Community Social and Economic Development: Applied Community Rural Health Project, Jamkhed, India

By

Marcie Fisher
PUBH 392
May 4, 2003

Approved By:

[Signatures]
First Reader
Content Reader
Introduction

The following paper will review a community-led movement that not only tangibly addresses core health concerns, but also tap into a larger community consciousness to create more systemic and comprehensive change within the population it serves. John Friedmann labels this genesis the “third system” which marks the collective potential we have as people to move towards and embrace “the humanization of man” (Friedmann, 1998). A review of the literature reveals that there little effort to address with skill such questions as, “What does the humanization of man, or women, really look like? Or, “How is there truly power in the people?” Global food and water shortages as well as a grossly unequal distribution of resources, causes one to wonder if individuals have any real power at all. Nevertheless, if indeed there is a “third system,” a space that is “not a party or an organization,” which serves as a framework for “human flourishing,” where citizens are successfully changing social infrastructures; we need to see it alive and working. The following project, though not without flaws, will serve as an avenue to explore “human flourishing” in motion, and perhaps, offer us insight into how we as professionals can be part of the process.

Jamkhed International Foundation

For the last year, I have had the opportunity to work with Jamkhed International Foundation (JIF) located in Carrboro, North Carolina. JIF’s
mission is to support the work of community-based primary care projects worldwide, and specifically the Comprehensive Rural Health Project (CRHP) in Jamkhed, India. My work with JIF primarily involved organizational development tasks such as drafting JIF’s tax-exempt paperwork and exploring funding options. What originally attracted me to JIF however, was their connection to the Comprehensive Rural Health Project. With a long history of community work in India, an international reputation in the field of comprehensive community health organizing, and as a self-supporting infrastructure, the implications of CRHP’s ability to work on a grassroots level and replicate its process was of great interest.

For the purposes of this paper I will explore CRHP’s methodology and work as a community health movement. I will begin by suggesting a theoretical framework we can see exhibited through the work of Jamkhed. Specifically, an explanation of popular education principles will help elucidate the values underlying some of the specific elements of CRHP I will discuss later in the paper. I will then focus on the project’s background, its comprehensive approach to health, organizing strategies, and inclusion of low-caste people and women as leaders of the project. Finally, I will discuss the implications for our work as public health professionals and explore if there are applications for CRHP’s process in more developed countries.
Popular Education Theory

Educator and activist, Paulo Freire, originated the non-formal or popular education philosophy. Freire’s approach to education and development work greatly contrasts the traditional didactic model of health education and prevention that still exists today. The traditional “banking system” of education positions individuals as “empty vessels” to be filled with knowledge by the teacher or expert. (1970). “In the banking concept of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those who they consider to know nothing.” In contrast to the traditional student/teacher relationship, Freire offers a “co-learner” approach, which sets an equal relationship between the learner and the teacher. Freire’s concepts of “teacher-learner” and “learner-teacher” reflect the flow of knowledge and information as traveling both ways—the teacher learns from the student as the student learns from the teacher (1970).

Freire illustrates that the traditional didactic educational model described above mirrors the inequalities in our society. As public health professionals, we are often working in opposition to these inequalities. The principles of popular education offer strategies to analyze these inequalities. Popular education “involves people in group efforts identify[ing] their own problems, critically analyze[ing] the cultural and socioeconomic roots of the problems, and develop[ing] strategies to effect positive changes in their lives and in their communities” (Wallerstein,
1994). Table one contrasts Freire’s problem-posing strategy to the traditional banking model of education and community organizing.

Table 1. Banking Vs. Problem-Posing Model (Based on Freire, 1970)

<table>
<thead>
<tr>
<th>THE BANKING MODEL</th>
<th>THE PROBLEM-POSING MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptualizes education and development as a process by which “experts” impart their knowledge and skill into the empty mind or “accounts” of the individual or given community.</td>
<td>Conceptualizes education as a process where “experts” and the community create knowledge together in a variety of contexts, and generate themes to address critical questions about the community’s growth</td>
</tr>
</tbody>
</table>

Is characterized by:

- Expert-centered strategies
- Information dissemination
- Quantitative data on “what the community needs”
- Experts as authority and change medium
- Didactic pedagogical approaches
- “Right” answers and strategies
- The status quo

Is characterized by:

- Participant-centered problem solving
- Developing connections between beliefs, questions, and facts
- Encouraging critical reflection of community needs and development
- An emphasis on the process of exploration and application
- Pedagogical approaches which include discussion, group work, alternative assessment
- Challenging the status quo

The tenets of popular education Wallerstein describes offer a framework for the “problem posing” approach of popular education, and are evident in the organizational strategies of CRHP which invited villagers to identify strengths and problems for themselves. Through informal group gatherings within the community, people and leaders began to
acknowledge and explore some of the root issues such as caste, extreme poverty, and sexism that had a negative affect on village development.

Another major part of popular education theory seen within CRHP involved the adult learning cycle. The adult learning cycle emphasizes beginning with participants' knowledge and skills, providing a collective framework, introducing new information and skills, and applying those new skills and information in practice (Arnold et al, 1998). This is demonstrated in the development process of the farmers groups and in the mahila mandals, or women's groups, discussed later in the paper.

This model offers a technique for moving group processing and discussion toward group action. The experience of individual participants is an integral aspect of popular education and adult learning theory; adults learn better when the content to be learned relates to their experience. “Popular education techniques challenge trainers and facilitators to design projects in which the experience and expertise of the participants is just as valid as that of the trainers” (Vella, 1994). Jack Rothman situates the Freirian approach within a development/action social model. Beyond offering a framing for training or formal education, Rothman suggests that the techniques offered by Freire assist in wedding the work of "locality development and social action" to create community transformation (Rothman, 1996 p. 80). It is this precise joining of grassroots community work and village development with social change that is expressed in the work of the Comprehensive Rural Health Project.
Comprehensive Rural Health Project (CRHP)

The Comprehensive Rural Health Project is a community-based health care movement in India founded on the principle that, with a limited amount of training and support, people can harness their collective potential and create lasting social, economic, and personal change. Drs. Raj and Mabelle Arole started the CRHP in Maharashtra, India, in 1970. They realized that the usual way of providing medical care – mainly curative and based on a western medical model – was not improving the health of individuals or communities and was instead creating a system of dependency that was ill-equipped to address the deeply rooted social and economic disparities that contributed to disease and poor health. The mission of CRHP was simple: Enable and empower people and communities to take health into their own hands (Arole M & Arole R, 1994). From the beginning of the project, the different village communities were involved and participated as full partners with the project staff in setting and directing the development goals of the village. Now in 2003, 500,000 persons in 400 villages in the Ahmednagar, Beed and Osmanabad Districts of India have been involved in transforming their lives and communities through CRHP (Arole M. 2002).

CRHP, Health, and Community Social and Economic Development

While the gateway into the village community for the Arole’s in 1970 was their role as physicians, they knew that the real work lay in
addressing the deep caste, gender, and economic disparities that created and perpetuated ill health. For this reason, CRHP, as an organization, could be describe as a community social and economic development (CSED) organization as outlined by Weil and Gamble (Weil and Gamble, 1995). CHRP targeted primarily women and low caste farmers and created opportunities within these low-income and "oppressed" communities (Weil and Gamble) on the premise that, "starvation and under-nutrition resulted more from rigid social attitudes toward women and children than from an actual shortage of food" (Arole M. & Arole R. 2002).

As the CSED model outlines, capacity building and specifically "technical and management skills" are important components of locality-driven social and economic development. These elements are apparent within the CRHP project, which has taken a multi-sector approach to healthcare and prevention. Before discussing in more detail the specific strategies and scope of the project, it is necessary to first give some geographical background.

India and the CHRP Villages

With a population that surpassed one billion in 2000, an annual income of less than $400 (1/3 of the rest of the developing world), and a largely rural population, India is a country of distinct need (World Bank, 2002). The area surrounding CHRP is one that is particularly drought-prone and whose arable land base is used primarily for sugar cane—an
export crop requiring an inordinate amount of irrigation (an obvious problem is an area with limited water resources). Lack of food security, extreme poverty, and caste and gender discrimination permeate the culture.

Health problems are largely due to lack of access to safe water, food, and sanitation. Poverty and inadequate medical help or facilities complicate matters. Caste distinctions and gender discrimination often ensure that limited resources are kept in the hands of the middle to upper class and largely controlled by area bureaucrats, all men. This is particularly true in the rural areas. What state and government programs do exist generally offer ‘selective’ medical care and vertical programs that only address specific high-risk groups (Daniel, 1994). A common example is the issue of iron deficiency in women. The typical state approach to this problem is to provide supplementation. This strategy fails to address the real issue of poverty and the second-class citizenship of women that results in women often choosing and being expected to feed their husbands and children before themselves. While “empowerment-based” and “capacity-building” programs are certainly not revolutionary concepts today there is still a significant gap between theory and practice. Thus, in 1970, in India, what the Arole’s were building was truly groundbreaking.

CRHP's Approach

It soon became evident that poor people were not interested in health. They were interested in relief from
unbearable pain. Other illnesses were mere irritations. “You ask us to wash hands, to use soap. Where is the water? Do you now the cost of soap?” they challenged us. It was we who had to change first. Their questions forced us to think about poverty (Arole M. 1999).

Early on it was clear that this project must be different. The Arole’s came to the area to begin a community-driven health care movement with a focus on prevention. The location was chosen primarily on the basis of need. The Jamkhed block (the largest village in the district) lacked government health services, had no nongovernmental organizations (NGOs) working in the area, and had expressed community interest. While the village leaders from the area invited the young doctors to come and begin their project, the leaders did not want what the team originally had planned. The “elite” decision-makers in the community wanted a speciality hospital. They perceived the Arole’s prevention-focus enthusiasm as a lack of medical competency. This meant that, for the first year, the program took a short detour into medical care. This initial decision had positive results: “We soon gained the confidence of the people, and the curative services became the spring board through which we could carry out various health activities” (Arole, M.1999).

Like the World Health Organization, CRHP defined health as not only the absence of disease but also social, economic, spiritual, physical and mental well being (WHO website). With this comprehensive understanding of health, the project moved quickly from curative services to improving the socio-economic well being of the people as well as other
aspects of health. It was clear that health did not exist in isolation, but in relation to education, environment, sanitation, socio-economic status and agriculture. Why would someone who could not afford enough food for his or her family buy a bar of soap? Through working within the community the project staffed realized that is was so action, and not medical technology that could reduce infant mortality and improve the health of the villagers.

Community Organizing

Gathering community "buy-in" was not simple. Deep religious, political, and caste lines divided the community. Key leaders within the different factions were identified and relationships began to develop. CRHP knew that the real work would entail gaining the trust of the poor who were suspicious of outsiders and were historically absent from village decision-making (Raj Arole, 1994).

One of the major needs of the area was for safe drinking water. A governmental grant was written by CRHP and enough money was given for 200 tube-wells. The village leaders had very specific ideas as to where these wells should be constructed—in front of their homes. Project leaders knew that the people needing water the most were of low caste and would not be allowed by custom to use the wells of the upper caste. To solve this problem, the Arole's hired a geologist who was also a water "diviner" to identify the most plentiful spots in the village for digging. As this was an accepted custom, the village leaders agreed. The diviner was privately
instructed to ultimately choose the locations for the wells in the lower caste sections of the village—this would ensure they would have the safe drinking water they needed. The plan worked, and in the process laid the foundation for the project’s acceptance by the poorest segments of the community. Because water was a commodity that was needed by all villagers, the upper caste residents had no choice but to go to the slum areas to retrieve water. This process began to break down caste lines (Arole R. & Arole M. 2002).

As trust was slowly built with the low caste villagers, the next task was to bring the larger community together. Village volleyball games were organized. Men began to come together, talk, and socialize in ways that they had not before. These informal sport events eventually became Farmer’s Clubs. As droughts, food supply, and farming techniques were issues for all men regardless of class, there was a vested interest in meeting. CRHP leadership arranged for “experts” to share information on modern farming methods and animal husbandry. Soon, these groups began to also address larger community issues such as long-term improvements of land, need for community jobs, and sustainable farming. Group farming practices taught men of all castes to work together to plan and carry out programs of benefit to the community as a whole.

These informal farming meetings made way for larger health issues to be addressed. Community kitchens were developed, underground drainage systems were developed for wastewater and men were
beginning to understand the important role women played in caring for their children and creating healthy homes. After initiating a community-wide survey that looked at basic health issues, the men realized that many of their wives and children were sick and malnourished. The Farmer’s Clubs decided that women should be “taught” to care for their children. While their sentiment was perhaps a little misguided, the result was that women were beginning to organize themselves in ways that are still discouraged in rural India. The role of women in the CRHP process and their role in decision making is one of the unique hallmarks of the project.

Before discussing women’s participation in the development of CRHP and various health initiatives, it is important to first discuss some of the theoretical approaches that are present within the project. From the first initial men’s meetings, to the extensive training offered to volunteers, one of CRHP’s core values is achieving equity among people by using non-formal or “popular education” approaches. This means not only involving all villagers in the decision-making process, but also actually utilizing citizens to generate their own ideas, and “trusting that the village people know what it is that they need and have the ability to achieve it” (Arole M. and Arole R. 1994).

Women and CRHP
Women have initiated many of the changes that have resulted in the villages of CRHP with participation spanning across caste lines. Like many places in the world, women are of low status, and only understood in relation to men and their role as mothers and caretakers. The next section of my paper will focus on the tremendous role of women in CRHP’s success. Denied education, a voice, or opportunities to connect with others, women, particularly in the rural villages surrounding Jamkhed, were sceptical of involvement and afraid to speak.

By receiving support, education, and a space to share, the women became more active and accountable for creating change within the village and the health of their families. As one outside evaluator noted, “The women in the villages of the project area have come out of their timid shells and have become vibrant individuals” (Encon Evaluation Report, 3).

**Village Health Workers**

Demystifying health knowledge was essential to CRHP’s mission and so the project leaders decided to recruit female nurse midwives to work within the village women to diversify the program. Three test villages were selected and the nurse midwives went to the live in the villages for one year. For their medical knowledge, the nurse midwives were embraced. Yet, mothers were not coming forward for assistance with deliveries or more preventive services for themselves or their children.
The “childless’ midwives were “outsiders” who the women did not trust. They would ask, “What does this unmarried young girl know about women, pregnancy, and deliveries?” (Arole M. & Arole R., 1994) Village meetings were held and CRHP staff also went to farmers meetings to inquire why the services were not being fully utilized. Villagers suggested that women within the communities should be trained to provide health services, as the village did not easily trust people from outside the village who did not understand the rules of the village.

While the health team was originally skeptical, particularly of training illiterate women medical skills, they agreed to work with the villages to identify their own health workers. It was not initially easy to recruit volunteers. Women were not generally welcome at public meetings and to go from house to house could be looked upon strangely as most women were confined to their house. The honorarium was small which was also a deterrent. Finally after a number of community meetings, eight women from eight villages were selected. All the women were of low caste and illiterate. They were to be the first Village Health Workers (VHW), and the first of a long line of skilled, respected community health providers. Within sixth months of weekly trainings, the VHWs were providing immunizations, nutrition information, and meeting regularly with the farmer’s group to discuss the health needs of the village. Before long, VHWs were being trained to address minor illnesses and deliver children.
Now, the center of the CRHP project is the Village Health Worker (VHW). Village Health Workers are still selected voluntarily by the community and with help from a monthly medical team from the main Jamkhed village and ongoing training, are revered in their community for their expertise (Arole M. 1996). The process of adopting a prominent role in community change, led the Village Health Workers to want to share their discoveries and roles with other women. As villages became more self-sustaining in their health process, VHWs began to travel to other villages to share what they had learned. When asked why they went alone without program staff into a very poor, tribal area to replicate the rural development strategies in CRHP villages, some women shared (Daniel, 6):

“Development depends upon psychological transformation of the people.”

“Development is restoration of human dignity.”

“Human development has a close bearing on values such as love, forgiveness, sympathy, and kindness.”

Because the development process was so personal and powerful, VHWs wanted to utilize it for deep, lasting village change. This desire also led to organizing women’s groups within area villages.

Mahila Mandals

We had to get the women one by one. The village health worker would be able to convince just seven or eight women to get together. In the beginning, just these eight women would sit together and share each other’s problems. All that we did was
listen. This was a new experience for them. The average woman is a complete slave in her family, and the beck and call of her elders... but in these meeting she was experiencing something new.

Ratna Kamble, CRHP Social Worker
(Arole M. & Arole R., 1994 p. 184)

One of the most important organizational developments to evolve through CRHP was the Women's Clubs, which now exists in most of the four hundred project villages. Since the low status of women is still a major challenge in India today, the primary objective of the Women's Clubs was to bring about social changes, especially those which will improve the lives of the women and children. At the beginning of the project, women from various castes were not permitted to socialize. Just as the men of the village originally gathered around a leisure opportunity (volleyball), women originally met to sing traditional songs and socialize. Slowly, as the groups became more known and trusted, women from different caste groups came together. The groups were called mahila mandals, or women's development associations.

Eventually they began to talk about childcare, food, health, and share frustrations over lack of money and power. It was decided that each member (that could) would contribute a small amount of money to the group each week. The money collected was then given to the woman with the most need to start an income-generating activity such as selling vegetables or buying a hen. In this way the women's clubs began to grow and became a powerful financial force, a source for women's
empowerment, and a space for work on other health issues. As the
groups became more confident, they began to organize to talk with bank
officials, government health works, and others about their needs and the
needs of the village. Now, in a number of villages, the Women’s Clubs are
more active than the Farmers’ Clubs as the prime movers on such things
as nutrition, health and hygiene, safe drinking water, kitchen gardens, and
credit banking.

Health Outcomes and CRHP

While much of the strength of CRHP is in the process, amazing and
outward changes have occurred in the last thirty years within the Jamkhed
villages. As the area is drought prone, farmers have learned new farming
strategies and have focused less on the production of export crops such
as sugarcane which require a great deal of water (Daniel, 1994). Group
farming practices have led to greater food security and less nutrition

Attitudes concerning family planning have shifted and as seen in
the table below, by the early 1990’s 70% of villagers were using some
family planning method. One of the greatest outcomes from the project
has been the dramatic reduction in infant mortality. From 176 deaths per
1000 births in 1970, to 19 in 1993, infant mortality occurs primarily in the
neonatal period. Since there are no other health initiatives or state
programs in the villages, CRHP can be seen as a major driving force for
these changes. Other important development in terms of quality of life related to increase immunizations, an increase in prenatal care, and complete irradiation of tetanus in the village (Arole M. & Arole R. 1994, Ch 16).

Table 2. CRHP Health Indicators (Jamkhed Website)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant Mortality Rate</strong></td>
<td>176</td>
<td>52</td>
<td>49</td>
<td>19</td>
</tr>
<tr>
<td><strong>Crude Birth Rate</strong></td>
<td>40</td>
<td>34</td>
<td>28</td>
<td>20</td>
</tr>
<tr>
<td><strong>Children Under Five</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Immun. DPT &amp; Polio</td>
<td>0.5%</td>
<td>81%</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>* Malnutrition: Wt for age</td>
<td>40.0%</td>
<td>30%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Maternal Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Prenatal care</td>
<td>0.5%</td>
<td>80%</td>
<td>82%</td>
<td>96%</td>
</tr>
<tr>
<td>* Deliveries by trained attendants</td>
<td>&lt;0.5%</td>
<td>74%</td>
<td>83%</td>
<td>98%</td>
</tr>
<tr>
<td>* Couples practicing family planning</td>
<td>&lt;0.1%</td>
<td>38%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Chronic Diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Leprosy Prev. (/1000)</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>* TB Prevalence (/1000)</td>
<td>-</td>
<td>15</td>
<td>11</td>
<td>6.0</td>
</tr>
</tbody>
</table>
Not all changes that have resulted from CRHP's work are specifically health related. In 1983 the non-medical components of the project were evaluated. Representatives from the women's groups, village health workers, and farmers groups came together to determine an evaluation strategy. Being familiar with house-to-house surveys, the group decided to utilize this method along with focus groups to determine villagers' ideas and beliefs about larger community change. The village leadership wanted to specifically hear about changing perceptions of caste and gender (Arole M. & Arole R., 1994, p. 217-223).

Almost 6000 families and 60 villages were surveyed. The surveys did show changes in attitudes specifically around working with people across caste lines and seeing increased female leadership within the villages. However the survey also revealed that villages with an established women's group (a minimum of five years), were more likely to show changes in the social structure that was more inclusive of marginalized groups (Arole M. & Arole R., 1994, p. 221).

A point worth mentioning is that for CRHP data collection is completely driven by the community and the need to inform the community about where change needs to happen. Their process is not data collection for the sake of data collection, but instead a well-planned process that has involved putting the information back in the hands of the villagers. The process of weighing children for example, is a common
"report card" type process in developing countries. Often times this information is collected and kept by medical professionals never to benefit the people being measured. This is not the case with CRHP. From "road to health" cards that monitor children's growth, to whole village surveys, the data is given to the people and utilized to organize change (Arole M. & Arole R., 1994, p. 210).

Implications for Public Health

As demonstrated by CRHP, real change is incredibly personal. It involves time, listening, and most of all, people. There is an element of hope that is fundamental to the community process. This hope is not necessarily tied to a particular doctrine or ideology, but rests on what McKnight labels a "capacity-focused approach" which identifies and mobilizes community strengths (McKnight 1997, 158). The typical medical model of prevention tends to concentrate not on what is present, but on what is missing. As John McKnight notes:

The medical model, for all its utility, bears a hidden negative assumption that what is important about a person is his or her injury, disease, deficiency, problem, need, empty half. The able, gifted, skilled, capable, and full part of a person is not the focus of the medical model. And yet communities are built upon the capacities of people, not their deficiencies. Communities are built by one-legged carpenters. Medical systems are built on the missing leg (McKnight 1997, 24).
What CRHP offers is a framework that moves beyond the “top down” or “expert-driven” approach that often typify public health interventions. While there are numerous intricacies and levels of organizing that could be explored through CRHP, the preceding overview is intended to highlight a few fundamental strengths that shift the project from a mere health intervention project to a community-driven development movement.

Given that much of the ill health in the world is due to poverty and lack of social and economic resources, we as professionals are taught to be advocates for the “underdogs.” To recognize “social ills” and to work on behalf of “marginalized” groups. Yet working on behalf of a group is to assume that they are not able to act for themselves. To work with a group is to partner with people, to see “their issues” as your own. This is a strategy that is not limited by locality or by problem, and can be utilized regardless of the population involved.

CRHP brings us back to the basics of community, organizing, to a process in which communities are challenged, respected, and transformed. From the very beginning, thirty years ago, until now, there has been a continual exchange of learning and understanding occurring between project team members and members and community members, with a focus on addressing the root causes of disease and illness. The Frierian model of promoting active-listening and dialogue within the community have been a constant strategy. The staff of CRHP had to
adapt to the real needs of the poor, to listen, to provide technical support when needed (i.e., writing grants), and help people created their own change from the ground up. Their organizing strategies and process has gained worldwide attention and since 1995, Jamkhed has served as a training center for groups and organizations worldwide to learn how “capacity-building” and “empowerment” can become realities within a community.

CRHP offers practical, accessible, and necessary skills for conceptualizing and implementing community change strategies. Fundamentally, CRHP realized that while some specific skills are needed for community development, given a space to speak and be heard, most people could be their own agents of change. As one village woman expressed, “People are like wick lamps, simple inexpensive, and unattractive. But unlike the expensive chandeliers (which professionals are), the wick lamp has a tremendous energy. It is capable of lighting another lamp and another and another . . . to cover the whole planet.”
References


