community which can be self-reliant. From the start, the Aroles built CRHP’s community development work on the expressed and felt needs of the villagers, rather than trying to impose any external priorities and agenda on the community (Arole & Arole, 1994). CRHP has gained a global reputation due to the dramatic improvements in health achieved as a result of its PHC model. CRHP’s health achievements are shown in Table 1 in the Appendix.

CRHP facilitates and supports capacity-building activities within communities by providing training, knowledge and support, which enables people to assess their own problems, analyze root causes, and take appropriate actions. CRHP aims to “help people help themselves”, and considers itself a partner and facilitator in community health and development. Through this approach, individuals and communities realize their own power and ability to solve their problems by relying on the resources and abilities within themselves and their communities, as well as by advocating for their rights to external entities (Arole & Arole, 1994).
CRHP’s Model of Community-Based Primary Health Care (CBPHC)

As CRHP’s work lies at the intersection of public health and grassroots community development, CRHP’s model is a PHC model which is community-based, known as community-based primary health care, or CBPHC, within the field of public health. What makes CBPHC community-based is (1) the provision of services and programs outside of physical health facilities, in the communities where people live and work, and (2) the emphasis on enabling and empowering people and communities to take health into their own hands. Specifically, CBPHC a value-based process that both provides health services in the community, and develops the capacity of the community to assess, analyze and develop actions for any problem or situation that they identify while building a sense of community (Perry, 2012; WHO, 1978; Arole & Arole, 1994).

CRHP’s CBPHC process is summarized as follows (CRHP, n.d.):

1. Identify village(s) that want or invite you
2. Get to know and build rapport with the villagers
3. Gather the people
4. Identify socially minded persons
5. Organize community groups
6. Select and train village health workers
7. Identify and address the community’s problems
8. Learn about government programs and other resources and agencies in the area
9. Conduct seminars for villagers to share information

In order to achieve effective health care, CRHP’s CBPHC model is an interrelated support structure that consists of three main components (see Figure 1 in the Appendix): the
Village Health Worker, the Mobile Health Team, and the health center which includes the Julia Hospital and the CRHP training center (CRHP, n.d., 2014).

The Village Health Workers, or VHWs, are the key agents of sustainable community development and are the backbone of CRHP’s community development approach. They are often illiterate and low-caste women who are selected by their villages. Through weekly trainings at CRHP that focus on teaching essential knowledge, skills, attitudes, and values, the ongoing support of CRHP staff, and the growing trust and confidence of their fellow villagers over time, they evolve into confident community leaders, healers and teachers. By focusing their efforts on prevention, health promotion and provision of basic screening, curative and referral services, VHWs are able to resolve the majority of health concerns within the villages themselves, putting power into the hands of the villagers and reducing their reliance on expensive and distant doctors and clinics. They also help to organize community groups through which they spread health knowledge and provide services (Arole & Arole, 1994; CRHP, n.d., 2014).

The Mobile Health Team, or MHT, is currently comprised mainly of social workers, though in the past, it has also included a paramedic, nurse and physician. The MHT trains the VHWs at the CRHP training center, provides support to VHWs in the villages, guides villagers in community development projects and the formation of community groups, helps connect the villages to CRHP’s on-campus medical staff, and assists in ongoing data collection and monitoring of health. The MHT conducts monthly visits to the 28 villages CRHP is currently working in (Arole & Arole, 1994; CRHP, 2014).

The Julia Hospital is a 50-bed secondary care facility serving a population of 500,000. It is equipped with the necessary and appropriate technology and equipment such as x-ray,
diagnostic laboratory, maternity ward, labor room, operating theaters, intensive care unit, and pharmacy to achieve its goal of providing cost-effective care for problems not able to be treated by the VHWs. It is catered to the needs of the rural poor, and operates as a charitable trust that provides care on a sliding scale fee system (Arole & Arole, 1994; CRHP, 2014).

The CRHP training center, formally known as the Jamkhed International Institute for Training and Research, was established in 1992 for those who wish to learn from CRHP about its CBPHC model. Many courses in community-based health and development are offered, and to date, more than 2,700 individuals from over 100 countries and 40,000 individuals from within India have learned through the Jamkhed Institute (CRHP, 2014).

As CRHP is focused on health, its model has heavily emphasized addressing the health problems of the rural poor in the Jamkhed area, particularly during the initial years, as providing access to curative care in remote villages was the urgent need at the time. However, as CRHP has been invested in listening and responding to the expressed and felt needs of the villages from the start, CRHP has understood that in this drought-prone area of rural India where agriculture is the lifeline of the people, health services alone cannot improve quality of life, as the primary concerns of the people are to ensure survival by overcoming the challenges of farming in a drought-prone area. Thus, CRHP facilitated the creation of Farmers Clubs to discuss and develop solutions to farming challenges, and has worked with villagers to create food-for-work programs, watershed development programs, the digging of tube and irrigation wells, and also a demonstration farm to try new techniques to increase crop yield and replenish the water table.

Moreover, to reduce gender discrimination and gender inequality, CRHP has also created women’s groups known as Mahila Mandals, as well as Self-Help groups for women to gather and develop strategies to address the challenges they face. In addition to providing social
support, the Self-Help Groups also participate in a micro-lending scheme to support entrepreneurship and income-generation activities to put money in the hands of women and promote their financial empowerment.

CRHP has also created 6-month educational programs for adolescent boys and girls to change social norms by educating both genders about mental, physical and reproductive health, the environment, and social issues such as gender equality. Additionally, CRHP operates a rehabilitation center for female survivors of domestic violence and women suffering from HIV/AIDS or tuberculosis. The goal of this center is to prepare women to return to their communities with confidence and self-worth (Arole & Arole, 1994; CRHP, 2014).

Thus, by taking a truly comprehensive CBPHC approach, CRHP is promoting the empowerment of people as both a health and a community development NGO. As the Aroles have stated, PHC’s ultimate goal is to “empower individuals and communities so they have control over their own lives, an essential part of which is the involvement of communities in the development of services so as to promote self-reliance and reduce dependence” (Arole, 2007a). This is the heart of the CRHP approach.

Values and Principles of CRHP

CRHP has been successful due to its strong foundation in human values, human connection and the belief that all people are worthy and have innate abilities and talents, guided by the vision, dedication and leadership of the Arole family. In addition to knowledge and skills, CRHP teaches positive values and attitudes that help build a sharing and caring community, so that the power that is gained is used for constructive, community purposes. Values emphasized by CRHP include selfless service, complete love and acceptance for people served, trust, patience, equality, team spirit, complete sharing of knowledge, equity, upliftment of the status of
women, community participation and empowerment, talking with all villagers, and taking a comprehensive, holistic approach (Arole, 2007c).

CRHP’s model is founded upon three core principles: equity, integration and empowerment. Equity is achieved by focusing on the needs of the poorest of the poor by reaching out to them, bringing them into the community, and ensuring their participation in the planning and development of programs in health and community development and in prioritizing them to obtain access to needed services.

Integration is practiced at CRHP in many ways – working within multidisciplinary teams, integration of physical, mental, social and emotional wellbeing, providing health care services that focus on prevention, promotion, cure and rehabilitation, and the integration of programs in multiple sectors including health, education, environment, sanitation, socio-economic status, and agriculture. Fundamentally, it is the idea that integration of skills, talents, disciplines, and sectors can achieve holistic, comprehensive, effective and sustainable improvements in community health and wellbeing.

Lastly, the principle of empowerment at CRHP is the idea that once people have knowledge and can make informed decisions, they have power they can use in constructive ways to transform their lives and communities. CRHP’s dedication to empowerment is described in greater detail in the following sections.

**Special Focus on Empowerment**

CRHP gives special focus to the empowerment of women, and villages as a whole (Arole & Arole, 1994; CRHP, 2014).

The emphasis on women’s empowerment is due to the fact that women are closely concerned with the health of their families, and can relate best to other women and children, who
constitute two-thirds of the population. Moreover, women and children are often the most vulnerable and neglected groups as they often need health care services the most yet are the last to receive them, due to gender norms (Arole & Arole, 2007). Additionally, due to local social and cultural norms, women are the oppressed gender as compared to men. They are dependent on men in many ways, face gender discrimination and abuse from men and other women, are often forced into early marriage, and face numerous social restrictions (Kamble, 2008). Thus, CRHP aims to promote gender equality by focusing on women’s empowerment.

The Farmers Clubs, Mahila Mandals, VHWs and Mobile Health Team staff also work to promote village empowerment by reducing discrimination and division between villagers on the basis of caste. The caste system is an ancient system of social class hierarchy based on birth and occupation, and has ties to Hinduism (Sachau, 2003). Though the caste system in India has been outlawed, it has existed in India for more than 5,000 years (Arole, 2009). Thus, caste is a major social and cultural concept which is embedded in social interactions among people in much of modern India. While people of different castes often live together in the same village, discrimination, restrictions and differential treatment on the basis of caste have been the norm in most villages in the Jamkhed area (Arole, 2009). CRHP works to reduce discrimination based on caste and promote unity within villages to achieve village empowerment.

Therefore empowerment is the ultimate and perhaps the most important outcome of CRHP’s work, as empowerment goes beyond improving physical health status to changing the social, political and cultural landscape of the community to create social change that improves quality of life holistically. When visiting CRHP’s project villages, one can sense that people are empowered through observing, for example, the confidence with which women carry themselves and speak boldly, the clean and organized environment of the villages, and the equal treatment of
both genders and people from all castes. However, as Herbert and colleagues (2009) state, empowerment is not a directly observable concept. In order to measure empowerment, we must capture the subjective reality of the people whose empowerment we wish to understand (CDX, 2008; Jupp, Ibn Ali & Barahona, 2010). Moreover, it is necessary to measure how empowerment is occurring as a process and an outcome. Thus far, CRHP has collected stories and case studies of individuals and villages to demonstrate the changes and improvements that have occurred in people’s lives and communities, but there is a need for a more well-defined, systematic, and relevant method of describing, documenting and measuring the empowerment of individuals and communities as it is occurring through the CRHP CBPHC model.

Empowerment as a Process and Outcome of CRHP’s CBPHC Approach

Dr. Raj Arole’s Observations

One of the founders of CRHP, Dr. Raj Arole, has written in detail about empowerment as a process and outcome of CRHP’s work.

Definition of empowerment. Arole defined empowerment as “improving self-esteem and gaining self-confidence; developing critical assessment and analysis skills; identifying with others as a member of a community; participating with others in organizing for community change, and realizing environmental and political change” (Arole, 2007a).

Empowerment and PHC. As stated earlier, Arole felt that PHC is “ultimately about (the) empowerment of individuals and communities so they have control over their own lives” (Arole, 2007a). The involvement of communities in the development of PHC services is essential in order to promote self-reliance and reduce dependence. Moreover, the provision of health services alone cannot improve health, but rather health depends on the decisions taken by individuals and communities – about how they live, how they take care of their children, how
they treat others, how they look after the environment - and the ability of people to have control over their lives and make decisions within their families and with community members for the betterment of the community (Arole, 2007a). Even the overriding political and economic forces could be addressed by communities through organizing and advocacy. Thus, Arole truly viewed communities as powerful; the role of CRHP was to unleash that power and help individuals and communities to realize their power.

Arole described how in the early years, he and Dr. Mabelle Arole thought that providing information to community members alone was sufficient for people to become empowered. But they realized that since he and Dr. Mabelle were still making the decisions about what services to provide, this was really more cooperation and compliance than empowerment of the community (Arole, 2007a). Thus, the Aroles learned over time what empowerment really meant and how to achieve it.

**CRHP process of empowerment.**

*Personal development.* Arole stated that the first step in empowerment begins at the level of personal development of the individual, specifically building self-esteem and self-confidence. He stated that this step takes time, but is quite simple: “you treat people with respect, and you take the time to listen and to share your knowledge” (Arole, 2007a). Secondly, he emphasized demystification of health information, and helping people realize that they have more control over their own health than any other external factor. He saw the role of the health profession as critical, “health professionals must devolve their power and let people take control of their own health by helping people realize that their health does not depend on medical services…rather than withholding medical information, health professionals must share it freely; this is empowering health practice” (Arole, 2007a).
**Community participation.** The next step was to foster community participation. Arole stated that community participation takes time, as communities do not generally exist; we must build them by bringing people together. Building trust takes time, especially with marginalized populations, as they have been exploited and ignored, resulting in a lack of trust. People are the key actors in health; no matter how good health services are, it is up to the individual or family to avail themselves of the services. Therefore, people must realize that they – not the medical profession – are the key actors in health. Thus, since people’s action is the key determinant of health, community participation is the key determinant of community health. The key pillars of health are adequate food, safe water, clean environment, hygiene, and healthy habits – all of which are dependent on individuals, families and communities. Therefore, health cannot be achieved unless people participate fully in health programs (Arole, 2007a).

**Community organization.** Arole stated that the first challenge is that no true community exists, and people must be brought together. Villages are heterogeneous, with people divided by class, caste, political and traditional factions and religions. Thus, an external facilitator is often needed to bring people together, which is the prerequisite for community participation. The facilitator must be careful to understand the power dynamics in the community and be inclusive of all factions and groups, with a special emphasis on including the most marginalized groups in order to promote equity. Identifying socially-minded people in each group is crucial, as bringing these people together facilitates constructive dialogue. Confidence building must lead to trust in each other; as confidence builds, barriers and mistrust break down, leading to a well-knit organization brought together for a common cause (Arole, 2007a).

Arole highlighted the importance of taking creative approaches to bringing people together, “by organizing volleyball games in villages and inviting leaders and interested people
from the various factions within the community, people had a reason to come together. After the
game, they stayed and talked, and were drawn together repeatedly in discussions. These groups
became the Farmers Clubs, which was the first time village people from different caste
backgrounds had come together” (Arole, 2007a).

The Farmers Club became a popular forum and people were attracted to it because it was
organized around their self-interest in agriculture and farm animals. CRHP’s primary purpose in
developing the Farmers Club was to have a local working group. At every Farmers Club
meeting, health was always included as one of the subjects. The constant sharing of health
information eventually led the men in the village to suggest that it was necessary to have a
woman from each village teach women about health. They selected a VHW from each village for
this purpose. As the need for women to become knowledgeable was recognized, the Farmers
Club members encouraged the women to form women’s groups, or Mahila Mandals. The VHW
played a critical role in organizing these women’s groups. Like the Farmers Clubs, the Mahila
Mandals were also organized around self-interest, usually income-generating activities. Women
became quite interested in health due to their role as caretakers of the family; thus, they became
more active in health programs (Arole, 2007a).

Assessment, analysis and action. Arole stated that as interest and support for health
programs increased, the MHT started visiting villages. The MHT worked with Farmers Club
members to conduct health and social surveys in villages, with Farmers Club members playing a
critical role in collecting reliable information due to their intimate knowledge of the village
community. They also helped in the analysis of the data, which in turn helped them to understand
the health problems of the village. Because they discovered the health problems themselves, they
were more motivated to address them. Discussions about the root causes of health problems
followed, and they began to understand the relationship between the environment and disease. They realized for the first time that there were many things they could do to prevent illness; that the health of their family and community was really in their control. The MHT also saw the value of involving the community in their work, as they were impressed with the way the village people were taking an interest in their health (Arole, 2007a).

Arole described that the Farmers Club members began to give more support to the MHT during weekly visits; they were willing to give more time and effort because they understood that it was all for their benefit. They developed a network among the Farmers Clubs in different villages, and started participating in providing health education to their families and village as a whole through skits and dramas (Arole, 2007a).

Health in their own hands. Subsequently, the Farmers Clubs and Mahila Mandals began to take health into their own hands by doing their own house-to-house surveys and analyzing findings. Instead of CRHP or the health system setting objectives, the people decided what their priorities were. Arole stated, ‘today, the Farmers Clubs and Mahila Mandals work with the support of the VHW and government programs to maintain and monitor the health of their village. Over time, the health concerns of the villagers have changed; starting with maternal and child health, they have moved on to newer areas such as women’s health and cancer. They also continue activities in other sectors such as water, sanitation, education, and environment’” (Arole, 2007a).

In this way, Arole has highlighted how empowerment is both a process and an outcome that has resulted not only in the health improvement of communities, but community development as a whole. Community participation is an essential factor that facilitates empowerment and sustainability (Arole, 2007a).
Studies of Empowerment at CRHP

As CRHP has a 45-year history of working in the Jamkhed area and is well known within the field of primary health care, numerous studies have been conducted at CRHP over the years by researchers from various universities throughout the world. No study has attempted to directly and comprehensively measure community empowerment occurring through CRHP’s model, but several studies have focused on an aspect of empowerment or concepts related to empowerment. These studies have focused primarily on the empowerment of VHWs as individuals, with a small focus given to overall village empowerment. These studies utilized methods from community-based participatory research (CBPR) and Participatory Rural Appraisal, involving villagers as key stakeholders in the research process (Brenden, 1990; Arcaro, 1995; Kaysin, 2010; Chitnis, 2005). Findings from these studies are discussed here, with a focus on key factors contributing to empowerment both as a process and an outcome. VHWs, the MHT, CRHP staff and villagers are described as agents and beneficiaries of empowerment, and key values and principles contributing to empowerment are highlighted.

Individual empowerment of VHWs. As VHWs are themselves women from CRHP’s project villages who are often illiterate and from lower castes, these findings are important to understand how CRHP is empowering individuals, and specifically, women who represent the most marginalized section of society.

Brenden (1990) conducted a descriptive study in 1987 to measure change in self-esteem levels of VHWs over the course of 8 months, as well as to understand whether self-esteem of VHWs was related to their performance as health educators in their villages. Brenden developed a quantitative tool called the Jamkhed Index of Self-Esteem (JISE) for this study to determine self-esteem levels, as a secondary goal of the study was to develop a way to measure and
quantify changes which take place with and within people as a part of development programs (Brenden, 1990). Self-esteem is a concept that is considered separate from, but closely related to, empowerment (Wallerstein, 1992).

Brenden (1990) found that the self-esteem levels of VHWs trained at CRHP rose during the initial training, declined slightly immediately following the initial training, and increased with experience over time. He had included government health workers in a nearby area and women living in local villages as control groups, to help attribute any changes observed directly to CRHP’s efforts. Brenden summarizes his observation of CRHP’s role as an organization engaging in empowerment practice through primary health care as follows:

"CRHP is a model of a project which has intentionally sought to ‘empower’ the poorest segments of the local society, using the medium of a socially sanctioned primary health care program to bring about profound social changes, including shifts in power relationships...This study of the self-esteem of VHWs, then, is a case study in the ability of a development initiative to intentionally invest in people. Self-esteem, in this frame of reference, is a measure of the extent to which changes have taken place at a very personal level in the lives of individuals who have directly experienced the work of the project.” (p. 11)

Specifically, Brenden (1990) found that trainees experienced increased self-esteem at the completion of initial training programs relative to the beginning of the training. He also found that the self-esteem of VHWs increases with the duration of their experience as health workers, and that the performance of VHWs in the villages is related to their self-esteem levels. Self-esteem was influenced by the VHW’s perceptions of how she is regarded and treated by others. However, he found that VHWs experience a slight decrease in self-esteem immediately upon the completion of the initial training. This was due to the fact that it often takes two or more years for the villagers to accept the VHW in her new role and respect her contribution to the village. She must work to prove herself during this initial period, where she may face criticism, ridicule and mistrust from villagers, while also dealing with new and unfamiliar responsibilities.
However, over time the VHW becomes more assured in her ability to make a positive contribution to her village’s health, and neighbors begin to accept her value, resulting in an increase in self-esteem.

Among the control groups, a statistically significant increase (p<.05) in self-esteem was observed in villagers living in the CRHP project villages, which could be due to the work that CRHP had recently begun in these villages, including the training and selection of a VHW and the formation of the Mahila Mandal women’s groups. The increase could also have been due to a ‘research effect’ of higher performance on the survey when taken a second time. Villagers living in non-CRHP project villages and VHWs in non-CRHP project villages also experienced a slight increase in self-esteem, though it was not statistically significant (Brenden, 1990). Perceptions of the training experiences of government health workers and CRHP VHWs were also collected through interviews, highlighting differences in training practices that may have contributed to the difference in increase in self-esteem between government workers and CRHP VHWs.

A follow-up study done by Arcaro (1994) with a slightly modified version of the JISE survey found that the self-esteem of VHWs hadn’t changed in the 7 years since Brenden’s study, but had been maintained.

A study done by Chitnis (2005) aimed to look at how CRHP facilitates individual and community-level social change from the lens of communication. The specific goal was to use CRHP as a case study to understand how communication can facilitate participatory development, based on the principle of empowerment (Chitnis, 2005). This qualitative study used case-study methodology to gather data from CRHP senior staff, MHT members, and villagers, including VHWs, Farmer’s Club members and Mahila Mandal members. Data was
collected through individual and group interviews, participant observation, transect walks, and other PRA methods.

The overall conclusion of the study was that communication processes using Frierean principles (such as education to raise critical consciousness) can contribute to empowering poor people if conducted over a long period of time (Chitnis, 2005). Chitnis also described specific practices of CRHP that facilitated the empowerment of VHWs, the MHT’s role in being a change agent to improve community health, and methods used by CRHP to promote local knowledge, encourage community participation, and conscientization. Chitnis (2005) states the following about CRHP’s model and work in empowerment:

"CRHP shows that empowerment is possible if project staff, change agents and community members are motivated and willing to continuously change and adapt to the environment, and also challenge oppressive social and political practices... [the] ultimate purpose of CRHP is to ensure that poor people take control over their future and demand universal human rights such as good health, clean drinking water, and opportunity to participate in the projects that are designed to benefit them." (p. 5, 8)

Chitnis describes the way in which CRHP organizes and carries out the VHW trainings, highlighting key strategies, principles and values put into action, which exemplify empowerment practice.

Kaysin (2010) also studied VHWs as a case study of women’s empowerment through comprehensive grassroots training. Kaysin conducted focus groups with 18 VHWs, stratifying by age. The goal of the study was to ascertain the characteristics of the learning environment created by CRHP that foster empowerment as well as the internal characteristics and qualities of VHWs themselves. Kaysin found that “the empowerment of VHWs was a concrete and logical process involving the creation of a safe and supportive environment conducive to participatory and experiential learning with involvement of professionals as facilitators. Emphasis is placed on learning, which is a decentralized and continuous process.” He describes the VHW training as an
environment that fosters self-development and creative expression, a useful model for community-based organizations seeking to nurture a sustainable empowerment process. The VHWs are described as oppressed women who have become bold, proactive leaders and agents of social transformation (Kaysin, 2010).

Detailed findings from these studies are presented below, organized by theme.

**Participatory selection and training of VHWs.** VHWs were selected from the villages in which they lived and worked, by their fellow villagers. This was empowering, as it gave the community control and choice in selecting the person whom they wanted to represent their community and work for them. The criteria for selection of a VHW also represented CRHP’s commitment to equity and empowerment, as education level was not a criteria for selection; rather emphasis was placed on the willingness of the worker to volunteer her time, learn new knowledge, and develop skills that she could use to help others (Chitnis, 2005). Moreover, preference was given to poor and lower caste women, which reflected CRHP’s commitment to the poorest of the poor. The selection criteria represented the values of CRHP in action; they gave importance and opportunity to those who were most deprived.

The VHWs also described numerous characteristics of effective VHWs: patient; having a compassionate nature and a smiling face; willing to abandon casteism and bigotry; selfless; having an even temper; being respectful; generous; being accepted by people; having good listening skills; and being hardworking, humble, honest, and bold. Some VHWs saw literacy as a positive characteristic, stating that literate VHWs would have an easier time understanding health knowledge and would be less likely to be taken advantage of by others. However, other VHWs felt that literate women may be less interested in learning and less attentive to detail. VHWs also echoed the selection criteria of CRHP; that interest in learning, good memory,
attention, zeal and passion for work were the most important qualities to make a good VHW (Kaysin, 2010).

**Importance of positive messages.** One of the main factors found to influence the self-esteem of VHWs was receiving positive messages from three sources: CRHP staff, the VHW peer group, and villagers served by the VHW’s work (Brenden, 1990).

Many of the VHWs described the importance of the love and affection they received from the Aroles, and how they were treated as part of their family. They also received a great deal of encouragement from other VHWs and love and affection from all of the CRHP staff. They shared that after becoming VHWs, they received more respect from the people in their villages, and that the status of their entire family had been raised. This, in turn, led to an increase in the VHWs’ self-confidence (Brenden, 1990).

When comparing the VHWs with the control group of government health workers, it was found that self-esteem only increased when special attention was given to personal development during the VHW training. The consistent positive messages communicated to VHWs from the time of selection as a VHW to the initial training, and then throughout the ongoing training was the differentiating factor between a program that has a positive effect on self-esteem versus a program that does not (Brenden, 1990).

**Benefits gained from VHW training.**

**Motivation to serve.** Many VHWs described Drs. Raj, Mabelle and Shobha Arole as their main sources of inspiration to dedicate their lives to serving their villages. Through the Aroles, the VHWs learned the importance of showing love and concern for all people, and gained the satisfaction of improving the health of their families and villages. The knowledge they gained through CRHP earned them respect and status in their villages, and elevated them to the status of
a doctor. This was very empowering for the VHWs as many of them were from low caste backgrounds and had faced great hardship and discrimination in their lives. They often described how they had previously been treated as less than animals, having no sense of self-worth, and how their lives have been completely transformed due to the love and support given to them by the Aroles and CRHP staff (Chitnis, 2005).

Knowledge. The VHW training taught health information and skills, and was also designed to nurture self-esteem, self-confidence and leadership qualities in VHWs. Thus, a major focus of the VHW training was on personal development. The overall goal was to promote an empowering and relevant learning process where VHWs were able to integrate knowledge acquired during the VHW training at CRHP, knowledge shared by MHT staff during village visits, and the VHW’s own life experience. The Aroles, MHT members, older VHWs, traditional birth attendants, and community members were all seen as trusted sources of knowledge by the VHWs (Kaysin, 2010).

Superstitions were removed during VHW training, eliminating fear that VHWs had about various illnesses and conditions. One VHW stated that she “now believes that she has some control over her life and that it is not determined by fate” (Brenden, 1990). Gaining control over one’s life, or the perception of increased control over one’s life, is a key aspect of empowerment (Page & Czuba, 1999), and also corresponds with the Aroles’ definition of empowerment: “ultimately it [empowerment] is about increasing individual and community control over their own lives” (Arole, 2007a).

One VHW stated that she has “so much knowledge” now as a result of the training (Brenden, 1990). She stated that the most important thing she learned at CRHP was the importance of treating everyone as a human being. This describes the importance of values
education, and how in learning these values, the VHW was not only empowering herself, but her village as well, by treating others with respect. She stated “we are all human beings and deserve respect, including self-respect” (Brenden, 1990). Learning the importance of cooperating with others in the village was another lesson that a VHW stated was the greatest impact of the education she received during CRHP trainings (Brenden, 1990). These “soft skills” that VHWs received during their training not only improved their ability to be successful as VHWs, but also contributed to their own personal development, which was the intended goal of the VHW training, as stated by the Aroles: “the VHW training is as much about transforming the lives of these women as it is about training primary health care workers” (Chitnis, 2005).

Confidence. Though VHWs often stated that they had gained knowledge from CRHP, Chitnis (2005) and Brenden (1990) highlighted that the VHW training actually provided a space for collective knowledge creation and confidence-building. As all of the VHWs, training staff and doctors sat on the floor together in a circle as equals, the role of the facilitator was to listen to the VHWs and engage them in a dialogue that led to problem posing and co-creation of solutions. The facilitators, who were CRHP staff, aimed to treat the women with dignity and compassion. Songs were composed and sung by VHWs, and sung repeatedly, reinforcing the information they learned and building their confidence to share their knowledge with people in their villages. VHWs also described how the act of sharing information with each other during the VHW trainings helped to increase their confidence. Repetition was a key strategy used by CRHP in sharing knowledge with VHWs; by discussing information they already knew about, VHWs were able to increase their self-efficacy and confidence as health educators (Chitnis, 2005).
Additionally, small group breakout sessions held during the VHW trainings were seen as an effective learning method as the VHWs were able to learn a lot from each other, discuss everything that happened in their villages, and if they had any problems, could ask a friend to help them or discuss the issue with CRHP staff. Moreover, the existence of relationships based on love and concern between the VHWs allowed them to help each other learn about health topics and provide each other with support when faced with challenges. This peer-learning model blurred the lines between teachers and learners, and through the creation of a safe space, encouraged openness, sharing and giving support.

Another key aspect of building confidence through learning was the conscious effort of CRHP to demystify health knowledge. Brenden (1990) describes the information taught during VHW training as “both highly technical and extremely common.” By conveying scientific information in a simple, practical, and locally relevant way, through repetition, health conditions were demystified. Moreover, the Julia Hospital also played a key role in demystifying health, as VHWs were able to learn by doing and observing, within the safe and supportive environment of CRHP (Chitnis, 2005). Anatomical models and the use of animals to learn about anatomy also helped VHWs learn by seeing and doing (Kaysin, 2010).

VHWs also described that they gained confidence to speak with anyone in their village, as a result of the support received and opportunities to speak in front of other VHWs and CRHP staff during VHW training (Brenden, 1990).

*Respect for own capacities and knowledge.* The CRHP staff conveyed a deep respect to all VHWs and community members by listening to them and allowing them to express their feelings and desires. As Brenden (1990) observed, “each person is seen as of infinite value by CRHP, and the welfare of the people is the reason for social change, and not the means to some
other need…the villagers and the VHWs are the reason for the work, and not instrumental means for the achievement of some other goal” (p. 216). Thus, the VHW training focused on helping VHWs recognize their strengths and understand how they could be useful to their communities. Chitnis (2005) viewed the VHW training as one of the most critical elements of the overall empowerment process of the CRHP model.

The training staff also showed that they respected the opinions of the VHWs, as the training built on the existing knowledge of the VHWs rather than trying to replace it with scientific information. CRHP valued different types of health knowledge, based on the understanding that there is no single way to good health, but many types of wisdom that exist. Thus, the trainings focused on integration of Western biomedical knowledge with local knowledge about herbal and home remedies (Chitnis, 2005). Moreover, hierarchy was minimized during the training as doctors showed their respect for the VHWs and promoted a culture of equality by sitting on the floor along with the VHWs and sharing meals with them, a cultural sign of acceptance (Brenden, 1990).

Acceptance. During the VHW trainings, the Aroles intentionally used tactics to build social cohesion and unity between the VHWs to overcome barriers of caste and other taboos, and spread the powerful message of acceptance and create a culture of love. Specifically, they asked VHWs from lower castes to prepare and serve food to everyone, and VHWs from both lower and higher castes to eat together (to combat the cultural norm that food of the higher caste people would become “polluted” if touched by or eaten with a lower caste person), and also led by example themselves by eating with VHWs from lower castes (Brenden, 1990; Chitnis, 2005). Since VHWs would stay overnight for training twice a month, they asked the VHWs to stitch a large quilt together, under which all of them would sleep, to send a message of unity and
solidarity. By providing time for social interaction during training, CRHP helped the VHWs build a supportive community. Many VHWs stated that this group experience also helped to increase their self-confidence and self-worth, as they were able to share their challenges and experiences with one another, seek support, and share knowledge. Thus, by inculcating these values in the VHWs, providing time for social interaction, and promoting their own personal development and change through a culture of love and acceptance at CRHP, the Aroles prepared the VHWs to share these values in their villages as well. Thus, the individual empowerment of VHWs served as both an end in itself, as well as the means by which the social transformation and empowerment of villages could occur (Brenden, 1990).

Identity. One VHW stated that because she was of lower caste herself, and was able to reduce caste barriers in her village by sharing what she had learned during VHW training, she now experienced greater respect from her fellow villagers and had gained a sense of importance and identity, “people respect me now because of my work…people giving me respect makes me feel that I am somebody” (Brenden, 1990).

This idea of gaining an identity and “becoming somebody” was a recurring theme among VHWs and is a clear outcome of the VHW training. Several VHWs stated that they had no identity before, not knowing even their given name or date of birth. One VHW stated “before I was nothing…now when I return to my village, people are waiting for me, I am important” (Brenden, 1990). Through the importance given to personal development, building confidence, self-esteem and self-efficacy during the VHW trainings, VHWs acquired a new identity both in terms of self-concept, as well as how others viewed them in their village. Many VHWs described how they went from being “nobody” to being someone who is respected, valued and often seen as a leader in their village. This dramatic transformation of identity is a strong indicator of the
empowerment of the VHWs that resulted from both the personal development efforts of CRHP as well as the concrete health knowledge and skills VHWs gained through training, which showed both the VHWs and the people living in their villages that they possessed valuable skills, abilities and knowledge, which could tangibly improve the health and overall condition of the village (Brenden, 1990).

**Relationship of self-esteem to VHW performance.** Brenden found that the self-esteem of VHWs was positively associated with their performance. Specifically, as the VHW gained more skills and knowledge, became more experienced in putting these skills into practice, and achieved more positive health outcomes, her self-esteem increased, and as her self-esteem increased, it reinforced her ability to perform well, creating a positive feedback loop between performance and self-esteem (Brenden, 1990). Moreover, the status of VHW in the village was further increased as she became the gatekeeper to additional programs and services offered by CRHP. Moreover, the MHT reinforced the status and legitimacy of the VHW’s knowledge and skills during regular visits to the village (Brenden, 1990).

**Role of VHWs in individual and community empowerment.** Chitnis (2005) highlighted that the empowerment of VHWs represented social change at both the individual and community level. The VHWs experienced empowerment as individuals as they enjoyed new social status in the community, and when other villagers saw the transformation of the VHWs, they realized that they too could bring about positive change in their lives and communities. The VHWs were role models in their villages and represented an ideal of empowerment which others could strive to achieve.

VHWs also challenged existing gender and caste norms, as they were often low-caste, illiterate women who, before becoming VHWs, experienced a lot of discrimination and
marginalization. They went from house to house sharing knowledge and information and traveled from their village to Jamkhed alone for training, which was a radical deviation from the gender norm for women. Traditionally, women were expected to stay within the home and were rarely permitted to visit others’ homes or go to Jamkhed on their own (Chitnis, 2005).

**Empowerment through critical assessment and community organizing.** A key role of VHWs in the villages was to bring people together. By overcoming casteism and division among their peers in VHW training, VHWs understood the benefits of organizing and achieving unity. They also recognized that people in their villages needed to come together to address the problems their villages were facing, as the VHW alone could not single-handedly improve the health of the village. As VHWs were taught to think critically, pose problems, and analyze and address root causes, they brought these strategies and principles to their villages as well, encouraging villagers to do the same (Chitnis, 2005).

Using creative strategies of community organizing, VHWs worked to bring villagers together. CRHP began many of the Farmer’s Clubs that exist in villages today by organizing sports activities in villages to bring men to a common place, and after the games, men would stay to discuss community issues that were important to them. By incorporating such activities into the normal life of the village over time, VHWs, along with the support of CRHP staff, were able to facilitate the formation of formal community groups (Chitnis, 2005). Similarly, for women, musical instruments were given to villages, bringing women together to form bhajan groups to sing devotional songs (Chitnis, 2005). In this way, VHWs worked to bring villagers together to engage in a process of critical assessment of local health and development issues, facilitating community self-diagnosis. They engaged in consciousness-raising and enhancing people’s understanding of the root causes of health and other social problems (Kaysin, 2010). As
community organizers, they started first with a few people who were willing to meet. They shared the knowledge they learned in CRHP training and employed the same principles used by CRHP staff when facilitating VHW trainings; they listened attentively with respect, and engaged in a discussion that posed problems and encouraged co-learning and co-creation of solutions. Within these groups, they worked to share health knowledge, reduce stigma, promote inclusiveness of people within the community, reduce casteism, plan for solving problems, and create a safe and inclusive environment for community members to work together (Kaysin, 2010). VHWs built the motivation of community members to take collective action to improve the village (Chitnis, 2005).

**Role of the Mobile Health Team in individual and community empowerment.**

Chitnis (2005) viewed the MHT as a principle change agent, representing CRHP in promoting health in villages. The MHT served many functions by bridging the information gap between CRHP, VHWs and community members, and by reaching out to the most marginalized people in the villages to ensure that the project was meeting their needs.

**Direct interaction with villagers.** By providing health information and services to villagers, the MHT had direct interaction with villagers and was able to introduce new ideas and information to community members to encourage behavior change. By providing curative services in the villages and visiting households to inquire about health and wellbeing, the MHT established trust and credibility with villagers and provided much needed access to health services. The MHT also worked to reduce harmful practices such as casteism and gender discrimination by setting examples while they were in the villages. For example, while visiting a high-caste home in one of the villages, the MHT had brought a low-caste VHW along with them. When the MHT staff were offered tea, they gave it first to the VHW, to set an example and
convey the message that the VHW was to be respected equally, despite her low caste (Chitnis, 2005).

**Support for VHWs.** The visibility of the MHT in the village and the inclusion by the MHT of the VHW as an equal and respected health expert gave the VHW credibility, legitimacy and support. It helped her to be taken seriously by the villagers and earn their trust and respect, which was critical to her success as a VHW and the overall improvement of the community’s health (Chitnis, 2005).

Moreover, the VHWs saw the MHT as a trusted source of information (Kaysin, 2010). The MHT visits to villages allowed VHWs to participate in experiential field learning, as MHT members showed VHWs how to do things in the field (such as provide health education, perform basic curative services and tests, and organize community members) and gave the VHWs support and guidance. The VHW was able to learn by doing, which gave an opportunity for CRHP to build transparency by showing villagers what was taught to the VHW during her training in Jamkhed. It presented an opportunity for both the MHT and the VHW to demystify health knowledge by explaining concepts in simple terms to both the VHW and villagers (Kaysin, 2010; Chitnis, 2005). Moreover, the VHW also provided support to the MHT by reducing the distance between the MHT and the villagers, since she herself was a member of the community, and through her relationships with villagers and the local knowledge she possessed, she could help guide the MHT to better carry out their role during village visits (Chitnis, 2005).

**Community capacity building.** Furthering the community organizing work done by the VHWs, the MHT taught the members of Farmers Clubs and Mahila Mandals how to monitor changes in the community by teaching them methods of data collection and basic community health assessment. The MHT engaged community groups in village mapping and reflection to
identify both existing resources and needs in order to plan how to address issues. The MHT also reinforced the importance of healthy behaviors and practices, such as the importance of growth monitoring in children (Chitnis, 2005). Thus, the MHT played a key role in building the capacity of the community to take collective action. Since the MHT also worked in numerous villages, the MHT also disseminated best practices, successes, and knowledge between villages, as many villages faced the same issues. Examples of this include building soak pits to eliminate standing water and mosquito breeding, thereby reducing malaria prevalence, and the construction of check dams to conserve water. In this way, the MHT strengthened the ability of communities to be self-reliant by empowering them with information, connections, and tools to better understand the issues they were facing and how to tackle them (Chitnis, 2005).

**Additional ways CRHP engages in empowerment practice.** In addition to the work done by VHWs and the MHT, CRHP put its values and principles into action in several other ways to promote the empowerment of individuals and villages in the Jamkhed area.

**Starting with community priorities.** From the very beginning, CRHP’s work has been based on listening to villagers, understanding their priorities and concerns, and addressing them first. When the Aroles first came to Jamkhed and began working with villages, they understood that food and water were the primary concerns of the villagers in this drought-prone area, and as it was a matter of survival, the Aroles’ own interest in providing health education was not the priority. Thus, they started their work with food-for-work programs to address the immediate need for food, and through these programs, the villagers worked to build check dams and watershed management projects to conserve water and increase the local water supply. Over time, as the Aroles gained the trust of the villagers, they began to slowly integrate health information into the food and agriculture programs. They also provided basic medical care to the
villagers and their children, and slowly introduced the idea that illnesses could be prevented through health education. As the livelihood of the villagers is farming, the Aroles worked to set up the first few Farmers Clubs to respond to the need to organize, discuss, and develop sustainable solutions to the crisis of low food production. As they built relationships with villagers, the Aroles realized that women were more interested in caring for their families and children, and were therefore more receptive to health information. They shared health knowledge by organizing women’s groups (Mahila Mandals), and through these groups saw the need for women to have money in their hands, which could further improve the health of families. This led to the creation of self-help groups with micro-lending programs. When the first VHWs were trained, they carried on the organization and support of all of the community groups – the Farmers Clubs, Mahila Mandals and self-help groups. In this way, CRHP has always valued the concerns, needs and priorities of the villagers first, and taken concrete steps to work along with villagers to address these priorities while building the village’s capacity to address future problems on its own (Chitnis, 2005).

Giving voice to the poor. As equity is a key principle upon which CRHP operates, there is always an emphasis on giving voice and priority to the poorest of the poor. There are several examples of how CRHP has done this through practical, simple means. In villages during times of drought, the poorest suffered the most and many families starved. To address this issue, CRHP asked village children to bring a handful of rice to school, which was cooked by community members and shared by all the students. Those who could afford to bring more did so, and in this way, all children were fed. This became a regular practice in villages during difficult times, and not only did it help to reduce starvation, but also helped to break caste barriers, as the rice from both high- and low-caste homes was cooked in one pot and shared by all. This simple act
changed the mentality of the village and increased solidarity to the point where it paved the way for organizing community weddings. As poor families often found it difficult to bear the expense of marrying their daughters off, the wedding too became a shared community affair where multiple marriages would occur at one wedding, and the families would pool their resources and share the expense, reducing costs for everyone (Chitnis, 2005).

CRHP has also leveraged its reputation and influence to connect villagers with government officials by inviting them to come to VHW trainings and villages to meet with VHWs, Farmer’s Club members and Mahila Mandal members. These meetings helped officials to understand the context of the villages and challenges faced by villagers, as well as reinforced the accountability of government officials to the villagers. Villagers were able to directly ask questions and engage in dialogue with officials to request assistance. It also gave officials an opportunity to see what empowered communities look like, and how the government can best support them (Chitnis, 2005).

VHWs and villagers have also had opportunities to participate in local and national seminars, giving them an opportunity to have their voices heard, while also building their confidence and self-esteem (Chitnis, 2005).

**Discussion**

In considering the findings of these studies within the context of the academic literature on empowerment and CRHP’s model and definition of empowerment, it is clear that significant aspects of community empowerment have been achieved through CRHP’s CBPHC model. Individuals and villages have gained greater control over their lives, built their capacities, and gained access to partners, networks and a voice. Self-esteem and confidence of VHWs has demonstrably increased. By forming and working together within community groups, people
have identified with others as a member of a community, and have accepted and willingly discharged responsibilities towards themselves, others and society by participating with others in organizing for community change. As villagers have developed skills in critical assessment and analysis, they have taken ownership and action to achieve social and political change, and have been successful in building sharing and caring communities by reducing the barriers and prejudices that divide people. Discussed below are key practices of CRHP that have led to these changes.

**Empowerment as a Process: Key Practices that have Facilitated Empowerment**

Though the studies reviewed in this paper have not studied community empowerment comprehensively, we can identify several key practices of CRHP that have facilitated community empowerment.

**Values-based leadership.** The Arole family, due to their own deep-rooted conviction in and commitment to human values, created a strong foundation for CRHP’s work in a values-based approach which permeated every aspect of CRHP’s CBPHC model. The core of CRHP’s work, and what has ultimately led to empowerment, is the sharing of these values through various pathways and agents of change.

**Role modeling values.** The Aroles embodied all of the values which they wished to spread to the villages, and through teaching by example, they became role models for VHWs, the MHT and villagers. The VHWs, MHT and villagers all saw the commitment of the Aroles to achieving the welfare of the people. They never strayed from this goal, and rather than focusing on indicators of process (such as number of VHWs trained, number of villages served, etc.), which health programs often use to measure success, the Aroles measured success through dialogue with the villagers, to learn from the villagers how best to help improve their quality of
life. Every action that was taken was very deliberate and purposeful towards achieving the welfare of the people, and the Aroles did not hesitate to revise their methods and approaches. Moreover, they understood that change would not occur quickly, and were patient and invested in a process that would take many years to achieve community empowerment. They taught this attitude to the VHWs also by creating a safe learning environment in the VHW training where VHWs were encouraged to learn through trial and error and taught to be patient and determined.

**Respect for local knowledge and community self-interest.** The Aroles truly valued local knowledge and allowed the wisdom and self-interest of the villagers to guide their work, which not only contributed to the success of CRHP’s model in improving community health, but also facilitated empowerment. By providing practical training that was rooted in the current concerns and priorities of the villagers, whatever was taught by CRHP staff to VHWs during training or by the VHWs or MHT to villagers was immediately applicable and relevant, and could lead to immediate improvements by addressing the current concern. Community groups were built around the self-interest of villagers, which facilitated genuine community participation and collective action. Moreover, by engaging in collective knowledge creation through true dialogue involving equal information exchange between CRHP and the villagers, the power of local knowledge was also realized in the improved health outcomes and community empowerment that was achieved.

**Respect for all persons.** Moreover, the Aroles truly valued and appreciated the worth and ability of every individual. Dr. Arole’s statement that “the VHW training is as much about transforming the lives of these women as it is about training primary health care workers” reflects this sentiment well. By embodying respect, love, compassion, patience, and
commitment, the Aroles passed on these values to the major agents of change, the VHWs and the MHT.

**VHWs as both beneficiaries and agents of change.** The VHWs played a critical role in community empowerment. Firstly, they experienced empowerment themselves through the personal development, knowledge and skills they attained through the VHW training. The transfer of values from the Aroles to the VHWs is the core aspect of the training that contributed to empowerment. These values enabled the VHWs to improve their ability to interact with others and develop relationships based on trust, love and compassion, which is what allowed them to be successful in their work. Several VHWs stated that the ability to respect oneself and others and cooperate with others, and the great love and acceptance they received at CRHP were the greatest lessons they learned from the VHW training. Moreover, Brenden’s (1990) study highlights that when comparing the CRHP VHWs with government health workers, the emphasis on personal development was the main factor that contributed to the higher increase in self-esteem of the CRHP VHWs. The health knowledge and skills taught to VHWs also enabled empowerment through improved community health outcomes, as well as the increased respect and status VHWs gained within the community. By providing tangible health services, VHWs gained the trust and confidence of community members, which enabled them to be more successful in organizing villagers them for collective action.

**Experiential learning.** During the VHW training, the CRHP staff used various strategies to create social and cultural change among the VHWs, focusing on overcoming caste barriers and building confidence, trust and strong relationships by creating a safe, loving, and accepting learning environment. In essence, the CRHP staff taught the VHWs how to build sharing and caring communities in their villages by first applying the same methods to create a sharing and
caring community among the VHWs. Specifically, CRHP showed the VHWs the value of unity through overcoming casteism, division and negative thinking about others, how to cooperate with others and treat them with respect, how to organize people and the importance of creating a relaxed, safe space for social interaction, and how to build the trust and confidence of people. Thus, as the VHWs first experienced personal transformation and a change in their values, and understood the benefits of achieving unity and supporting relationships among their VHW peers, they were then prepared and motivated to become agents of social and cultural change in their villages. They could understand the biases, prejudices and ways of thinking of the villagers, since they too had held many of the same beliefs before beginning their training at CRHP, and thus could relate to the villagers and also convey to them the importance of changing harmful social and cultural norms and the values and benefits to be experienced through change.

Moreover, as VHWs had experienced empowerment themselves, they had gained control over their own lives and realized the true power and control that a person could have over their own life and health. The combination of personal empowerment and health knowledge they had gained through their training at CRHP prepared them to authentically convey the message through health education that health was really in the hands of the people, and could be improved by changing daily activities and behaviors.

**Support to take risks.** For a marginalized woman who has experienced her own empowerment to challenge existing social and cultural norms in her village by introducing new ideas and attitudes is no easy task. The VHWs required a great deal of bravery to take on the task of being the primary agents of change in their villages. Because CRHP created a loving and safe learning environment and built a strong sense of community and support between the VHWs and also between the VHWs and CRHP staff, the VHWs received the support they needed to face the
challenge of facilitating change in their villages. The difficulty the VHWs faced is represented by the dip in self-esteem after the initial training period as found in Brenden’s (1990) study. However, the VHWs persevered due to the support they received at CRHP during their trainings and from the MHT during village visits. Slowly their self-esteem and performance in health promotion and curative care improved, and became a positive feedback loop to further increase their performance and self-esteem, facilitating their empowerment.

**Spreading empowerment.** In the same way that the Aroles were role models for the VHWs, the VHWs then became role models for their fellow villagers. Thus, the transfer of values and health knowledge continued through the VHW’s activities in the village; as she provided health services, she also shared the positive human values she learned at CRHP both through her actions as an empowered woman who had elevated her status in the village, and through health education by removing superstitions and harmful social cultural practices such as casteism and gender discrimination. She also shared her values and knowledge by organizing villagers into community groups, encouraging discussion, self-diagnosis and collective action to improve the conditions of her village. In organizing the villagers, the VHW applied the same approaches that the CRHP staff had applied to the VHWs in training: sharing love and compassion, starting with socially-minded people, organizing creative activities to promote social interaction among villagers, promoting equity by including the most marginalized villagers, and facilitating the formation of a community through the creation of a safe environment that fostered trust and confidence among villagers. In this way, the VHWs spread empowerment. The empowerment they experienced as individuals was spread through their actions within the village, and resulted in changes in the attitudes of villagers through the individual interactions VHWs had with people in their villages, as well as changes in the broader
social and cultural norms and health practices of the village over time through the VHWs’ efforts to educate and organize the community. In this way, VHWs became agents of change, promoting the empowerment of both individual villagers and villages as a whole.

**Mobile Health Team as a secondary facilitator of empowerment.** By providing health services to villagers and values-based health education, the MHT facilitated individual empowerment by improving health status and helping to change harmful attitudes and beliefs. However, The MHT’s main role in facilitating community empowerment was by supporting the VHWs’ change efforts. By working with the VHW during village visits, the MHT gave legitimacy by including her as a member of the health team. This enhanced her status among villagers and enhanced her ability to be effective as a change agent. Secondly, the MHT served as a trusted source of information for the VHW and helped her improve her performance and increase her self-efficacy by giving her hands-on practical training in the village. Thus, by enhancing the VHW’s capacity, the MHT helped her to be more effective in facilitating individual and village empowerment. The MHT also facilitated village empowerment directly by teaching community groups basic research skills including data collection, assessment and planning by involving Farmers’ Clubs and Mahila Mandals in community surveys, mapping and data analysis. This gave villagers the skills and tools to then engage in self-diagnosis, rather than having to rely on the MHT. The MHT also supported villagers’ ability to engage in collective action by sharing knowledge, best practices from other villages, resources such as government schemes, providing access to government officials, and creating a network of Farmers Clubs across villages. Though the MHT played a major role in empowering individuals and villages as a whole, the MHT’s success depended on the VHW’s reputation and efforts in the village; the
MHT could not have achieved the same level of empowerment without the VHW’s work; thus the MHT functioned as a secondary facilitator of empowerment.

**Conclusion**

In conclusion, the emphasis on sharing values and locally-relevant health knowledge and skills through community-elected VHWs was the main facilitator of community empowerment in CRHP’s project villages. This primary pathway of empowerment was supplemented by the MHT’s role as a secondary facilitator of empowerment. A focused study of community empowerment would likely highlight additional pathways and practices that have fostered community empowerment through CRHP’s CBPHC model. Organizations such as CRHP should invest in measuring empowerment as an outcome and a process, in order to identify and share best practices in empowerment. As demonstrated by CRHP, the benefits of community empowerment within the context of health programs are immense. Community empowerment, of which community participation is an essential part, not only ensures the relevance, success, and sustainability of community health programs, but allows the attainment of “the highest possible level of health” of both individuals and communities, as a true “state of complete physical, mental and social wellbeing” (WHO, 1978). In closing, a quote from Dr. Mabelle Arole captures the unique spirit of CRHP and the organization’s dedication to community empowerment:

“We began with a hope, a vision that has continued to sustain us. But most importantly, we have learned over and over that empowerment is not a one-way process. It is not that we, that one set of people ‘provide’ empowerment for others who receive it. Rather, like water from a well dug in a fortunate spot, the power flows in many directions and sustains those who may set the process in motion as well as those disempowered for such a long time. It is a dynamic process which once set in motion transforms us, persons and communities. So from the beginning, we ourselves have been given power by the very processes and people involved in realizing the vision. We have firmly come to believe that through a process of recognizing and sharing the resources and potential of everyone, communities claim their right to health. Only people empowered and empowering others for the common good can find and keep the respect, cooperation and peace so much needed in this world.” (Arole & Arole, 1994, p. 254)
References


## Appendix

### Table 1. Health Indicators in CRHP-Served Villages in the Jamkhed Region by Year

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<tbody>
<tr>
<td>Infant Mortality Rate (per 1,000)</td>
<td>176</td>
<td>52</td>
<td>49</td>
<td>26</td>
<td>24</td>
<td>57</td>
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<tr>
<td>Crude Birth Rate (per 1,000)</td>
<td>40</td>
<td>34</td>
<td>28</td>
<td>20</td>
<td>14.8</td>
<td>24</td>
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<tr>
<td>Women’s health</td>
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<tr>
<td>Prenatal care (%)</td>
<td>0.5</td>
<td>80</td>
<td>82</td>
<td>97</td>
<td>99</td>
<td>74</td>
</tr>
<tr>
<td>Safe deliveries (%)</td>
<td>&lt;0.5</td>
<td>74</td>
<td>83</td>
<td>98</td>
<td>98</td>
<td>47</td>
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<tr>
<td>Couples practicing family planning (%)</td>
<td>&lt;1</td>
<td>38</td>
<td>60</td>
<td>60</td>
<td>65</td>
<td>56</td>
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<tr>
<td>Children Under 5 Years</td>
<td></td>
<td></td>
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<td>Immunization: DPT &amp; polio (%)</td>
<td>0.5</td>
<td>81</td>
<td>91</td>
<td>99</td>
<td>87</td>
<td>55*</td>
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<td>Malnutrition: Weight for age (%)</td>
<td>40</td>
<td>30</td>
<td>5</td>
<td>5</td>
<td>&lt;1</td>
<td>48</td>
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<td>Chronic diseases</td>
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<tr>
<td>Leprosy prevalence (%)</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>&lt;1</td>
<td>0.4</td>
<td>0.9**</td>
</tr>
<tr>
<td>Tuberculosis prevalence (%)</td>
<td>18</td>
<td>15</td>
<td>11</td>
<td>4</td>
<td>1.2</td>
<td>2.9**</td>
</tr>
</tbody>
</table>

Note: 2006 India statistics are from UNICEF.
*One year old children immunized against Polio only.
**Statistics from WHO, India, 2006.

*Source: CRHP, 2008.*

### Figure 1. Comprehensive Rural Health Project Model of Community-Based Primary Healthcare

*Source: CRHP, 2014.*