Facility and Community-Based Services for Rural Remote Tribal Communities by Medical School with Concepts of Social Accountability

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Summary

The Melghat region of Maharashtra has high maternal, perinatal, infant, and child morbidity and mortality compared to the rest of Maharashtra, India. Kasturba Health Society, Sevagram which runs Mahatma Gandhi Institute of Medical Sciences, took the initiative to change the scenario. After struggle for almost a year with government, change took root beginning January 1, 2012 with help from a philanthropist. With guidance, the support of MGIMS of KHS, Sewagram, the team offered 24-7 service including Caesarean sections, minor and major gynecological procedures, and cataract surgeries performed regularly and surgical cases, all by camp approach. While trying to do whatever we could, many difficulties came and solutions were found with the realization that community-based services, community

motivation, mobilization, and behavior changes were essential. Steps were taken. Nurse midwives provide community-based antenatal services with advocacy of intranatal, postnatal, neonatal and child care, started with 52 villages served by four nurse midwives that grew to seven nurse midwives serving 140 villages within 10-85 kilometers from the health facility created. There are monthly meetings for monitoring, feedback advice, and planning. General diagnostic therapeutic camps have been become an annual event. In March 2012, the facility served 226 patients; in February 2013, there were 1036 patients; in February 2014, 1107 patients; in February 2015, 1883 patients; in February 2016, 2197 patients; and in 2017, 268 differently abled patients were provided with supports and aids including hearing aids, crutches, calipers, and surgeries for Cleft lip and Cleft Palate. In 2018/2019, there were a total of three monthly camps with 2,665 beneficiaries. A medical institute as backbone can do a lot for communities in rural, remote regions by sending health providers in rotation and taking care of health providers everyday life needs until the time there are a sufficient number of providers who take interest in the health of rural remote communities.

Background

Social accountability in health care and medical education has been the hallmark of Kasturba Health Society, Sevagram in the Wardha District of Maharashtra, India

which runs Mahatma Gandhi Institute (Institute) of Medical Sciences, with Kasturba Hospital, Sevagram. Actually, the Institute came into existence as a consequence of social responsiveness by none other than Mahatma Gandhi, himself. A two bedded dispensary was started in Gandhi's Ashram at Sevagram in 1938 for rural women to receive health care during the Cholera epidemic. It was in 1944 that the two bedded dispensary was moved from Ashram to a makeshift hospital in the guest house donated by a local philanthropist, because patient inflow was affecting the serenity of Sewagram Ashram. The 15-bedded hospital was named after "Kasturba," Mahatma Gandhi's wife. Resources were collected from rural families, as well as in kind contributions, and "Chogum" grown by rural communities contributed based on population, with benefits equal for all whether they contributed less or more. India's first auxiliary nurse midwife training was started at Kasturba Hospital (now there is a general nursing midwifery school, BSc, MSc College and PhD in nursing program also). As more and more people started using services, the need for a better system was felt. So, in 1964, Kasturba Health Society, Sevagram (Society) came into existence, registered under the Society's act of India. The Society could also receive donations. The 15-bed hospital was converted into a 50-bed hospital with better services. It was in 1969 that late Prime Minister Shri Lal Bahadur Shashtri suggested the establishment of a rural medical college so that more rural students would be trained in the

rural region to better understand rural health needs to serve the villages. Sevagram with Kasturba Hospital was the obvious choice. So, the first rural medical institute of India, Mahatma Gandhi Institute Medical Sciences, Sevagram with the 501-bed Kasturba Hospital was established on September 12, 1969. Since it was in Maharashtra, the local government of Maharashtra was asked to contribute along with KHS, as part of the concept of ownership by all stakeholders. So, it the hospital was funded 50:25:25 Central, State, and NGO, for running of the one-of-a-kind medical institute. The sapling now became a blooming tree of a 1,000-bed hospital, in the truest sense a public-private partnership with the social accountability the focus of the government and civil society. It offered neurosurgery and cardiac surgery. To date 2,900 basic doctors, and 1,700 post graduates have been trained and earned their respective degrees and diplomas. There is a long road ahead, if one looks at the community's health needs. In the neighborhood of a rural, remote, hilly, forestry terrain, Melghat in Amravati District of Maharashtra, is a five-hour zig zag journey from the medical institute, where there were persistant problems of high maternal, perinatal, infant, and child morbidity and mortality despite reasonably good health indicators in the rest of the Maharashtra.

How to Provide Services Was a Big Question

Governments of India and Maharashtra were approached to help the institute to help the needy. The government of India did respond, but desired that the proposal needed to go through the State. The government of Maharashtra was approached again in an effort to get them to understand. After multiple meetings, Kasturba Health Society planned everything for comprehensive services in the already existing 50-bed subdistrict hospital. A memorandum of understanding for 10 years was made. However, suddenly there was political opposition to allow a civil society to the government hospital, although it was failing. The negotiations continued, but delays were worrisome so an alternative search was started. A charitable trust from Mumbai "Bhartiya Brihad Samaj" made a generous donation. So, a new beginning was made on January 1, 2012 with alterations/additions made in a makeshift area for a 25-bed hospital with a mini ward, delivery area, and operation theater in Utavali where the services of a physician and ophthalmologist debuted by MGIMS Sevagram were being provided on the couple's family land for a number of years. Nearby huts were converted into a kitchenette, dining area, and office. The guest house was converted into a residential area and a mini library, and sports, mobile phones and televisions were arranged for health providers from MGIMS Sevagram to make their lives a little more comfortable and reduce the general reluctance to work in such remote forestry regions. However, as health providers started settling and plans for construction of better facility in the same

campus, many problems became obvious. So new land was procured which needed more than a dozen objections for creating a health facility on the agriculture land with maize and other crops visible. Construction of a 50-bed hospital with basic services and accommodations for health teams in the same building including bored wells was done. Electricity was a problem so more big and medium sized generators were bought. With continuous follow up with the state and district's electricity boards, electricity was made available almost 24-hours a day. The generators are still there, with the understanding that the problems of breakdowns and delays in repairs in the forestry region is a challenge. The 50-bed hospital has been set up for expansion to a 150-bed hospital, without disruption to the 24-seven services. The hospital was commissioned on February 4, 2016, named Dr. Sushila Nayar Hospital after late founder and president of KHS, who also served as the founder director of the institute at Sewagram. Once the agenda was achieved, there still remained a long road ahead. The basic facilities, x-rays, pathology, and biochemistry lab were made available. The sonology machine took seven years to put to use because of unavailability of a sonologist. But, where there is a will, there is a way. As this article was being written a sonologist from a nearby city of a neighboring province has offered to help on a monthly basis during the last two months. Our hypothesis is that this is a solution to some of the problems related to the lack of services to communities in rural remote regions, specifically the

reluctance of specialists and basic doctors who will work in rural communities. The medical institute using a social accountability concept should try whatever is possible within their available systems by deputizing consultants, post-graduate trainees, and interns in rotations and keeping in mind their basic needs of housing, food, electricity, library, mobiles, television, sports, et al. This is how we tried to change the scenario and help rural communities and learn needs of rural masses better. Interns and post graduates are better trained in the beginning of their carrier because they have first-hand information and understanding of the communities and its needs.

Results

With the guidance, support, and help of MGIMS of KHS, Sewagram, the teams of working for managing obstetric, gynecological cases, neonatal, and child care with a system for care of families with physician, ophthalmology, and other specialists' visits. Surgical camps are held as per the need. Caesarean sections, minor and major gynecological, and cataract surgeries are being performed regularly as well as general surgical cases by camp approach. A blood storage system has been created with support from a mother bank at MGIMS Sevagram and the approval of food and drug department of the district administration. In the last seven years (until March 2019) a total of 83,193 patients have been treated

through the outpatient program; 27,125 through medicine; 11,070 in pediatrics; 11,605 in obstetrics & gynecology; 18,552 in ophthalmology; and 5,819 in other speciality areas. A total of 6,579 inpatients have also been treated with 1,435 through medicine; 1,697 in pediatrics; 2,144 in obstetrics & gynecology; 857 in ophthalmology; and 447 in other specialities. A total of 1,385 births have taken place with 499 caesarean sections and 886 vaginal births and 287 gynecological cases including hysterectomies and laparotomies for ovarian tumors and malignancies. A total of 705 obstetric surgeries, 1,407 cataract surgeries of which 246 were general surgeries, 36 ear, nose, and throat procedures, and 223 other specialities including orthopedics and plastic surgeries have been performed. We have had four maternal deaths over the span of these years in the hospital, two probably due to pulmonary embolism and one ruptured uterus following a fall, and one postpartum haemorrhage.

While there is a good understanding and cooperation between the subdistrict hospital of the government 10 kms away, we still await the government's direct support to this health facility under various financial schemes of the government of India and government of Maharashtra, especially for mothers and babies and benefits of these schemes for families who live with scarce resources in the terrain. There is a need for deviation from prerequisites for the provision of assistance with out of the box thinking for running such centers.

While trying to do whatever we could do, many difficulties came and with them ideas for solutions and experiences too. We realized that though malnutrition, anemia and poor health were both economical and medical conditions, and the health issues in these communities were deeper, with ignorance, gender bias, unemployment, and most importantly their strong beliefs of faith. Use of alternative traditional therapies for achieving good needed research. Sometimes making the woman stay in the hospital for her own good or her child's good continues to be a tough job, testing the best counseling skills and dedication of service providers. We realized early on that a lot more, including community-based services, community motivation, mobilization, and behavioural changes, were needed. So, a first step was taken for peripheral services mainly for mothers and neonatal patients after a year of creating the health facility in January of 2013 in 52 villages looking at the distance and available resources with four nurse midwives, responsible for 13 villages each. Now seven nurse midwives provide community-based antenatal services with advocacy for intranatal, postnatal, neonatal, and child care in 140 villages, within 10 to 85 kilometres from the health facility created. For some time, delivery kits donated by Jeev Daya Foundation, USA were provided to the Accredited Social Health Activists (ASHAs), for use in home births, but now they are not available. Medical officers posted under the rural posting scheme of the Mahatma Gandhi Institute of Medical Sciences Sewagram, used to run

community-based health clinics in rotation. Clinics were either in Gram Panchayat or Temple or ASHA's home, and were composed of one doctor with nurses so that the rural communities could get doctor's services and day-to-day medication in their own villages. So, while nurses were providing care for mothers every month, the doctor was available to each village every 10 weeks. However, nurses helped villagers to seek the services of a doctor sitting in one village on monthly basis. The government's national entrance cum eligibility test for admission to medical colleges has taken away this privilege of NGO posting, a prerequisite for post graduate admission applications from MGIMS, Sevagram. Sometimes policies made for good, spoil other good systems. Now interns do this job, every 15 days a new batch of three to five is posted. NMs Interns visit assigned villages five days a week, track mild to severe malnutrition in children, and provide advocacy whenever available in cases of mild to severe hospitalization with free nutrition therapy. In communities in adopted villages with regular recording, 983 women have delivered with 201 C-sections and 782 vaginal births at various places with more than 50 percent home births. In the community, 26 mothers died in six years, some after migration to other places, others at the district hospital, in the subdistrict, and at home, with quite a few preventable even in this region with limited resources by improving timely, quality care and women's acceptance of health care.

Anemia is still rampant, with limitations on blood transfusions and therapy. Diagnostic cum therapeutic camps have been made into an annual event. In March 2012, 226 patients; in February 2013thifferently abled needing help with hearing aids, crutches, calipers, shoes, wheelchairs, and surgeries for cleft lip and cleft Palate (normally done in infancy, while here had to wait until adolescence). In 2018-9, there were three monthly camps with 2,665 beneficiaries. Surgeries were performed on camp days and additional operations addressed within days. Looking at the dilemmas cropping now and then after some research, service has been oriented to get answers to the dilemmas, shared by publications and presentations.

Persisting Challenges

- Resources for free services to real needy, especially mothers and babies;
- Government's financial support for free maternal, neonatal, child care, and care of families living with extreme poverty;
- Extreme poverty of people;
- Strong beliefs; and
- Health providers general lack of interest in understanding the genuine needs of tribal communities of rural remote regions.

Glimpses- Diagnostic cum Therapeutic camps