Jamkhed Institute for CBPHC: The Evolution of a World Training Center

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Lalanbai Kadam, a woman in Jamkhed, says,

"I am a Dalit (low caste) widow. As an outcaste I used to think I was a nobody. I lived in constant fear because I was treated worse than an animal. My son died when he was less than three years old, and I was blamed for it and sent away by my husband. My parents made me marry an old man who had tuberculosis; then he died. I returned to my village in shame. I lived in darkness. To support myself, I swept and cleaned the village and did hard manual labor. I received a pittance. Even dogs were welcome in the houses, but I, as a Dalit, was not. Then along with many other women, we decided not to accept this anymore.“

As young doctors, we made a commitment to each other that we would devote our lives to improving the health of the poorest of the poor in rural India. After graduating from Vellore Christian Medical College, we worked in a rural mission hospital. We were competent, skilled and hard working. The hospital flourished and expanded. From this base we went out into the villages and held village clinics. We were successful as medical professionals.

Our commitment, however, was to the poor, and we asked ourselves constantly if our work and services made a real difference to the health of the people. To our dismay we found that our hospital, as well as our village work, was having little impact on the health of the people. Infant mortality continued to be high. Most diseases we encountered were preventable. Children were brought in dehy-drated, malnourished, and with diarrhea. Many women had problems such as obstructed labor and then came in too late. Further analysis proved that only a few people out of the total population were coming to us. Traditional cultural practices, high cost, poverty and distrust of modern medicine prevented people from coming to the hospital.

We started questioning the top-down, doctor- and hospital-centered health care approach. This led to a search for a more relevant and equitable health care system. Learning from the collective wisdom of many pioneers with similar concerns, we planned a program that would involve communities at all stages in the development and implementation of the work. It was to be a health program that would respond to the needs of the people, particularly the poorest of the poor.

The Beginning

As we looked around for an area where people were interested in starting such a health program, an enlightened political leader in Jamkhed, a community development block in Ahmednagar District in the state of Maharashtra, invited us to visit. They wanted to start a hospital to take care of obstetric and other emergencies, a place that mainly provided relief from pain and suffering. We explained our intention of working with the people to improve health through preventive programs. The leaders were not impressed. However, having no other group that was willing to help, they emptied a veterinary dispensary in the middle of a cattle market and provided a couple of sheds to start the ‘hospital’. We accepted what the people had and made the place safe for surgical care.

Soon we were called upon to prove our skills. A woman was brought in with a ruptured uterus, and we had to operate on her to save her life. We followed up by developing direct links with her and other patients’ home villages. Gradually we expanded to other villages. Using curative services as an entry point, we came into contact with more and more people. It soon became evident that poor people were not interested in health. There were interested in relief from unbearable pain; other illnesses that were not painful were mere irritations. When pain was gone, there were other pressing needs. *"We need water, we need jobs so that we can buy food to kill the hunger pangs, and then we will not have to migrate to cut sugar cane,"* was a repeated comment. *“You ask us to wash hands, to use soap. Where is the water? Do you know the cost of soap?"* they challenged us.

It was we who had to change first. Their questions forced the medical team to think about poverty. We had to redefine what we considered to be the scope of our work. How can we share scientific information in a meaningful way unless we understand people’s problems? We decided to live on Rs45 (about US$ 7) per month, the prevailing average wage at that time. We were in for surprises: soap cost almost two days’ wages; in that desert area water needed to flush a toilet was more than a month's wage. Our eyes were opened to reality. The poor people taught us how they cope with the situation, born out of experience. When living at that basic level, we learned that our needs for food and water felt more urgent than our needs for health interventions. Setting aside our own agenda for health promotion, we responded to the need for safe drinking water. Water was probably every-

where, but until now wells simply had not been dug deep enough.

We identified a non-government organization (NGO) involved in drilling tube wells and obtained a grant. As we went from village to village, the dalits ('untouchables') were concerned that they would not have access to the water if the well was in the main part of the village. A traditional practice was used to solve the dilemma. We took a water diviner into our confidence and asked him to walk through the whole village but to divine water only in the dalit section. More than 150 tube wells were drilled in dalit areas of villages. Everyone, rich and poor, needed water, so people of all castes came to the wells; the commodity was too precious for anyone to object to its location. More importantly, we had gained the confidence of the poor people -- we were in!

Awareness was expanding; an entry point was established; a success to build from. To carry out our project, we needed more than support from officials. The participation of only leaders was obviously insufficient. Health improvement in the whole village needs total community participation. For example, the physical environment of a village has to be protected by the whole community. Eradication of harmful social practices requires community action. Starvation and undernutrition resulted more from rigid social attitudes toward women and children than a shortage of food. Religion, caste, and politics divided both rich and poor people. To start momentum, it was vital to create partnerships; and to keep momentum going, it was important to prevent confrontations.

We started informal volleyball games, which brought together people from all groups in the village. After the games, both onlookers and players stood around and talked. It soon became the meeting place for more serious discussions on village development, especially with those who were socially minded. These informal groups were then organized into Farmers' Clubs (FCs). In these clubs not all members were farmers; many were the landless poor. Seminars followed on subjects according to their interests, such as agriculture, dry land farming, and veterinary medicine. People were more interested in the health of farm animals than in their own health or that of their children. In each village men were trained to provide primary veterinary care. Government extension workers joined as partners in these meetings and training. People became interested in human health only as larger life needs were addressed.

Assessment and Analysis Lead to Community Action

FC members and project staff conducted a health survey of the villages. The data from this survey created a starting point that transcended local factions. One villager recalls: *"The survey helped us to understand the needs in the village. We saw it as for our own good, so we did an accurate survey. Each of us took one area of the village and filled in all the information. No family was left out. We knew who was missing at the time of the survey, so we went back and questioned them later. The questionnaire was not difficult to complete. There were questions about immunization of children and whether they had been ill in the past two weeks. We reported any child's death in the past 12 months and details of how the child had died. We learned to assess the nutritional status of children by measuring their arm circumference. To our surprise, many children we thought had severe illness turned out just to lack adequate food! There were questions on pregnancy and family planning. We analyzed the results with the help of project staff. We learned a lot and began to understand the causes and effects of disease."*

At a public meeting afterwards one of the villagers gave this report, *"We had believed earlier that children did not thrive because of a curse from God. When we looked at our surveys, we understood that the problem was lack of food and preventive care. So we organized a community kitchen. We monitored growth of our children through weighing every month and plotting weight on a 'road to health' card."*

Improving the village environment grew as a priority. Many in the village were having repeated attacks of fever and chills; diarrhea was common. These and other conditions led to a better understanding of sanitation. In the words of a villager, *"Our data became more powerful as people gathered more facts and learned to use them. In the year before, we discovered that 80% of our families had had at least three episodes of fever with chills (presumed to be malaria). We learned that if we got rid of the puddles made by waste water and composted our rubbish, then much of the breeding of mosquitoes and flies would be eliminated and the frequency of diseases reduced. Previously we had spent close to 10 rupees when we got these fevers. Imagine the amount we were spending for something we could prevent? Now we learned that even if we had such illnesses, we did not need injections and expensive medicines.*

"The more we talked, the more we agreed: Why not clean up the village? The social worker showed us several methods of draining waste water. The soak pit, with water draining underground, appealed to us most. We appointed people to mobilize the whole village to build soak pits. Most families showed interest. FC members dug the pits that drained away standing water, and the owners provided the filling of sand, broken bricks, and a plank to place over them. It made a great difference to the amount of illness in our village."

Status of Women and Health

In each village the FCs were enthusiastic about doing the surveys. It helped the people to assess their own priorities. Such discussions eventually led

them to demand that women be involved, trained as village health workers (VHWs). *"Educators or professionals from the city do not understand our problems, our traditions. They speak an educated language. Our women have never been to school, but they will accept someone from their own community whom they trust,"* was what one group of village leaders said when they came to us.

As the VHWs discussed topic after topic, an understanding of the connection between the status of women and health became more apparent. They realized how much their lives were affected by pressures and norms imposed on them. One VHW, Sarubai, described her experience: *"I was married when still a child, got pregnant at 14 and, as is the custom, came to my mother's house in Rajuri for delivery. I was in labor for three days. Finally a dai (traditional midwife) arrived and said the baby was too big and I would not be able to deliver normally. The only way to save my life was to remove the baby from inside me piecemeal. I recovered but remained weak and ill for months. During that time I never heard from my husband. Later he sent word that he did not want a woman who could not produce a living child. As a woman left by her husband, I became an outcaste, unwanted, uncared for, living at the mercy of my brother. Why did all this happen? Because we women have no value in society. Because I was a girl, my parents were interested in getting me married off as soon as possible. I was too young to bear a child . . . only fourteen. Then like a piece of property, I was thrown off by my husband."*

Another VHW replied, *"At least you lost your baby. My daughter has two healthy children. She needed a Caesarian operation, and now her husband has sent her away, fearing that she may not be able to do hard manual labor and carry heavy loads because of the operation."* That mother had welcomed this cast-out daughter back home and worked to change the attitude of the husband so the girl would be accepted.

Organizing Women and Overcoming Barriers

When our work began, women from different castes were not permitted to socialize. They were unwilling to break caste prejudices, since women were viewed as the keepers of tradition. Centuries of subservience had made them accept their place; they were trained to suffer in silence. This attitude had to be changed. But how could a lone village health worker such as our VHWs do that? The village health workers expressed their conviction that all women in the village should experience the liberation they experienced as part of their training. Though the FCs helped them in their work, the VHWs needed the support of other women. A counterpart to the men's club was needed for women's issues. The FCs members encouraged their wives, sisters and mothers to be part of the new women's groups. VHWs began to meet with women of their villages every week or two. In the beginning, only eight or ten women from different castes in a village were interested in meeting for a couple of hours, never sure whether their gathering together would arouse wrath from their husband's family, as it was a radical move for women from different castes to meet at all.

Sarubai told how she organized women in her village. *"I was able to convince seven women to come together in the beginning. We gathered in one woman's home, sang songs, and listened to each other. In between, I taught child care."* More and more women began to attend these informal meetings in different villages. As they began to take their gatherings seriously, they decided to call their groups mahila vikas mandals (MVMs) or women's development associations. Discussions on health and social conditions were not enough to hold the women's interest for long. The need for money was a constant preoccupation. Children needed food or medicines. Older children needed books and school uniforms. They depended upon their husbands or mothers-in-law for any money they got. They needed their own income and wanted control over the money. The associations began to think about income generating activities.

Traditionally when village women needed financing, each woman contributed a small sum to build a fund; and at the end of a given period a name was drawn, and that person received the pooled contributions. Eventually every woman had her turn. The MVMs modified this system so that instead of being based on a lottery, the money went to the neediest in turn. This system built a sense of trust and helped women to be sensitive to one another's needs. Often the money bought food or treatment for a sick child. Others used the money to raise poultry, to market vegetables or dry fish, or to improve a vegetable plot. Organizing women around their self-interest in earning money brought stability and trust to the MVMs.

The MVM became a platform on which a VHW could build her health activities. As members increased, women began to realize that they had greater power as a group than as individuals. Sarubai described the women's involvement in her village: *"We divided the village into four sections, with one MVM member responsible for the health of her section. She ensures that all children are immunized and all the pregnant women receive prenatal care. The other women in her section help her. We also trained three women to be in charge of deliveries when I am not around. Every year we repeat the house-to-house survey to find out the health and economic status of the village. Both the MVMs and the FCs participate. The survey helps us plan our programs and understand what to emphasize."*

MVM members assist with health education. They plan the programs according to special needs and invite health personnel to guide them. In the beginning, the health professionals went from

house to house and asked mothers to accept pre-natal care; now the women are knowledgeable enough that they invite health personnel only when necessary.

The MVMs have ‘keep the village clean’ drives. They got rid of allergenic weeds, constructed drain-age pits, and encouraged the use of toilets. They help the VHW follow up patients with tuberculosis and leprosy and assist in the rehabilitation of these patients and their families. Tuberculosis patients need adequate nutrition in addition to medicines; often such patients starve because they are unable to work. The MVM members take turns providing vegetables and grains according to the patient’s needs.

VHWs gradually introduced social issues, especially the problems of women and girl children. They asked questions about why daughters were treated differently from sons, or why girls were not fed properly or sent to school like their brothers. They talked about alcoholism, wife beating, and the harsh treatment of unwed mothers, and discussed how these problems could be solved.

Increased food production, safe drinking water, and increased access to money and earning capacity were the needs identified by the village-based surveys and local understanding. The MVMs addressed these, starting with a dual focus on increasing income and health. That widened into areas of social and ecological development that make healthy lives possible. In many villages the FCs turned over most of the health responsibilities to the MVMs. The men concentrated on farm issues, especially the activities of planting thousands of trees and building small dams, thus reducing the frequency of drought and the need to leave the villages during droughts to find work elsewhere.

Most village women had never attended school or been involved in decision making or control of their time. Someone else had always controlled their thinking and their time. Now they were begin-ning to think for themselves. They have learned to work together to share responsibility and to trust each other. The MVMs became their schools and gave them a structure in which to organize. By 1978, there were associations in 31 villages.

The health center has also functioned as an information bank for the women. Health alone would not have sustained the women’s long-term interest.

Women Learn to Deal with Officials

Previously women had feared government functionaries, who tended to exercise their authority rather than serve. They were terrified to enter a court, police station, or other government offices. For village women, officials were the rulers. Now in their meetings the women adopted strategies to remove these fears. Women went out and practiced meeting high-level police and revenue officials, local judges, jailers, bankers, and others. Contrary to their expectations, they found these well-educated officials cordial and genuinely interested in their work and welfare. Women grew confident as they came to understand their own worth as part of a democratic society and realized that the officials’ role was to serve the village people.

They soon had opportunities to deal with these local bosses. Bank officials, accustomed to providing credit to rich businessmen or farmers, at first treated women condescendingly. The paperwork for small loans to scores of women was a bother. How-ever, the government had a special program for credit at low interest rates to women and marginalized people. In one village the women had read the rules and were sure they had met the criteria. At first the bankers refused, offering many excuses: the women had no property, no collateral, were illiterate, and so on. They harassed the women through bureaucratic procedures. But the women did not give up because they knew they were eligible. They sat in the bank until the banker made a decision either to grant the loan or to give his refusal with reasons in writing. Sensing their determination, the manager granted the loan.

The first women triumphantly shared their story with other villages. They used the loans to enhance incomes. They bought chickens and goats for breeding. They started small businesses, buying and selling bangles, dried fish, or vegetables. Some dug wells for irrigation, bought a pump, or acquired bullocks to help in farming. One woman bought a small canopy, loud-speaker, microphone and record player, which she rented for weddings, elections, and the numerous festivals in the village -- she repaid her loan in six months. Lalanbai leased fruit trees that grow by the roadside from the government; now she sells the fruit and makes a yearly profit of 10-30,000 rupees. Soon other banks started taking women seriously and extended credit to them.

Access to credit made being part of the MVMs popular. Such successes helped women gain self-confidence. More than 3,000 women who had never had a hope of getting out of poverty now took out loans and improved themselves economically. Their performance attracted the attention of higher bank officials at the state headquarters. The women were invited to share their experiences with bankers in other parts of the state.

Expansion

As outside physicians who had pledged to help, we were catalysts for development activities. We introduced ideas and supported new behavior, encouraged and forged partnerships between people in the villages and government officials. We created a three-way partnership that focused on community; it was a partnership of an empowered, more unified community with officials of many departments and levels of government, and we as experts helped the partnership grow. In this effort, it was helpful to have the health center functioning as an organization, independent of both community and government.

Health awareness has led both to demand for health services from the government and partnership with them.

Every FC and MVM has its own history, its own individuality, reflecting the uniqueness of its members. In both organizations, vital vehicles for social change, growing participation and awareness have led to dramatic improvements in many indicators. Men and women constantly assess, analyze and act to improve their lives. Increasingly these groups were standing on their own feet. We certainly were not the only catalysts any longer.

The project had begun in 30 villages. As village men and women realized the changes taking place, they contacted their relatives and friends and organized FCs and MVMs. The program expanded to cover a region of 250,000 people. As people became more self-reliant, more than 300 volunteers went to remote villages to start new programs. In their turn, those village people became facilitators for change in what has become a growing people's movement.

Though it started with health, the program expanded to many aspects of development. Through frequent seminars and meetings, government personnel joined with the poorest of the poor in providing services. More recently, villages have cooperated with the social forestry department in developing plant nurseries and reforestation, winning the highest national award for planting of trees in their area of India. Expanding linkages among sectors, they joined with NGOs and with government in watershed management programs.

The accumulated statistics are gratifying. Infant mortality (a sensitive indicator of overall health) fell from over 175 to 18/1,000 births. Although more people now live longer, the rate of population growth is moving toward stabilization as the birth rate has declined from over 40 to 17/1,000 and continues downward. Small families have become an accepted social norm, with 70% couples using family planning.

Over a period of 25 years thousands of marginalized men and women improved their own lives and those of the people around them. A desert area from which people were deserting is now increasingly fertile with check dams that feed the soil, with grass that can support cattle, and most importantly with people who are trying one idea after another to improve their lives.

Becoming a Learning Center

After we had worked in these villages for 20 years, some of the VHWs came to us with the suggestion that it was time for us to go somewhere else. *"We can look after ourselves now,"* they said. *"Many other places in India have greater needs than we. You can start similar projects in other places."* Soon afterward we received a grant to return to Johns Hopkins University for two years to write a book about our experiences. The time seemed to have come to start over. Before we left Jamkhed, we identified a new area in Ahmednagar District at Bhandaradara, about 200 kilometers away. Several years earlier 60,000 tribal people had been displaced from their tribal forest heritage to create space for a dam that would irrigate large sugarcane plantations, but the tribals had no access to the water.

As we began writing the book behind desks in the USA, it was hard to recall the early days at Jamkhed; we kept focusing then on what we were going to do next. After a year, Raj went back to Jamkhed to get tape recordings of our early partners talking about what had been important to them in those days of great uncertainty. To our great surprise, the first thing he learned was that the new project at Bhandaradara had already been established. Groups of VHWs had bought their own bus tickets and had gone to Bhandaradara. They moved into village homes for a week at a time and trained local VHWs, creating a new model of extension in transmitting their experience without going through our approach of slowly developing village contacts and trust through volleyball games and tube wells and taking years. They had directly translated the entire package of locally relevant interventions into village dialogue based on local adaptation. Within a year the new movement was spreading throughout this community of 60,000.

In Baltimore, as we finished writing our book, we realized that an opportunity had emerged to change our orientation from demonstration to training. The opportunity was not to start one more project but to train people so they can start their own projects. Jamkhed could become a learning center for people from all over India and many countries. These villages could be the base for a training institute. Very kindly, donors provided funds for dormitories and classrooms for groups of about 25 students at a time and for faculty. The first course started in 1994. In the first four years nine groups of trainees (180 participants from 16 Indian states and 16 countries) completed diploma courses.

The diploma program began with three months of intensive training in Jamkhed. Trainees accompanied VHWs who explained their routine tasks and how they had learned what worked. They talked about why different villages were doing the same activities in different ways and how procedures had evolved. These demonstrations prompted intensive discussion about conditions in the trainees' regions and countries and how Jamkhed ideas could be adapted there. Classroom sessions were divided into modules according to group interests, focusing on both theoretical implications and practical applications.

In the final module trainees developed their own action plans. They then returned to their own work environments for six months to implement them. During this time Jamkhed faculty visited each project at least once to monitor progress. Finally,

the trainees returned to Jamkhed for two weeks of intensive evaluation. Behavior change proved essential for both trainees and their employers and colleagues to create a cooperative environment for the new projects.

In addition to the diploma courses, demand grew for short courses, most of them lasting one week to one month. In the first four years 1,135 people, mostly from NGOs, participated in 97 such courses. Of these 32 were international courses given by and for professionals from 18 countries. The remainder was for Indian participants from 17 states, including 28 courses for Maharashtra and four all-India courses.

Mabelle was hired by the United Methodist Global Mission Board in New York to run workshops in Latin America and Africa describing what we had learned at Jamkhed and to help develop new projects in these continents. She then joined the UNICEF regional office in Kathmandu to run training workshops throughout South Asia. Trainers came to Jamkhed from Pakistan, Bangladesh, and Nepal to take courses. In 1998 Mabelle returned to Jamkhed to teach full-time.

Since 1996, Raj has provided special orientation courses for candidates from India’s elite government cadre, the Indian Administrative Service, in community health care, conducting seven-to-ten-day sessions both at the academy and at Jamkhed. The Jamkhed approach to health services has extended to several other states through participants in the diploma course as well as short courses for agencies. In Maharashtra the primary health centers and district health officers are trained at Jamkhed for one week; the government of Orissa has sent its newly recruited doctors; and the Jamkhed book is in every primary health center in West Bengal. CRHP is also the central training center for a statewide application now in Arunachal Pradesh, in northeast India.

Key Learnings

People are the key actors in health and human development. Poor people have coping mechanisms based on collective experience and wisdom. The Jamkhed experience shows that through community-based action they can enhance their skills and knowledge to increase their choices.

Addressing economic poverty and building large infrastructures alone will not lead to better health. Health depends on individual and community action. The knowledge to acquire and maintain health is a human right. Professionals need to change their attitudes and demystify medical knowledge. They should share knowledge freely, not by providing a few filtered messages that they think are best for the people. Knowledge should be shared in such a way that people can be empowered to assess, analyze and make the right choices. The knowledge should liberate people and not intimidate them. It should lead to building self-esteem and confidence in oneself and others. It is necessary to address the basic causes of problems and share values leading to greater humanity by showing concern for the dignity of others with equity and justice. It is necessary to respect and trust people and facilitate the process of awareness building.

In the words of a Jamkhed woman:

"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."

Hundreds of thousands of people have realized this energy and potential and are responsible for a worldwide movement for social change.

Comments

Jamkhed went through the following sequence in the scaling-up process to share its model and experience with others:

Phase 1: The first ten years were a progressive expansion, with a distinctly bottom-up emphasis on community empowerment. In an extremely poor and rigid social structure, a process of village-to-village extension of social development permeated and revolutionized the traditional culture. The people became aware of their own potential and were then empowered to meet their own desperate needs for a better life.

Phase 2: Blueprint extension of the Jamkhed model was tried by the Indian government but met with almost no success. There was spotty extension of some ideas to other local projects in India, especially in Maharashtra. A project near Pune in a whole district was a model for a national program called the Village Guides, which has had continuing difficulties. Bureaucratic rules distorted the community base. Primary health center doctors were made responsible for local training of Community Health Workers but had little idea of what was involved and poor preparation for the innovation needed. The Community Health Workers are unmotivated young men, such as leaders' unemployed nephews, rather than mature village women selected by village people as someone they would trust.

Phase 3: Jamkhed became a learning center by carefully designed training that serves multiple needs, bringing together communities, officials, and experts.

Phase 4: Now Jamkhed has developed its potential to expand from statewide extension in Maharashtra, to nationwide extension in other parts of India, and finally to global extension with adaptation in many countries.