ASHWINI Annual Report, January to December 2004

INTRODUCTION

The adivasis of Gudalur Valley, once a self-reliant community whose needs were completely fulfilled by the forests, over time, were deprived of this right to their livelihood. They were exploited and marginalized, many becoming slaves and bonded laborers, sometimes on their own land. But since the creation of ACCORD in 1986, this community has worked hard to regain their self-reliance, through organizing themselves into sangams. For almost 20 years, *ACCORD*, and its associated organizations *ASHWINI* and *VIDYODAYA TRUST,* have committed to supporting the tribal community to regain their rightful place in society, through the creation of a strong community organization called *The Adivasi Munnetra Sangam, or AMS*. Community-owned and run institutions have been set up to deliver vital services to the tribal community and to be an important tool in facilitating them to enter mainstream society as equal partners, on their own terms.

The health status of the community was once appalling. There were countless unnecessary deaths and the quality of health care available was shocking. A community health programme was launched in 1987, initially through training village health workers (VHW's), to carry out preventative health care, monitor pregnant women and children, and improve people's health awareness. In 1990, Gudalur Adivasi Hospital was started to provide the adivasi community good holistic health care that was so badly needed. Thus, ASHWINI was born. Over the last 18 years, there have been dramatic improvements in the health of the community. Maternal mortality has been brought down to almost zero, death rates have declined, and people are no longer afraid to access health care. Through extensive training, ASHWINI's tribal staff have been equipped with the skills to undertake much of the day-to-day running of the Hospital and Community Health Programme, being actively involved at all levels in the decision-making processes. The ASHWINI team prepared this report.

THE COMMUNITY HEALTH PROGRAMME (CHP)

Over the past 3 years, *The Paul Hamlyn Foundation's* financial support has provided much-needed stability to the ASHWINI Health Programme, whilst *Skillshare International* has lent valuable support to the Training Programmes for the Health Animators, the new batch of Nurse Trainees and the Village Health Volunteers.

The Community

Every one of the field Health Animators has, over many years, built up a strong relationship with each member of the tribal community within the villages in which they work (close to 13,000 people, or 3000 families). This is the Community Health Programme's greatest strength. Since they come from the same villages, speak the same languages and understand the situation of each individual family, they are in the best position to be able to improve the community's health awareness and influence their health-seeking behavior. There has been a significant increase in the number of villages covered as compared to the previous years, with over 1800 village visits made this year. 5 new villages, not yet AMS members, were visited during the last year. Health awareness in the non-sangam villages is often very poor, but we are confident that, with sustained inputs from the ASHWINI field staff, this will change.

Total no. villages covered: 282

Sangam villages: 218 — *Non-sangam villages*: 64

Antenatal Care

In the villages where we have been involved actively for a sustained period, the mothers have received excellent care and there have been few complications. Tragically, however, this year there were three maternal deaths, there had been none in the last 3 years. In one of these cases the mother was from a far away village. She had bleeding and was unable to access health care in time. One of the deaths was in a non-sangam village and the mother had been taken to a private hospital. One death was from a heart disease and it was not preventable.

It is heartening to note, however, that the number of hospital deliveries went up this year to 49% of all deliveries, from 43% last year. As heartening is the fact that most mothers are accessing

health care somewhere, be it via the Government sisters or our health programme. Our inputs at the village level remain as crucial as ever, as we endeavor to ensure that no mother should die unnecessarily of a pregnancy-related cause.

Total number of deliveries:	268
Antenatal check-ups:	
3 or more check-ups:	**78%**
Full tetanus immunization:	**78%**
Pregnancy outcome:	
Hospital delivery:	**49%**
Normal delivery:	**91%**
Complicated delivery:	**9%**
Abortion:	12
IUD:	4
Stillbirth:	1
Maternal mortality:	3
Eclampsia:	0

Under 5's Monitoring

1. Immunisation

Children 1-2 years of age: 340

Received all 8 doses of Immunisation of (i.e. primary course): **85%**

Children 2-4 years of age: 647

Received all 10 doses immunisation (i.e. fully immunized): **89%**

The Health Animators have been providing mothers clean needles for immunisation, whilst some mothers have bought their own. Hepatitis B immunisation is now being given (and actively sought by mothers) to all newborn children by the Government sisters. The relationship between these two health providers, the Government and ASHWINI is very good. The Government sisters have been very supportive, sometimes helping in home deliveries, and in getting birth certificates for newborn tribal children. A large measles outbreak occurred in February/March 2004, affecting over 250 tribal children and countless non-tribal children in the area. Sadly, this lead to at least 2 measles-related deaths. The vast majority of children were supposedly already immunized against measles. The health team conducted a survey to determine the scale of the outbreak and liased with the Government to carry out a re-immunisation programme in many tribal villages. When our health work first started, less than 10% of tribal children were vaccinated against diseases such as measles, diphtheria, whooping cough and polio, and unlike now, deaths due to diseases like tetanus were not unheard of.

2. Growth monitoring

Number of children 4 years and under: 1241
Their Nutritional Status:
Normal weight: **29%**
Grade 1 malnutrition: **37%**
Grade 2 malnutrition: **30.6%**
Grade 3 malnutrition: **3.4%**
(This is down by 0.4% on 2003)

We regard Normal and Grade 1 as acceptable weights, whilst Grades 2 and 3 signify malnutrition. Thus we can say that 1 in 3 of the tribal children are malnourished. Grade 3 malnourished children are considered as a medical emergency, because a subsequent minor illness can compound the problem of malnutrition, and lead to the child's death. Such children are given special attention and are treated initially with Vitamin A and iron, they are dewormed and supplemented with raggi. In 60% of cases these interventions led to a significant improvement in the child's weight. If it is found that their weight still does not increase significantly, they are investigated and treated for any underlying factors, with Tuberculosis often being the cause. Often a lack of spacing between pregnancies is a reason for children to become malnourished. This is tackled through health education regarding family planning and good nutrition. Other causes include low birth weight and parental death/illness. In the community it is now widely accepted that weaning of babies should take place at 4 months, usually with raggi.

Child mortality

- *Neonatal mortality – (1-28 days)*: 7 deaths (10 in 2003)
- *Infant mortality – (28 days to 1 year)*: 4 deaths (19 in 2003)
- *Child mortality – (1 year to 5 years)*: 6 deaths (9 in 2003)

Neonatal, infant and child deaths all fell this year compared to the last 1-2 years. The abnormal increase in the last 2-3 years was most probably because of the severe economic depression in the area. Things have improved a bit this year. Some of these were preventable deaths. In some cases the families were extremely poor and had not accessed health care in time. A more detailed Infant Death Analysis showed that infections (such as bronchopneumonia and diarrhoea) accounted for the majority of neonatal, infant and child deaths. This emphasizes to us the importance of the village health volunteer training programme, so they can act as a resource at the village level, to detect illnesses early and ensure that these children receive prompt treatment.

Family planning

Within the tribal community, the birth rate is falling, with people voluntarily opting to have fewer, healthier children. Acceptance of family planning measures continues to increase steadily year on year.

91 couples started a family planning method this year. People are also developing more faith in the health care system. One additional beneficial effect of this has been better spacing of pregnancies, which has undoubtedly been one of the factors in the improvement in the nutritional status of young children. The total no of deliveries fell from 344 to 268 this year.

Curative care

Basic curative care is given during village visits, in addition to outpatients seen in the area centres. Anyone requiring more specialized care is referred to the Gudalur Adivasi Hospital.

Number of patients seen in the area centres: 5122
(A further 3220 were seen on village visits)

The commonest problems are acute respiratory illness, fever, anaemia and gastritis. Due to early treatment at the area center or the village, most people need not go to hospital. Scabies, impetigo and diarrhoea have all reduced, but the Health Animators are seeing more tribal people with chronic non-communicable diseases, such as hypertension, heart disease, diabetes and mental illness. Their treatment and compliance is monitored regularly, but it is a difficult task. We feel that, by having trained village health volunteers, we can address this difficulty.

Chronic disease monitoring

Tuberculosis is a highly significant cause of morbidity and mortality. 35 new cases were detected and treated this year, while there were 2 TB deaths.

Psychiatric illness is also becoming an increasing cause of morbidity in the tribal community, 65 patients are now registered as suffering from mental illness and are on treatment, although ensuring treatment compliance is difficult. We feel that this number may only be the tip of the iceberg, with many more undetected. Having health volunteers in many of the villages, however, has led to better follow-up of patients on long-term treatment for chronic illnesses.

Other increasing trends are in Diabetes, Cardiovascular diseases and Strokes. Very few diabetic patients existed a few years ago, whereas 28 patients are currently on treatment. There also seems to be an increasing trend in young males with hypertension. This needs further investigation to reveal the risk factors and to enable us to develop suitable prevention strategies. 30 people have been identified as having sickle cell anaemia and are on treatment.

Mortality (above age 5)

Total deaths over 5 years:	106
Suicides:	15
Cancer:	18
Strokes/Cardiovascular diseases	24
Diarrhoea/Vomiting:	7
Bronchopneumonia:	5
Accidents:	4
Tuberculosis:	2
Renal failure:	2

Cancer, predominantly of the gastrointestinal tract, has become one of the leading causes of death in our tribal community. Other cancers included those of the lung, ear and throat. Most victims were middle-aged. A poor diet and habits such as smoking, alcohol consumption and chewing tobacco and betel nut are the most important causative factors. Another important cause of death is heart, vascular disease and stroke. Whilst deaths due to communicable or infectious diseases, such TB, diarrhoea and pneumonia, are decreasing, we are seeing a marked shift towards

a non-communicable disease morbidity and mortality profile (i.e. cardiovascular disease, stroke, diabetes and mental illness).

Suicide and Mental Health

If one were to extrapolate the number of suicides in our tribal population to a population of 1 lakh, we would arrive at a suicide rate of well over 100 per 100,000 people. This is an extraordinarily high figure, around 4 or 5 times the national average, more than triple the figure in the neighboring Kerala districts. It is an indicator of the severe socio-economic stress faced by the tribal community and of the increasing prevalence of mental illness. In the past few months we have drawn up a strategy for a *Mental Health Plan* and a *Suicide Prevention Programme, which will commence this year*.

Health Education

25 planned sessions were carried out by the team in the villages, often in the evening or on Sundays, to maximize the number of people present.
More stress was given to school health education (37 sessions carried out with school-age children, either in villages, area centres or Government Tribal Residential (GTR) Schools – covering topics such as tooth and general hygiene, germs, diarrhoea, TB, and the dangers of smoking and alcohol).
We are confident that, by targeting the younger adivasi generation, and creating better awareness of the factors affecting health and disease, our Health Programme will have a more powerful and sustained impact on the tribal community as a whole.

Training

1. Health animators' training

Training for the 11 new trainees continues intensively. One of them has moved from nursing to accounting. One of the trainees, Sheela, a Mullakurumba girl, has joined for a nursing course at The Amritha Institute of Medical Sciences in Kerala, while one rejoined school to complete his 12th class education. Throughout the year, the students received training inputs in health, sangam and economic issues, as well as in communication skills, drama and role-play. In May / June 2004, they spent 2 months doing an Adivasi Economy Study.

2. Village health volunteers' training

186 village health volunteers (representing 104 different villages) are attending training and working actively at the village level. Training was given to them through different workshops and camps, during visits to the villages, at the area centres and at Gudalur. One particular camp focused on the traditional birth attendants in the villages, a remarkable group of women from whom our own health team learnt a great deal. Aside from health-related topics, inputs were given regarding community organization, savings, the tribal economy and women's issues. These sessions have also helped to considerably develop the Health Animators' own training skills.

One-day sessions:	82
Two day camps:	8

3. Exposure trip

Exposure trips have always been an important part of our training, from educational, motivational and team-building perspectives. In previous years, mainly members of ASHWINI's staff have been able to see the work of other organizations. In March 2004 36 people, 26 village health volunteers and 10 staff, went to visit an NGO called The Dhan Foundation, in Madurai, Tamilnadu. Its main objective is to help organize and provide ongoing support to Women's Self Help Groups, which they refer to as *"Kalangiums"*, through microcredit activities. These Kalangiums, composed of 10-20 women from a village, deposit a fixed amount of money each week or month, with the accumulated money utilized to provide loans to individuals (not to groups) within the Kalangium at minimal interest rates. Within each Kalangium there are 3 individuals selected to take overall responsibility for the savings, loans and interest. 20-50 Kalangiums form a *"Cluster"*, 13 Clusters forming a *"Federation"*. There are a total of 75 Federations under The Dhan Foundation's wing.

An important reason for the success of The Dhan Foundation's work lies in the fact that the support provided to these groups is sustained. Before an individual decides to take a loan, there is much discussion about what will be the best way to utilize that money and whether it is really necessary. If an individual plans to start a small business venture, support workers will first help to analyze if such a venture is financially viable. This is in stark contrast to the micro credit schemes set up as Government programmes in Gudalur. They are implemented through various NGO's, whose support is minimal and not sustained. This has resulted in many unsuccessful tribal Women's Self Help Group ventures.

Another part of the Dhan Foundation's work is in providing training to individuals and representatives from other organizations and institutions. For them, having a visit of village volunteers from a tribal community was indeed a novel experience. The hospitality shown to our group of volunteers and ASHWINI staff was exceptional, which, for all of them, made it an even more worthwhile trip.

No trip is complete without taking in some of the tourist attractions, which on this occasion included the Madurai Meenakshi and Palani temples. Before returning, the group visited The Christian Fellowship Hospital, in Oddanchatram, where two former doctors and friends of ASHWINI, Drs. Raj and Mary, are presently working. This was also a new experience, to see how a much larger, busier hospital works, as most of the group was accustomed only to our much smaller, but more personal Gudalur Adivasi Hospital.

Since returning to Gudalur, the group has decided to talk to others about their experiences on the trip and to try and to start small savings schemes in their own villages, for which the health animator team have pledged their support.

THE GUDALUR ADIVASI HOSPITAL

The Hospital has now been running for 15 years. 11307outpatients were seen (tribal), whilst 1007 patients were admitted to the hospital (90% tribal). With 112 surgeries and 135 deliveries also taking place, the hospital remained busy.

The non-tribal OP continues twice a week. However, non-tribal admissions are restricted due to limitation of beds and personnel, and because it is contrary to the overall aim of our organization, to create a community-run and managed health programmed and hospital for the tribal population. Specialty Clinics in ENT, General Medicine and Geriatrics continued throughout this year (by Dr. Ramesh from St. John's Hospital, Bangalore, and Dr. Sunil from Amritha Hospital, Ernakulam respectively).

Out-patients:	**10,276**
Tribal:	5407 (53%)
Non-tribal:	4869 (47%)
In-patients:	**1007**
Tribal:	906 (90%)
Sangam:	805 (89%)
Insured:	743 (82%)
Paid premium	685 (76%)
Non- tribal:	101 (10%)
Surgeries:	**112**
Tribal:	77 (69%)
Non-tribal:	35 (31%)
Deliveries:	**135**
Tribal:	110 (81%)
Non-tribal:	25 (19%)

Health insurance

The policy with The Royal Sundaram Insurance Company is working very well. The working relationship has been very healthy and both the company and ASHWINI have the one goal of evolving a workable health insurance program for the poor people in India. Although the claim ratio was above 100%, the company made a donation of Rs50000 towards a **Royal Sundaram ward** to help take care of patients whose expenses were not claimable.

A different approach to premium collection was adopted by different areas this year to improve community participation. Devarshola decided to insure all its people with Rs 10 premium collected from all the people who could pay. The participation was much higher and many paid more than their share to support others. The overall premium collection was the same as in previous years.

Insurance study – Dr Devadasan, one of the founder members of ASHWINI, as part of his PhD, is to undertake a one-year study of ASHWINI's health insurance programme. 500 insurance premium paying and 500 non-paying families will be followed up over a 12-month period, to look at their illness patterns, health seeking behavior and health care costs incurred. ASHWINI was invited to several workshops on group insurance all over India. This is one of the few working models on group health insurance for the poor.

The Medical Student Elective Program:

This year saw the beginning of an organized training program for medical students from different parts of the world as part of their training. Over the years many students have been

spending time at the hospital and the health program. As this was getting difficult to coordinate, a formal program has been started. Charities Advisory Trust, a UK based organization has been supporting this activity. The feed back from students has been very encouraging.

Kevin O'Brien –an Irish medical student wrote:
'The month was probably the best of my medical education to date and has really provoked me to think about many other aspects of society as well. The people I've met here are possibly the nicest, most dedicated and most inspirational crowd I have ever come across and I hope that I can maintain contact with them and the hospital. Thanks a million for everything!'

Dental clinics

The Toshniwalla Trust continues their support of the dental program. Dr. Venkatesh continued to do his Dental OP and clinics. This year, with the health animators and trainees, he visited villages and screened adivasi children for dental problems.

Dental OP (hospital) 166
Procedures 125

OTHER EVENTS

The Adivasi Festival

The annual tribal festival, which took place on March 21st 2004 at Pattavayal, was once again a huge success, with over 1000 people from each tribe and each of the eight areas attending the celebrations. Activities, all organized by the adivasi youth, included Archery, Stilts-Walking, Tug-of-War and the traditional Pot-Breaking game (see above). There was much singing and dancing that night. In the weeks preceding the festival many of the tribal community had donated small sums of money or rice. So, for the first time, *"annadaanam"* (free food) was served to all those who came. In addition, the leftover rice is to be donated to the Hospital kitchen, to be used for the poorest patients.

Tsunami relief:

The team was most upset by the news of the damage caused by tsunami and immediately prepared to help in any way possible. 10 members of the team proceeded to Nagapattinam to help. Stan, Mari, Durga and Manoharan were at the scene helping in many ways. It was a very moving experience for the whole team.

THE CHALLENGES AHEAD

The years ahead hold considerable challenges for the AMS and its associated institutions. The focus for the AMS and ACCORD will be:

- ***To strengthen the sangams and build village level tribal leadership and governance structures***

1. To put in place an adivasi self-governance system, which attempts to fulfill all their needs as a group, not as individuals, and such that the AMS's institutions are accountable to the community and are most effective in responding to the needs of the community.
2. To create a vibrant leadership from the community, capable of responding to new challenges and sustaining the development process of the AMS.
3. To strengthen the political movement of adivasis by actively collaborating and networking with other movements in the region.

- ***To build on the existing economic development programmes*** – e.g. Adivasi Tea Leaf Marketing Society (ATLM) and Honey Marketing Society

- ***Capacity building*** - of the adivasi staff and the tribal village youth

ASHWINI's focus will be:

- ✓ To consolidate on the ***Village Health Volunteer Training*** programme – with the aim to build a team of volunteers covering every village.

- ✓ To consolidate further on the considerable ***improvement in the health status of the adivasi community*** – especially that of women, children and the elderly.

- ✓ To ***create strategies to tackle the newer emerging health problems*** – e.g. mental illness, suicide, heart disease and cancer.

- ✓ ***Capacity building of the tribal staff***

    - To take over the management of the hospital and health programme
    - To build on the motivation and skills of the nurses, health animators, and the newer ASHWINI trainees

Through the work of the AMS and its associated institutions, the adivasis of the Gudalur valley have come along way towards realizing their goals of self-reliance, preserving their tribal identity and entering society as equal partners and on their own terms. But there is still work to be done. Ambika, one of the most experienced and committed nurses, summed up the resolve within the ASHWINI team to achieve these goals:

"We are ready to take up any work to serve our community. We all just want this work to be a success."