SWASTHYA SWARAJ NEWSLETTER

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- EDITORIAL

ISLANDS OF PEACE & TRANQUILITY IN A RESTLESS WORLD

As the covid pandemic is raging, sowing fear and frustration in all spheres of life, there is one place where life goes on as usual and people remain undisturbed. People here in the tribal villages of Thuamul Rampur Block are calm and busy with their routine livelihood activities, while elsewhere people are jobless and panicking. Covid is not a subject discussed in the village corners and work places. Their reaction to the question 'How are covid and the lockdown affecting your lives' is, 'earlier we were also facing difficulties and misery, and now we are also facing the same'. They have not lost much because they did not have much to lose in the first place. So the present situation does not make a difference to them. How can they continue to be islands of peace and tranquillity in a restless world?

Our current lifestyle is immersed in technology, competition, high speed and 24x7 communications, news channels, high calorie diets, no physical exertion, and accumulating wealth for future generations. Is this all not unnatural? Can all this be sustained by our planet, constantly trying to satisfy the greed of some human beings?

There are many reflections on these issues from people all over the world, from many different people and groups. Many organisations are offering courses on 'Resilience'. I feel the tribal population teaches the whole of humanity lessons in resilience and endurance in the face of calamities. Certainly covid is making us all slow down, pause, and ask some soul-searching questions to oneself and to humanity.

As the world is going through the pain of destruction of the existing systems and values, let us hope that these are the birth pangs of something new which is yet to emerge- something which will lead to a more just and equitable distribution of resources. It is with these sentiments that we present this newsletter.

Dr Aquinas Edassery

In this issue

Impact of COVID on life and health in tribal areas

Covid-19 has hit the whole world with such ferocity that it has caused a collapse of healthcare all over the world, including countries considered to have good healthcare systems. Fragile healthcare systems folded in country after country in a matter of months. There has not been much headway since the pandemic started – innumerable theories about the nature of the virus, its modes of spread, the immunity acquired, the treatment, possible vaccines – nothing is clear as yet. All this as the virus rages on, defeating every system and creating chaos everywhere. It has left everyone groping in the dark for answers and solutions, including scientists struggling to know more about the virus. The economies of many countries have also been badly affected, leaving millions jobless. The fear which has gripped the whole world, the confusion and misery caused is unimaginable.

As covid struck a rude shock to the developed and developing cities and towns of the country, it seems to have been sympathetic to the tribals, largely sparing their communities. This is a section of the population where more than 90% of the families live below the poverty line, which means that they survive on less than Rs. 30 per day. These communities are fully agrarian; they are all marginal farmers on subsistence agriculture, or landless living on agricultural labour. Their lives are intermingled with jal, jameen and jungle from birth to death.

Though these simple people were spared selectively by covid, they were badly affected by the lockdown which was a rude shock to them. When public transport was suspended and the weekly markets (which are the lifeline of villages) came to a halt, these people who live on a day to day basis, had nothing to live on except rice, which was supplied in abundance, by the Odisha government. In the people's own words - 'we do not even have salt to take with rice'. Their poverty and food insecurity were worsened by the lockdown.

One of their major problems is not having enough cash in hand to buy essentials. They earn money from the sale of forest products like leaves, firewood, other seasonal products and portions of their cash crops. This sale came to a complete standstill leaving them strapped for cash. Along with the non -availability of essentials of daily life, the situation was a blow to them - aggravating their poverty, or pushing them into deeper poverty, and thereby worsening their already compromised quality of life.

This situation has improved as the lockdown was relaxed, and the MGNREGA works starting in the villages. As the monsoon is picking up momentum, the tribal community are pre-occupied with ploughing, sowing, planting, fencing and so on. They are not at all bothered about covid and the associated confusion and turmoil in the developed and developing areas of the world and of the country. The tribal people are, for most of the time, up in the hills, in the open air, trying to grow their food for the whole year.

Impact on health :

When the peace and tranquillity of tribal villages are not affected by covid and life seemingly goes on as usual, their health is affected in different ways.

Our observations are the following :

Maternal health: There is a very high incidence of severe anaemia in pregnant women (23%). As malaria in pregnancy in the project villages has reduced drastically from 34% in 2015 to 3.6% in 2019, this high level of anaemia is attributed to a lack of antenatal care services and nutrition. There is a stark difference in villages which can access healthcare and those which cannot.

Health seeking behaviour: In both health centres of Swasthya Swaraj, in this predominantly tribal block, there was no decrease in the number of patients during the period from March –July. Rather, the numbers are higher than during the same period in 2019. This is in spite of the lack of bus transport facilities which have not been fully restored. The patients who visited the health centres were from around 30 km, which distance they could walk, or travel using two wheelers or the occasional autorickshaw. There was a drastic reduction in the number of people coming from very far off places within the Thuamal Rampur block and adjacent blocks.

Disease profile: There continues to be a heavy load of infectious diseases. Malaria has more than doubled during this period compared to the same period in 2019. As monsoon sets in, the number of diarrhoea and ARI (acute respiratory infection) cases increase as usual. Medical emergencies are mainly paediatric (73%), severe malaria being the highest.

Tuberculosis: Detection rates have decreased by about 40%. About 50% of patients stopped their treatment as they could not reach the health centre for monthly review, collection of medicines and nutrition supplements. The programme staff managed to reach some patients' houses, but not all. Government staff have also helped in this effort, as our patients are mostly from distant places.

Non-communicable diseases: The prevalence of diabetes and hypertension in this population is negligible. There was a sharp decrease in patients with NCDs like rheumatoid arthritis, hypo and hyperthyroidism, sickle-cell disease and psychiatric problems attending the health centres during this period.
Informal doctors: One interesting phenomenon is that the informal doctors (so called 'Bengalis / kabirajs') had a good time as they were in great demand, and their business flourished. They treat every fever case with arteether injections. Every fever is malaria for them, every case of amenorrhoea in young women is pregnancy for them. But in the circumstances of the lockdown when people could not access regular healthcare facilities, these practitioners were regularly accessible in every village.

Conclusion: Reports say that in India 40 crore more people have been pushed below the poverty line, to join the 56 crore people already at that level, out of a total population of 130 crore. This means that a population of 96 crore is now suffering from chronic undernutrition, high mortality and morbidity.

The situation is grim. It looks like we all have to learn to live with covid for several months or perhaps years. As the large 'big time' hospitals are trying to fight covid, primary healthcare, which is the bedrock of healthcare, also needs attention. The present crisis points to the need to strengthen primary healthcare. It is sturdy, even in the face of calamities and distress, when the hi- tech hospitals cannot cope. These small health centres are the solace and refuge for the patients.

Aquinas Edassery

My Surprises in Swasthya Swaraj

I am a staff nurse, trained and working continuously in well run secondary and tertiary level mission hospitals in South India. I also have been trained as a Nurse-Anaesthetist. I enjoyed my work in the regular hospitals but did not realize that nursing can be done in a different way. It has so much scope, if only we look beyond the institutionalised boundaries of the large hospitals.

I joined Swasthya Swaraj in March 2020, just when the lockdown was starting. Against everyone's advice and warnings, I moved from Bangalore to Odisha. Looking back, I think this was a right decision.

One of my important learnings is that I became aware of the difference between a hospital-based Staff Nurse and a Community Nurse. In the hospitals we play an active role in curing the diseased systems, and making the patients feel well again. This is like in a motor garage for few privileged patients whom we may not see again. On the other hand, the Community Nurse cares for multiple patients – healthy or unhealthy, and plays an important role in preventive, promotive as well as curative work. All sections of the society are cared for - infants, young children, adolescents, pregnant women, breast-feeding mothers, youth, elderly, the disabled, the invalid etc. Most of our work is in the community. Even though Swasthya Swaraj runs two full-time health centres, each with a full team of resident staff, we do not wait for the sick patients to come to the health centres. SS organizes targeted programmes like antenatal, under-five clinics, special TB clinics etc. reaching out to the people in hard-to- reach locations.

I am pained to see the lack of development, scarcity of healthcare services and levels of ignorance in these tribal areas, even as the healthcare services are developing rapidly in urban areas of India.

Surprise 1:
In the month of May, a 6 year old boy was admitted in our Kaniguma health centres - he was emaciated with an appearance of an old man. This was the typical text-book description of marasmus which I had not seen before. He was the only child and was ill for more than two months, and was not able to visit the hospital due to the absence of bus services. This boy was crying all the time, irritable, biting his parents, and not able to walk or talk. He was diagnosed as severe acute malnutrition (SAM)

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Surprise 2:

Training of tribal girls as Community Health Practitioners: This is a residential, two year diploma programme, affiliated to a university but being taught in a tribal setting in Kaniguma village. Even though this training is being done in an undeveloped village setting, the curriculum followed and the teaching are all systematic and of excellent quality. The students' main problem is to study the subjects in English and write exams in the same language, but they do succeed. These students are being prepared to work in remote, hard to reach locations where there are no doctors and nurses. They are equipped with knowledge, diagnostic and curative skills, and many other practical skills. Being tribals themselves and belonging to primitive tribal groups, they can connect with the tribal population where others would fail. This course, I think, is a wonderful idea and has to be supported in all ways.

Sr Rani Joseph.

Broken bodies, broken lives..... No.6

(Series of living stories)

'Dongerkam' (work in the hills) - at the cost of children's nutrition and their lives.

Jagladi Majhi, a 20 year old mother (age is anyone's guess) brought her young baby of 11 months along with her husband to the health centre in Kerpai. They had reached the health centre walking at least 10 km through hills and valleys, crossing two rivers over broken bridges in heavy rain. The baby had a cough and fever for the last 6 days. They brought the baby as it was not feeding well at the breast, which is an ominous sign. The baby was lethargic; its respiration rate was 84/min and the oxygen saturation level only 80%. The baby was diagnosed as having severe pneumonia and in respiratory failure. (Usually these children respond well to intravenous medications, oxygen supply and other supportive treatment in 2-3 days in our health centre). The parents were illiterate which is common in this area. There was no point in trying to refer their child, as they almost always are unwilling to visit any hospital. The district hospitals of Kalahandiand Rayagada are at a distance of 100 km each from Kerpai, which they have not visited.

The child needed to stay in the health centre for 2-3 days for round the clock intravenous medications and oxygen supply. In cases of such seriously ill children, the doctor and nurses have to struggle to convince the parents about the need to stay in the hospital. We tell them point-blank that their baby is seriously ill and is going to die. Usually, after much coaxing, cajoling and scolding, at least half will agree to stay and be treated.

But the mother Jagladi Majhi was unwilling to stay, and her husband also felt the same. The reason they gave - till the 'dongerkam' is over they cannot stay. They will come with the baby after the 'donger' work is over! She finally agreed to one injection of antibiotic to the child, and took other antibiotic syrups and medications for 5 days, and promised to bring back the child after the 'donger' work was over !

We watched helplessly as the mother walked away carrying her baby in a sling – the baby was still having breathing difficulties.

After 5 days, the swasthyasathi (health worker) of her village came and reported that the baby was well!

What is more important- the baby's life or their agricultural work in the hills? This is something which we doctors, with our urban backgrounds and medical education, do not understand. Up in the hills they cultivate different types of millets and pulses (kosla, kangoo, ragi, mung, cutting, biri, kandul, flax and many others). These are cultivated in patches cleared in the jungles, over which they do not have land rights. These crops are their sources of energy and protein, and what sustains their life. At 3 in the morning the women start their daily chores, and as soon as the sunlight falls in their huts, they are up in the mountains with their babies feeding at the breast, or sleeping in a cloth sling hanging on their side. They sell these products at a throw away price in the local market or to vendors, who come to the villages selling plastic vessels made of recycled plastic. Or they are sold in the local market to vendors in exchange for provisions like potatos, dal, chillies, onion, salt etc. If this seasonal work is not done, the child and the rest of the family will be starving. So JagladiMajhi's raw reasoning is wiser than ours and we have to bow to her wishes. We feel frustrated at not able to convince her to stay in the hospital and get her child treated.

This is the plight of the poor in tribal areas. Their livelihood is more important than their life or the life of their newborn child. They are not callous or indifferent people; rather, tribal parents are a deeply caring community. Their children grow up in complete freedom. But their life situation and extreme poverty forces them to make choices and these choices are beyond our understanding.

Alok Singh was a research student from TISS Mumbai, spent 6 months in SwasthyaSwaraj to study the Government's response to undernutrition in tribal villages. He exclaimed, in frustration, 'Oh, the donger is the stumbling block! Because of the donger the childrens' nutrition cannot be improved. Even in the few anganwadis where hot cooked meals are prepared, by the time the meal gets ready the children are already in the donger with the mothers including the suckling ones'.

Yes, dongerkam is indeed a stumbling block. It jeopardises children's nutrition, education and their growth. But just one single programme for child nutrition is not going to remedy this situation. It requires a comprehensive, inter-sectoral, well-planned programme to help these forgotten people who are outside the development dialogue and programmes.

The fact that these children in precarious health respond to healthcare in a good primary healthcare setting is also a valid argument for strengthening our primary healthcare system in remote villages.

Aquinas Edassery

COVID RELIEF DISTRIBUTION

The COVID-19 pandemic has led everyone devastated especially the poor and marginalized. People suffered in many ways- not having access to transportation which in turn restricted them to have access to health care service, food and put an end to livelihood of many. Food insecurity became one of the major issues during the lockdown. People in the town had access to food purchases at least for sometime which was not the case for the people living in villages. For people living in villages the only source of access to food is through their production, PDS and also from the weekly market. Lockdown completely shut the villages from accessing any transactions to food for them and the families. Thuamul Rampur the most backward block of Kalahandi district went through the same or even worse during this pandemic.

SwasthyaSwaraj society (SSS) with the help of Azim-PremjiPhilanthrophicInitiatives (APPI) decided to give relief to the 78 tribal-predominant project villages and hamlets in Kaniguma and Kerpai cluster of Th.Rampur block. SSS has distributed dry ration containing moong dal, arar dal, sugar, Kala chana

(chick-pea), salt, soya chunk, chuda with other essentials such as oil, turmeric powder, red chilli powder and onion, potato and 4 lifebuoy soaps to about 2,780 households in (78 villages and hamlets) of 8 gram panchayatsfrom 14-04-20 to 30-04-20 for which prior permission was obtained from BDO of Th. Rampur block for the vehicle movements to all our project villages for the dry food packet distribution.

The Govt'sCOVID ration (three month ration) which was distributed by the panchayat was supposed to reach to the homes of the beneficiaries was distributed in one place for the entire panchayat. But people from many villages of the panchayat had to walk 10 to 15 k.m. to get the rations which they carried it on their head and shoulders. People were so excited to receive the free dry ration packet in their own hometown brought by SSS. They didn't have to walk through the bad roads to get it. We heard one person saying to the other "Have you ever seen all these things in your entire life, we are using some of these things for the very first time". That was overwhelming. One month after the distribution when one old man was asked about the dry ration provided to him, the person said he is still using the given ration sparingly!

We acknowledge our gratitude to APPI which enabled us to render this help with their generous financial assistance to the people in need.

AbielKhosla, Anup Panda & all Field animators.

Kondha (Tubers) revolution in the land of Kondh

The Odiya name for tubers is **kondha**. The tribals here belong to Kondh tribal group. Perhaps our ancestors' staple diet was kondhaas they were struggling with soil, the jungles and mountains, and hence the origin of our tribe name - Kondh tribe. The tribals in Thuamal Rampur block belong to Kutia Kondh tribe which is classified as PVTG (Particularly Vulnerable Tribal Group).
Whatever the origin of the tribe's name, one thing is clear - we tribals love kondhas. In the lean season we dig up to 3-4 feet to get to the jungle kondhas and eat them. It is a food accepted and even liked by children and adults, infants and the elderly. We steam it, smoke it in a burning fire, and make different preparations. There are numerous varieties of kondha too - kambalu, rani kondha, sarukondha, simelkondha, jungle kondha

The tubers are rich in carbohydrates - it is a staple food and a supplementary food as well. People in tribal areas have a hard life, struggling up in the hills most of the time. Our people do need energy - rice, ragi and kondha provide it. What our people and especially the young children lack is protein in their food. We do not milk the cows, nor drink animal milk. This is because of the tribal belief that cows' milk belongs to their calves, just as human milk belongs to human babies.

Hunger alleviation programme by Swasthya Swaraj:
Understanding the importance and acceptability of tubers in a tribal community in alleviating hunger and reducing under-nutrition rates of under-five children, SwasthyaSwaraj initiated the tuber distribution in this community.

2018: A team of field animators including myself and Dr Sandeep Praharsha underwent training and exposure at CTCRI (Central Institute of Tuber Research, India) in Bhubaneswar on the scientific aspects of tuber cultivation. We procured from CTCRI 2 tons of tubers (kambaluor big creeper yam) and treated it according to instructions. It was distributed to 260 families after adequately educating the village communities on tuber cultivation and ensuring their acceptance. All families were covered in these two sub-clusters (14 hamlets) in the first phase.

2020: As CTCRI could not supply additional quantities of tubers, we procured them from a private nursery in Bhubaneswar. This time 3 tons of the yam were procured and then distributed to 500 families in Kerpai and Kaniguma clusters. The seeds were stocked in the village development committee hall, and treated using cows' urine, cow dung and anti-fungal medicines supplied by the firm. The farmers were given instructions and were able to clarify all their doubts in each village. Their acceptance and consent was obtained for not selling the harvested products, but to use them only for their own needs. The distribution was done in all these villages, with 5-7 kg of cut pieces for each. As the monsoon had started, all the families planted the kambalu(big yam) with great enthusiasm.

After one year the tubers will be ready for harvesting. From one piece, 5-20 kg of tuber would be harvested. In many villages, the people decided not to harvest this year from what was supplied in 2018, as there is plenty of rice this year, supplied by the Government. In 2021, we hope to assess how much undernutrition has been reduced in these villages.

We thank Mrs MadhuBhaduri who fully supported this programme for alleviating hunger in this tribal area.

Jaysankar Majhi

TB Control Programme in a tribal area

We know that tuberculosis is a disease closely linked to poverty and so no wonder it is one and half times more prevalent in the tribal population compared to non-tribals. Swasthya Swaraj works on health in a comprehensive manner in one of the very backward tribal areas and reaches out to some unreached villages and hamlets. This includes their detection, treatment, treatment of comorbidities, admission of critically ill cases, nutrition care, follow up and post TB care. Every month, a total of about 900 patients of all diseases and conditions come to the health centres for treatment. About 10% of these patients are TB suspects, whose sputum microscopy is done and sputum sent to the District Hospital, for the Cartridge Based Nucleic Acid Amplification Test (CBNAAT). TB suspects and children younger than five years who are contacts, undergo the tuberculin skin test (Mantoux test) and their gastric fluid is tested by CBNAAT.

Swasthya Swaraj has now become a Designated Microscopic Centre (DMC), recognized by the government. We have 4-5 new TB patients of both pulmonary and extra-pulmonary types, every month. All TB patients are treated free of charge at Swasthya Swaraj (investigations and treatment). All TB patients now receive government-supplied medicines. Swasthya Swaraj provides on its own a nutritional supplement to every TB patient - 2 kg Bengal gram, 1 litre oil and eggs. For children with TB,

a home-prepared high calorie nutrition mix is provided every month. Along with all this, a travel allowance (bus fare) is also given. These are not just incentives but essential components of the TB programme to ensure compliance and cure of the patients in a poor area.

The TB clinic is held on the last Tuesday and Thursday of every month for TB patients. In TB clinics, health education is an important activity. During these sessions, all information related to TB and answers to their questions and doubts are given. Health education on these subjects is given by the staff through posters, dramas and dialogue. Health education is also given to TB patients by doctors, in labs and in the pharmacy, by the staff concerned.

In this tribal area, most of the villages are not covered by mobile networks and many do not have mobile phones. When patients do not turn up on their due dates, they are informed through TB Postcard brought out by Swasthya Swaraj, which will reach their homes through the postal system. Some patients are unable to come to the TB clinic. In these cases our field animator, swasthya sathi or clinical staff go to their home and give the TB medicines and nutrition supplements. In the project villages, TB patients are supervised by the swasthya sathi and the field animator to make sure that they take their medicines and visit the TB clinic for review. In non-project villages, the ASHA or family members are the DOTS providers.

Swasthya Swaraj staff also facilitate the Direct Beneficiary Transfer scheme under which each diagnosed patient receives Rs 500 per month for 6 months and tribal area patients who get cured receive Rs 750 in addition. Though it is a pittance, to check that they have actually received this amount they have to stand in a long queue at the only bank in the Block, from morning till afternoon. It is a big amount for these poor people and they value it very much. Issuance of the Aadhar card and opening of a bank account for those who lack these facilities, is a long struggle, as we work largely with illiterate people.
Swasthya Swaraj is determined to control TB. Through our work, we aim to strengthen the National TB Elimination Programme of Govt.

Durgaprasad Gupta.

When we restarted the ANC clinics after a break …

ANC-Underfive clinics:

The ANC-U5 (antenatal care and under-5 care) clinics, held once a week at the Kaniguma and Kerpai Health Centres are something we always look forward to – travelling in the 4-wheel drive jeep to the far-off villages along the roadless forests, crossing rivers and broken bridges was indeed a great experience for us. We had to get things ready the previous evening itself, according to a checklist. When we reach these locations, we see the pregnant women and under five children (with their mothers) from 6-8 hamlets.

The venue of the clinics are usually some houses or dilapidated VDC gharsor Government primary schools, with broken floors and leaking roofs. These camps are considered to be like a mela/ festival, by the local people, which they look forward to. In some villages the school children become very active, showing their enthusiasm by arranging the area for the clinic, sweeping, spreading mats, setting up a cooking area for preparing nutritious snacks and lunch, putting up the banner. The swasthyasathi also helps with cleaning the room for examination of pregnant women etc. If by chance the boiled eggs get over and do not reach the last children waiting to be seen by the team, the parents would take the children away without being examined or blood tests done. For the children it is the egg what matters most, not medicines. The members of the health team are kept busy till the end of the clinic, after which they are able to have something to eat or drink.

The rationale of these camps is that the tribal population do not perceive the need for antenatal care, because of their ignorance and also the lack of this service till now. The pregnant women will not come to health centres, walking all the way for something which they do not see as their need. For them, childbirth is a natural phenomenon and they want it at home. Some die in the process – both mothers and the new born children – but the majority survive. In this scenario, SwasthyaSwaraj introduced the Antenatal - Under-five clinics targeting the most vulnerable groups, living in hard-to-reach locations, by reaching out to them.

These clinics are not run as the regular mobile clinics. The whole team from each health centre goes to these weekly clinics - the doctor, nurses, lab technicians, support staff, field staff and the driver, who also helps with weighing children or cooking etc. Every mother and under-five child gets their weight and height taken, the growth chart filled out, blood tested for haemoglobin levels and malaria, urine tested for sugar and albumin. The pregnant women are examined in detail by the nurse, and then the patient is seen by the doctor with all reports and the nurse's notings. Medicines are prescribed and dispensed. A nutritious lunch is provided. The mother is provided with nutritional supplements to take home. We strongly believe that food is of equal importance to medicines for pregnant mothers. In addition to take home nutrition supplements, if a pregnant mother comes for a fourth antenatal visit, she gets an additional incentive in the form of a steel plate, katora etc.! Dr Aquinas often says "the antenatal care is our need, not their need; for this to be recognized as their need it will take time. Till that time we have to persist in going to them".

Malaria in pregnancy is a harbinger of maternal mortality in this area. It causes anaemia (which does not respond to iron supplements), still births, abortions, preterm and low birth weight babies. With consistent efforts the incidence of malaria in pregnancy has been brought down very much now.

In all these ANC – U5 clinics, health education is an integral part which is given by the DCHP students.

In 2019-20 there was a reduction in the number of ANC-U5 clinics due to shortage of funds. When we planned to restart these clinics from April 2020, the covid-19 epidemic and the lockdown started, due to which these activities had to be stopped. During the lockdown period we confined ourselves to both health centres, in Kaniguma and Kerpai.

In June we decided to restart the clinics only for antenatal women, and avoid crowding and large groups of people. We announced the dates for the ANC clinics for the different sub-clusters and started the camps from June in a low key manner. Only pregnant women were called.

Restarting the clinics :

We were all happy and welcomed the idea of re-starting the ANC clinics. But when we restarted the clinics in different sub-clusters in Kerpai there was a shock waiting for us:

Almost 90% of the women had haemoglobin levels less than 10 gm%. 23% had severe anaemia with haemoglobin levels less than 7 gm%. Those with severe anaemia required iron sucrose infusion. In each clinic we had to put the patient on the floor and tie the infusion bottles on window bars. But we were sorry that we could not provide the second and third dose of iron sucrose for those who needed it. In these cases we had to rely on oral iron tablets twice daily which they may or may not take.

The antenatal women who were seen before the lockdown started, showed poor weight gain, indicating the forthcoming birth of low birth-weight babies.

These focused ANC clinics are not a mela. There are no under-5 children. This is to observe the current norms of social distancing in the covid-19 epidemic. We have not yet covered all the sub-clusters as the monsoon started early and in full swing. Some areas have already become inaccessible.

Chanchala Majhi & Kerpai cluster team.

My Tuber Nursery

In Swasthya Swaraj, a regular topic for discussion in which I participate is on how to root out the hunger and malnutrition in this area. I got inspired in 2018 when Swasthya Swaraj started the Hunger Alleviation programme. One main activity of this programme was propagating tuber cultivation in the villages. We distributed yam to more than 260 households in that year. In 2019 we procured sweet potato. We could procure just enough of this for 200 families, but the demand was much higher. It was Dr Vasu, during one of her visits, who suggested the idea of starting a tuber nursery.

The happiness of the people when they see tubers and the high demand for it prompted me to start a tuber nursery in our own premises. I have heard from the elders in Kerala that what protected the people there from famine and prevented malnutrition even during the worst of times was tapioca. This tuber was introduced in Kerala to take care of people's nutrition. Of course they eat it with fish or meat, which compensates for the lack of protein in the tuber. It is an open secret that Keralites love tapioca wherever they are (known there as kappa).

Swasthya Swaraj does not own any land, unlike other NGOs. So what can be done? I decided to make use of the small patch of land in the Kerpai health centre which was lying barren. All the clinic staff and field staff together cleared the area and we started with onion and garlic first. We then planted sweet potato vines. This was a tremendous experience for all of us. But protecting the crop from goats and cows was the main headache. All fencing were broken by animals who graze freely. Finally this too was taken care of by strong, cost-effective fencing.

The whole process of growing tubers is an unlearning, learning and re-learning process for me. In this area of PVTG (Particularly Vulnerable Tribal Groups) tribals, people make use of simple technology and simple division of labour, often limited to their immediate family. Their land holdings are small, lack irrigation facilities, and the terrain is hilly. They still practice what is called 'shifting cultivation' or 'podu chasa', also known as 'slash and burn'. They select a plot of land, generally on a mountain slope, cut down all the trees and bushes. They burn them to ashes, and then spread the ashes evenly over the land. Then they wait for the rain before planting their crops.

The Kondh tribals like kondha (tuber) very much. When they see the kondha, their faces beam with joy - both young and old. This is because they are very attached to nature – even their names say that. Some of their names are - chaval dei, am dei, dhan dei, chilika dei. Mother Earth is their goddess.

My experiences with growing tubers gave me so much happiness and satisfaction because it was a diversion for me from routine laboratory work. I was practicing a little of what I knew. What I am now learning is a lot from the tribals and from other sources like the Internet. Finally when the nursery was complete and the crops started yielding, it became a centre of attraction not only for the village, but also for the patients, the children and for the women especially. Different kinds of tubers are planted here sweet potatos, different yams, Chinese potatos, tapioca, and many different local varieties of tubers. I learned how to grow onion, garlic, ranikondha, nokalkondha etc. by different methods. It was a very enriching experience, giving much satisfaction to all the staff at the Kerpai health centre, and to the field staff.

There are numerous NGOs distributing seedlings and seeds to people. We provide these from our nursery only on demand. We are delighted to see the village women come to us for the tubers. They dig them up, or take seedlings of sweet potato and other kondha varieties with so much happiness and enthusiasm. In gratitude they give us a little cowdung and this replenishes the soil of my small tuber nursery.

I thank Mrs. Madhu Bhaduri for her support and encouragement which boosted my morale.

Angelina Didi

Community Health Practitioner girls speak ...

As we finish the two year DCHP (Diploma in Community Health Practice) course in SwasthyaSwaraj, we would like to look back at the past two years, as well as look ahead to the future. We would like to recall our past experiences first.

At the beginning of the course in August 2018 at Kaniguma, the course was inaugurated by Prof Dr Haribandhu Panda, the vice chancellor of Centurion University. We were all anxious as we were stepping into the unknown. Our biggest fear was the English language. Even though we had English coaching by Dr. Simon Coelho from Shillong and he eased our fears to some extent, we continued to struggle and even decided to discontinue the course.

In the 1st semester we did not like the subjects and found them difficult to learn- sociology, anthropology, epidemiology, understanding the community, public health etc. At the end of the 1st semester we were sent for a Tribal Leadership training in Bastar in Chattisgarh which was a turning point for us. There was a mingling of youth from many different tribal cultures, different talents, different languages - Hindi, Odiya, Chattisgarhi, English etc. We thought to ourselves about why we hesitate to learn English, which will build up our confidence? We changed our minds and so decided to stay on and continue the course.

In the 2nd semester, we started with clinical subjects and so could connect with people and diseases. We learned about human anatomy and physiology, communicable diseases, non-communicable diseases, emergency medicine, nursing procedures, pharmacology, microbiology etc. In the same semester our project was on Tuberculosis – which was a small dissertation on TB, assisted by Dr Randall.

In the 3rd semester it was all about antenatal care, post-natal care, child birth, adolescent health, Nutrition etc. We went to JSS at Bilaspur for experience for one week and then for two weeks to the Shaheed Hospital in Durg, Chattisgarh. In Shaheed Hospital, each one of us had to conduct 10 deliveries and monitor the patients in labour. We became confident in antenatal care, postnatal care, conducting deliveries, newborn care, sterile techniques, emergency care, dealing with patients and with other staff.

In the 4th semester it was again packed with newborn care, diseases of under-five children, ophthalmology, ENT, oral medicine, mental health, geriatrics, family planning, immunization etc. We had an exposure visit to the Nutritional Rehabilitation Centre (NRC) at the District Hospital in Bhawanipatna, for one week. We learned there how to manage the children with SAM, prepare their food, monitor them etc. We were also posted at the local anganwadis where we gave pre-school education to the children, in addition to caring for them and understanding the work of the anganwadi. We did a project on “Health issues of the elderly in tribal communities” assisted by Ashmadidi from Chennai.

We remember all our teachers in gratitude. Drs Sudhakar Reddy &Sangeeta Sharma who supported us so much, Drs Sandeep, Ajay, Vasu, Ashish Barbde, Randall, Abiel, and Sachin. We owe a lot to Sr. Madhu from JSS who trained us intensively, Christina, Ashma and Durga sir. Sr. Rani came towards the end and spent time with us, always accompanying us and teaching us again and again. We also are grateful to all the staff in Kaniguma and Kerpai who always supported and encouraged us.

Our course DCHP is different in many ways from the ANM and GNM courses. We are almost trained as chota doctors to provide primary healthcare in the communities. Our curriculum is much more vast, covering many topics and helping us to gain deeper knowledge and competence.

Looking ahead:

Now that we have completed the course, we are starting the 6 months internship in the health centres where again we are expected to pick up many skills related to work and life.

We look forward to staying in the tribal communities and working with them. Those people who are deprived of access to healthcare, for whom healthcare is essential – we hope to help them. Health education and healthcare are essential in our area. Preventing early marriage, improving the literacy of the mothers, improving nutrition, development of the tribal communities, education of children are all challenges awaiting us and have to be addressed if health of the people has to be improved. This course has helped us to open our eyes and understand the realities. We feel that this course needs to be promoted in the tribal areas and is a great need.

We thank Dr Aquinas didi who made it possible for us to do this course.

Napa Majhi, Chandni Majhi, Jananti Majhi, Sarojini Majhi, Anjana Majhi, Basanti Majhi

Thank You !

As covid pandemic wreaks havoc everywhere and widens the already existing gap of inequity in health, our work becomes more challenging . We keep striving to improve the quality of life of the poorest. Our work will be complete only when SWARAJ becomes a reality for these communities.
We are immensely grateful to you for your support and contributions which enable us to do the work we are doing here with enthusiasm.

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SWASTHYA SWARAJ COMPREHENSIVE COMMUNITY HEALTH PROGRAMME
Admin Office : 2/306, Nuapada, P.O. Bhawanipatna - 766001, Kalahandi district, Odisha, India
Tel. 06670-230162, Mob. 7326874618
Email : swasthyaswaraj@gmail.com, Website : www.swasthyaswaraj.org

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