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SWASTHYA SWARAJ NEWSLETTER

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Month of mixed feelings

EDITOR: DAANISH SINGH BINDRA

With the onset of the monsoon, our field areas are more beautiful than ever, with lush green rolling hills that extend till the horizon, and millions of fireflies that light up the nights.

While the area has bloomed, the life of the tribal individual has entered a period of withering due to the severe deterioration of network and transportation facilities. Malaria cases are at its highest, and even the smallest of infections develop into fatal conditions, which are often unattended as movement is restricted. However, life goes on. Every day, in pouring showers and prickling winds, the community continues to cultivate for survival, ironically praying that the rains don't fail the most essential harvest of the year.

The upcoming months can be marked as hardest for the community to endure, and to add to the helplessness, Swasthya Swaraj's activities also stagnate as rivers flood and cut complete access to the least developed.

Gaon Swasthya Poshana Gharo- (Village Health & Nutrition Centre)

WRITTEN BY DR. AQUINAS EDASSERY

Although the National Health Policies accord high priority to extending organized services to those residing in the tribal, hilly and backward areas as well as to the detection and treatment of endemic diseases affecting tribals, yet they continue to be one of the fragile population, mainly due to their poor health and disease management. Tribal health is one of the important areas for action in the health sector.

Tribal communities often carry a high load of communicable diseases, with a generally poor nutritional status which is ubiquitous spanning across all age groups. 30% malaria-related mortality is among tribal people, TB is 3 times more prevalent among them as compared to general population, 20% of under-fives are Severe acute malnutrition. Diarrhoeal outbreaks do occur due to lack of safe drinking water supply. Mortality rates are high. Immunization coverage is appalling. Clearly, tribal health demands urgent and primary attention.

However there is a huge gap between the demand and the availability of human resources in healthcare in tribal areas. The complex health problems of tribals cannot be managed by ASHA and ANM alone. The unwillingness of health care professionals to serve in these areas is well known, and directly translates into a lack of visits by the non-tribal ASHA, ANM and Anganwadi workers. Traditional tribal faith healers (referred to as Guru Guniyas) are the first port of call for almost 84% of tribals in illness, which is partly due to culture and partly due to lack of other viable options. Only when they are very sick, and have no other options, they seek modern healthcare.

Accessibility to health facilities is an important determinant of health. In tribal areas especially where particularly vulnerable tribals live even six kilometers can be equated with more than sixty kilometers in developed areas due to a difficult geographic terrain, lack of road connectivity, and poor transportation and communication facilities. A sick person may not walk 6 km to access healthcare and when a mother is carrying sick child this distance may be reduced to 3 km.

Revitalization of primary health care in tribal areas, thus, calls for an urgent need to review of the healthcare delivery model and a new cadre of healthcare workforce especially at the community level. The new approach to tribal health we propose, will ensure that the workforce understands the current health challenges in tribal areas and is competent to work with the people and community.

In order to improve the health and nutrition status of the marginalized tribal population:

a) Sub-centres have to be closer to people which will improve access to healthcare- one subcentre for a population of 1000 or 2000 population (Tribal Health Report 2018)

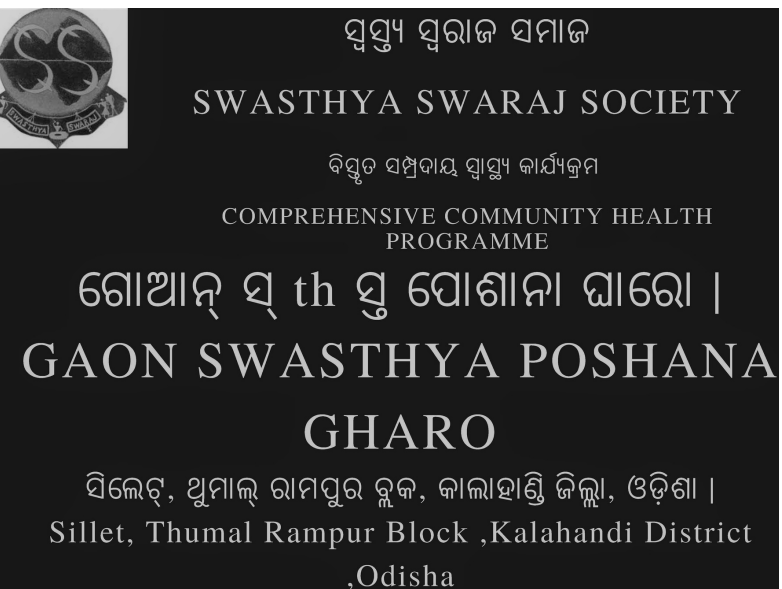
b) Facilities have to be designed in a tribal-friendly and tribal-specific manner which will improve the utilization of the healthcare services.

c) Sub-centres should be manned by health workforce trained in tribal healthcare practices and equipped with wide range of knowledge, skills and competencies (preferably trained tribal women).

Can we reduce/lessen the gap of inequity through tribal-specific GSPGs (Gaon Swasthya Poshana Gharos/Village Health & Nutrition Centres) run by well trained midlevel health professionals from the tribal community?

GSPG/tribal-specific mini Health & wellness centre, is the Swasthya Swaraj initiative to close the wide gaps in hard to access tribal areas. It aims at bringing comprehensive primary healthcare closer to people living in hard to reach locations and envisions addressing the crucial health issues in tribal areas and its determinants. It is set up with people's participation, support and co-operation. Such a structure has the potential to address the barriers to healthcare and lessen the impediments to its accessibility.

GSPG team consist of 4 full time staff members- one senior nurse and two trained mid level health workers (community nurses) and one male health worker. One doctor from Swasthya Swaraj health centres will visit GSPGs once a week and if-needed more times for supportive supervision and on the job skill enhancement.



Expected outcome:

- Improved health literacy index (HLI) of the community.
- >90% immunization coverage.
- Reduced Neonatal mortality, Infant mortality, under-five mortality and 0 maternal deaths.
- No of institutional deliveries/ by SBAs increased to 80% from 25%
- No of SAM children in the cluster reduced to 1% from 15%
- Improved mutual cooperation between tribal Shamans and GSPG healthcare team.
- Better functioning of ICDS with preschool education in the Anganwadis and in all the hamlets.
- Regular school health programs, health education in the schools and supervision of school mid day meal program.
- Close follow up of TB patients and contact tracing
- Regular VHND and GKS meetings.

GSPG is a cost effective intervention where people's participation is ensured. It is tribal-friendly and manned by trained tribal youth and provides comprehensive primary healthcare. These GSPGs are expected to improve the health and nutrition status of the tribal population. GSPGs can be further scaled and used as a tool to advocate for policy changes in tribal health.

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Our first day experience in the GSPG

WRITTEN BY ANJANA MAJHI,CHANCHALA MAJHI AND CHANDNI MAJHI.

On June 30th, we 3 travelled from Kerpai and came to Silet to start the Gaon Swasthya Poshana Gharo (GSPG) in the Thar jeep, driving through roadless mountain tracks and streams. The jeep was full of things loaded from Kerpai health centre to Silet. As soon as we reached Silet, after the tiresome journey, we wanted to freshen up and organize the things loaded in the jeep. Before we could do that, patients started coming. People from Marguma village came to call us to manage a serious patient. To reach Marguma we had to cross the river. Two of us immediately carried the emergency bag and went there leaving one at home to do some cooking. It was a case of acute gastroenteritis with severe dehydration. Already two had died in the village in the past one week due to fever, they said. After we managed the case successfully, on the way back there was another distress call- home delivery , but placenta was retained. This too was managed successfully. And then coming back to our new GSPG which is an ordinary tribal house in the midst of many houses, there were lot of patients waiting – all with fever, cough, headache etc. We did RDT (rapid diagnostic test) for all the fever cases and that day itself 16 cases of malaria was detected! Overall during the month of July we detected 60 cases of malaria of which 98% is plasmodium falciparum and 2% vivax malaria.

Yes, malaria is back with vengence. We are readying ourselves to restart the battle against malaria in full swing. We are excited that we are able to touch and heal so many of our sisters and brothers in this remote area.

Education for change

WRITTEN BY DAANISH SINGH BINDRA

Imagine that you are a child living in a small mud house in a green valley, with lush farms on rolling hills that extend till the horizon. Your family is mostly engaged in agriculture, growing rice and corn, and a good harvest can ensure enough food for surviving the upcoming months. Your community harbors a rich cultural life, with rituals and festivals that occur on a monthly basis. Some of your adventurous family members have even migrated to various parts of the country, hoping to find work and escape poverty as they see it. Most of the day you are engaged in farming, handpicking fruits and vegetables, or take care of the livestock that your village owns. There is a school in your village, but no teacher comes there for more than a week in any given month. With no real examples of the difference education can make to the life of someone in your community, would you have any motivation of going to school?

These were some of my thoughts when we started to plan a project on education that I would lead. Swasthya Swaraj, in previous years, had already tried to work on education, however due to lack of regularity and effectiveness, nothing sustained for the long term. For example, the organization had formed school committees in all the villages, and had also taken summer camps and teacher trainings, but due to many factors including COVID, the committees were soon forgotten, and the progress with children and teachers went back to square one.

This time however, we decided to focus on one school, to at least form an example to be followed and to also ensure regularity. Also, as the organization doesn't really have the human resources for actually educating the children, we decided to strengthen the existing government schools, by starting a School Sensitization Program (SSP). The primary aim of the program is to sensitize children to the concept of school and literacy, such that there is a higher enrollment rate and subsequently, more attendance by the teachers. Furthermore, we wanted to reach those children who had never enrolled or who had dropped out, with special attention to girls. The plan was to start slow, by first starting with short sessions, playing games or doing hands on activities that would make the children more comfortable with outsiders, and to also develop concepts of teamwork and trust. Then, we could start work on basic literacy and arithmetic based on child-centric localized educational tools, and with the help of our field staff, integrate local culture and knowledge that could be enriching for the children's development.

It has been more than a month since I started working on the program, and the experience to this point has been extremely insightful. The starting was challenging. Without knowing any Odia, going to the village and conducting sessions for children who belonged to a very different culture from mine was frankly pretty scary in the beginning. So many thoughts flooded my head. Was I being disrespectful in any way? Are they even understanding anything that I am saying? Over that, calling children from dispersed hamlets, or sometimes even from mango groves far from the village was taxing a number of times. However, over time, the children got comfortable with me, and more importantly got used to my presence. Not every child in the village came each day that I went, but I can call out a number of children who have been along with me for the entire ride, attending every session, and I see that as an accomplishment.

When we started the project, we knew that we might have to change parts of the plan as time progressed, as we had no prior knowledge about the state of education in the villages. On interacting with the children, one of the prior assumptions that is challenged, that many teachers have brought up in the region, is that the children don't have the motivation to come to school. With frequent visits to the school, I have noticed that there is some implicit motivation in the children and the parents for education, even though I cannot really pinpoint the main driver. If called, almost all the children are ready to attend the sessions, and I can only imagine it being more effective if the facilitator knew Odia. The children do not need to be pushed to come to school, they just need some sort of regularity, which will maintain their interest and will make the parents feel like there is something worthwhile happening in the few hours that the children cannot attend work. This means that the onus of the work is in in the hands of the teachers, who should attend regularly and be determined to make a change. While these tasks might sound like an essential duty for all the teachers, which cannot even come into question in a developed region, the area that we work in adds a lot of factors that makes public systems extremely difficult. While it is important to see through the eyes of the people we are trying to empower, let's imagine that we are a teacher that has been appointed to work in one of the most backward areas in the country. First of all, you are not local, and live at least 100 kilometers away. This means that you have no connection to the culture or the local language that the children speak. Above that, the school is not maintained at all. The toilets are broken, the roof leaks and there is not even a bed for you to sleep on. There is no network, and the transportation facilities are extremely poor. You have to be extremely motivated to be effective in this environment, and that is not something that we can expect from everybody. This puts us in a paradox that seemingly has no escape. We quote education to be the primary medium of change, however a lot of things have to change before that force can kick into action.

Lockdown or Locked down

WRITTEN BY DR. VANSHIKA GUPTA

The COVID-19 pandemic has not only wreaked havoc in the world, resulting in rising mortality and morbidity for millions, but has also exposed the weak public health infrastructure. The pandemic has shed light on how grossly inadequate our public health system has been both in the measure of quality and quantity. It has been observed time and again, that the lower economic classes spend a significant amount of their limited finances on healthcare, often resulting in delayed medical treatments. This can be attributed to the lack of public health infrastructure, which makes it inadequate to meet the demands of the people. The situation is amplified for those belonging to a rural tribal area who have limited means of finances, education, and are unaware of their basic rights. This piece majorly talks about the challenges faced by people seeking health care from the tribal areas of Kalahandi district, Orissa.

Lakhmi Majhi belongs to the interior areas of Rampur Block. Her family had a bike hence the transportation was not an issue for her. When asked if she was able to access health facilities during the national lockdown, she stated that it was not possible to come to the Swasthya Swaraj health centre in Kaniguma, because the Block borders were closed and were frequently patrolled by the police. To add to that, double seating on two wheelers was fined, rendering healthcare inaccessible to them. When asked why she did not search for healthcare alternatives in her own area, she stated that she had been undergoing treatment for Thyroid at the Kaniguma centre for the past two years. Also, the facilities in her area are inadequate. Lakhmi belonged to one of the more developed households in the district, however due to the extended lockdowns in the country, primary healthcare was made inaccessible for the likes of her too.

Jana Ram Majhi, a resident of Dhamanguda, Gopalpur, stated that the rising petrol prices, which varied between Rs130- Rs 140 in his area, was the biggest factor restricting his family from accessing health facilities. On questioning Jana about why he had to pay extra above the current official price of petrol (approximately Rs 100), it came to light that he had bought petrol from shops which did not only sell petrol at a higher price, but also adulterated it with kerosene to cut costs. A similar experience was shared by a lady suffering from Rheumatoid Arthritis making her every movement painful, who stated that she had to pay 300 rupees just for a seat on a bike that got her to the clinic. She and her husband had no access to a vehicle and were forced to pay Rs 600 for a single trip to Kaniguma, which, would have costed less than Rs 100 if they could use public transport. These instances make it clear why people in this region are forced to delay health-seeking, a situation that has further deteriorated during the lockdown.

Senapati Naik, along with his relatives, brought his ailing father to the clinic from Dalguma village. He hired a Jeep for Rs.1300 as his father was in no condition to travel on a bike. They had already sold a part of their land to pay for the various expenses related to the disease, even though the treatment was free in the centre run by Swasthya Swaraj. They stated that Senapati's father's health had deteriorated during the lockdown itself, but they avoided any treatment due to lack of money, as the earning members of the family had been unemployed for most of the year.

The stories shared by Senapati, Lakhmi and Jana Ram are not isolated cases but rather a norm in these areas. It is just a scratch on the surface which none of us are daring to explore further. A lot of similar experiences were shared regarding delayed access to healthcare, however, distress due to being locked down during extended lockdowns, with no access to public transportation was shared by most.

Although transportation is not a part of medical treatment, development in that area is an important stepping-stone for the most underprivileged to access healthcare. Being locked down at homes with no transportation facilities can set a chain reaction of delayed care seeking, resulting in unmet health care needs and the exacerbation of the existing illness leading to a rise in mortality and morbidity. This holds particularly true for PVTG (Particularly Vulnerable Tribal Groups) as for them transportation costs are a significant deterrent form accessing good quality and timely healthcare.

IN OTHER NEWS...

TRIBAL HEALTH FELLOWSHIP: A NEW INITIATIVE BY SWASTHYA SWARAJ OPENED FROM JULY 1. 3 YOUNG ENTHUSIASTIC DOCTORS FROM DIFFERENT PARTS OF THE COUNTRY HAVE BEEN SELECTED. THEY ARE EXPECTED TO JOIN IN THE COMING FEW MONTHS.

SWASTHYA SWARAJ
Tribal Health Fellowship

Azim Premji Foundation

TRUENAT DIAGNOSTIC SYSTEM AND ACCESSORIES (FOR COVID AND TB TESTING) DONATED BY AZIM PREMJI FOUNDATION (APF) ADDS TO THE QUALITY OF HIGH QUALITY DIAGNOSTIC SERVICES SWASTHYA SWARAJ IS PROVIDING IN AN UNDERSERVED AREA. THANK YOU, APF TEAM.

THE EDUCATION PROGRAMME IS RESTARTED AGAIN BY SWASTHYA SWARAJ IN JULY 2021 AFTER A LONG BREAK. THIS PROGRAMME TARGETS 14 GOVT PRIMARY SCHOOLS IN KERPAI & SILET GRAM PANCHAYATS, TRYING TO MAKE THEM FUNCTIONAL AND MAKE CHILDREN AND TEACHERS TO ATTEND THE SCHOOLS. WE AWAIT TO HEAR ABOUT THE INTERVENTIONS FROM ANANYA PANDA AND PINKI BURMAN IN THE NEXT ISSUE.

MOBILE COVID TESTING UNIT OF SWASTHYA SWARAJ (WITH THE SUPPORT FROM SELCO FOUNDATION) GOES FROM VILLAGE TO VILLAGE IN TH RAMPUR BLOCK AND TESTS THE COVID SUSPECT CASES AND MAKES USE OF THIS OPPORTUNITY TO CREATE AWARENESS ON COVID VACCINATION AND REMOVE THEIR VACCINE FEARS; INCIDENTALLY THE TEAM TESTS THE SYMPTOMATICS FOR MALARIA TOO IN FAR FLUNG VILLAGES IN THIS PEAK SEASON. SO FAR 11 GRAM PANCHAYATS HAVE BEEN COVERED BY THE TEAM.

NEW PRE-FAB BUILDING FOR THE SCHOOL OF COMMUNITY HEALTH SCIENCE & PRACTICE OF SWASTHYA SWARAJ IN KANIGUMA. THE NEW SCHOOL BUILDING IS MADE OF BOARDS OF RECYCLED PLASTIC AND LOOKS GOOD, SPACIOUS, WELL VENTILATED, FRIENDLY AND IS IN THE MIDDLE OF AN ORCHARD. SWASTHYA SWARAJ SINCERELY THANKS ANTODAYA CHAIRMAN MR DILIP DAS FOR ALLOWING US TO CONSTRUCT AND RUN THIS TRAINING CENTRE IN THE ANTODAYA CAMPUS AND SUPPORTING US.

Gandhi's Talisman

"Whenever you are in doubt, or when the self becomes too much with you, apply the following test. Recall the face of the poorest and the weakest man [woman] whom you may have seen, and ask yourself, if the step you contemplate is going to be of any use to him [her]. Will he [she] gain anything by it? Will it restore him [her] to a control over his [her] own life and destiny? In other words, will it lead to swaraj [freedom] for the hungry and spiritually starving millions? Then you will find your doubts and your self melt away."

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