Hormo Jivi Bhalai Pontha

(Towards Better Health and Life)

A Report on the People's Health Initiative by the Adivasis of Jharkhand

Supported by
The Pratichi (India) Trust
and
The Ayo-Aidari Trust

Introduction

The Pratichi (India) Trust sponsored and took part in a research-based public-action initiative in the area of public health, based in seven remote villages of the Gopikandar block in Dumka, a part of the newly-formed Indian state of Jharkhand. The project fulfilled the following goals:

- Setting up a free public health centre in a publicly unserved area.
- Establishing a supportive network with the closest public health facilities
- Building the capacity of local people to independently determine their needs, identify public resources to fulfil them, and assert their right to avail themselves of these resources
- Helping people remove themselves from the expensive private health options administered locally by quacks.

In this endeavour, the Pratichi (India) Trust was supported by the Asia Development Research Institute (ADRI) in Patna. The following is a report that encapsulates the story of the project: its history, its functioning, and its success.

A Meeting at the Village

The Project

The name, *Hormo Jivi Bhalai Pontha* (Towards Better Health and Life), was decided in the course of a five-hour deliberative discussion with Santhal and Pahariya villagers from the Dumka district. It was the last preparatory meeting in a series of six, aimed at building a people's health initiative in the region. The focus-area consisted of seven villages in the Gopikandar block of Dumka, which is one of Jharkhand's easternmost district, sharing border with western West Bengal. The seven villages are:

- Silingi Pahar
- Khatangi
- Kharikasol
- Mahaldabar
- Kundapahari
- Chirudih
- Chunjo

The concept of a people's health initiative had its roots in two local research projects undertaken by the Pratichi research team. Both projects concluded that poor delivery of public health were related to the poverty, ill health and sociopolitical powerlessness that pervades local populations.

In organising the discussion series, we received the active participation of local people, as well as those from beyond these seven villages. Organisationally, we are grateful to the valuable fieldwork support provided by the Ayo Aidari Trust (AAT), a Santhal women's organisation that has been active in the area since 1998. The research findings, our researchers' field experiences, and finally the conversations we had with the local people during the discussion series have shaped our public action in, and recommendations for, this region. This report briefly highlights the lessons and achievements of the meetings, which had become a repository for local needs and desires, and the root-platform for social change.

The Place and Its People

The newly formed state of Jharkhand (formalised November, 2000) is, for complex political and historical reasons, one of the least developed in the country. And while the district of Dumka fares badly when compared even to the low state-statistics of Jharkhand, conditions in the seven villages are worse.

One of the biggest problem in the delivery of public services is the difficulty of access. The villages are located on the Ramgarh range of the Rajmahal hills, and are surrounded by dense forests. The area is approximately 16 kilometres west of the state highway connecting Dumka and Pakur on difficult terrain, with no public transport connecting the two. The Primary Health Centre is 26 kilometres away from the villages, and there are no local alternatives.

The population consists mostly of adivasis – primarily Santhals and some Mal Pahariyas. The local economy is sustained by seasonal agriculture and gathering from the forests, neither of which provide requisite amounts of nutrition to the inhabitants. Poverty and hunger are pervasive.

The literacy rate is 25 per cent, and female literacy rate is at 16 per cent.

Table 1 and 1A show some of the major socio-economic indicators of the area (Gopikandar block), comparing them with the data at the cumulative district level (Dumka).

Table 1: Population and Literacy

Name	Total Household	TOT Population	% of SC to total population	%ST to total population	Litercay rate (%)	Female Literacy rate (%)
Dumka	331318	1759602	7.3	39.9	47.9	32.4
Gopikandar	7703	35541	2.0	85.3	36.5	23.6
Area of intervention	376	1786	0.0	94.3	24.9	16.1

Table 1A: Labour Patterns

Name	% of main workers to total workers	% of cultivators to main workers	% of agricult. workers to main workers	% marginal workers to total workers	% cultivators to marginal workers	% agricult. workers to marginal workers
Dumka	60.4	52.5	23.2	39.6	39.0	52.1
Gopikandar	58.3	77.4	10.5	41.7	56.2	32.8
Area of intervention	55.1	79.7	4.1	44.9	20.8	79.0

Public Participation: The Discussion Series

Initial interactions between Pratichi (India) Trust and ADRI were built on the sense of urgency shared by both organisations to plan an effective intervention to address the gaping chasms of public health delivery to these villages. There was a public discussion each month for six months, to ensure that the intervention did in fact address those problems that were felt locally, and not arrived at by non-resident experts. By the conclusion of the sixth meeting, the community had approved and welcomed the idea of a health centre spearheading the health intervention movement. They chose the village of Kundapahari, which lies at the centre of the seven-village cluster, as the location for this first centre.

The progress of the village meeting were educative in themselves The initial meetings were only attended by local women's groups organised by AAT. Other women and all men were indifferent. Others were suspicious of intervention projects that actually sought contributions from 'beneficiaries', and chose to watch from a distance at first. Gradually, however, as the community began talking about the

discussions at these meetings, greater numbers of people started coming to them, finally convinced that their voices were being heard.

The meetings sought opinions and discussions on the following major points:

- Current situation:
  - The general conditions of health
  - How each ailments affected their lives and livelihood
  - Status of the government health delivery system
  - Current health services they depended on
- Intervention and policy recommendation:
  - What sort of delivery did they expect from the health centre
  - How could the people take constructive and effective part in the initiative
  - How could the government health system be made functional
  - What other issues should the initiative incorporate?

Public Action: The Health Centre

After choosing a house in Kundapahari to house the health centre, effecting such repairs and construction as was needed and stocking it with medical necessities, the field team collated data collected from household level survey on health ailments, immunisation status, health expenditure, outstanding loans, schooling details of the children. This helped determine the largest threats, and prioritise their treatment.

Four people were chosen to run the centre – two health workers, and their two assistants. The health workers were sponsored for a six-month training course at the Shramjeevi Hospital at Howrah, West Bengal, and local administration and medical personnel were requested to volunteer their help as and when they could. The chief duties of the health workers and their assistants were:

- Providing curative services to those suffering from fever, colds, accidental or occupational pain, and headaches.
- Creating awareness amongst locals, especially mothers, about first signs of serious ailments, and getting immediate referrals to the Public Health Centre (PHC) or District Hospital (DH).
- Interacting with the local ANM and PHC to ensure immunisation and delivery of care.
- Accompanying those patients who felt unable to navigate the way to the PHC or DH on their own.
- Spearheading public mobilisation movement to demand a local government health centre in the area.
- Work with the local government primary schools and ICDS centres to ensure better, mutually inclusive functioning of the health and education structures in the area.
- Help launch and aid an anti-alcoholism campaign in the area, at the request of the local people.

The centre was inaugurated on January 28, 2004, by Munni Hembrom, Secretary of the ATT. The event was attended by nearly all villagers, members of the Pratichi (India) Trust's team, and the ATT.

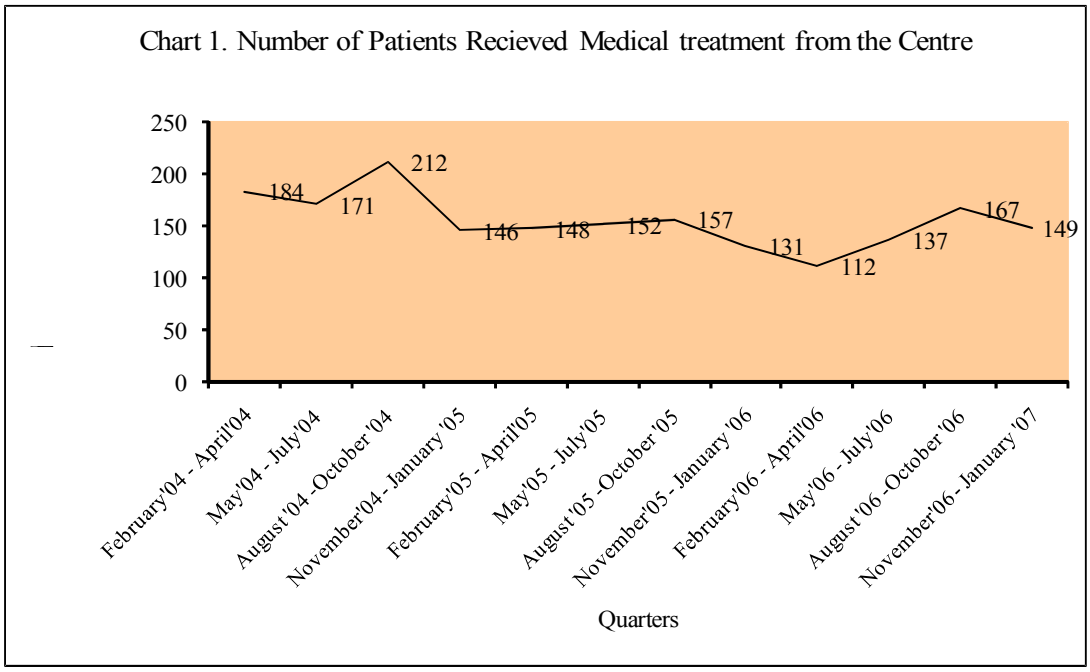
How It Works: The Health Centre in Action

The four workers divide their time between the centre, the villages, and at government health centres and administrative offices.

At the Centre

Mornings begin with check-ups for visitors, and either giving the required medication or referring them to the PHC or DH, as the case may be. Initially, several villagers needed or wanted their presence when they visited the unfamiliar PHC or DH, but over the years they have become confident enough to navigate these newly-familiar spaces on their own.

Immediately after the launching of the project the health workers and AAT members met the Deputy Commissioner (DC) of Dumka to seek his help in arranging for regular visits by government doctors to the centre, so that the centre could offer more emergency care. They also asked for occasional supplies of free medicine. Both requests were acceded to.



Currently, a doctor from Gopikandar PHC visits the centre once a week, and it has been supplied with pre-emptive medical tools like Chloroquine and Mebendazole, iron folic supplements for pregnant women, and disinfectants to purify ground-water from drinking wells.

In the last three of operation, the centre has treated 866 patients. The break up of the numbers of patients in the 12 quarters is shown in Chart 1.

The centre has also referred 151 cases to government health centres and hospitals. Table 2 below shows a gradual increase in the number of cases referred. This reflects the principle of the initiative of making public services – to which citizens have a right – more effective, instead of replacing them.

Table 2. Cases Referred to Government Hospitals

Year	Cases Referred to and treated at the government hospital
2004-5	41
2005-6	45
2006-7	66
Total	151

Initially, the villagers were reluctant to take their family or friends to government facilities. Their lack of access to public health centres and hospitals, and the government's indifference to providing it, had built a strong feeling of suspicion and distrust of public services. The weekly visit by the government doctor at the centre – unthinkable even a year ago – helped lessen this feeling of deliberate exclusion, though government services will have to work harder for wider acceptance. Friends or neighbours of the patient accompanying health workers to PHCs and DHs to pick up medicines or drop off test samples have also helped build a social connection between these institutions and the village people.

In the Villages

After the morning of visiting patients, the health workers start on their village rounds, either attending health awareness meetings or performing the periodic check-ups and documenting the results.

The health awareness meetings attempt to emphasise prevention. They recommend:

- Use of mosquito net to prevent malaria
- Immunisation of the children and pregnant mothers;
- Prenatal and antenatal care of the mothers;
- Clean drinking water
- Use of ORS during the occurrences of diarrhoea;
- Sending the children to the schools or ICDS centres on a regular basis;
- Stop drinking regularly and in large quantities, as happens frequently in these areas.

Building Contact with Government Departments

Apart from running the clinic and carrying out the health awareness meetings in the villages, the workers visit PHCs, the Block Development Officer, DH, and other offices when necessary. The purpose of the visit includes taking the patients to the government health centres, registering complaints against the poor functioning of the local health sub-centre, ICDS centres and primary school, asking for assistance in terms of medicines, disinfecting agents, and so on. During these interactions with the government offices, the health workers were accompanied by some of the villagers. Through this course a direct linkage between the government departments and the villagers was established. Later on the villagers started going to the offices independently.

Also it was through these interactions the area was frequently visited by the government officials including the Deputy Commissioner of Dumka and resulted in organising health fair (*swasth mela),* distributing mosquito nets among the households, and resuming of the regular government health interventions, such as free immunisation programmes.

Major Impacts of the Public Action

- **Drastic fall in malaria**
- **Increased level of health and nutrition awareness**
- **Dramatic increase in number of immunised adults and children**
- **Significant decrease in average annual household expenditure of private health options**
- **Remarkable decrease in outstanding loans per household.**

Impacts of Public Participation and Action

While the project had had a direct impact on the health condition of the population and thereby in the household economy, it also had brought forth some major social changes in the area, central of which is the very positive change in primary schooling.

Reduction in Episodes of Malaria

Before the centre existed, this was a malarial area, with several of the large number of cases proving fatal. In 2003, the year before the health initiative was launched, 35 cases of malarial death were reported. Since the inauguration of the health centre, there have been no malarial deaths. Moreover, there has been a dramatic decrease in malarial episodes: from 201 in 2004 to 65 in 20006.

Much of this healthier environment can be attributed to the dedicated health centre workers, who managed to create considerable awareness about risks and preventive methods in these three short years. For example, by 2007 every household in the villages had begun using mosquito nets, almost a hundred per cent increase from the pre-health-centre years.

Damage-Control for Quacks

Being far away and cut off from public health centres, most of these villages had their health needs catered to by private practices of untrained pseudo-medical professionals. The local quacks did not always administer the wrong medicine, but frequently administered wrong doses and prescribed adverse forms of care. For example, quacks seldom administer full dose of Chloroquine to malarial patients, leading to malignancy (giving two patients halves of the same dose maximises profits). At the centre, health workers supervise the administration of each dose to make sure every patient has been given the recommended amount of medicine, thus ending quack-caused malaise.

Amongst women, there is now greater awareness about gynaecological disorders. Ailments that went unreported because local women believed them to be untreatable, are now reported and treated. With medical aid close at hand, women have also begun to take care of themselves, and not suffer ill health resignedly.

Similar changes have taken place amongst the larger populace as well. Earlier, people frequently determined their current ailment as a ‘minor’ complaint, either because they did not know such conditions were treatable, or because it served as a coping mechanism. After all, admitting that one has a major complaint, but no better chance of accessing help than if he had a minor one, significantly worsens one’s state of mind without improving one’s health.

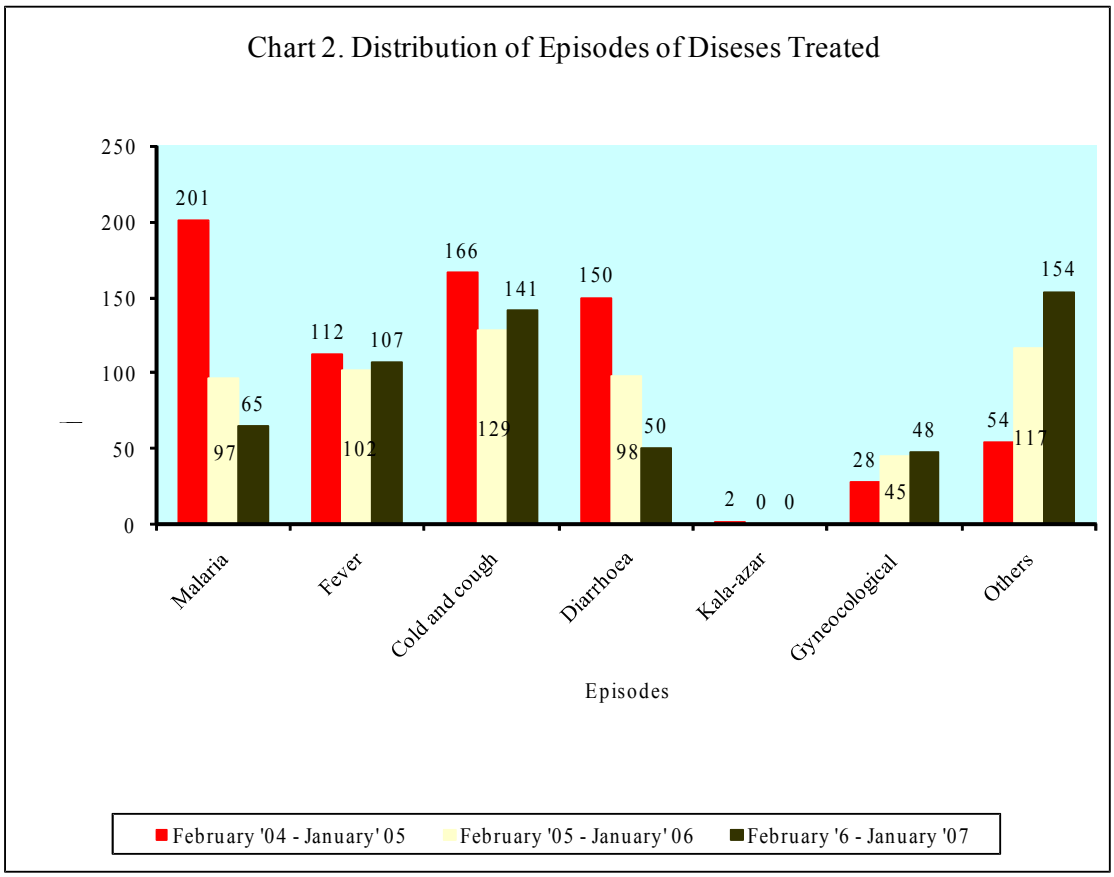
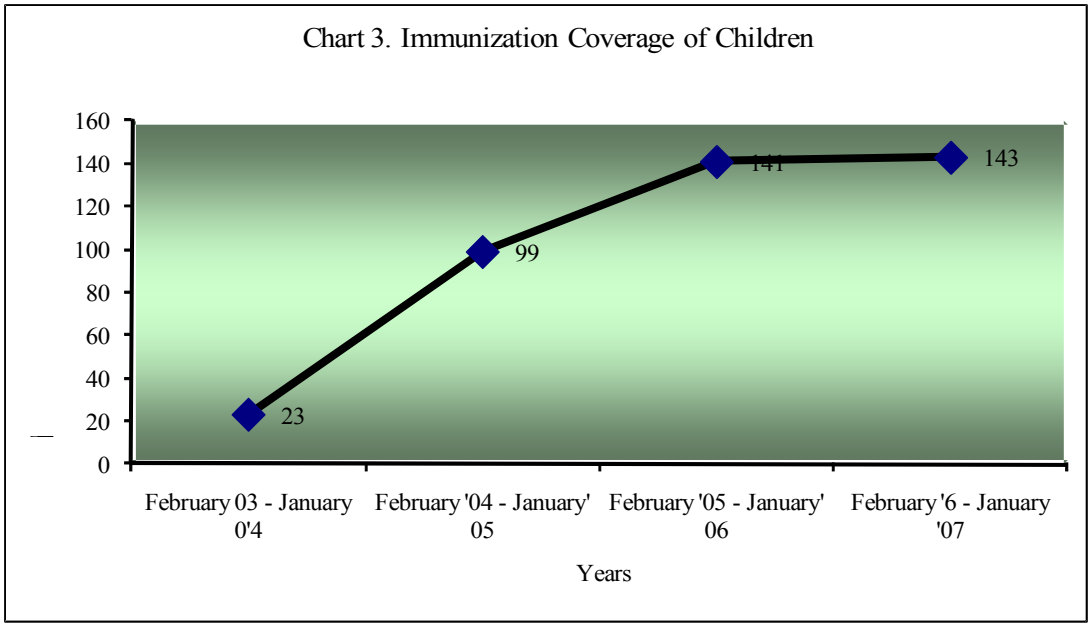


Chart 2 shows the increase in the reporting of 'other' or minor complaints, showing a growing local determination to ensure better health by not ignoring any problems, no matter how 'unimportant' or regularly they appear.

Increased Immunisation

Right from the beginning, the centre began campaigning for resuming the government immunisation programme, which had been almost non-functional for years. During our baseline survey in 2003, only 23 children received immunisations. At the end of the first year of the centre's inauguration, this number had increased to 99, and after the final year of the centre's existence, every single children (143 of them) had been successfully immunised.

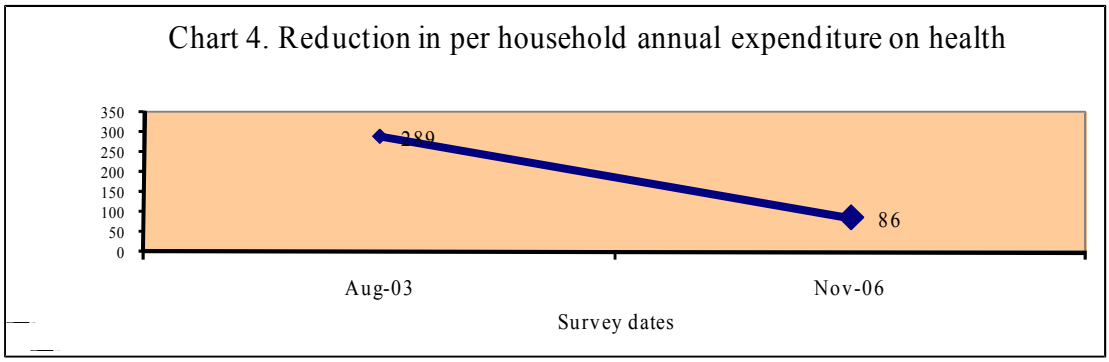
The health workers also visited pregnant women to make sure they received their daily prescribed dose of iron folic tablets, and tetanus toxoid before the delivery. They also provided antenatal care those mother that needed it. While social support and expressions of concern were traditional and very well-received, the centre had to work hard to make the iron folic tablets acceptable to the community. Families and the future mothers themselves, cautious about their and their future children's health, refused for some time to take the unfamiliar tablets. However, when the first few women convinced by the health workers to take the tablets did not suffer, the tablets became acceptable, and taken regularly.



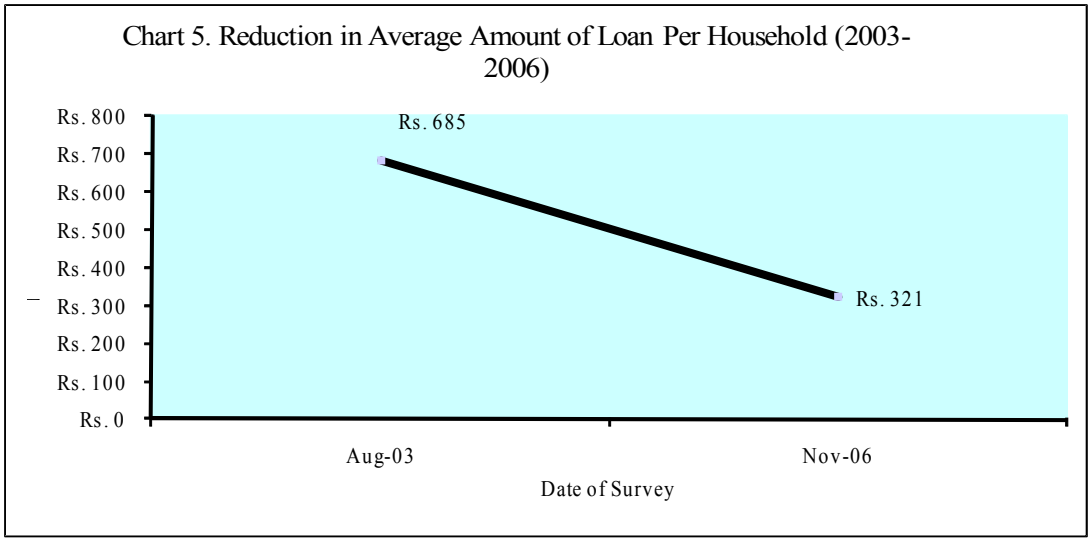
Impact on the economy

As mentioned above, the enormous health vacuum that existed before the health centre was filled with quacks, none of them medically trained, and some of them illiterate. They got the attendants at the closest medicine shops to colour-code each medicine, the colour indexing what disease it was to be prescribed for. Medicines past their expiry date were used, either because the quacks could not read, or because they did not care. This questionable care was also extremely expensive, sometimes amounting to extortion (we have discussed these issues in greater detail in the Pratichi Health Report).

As a result of the quacks' exploitative practices, our pre-participation baseline survey found that on an average, the annual medical cost of each household was Rs. 289. At the end of the intervention period this came down to Rs 86, a decrease of 70 per cent.



The enormous savings made in health expenditure has had a very positive impact on the health of the household economy, reflected in the 53 per cent decrease in the average amount of annual outstanding loans per household. In numbers, an average annual household loan of Rs. 685 was reduced, at the end of the intervention period, to Rs. 321.



Positive Corollaries

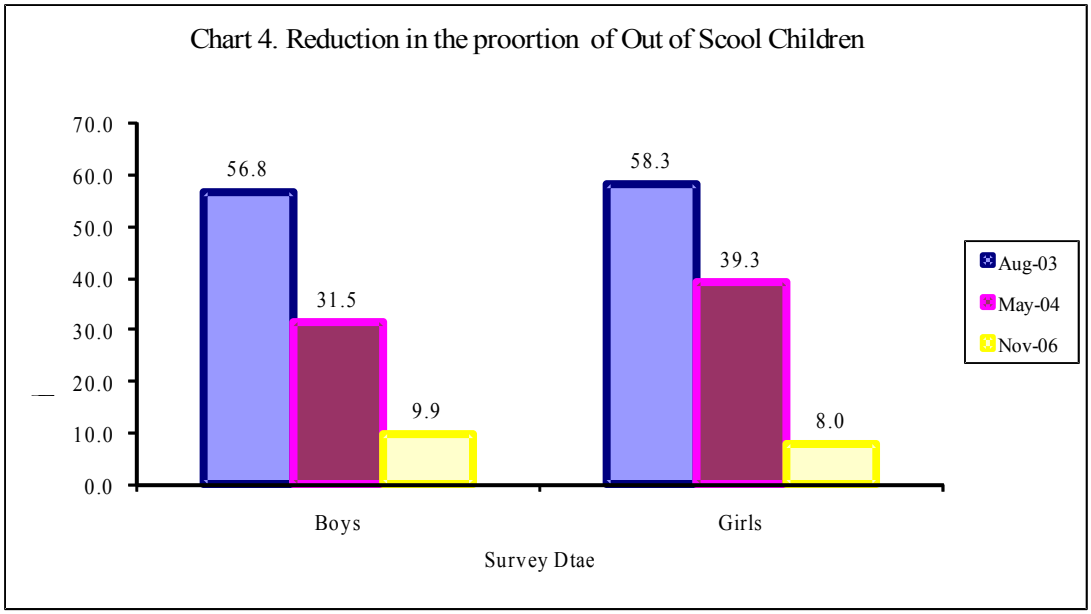
Enhancement in Primary Schooling

While the primary objective of the public participation and action was aimed at improving levels of local health and the public health delivery system in the area, the sustained acts of health and social awareness carried out by the workers incorporated primary education in its scope. The six-part discussion series saw several mentions of improving primary education, the connections between a child's health and her performance at school, and the ways in which the local people could help the process.

Encouraged, parents, especially mothers, met schoolteachers and appealed to them to come to school regularly (which had not been happening so far) and teach the children with more care. At home, they began supervising their children more closely to make sure they went to school and did not loiter about during school hours.

Improving attendance at school was aided by two factors: (1) the introduction of the Mid-day Meal (MDM) programme in the schools, providing a nutritious lunch to attending students, and (2) the exceptional performance of a particular school in the area (Chirudih). For malnourished children of these impoverished villages, the MDM was a very attractive reason to start attending school regularly. For teachers, the added daily responsibility of supervising the cooking of school meals ensured regular attendance, because the absence of promised meals, unlike academic underperformance, cannot be blamed on the laziness of students. The success of the school at Chirudih, in fact, encouraged previously indifferent teachers to improve the performance of their own schools. In the one case that the teachers continued to be indifferent and only sporadically present, the mothers, supported by the health centre workers, lodged a complaint against the teachers. The school authority intervened to ensure the school delivered both educationally and nutritionally.

The result of this intervention was miraculous. Before the inauguration of the health centre, about 57 per cent of the boys and 59 per cent of the girls in 6-14 year age group were found unenrolled at school. After the health centre had been functional for three years, the figures came down to 10 per cent for the boys and 8 per cent for the girls (Chart 4).



Mothers also intervened to improve the delivery of the ICDS centres in this area, most of which were non-functional before the health centre was launched. Mothers an health workers met the BDO and other officials regularly to repeat their request and urge reform, sometimes even openly grumble at the shameful underperformance of the government, till Anganwadi centres were established and made functional at all seven villages.

Conclusion

It has long been Pratichi's contention that sustainable social development has to be an integrated model of health, education, and social awareness. The seven villages of Gopikandar proved this thesis absolutely. Had it been limited to functioning as a health centre alone, the ADRI-Pratichi intervention might have ceased to function as the government immunisation programmes had before it. What made it flourish was its greater social role as a space for public debate, discussion, and consensus-building, leading to local movements that demanded to be heard, demanded to be given what was theirs by right, and was.

What makes this health centre particularly remarkable is that it was built by the internal consensus of a demography that is usually believed fit only for receiving governance or benefits designed outside the community. The participation of local people in choosing the modus operandi of an intervention project, facilitating the its establishments, staffing it with their own people, and using it as a axis to familiarise themselves with their rights and successfully demanding them, underwrites standard developmental narratives of ignorance, irresolution, and child-like dependence on external help. The success of the health centre serves to strengthen our belief in models of public participation and action, and sustaining improved lifestyles by enabling people:

- To be more aware of their needs, problems, and rights.
- Demand them from their government and other public deliverers.
- Organising themselves into a potent platform for social movement, to counteract the powerless position of passive 'beneficiaries' they are usually put into.