Transforming Tribal Health – Role of Community in Building a Sustainable Healthcare Model

Community Action Health, a concept not-so foreign today, was once a severely scorned and criticized topic of discussion, especially for its objective of including rural and tribal women in imparting basic health care. The 1980s was a period when public healthcare in the remotest districts of India was either utterly inaccessible or grossly ignored. That was also a period that saw the genesis of the novel idea – community-based healthcare. Pioneering this notion was a doctor -duo Mr. Abhay Bang and Mrs. Rani Bang. For every problem, there is always a solution, and typically the solution lies within the problem, the couple says.

Gadchiroli, a highly backward tribal district in Nagpur, Maharashtra, was and still is the focal point of their action research in neonatal and maternal health. “Go where the problems are; not where the facilities are.” That’s what Mr. Bang propagates in his inspirational TED talk. Gadchiroli, known for its poor economic status, dense forestation, almost zero to none basic amenities including transportation and hospitals, and prevalence of naxalites, was a hub of neonatal deaths. It recorded 121 infant deaths out of 1000 live births in 1988, averaging beyond the national statistics. This alarming number of deaths was identified when Mr. Abhay decided to involve the community in addressing their most pertinent issues. The habitually meet-at-night outings with the villagers led them to discuss major health problems and the lack of infrastructure to tackle them. A three-year intense groundwork and research paved the way for the creation of Annual Jatra – a People’s Health Assembly- held every year, where representatives from each village in the district talk about their health problems and vote for dealing with their health priorities.

The result of such meetings allowed the Bangs to create a research village – Shodhgram – that primarily handled neonatal and infant mortalities. They created a population laboratory within the village to count every childbirth and death, effectively measuring child mortality.

Another shocking revelation was, almost all births in Gadchiroli were home-based, due to the fact that there was only one hospital for maternal and childcare situated some 300 km away. Upon analyzing the reasons for child death, particularly within one year of birth, four causes stood out – low birth weight, asphyxia, sepsis, and the absence of hospitals. Also, the physiological, psychological, physical, geographical, and socio-cultural restrictions imposed on the mother didn't secure the much-needed care for newborn babies.

For a district as backward as Gadchiroli, where could one find hospitals, let alone trained professionals to solve such a pressing issue? The answer seems to be quite simple – go to the community. Inspired from the Chinese dogma of providing healthcare to a newborn within the distance a post partum mother can walk, Mr. Bang devised the idea of women-led Home-based Neonatal Care (HBNC). These women are called 'Arogyadoots' (ambassadors of health). They undergo a rigorous 36-day training program in diagnosing basic ailments, administering injections, and disseminating health education (Mr. Abhay calls it a knowledge vaccine). Consequently, the community health workers make door-to-door visits, perform medical examinations, record the family's medical history, and assist with child and maternal care.

The training is backed by a scientific approach that is on par with the 17-step algorithm developed by the American Pediatric Association. But the challenge is, these illiterate/semi-literate women have to follow all the 17 steps in 60 seconds of a baby's birth, in case of any complications. It's a ritualistic approach beyond one's imagination! They also learn to create warm bags – substitutes for incubators – to prevent preterm and low birth weight babies from succumbing to hypothermia.

But any interventional model comes with its share of skepticism and opposition, does it not? To dismiss any queries thrown at the credibility of the HBNC model, a 10-member expert committee headed by the Chairman of Pediatrics in AIIMS was constituted to evaluate the ethics behind such a practice. The team gave a thumbs-up to the initiative after a three-day assessment, which was the first feat for the program.

Eventually, Shodhgram adopted 39 villages in 1988 to carry out its interventions. They were called interventional villages. The remaining 47 villages were ‘control villages’ where only IMR and MMR were recorded but no interventions executed. By the end of 2003, the ‘Arogyadoots’ in the interventional villages had played a crucial role in reducing the NMR by 70% (30 deaths per 1000 live births, a number lower than the national average, and equal to the benchmark set by the Indian government in 2010). Mr. Abhay states that the women are responsible for saving the lives of 2000 infants every year.

According to him, an interventional model is only successful and credible when it is proven scientifically. As a result, the pilot program was published in the prestigious Lancet, and in 1999, Lancet released a special edition, The Vintage Papers from the Lancet, recognizing the HBNC action-research paper as one of its milestone papers. Also, the couple was honored as the ‘pioneers of healthcare in rural India’.

The success of the Gadchiroli experiment posed a significant question: What is the next step? An intervention can be impactful only when it is replicable, scalable, and implementable. Consequently, it birthed the Ankur Project, where 7 districts in Maharashtra from rural, urban, tribal, semi-urban contexts were selected to implement the HBNC model. The project saw immense response within three years of its implementation. Eventually, the Government of India inducted the novel approach in its 11th five-year plan and created a national policy. The term ASHA was coined for community health workers, and 800,000 ASHAs were sent to Gadchiroli to get trained in HBNC. Mr. Abhay proudly calls his ‘Arogyadoots’ trainers of national trainers.

The model found its global space when neighboring countries like Bangladesh, Nepal, and Pakistan, and African countries adopted a similar concept and sent representatives from the respective countries to have an experiential understanding of the HBNC program. More recently, WHO and UNICEF jointly endorsed the method of treating newborns at home by

trained community health workers. It has been released as a global policy statement in the 2030 SDGs urging developing countries to adopt such practices in places where access to basic healthcare facilities is arduous.

“Equipment on her shoulders, and the knowledge in her head, and the skills on her hand, and the compassion in her heart – she can convert any home or hut into a newborn care ICU.” These are the words uttered by Mr. Abhay while addressing the vitality of community intervention in healthcare. When local governance fails, it is the self-governance that prevails. The success of the Gadchiroli project reinforces three core objectives of any grassroots action: (1) Community is the focal point for any intervention to take shape. (2) Disseminating right knowledge determines the integrity of the intervention. (3) Every local problem has a global impact. The first step to identify and understand a community issue is to interact with them, listen to them, begin with what they have to offer, and build on from that. This requires a systematic approach in terms of administrative knowledge and skill development. The next step is to effectively implement the imparted knowledge with a well-built data collection and analysis system. Finally, the measure of its efficacy is determined by the unanimous acceptance from the national and global scientific fraternity.

When an empowered community takes responsibility for its smooth functioning, half the problems get solved. Transforming tribal health is not an instant miracle but a properly adopted method. The women of Gadchiroli, who turned out to be the ‘on-foot neonatologists,’ as described by Mr. Abhay are not extraordinary in their demeanor or socio-economic status. Rather, they are extraordinary in their undeterred conviction in becoming the change-makers of rural health. A country as large as India has colossal potential in terms of social capital rather than financial capital. Investing in people and trusting their experience builds the bridge between organizations willing to work for a social cause. Similarly, having an open discussion with the community builds their confidence and faith in the system that is striving to change. A self-sustained community development occurs with the combined power of people’s participation and the knowledge acquired by them.