

JAN SWASTHYA SAHYOG (JSS), CHHATTISGARH

“Doctors are the natural advocates of the poor.” – Rudolf Virchow, German pathologist

In the late 1980s, a group of like-minded doctors with common perspectives on health, hospital and medical academic systems, came together at the All India Institute of Medical Sciences (AIIMS), New Delhi. They felt the need to provide community and low-cost, curative health programs. The work at AIIMS was disorienting: the focus was on the body parts and not on the human body; and they questioned their own role in it.

In 1986, Jan Swasthya Sahyog (JSS) was registered. The original group was composed principally of Madhavi and Anurag Bhargava, Rachna and Yogesh Jain, Madhuri and Vishwasroop Chatterjee, Anju and Raman Kataria along with BR Chatterjee, a founding member.

After considering various regions, the organization finally chose Chhattisgarh. Literacy activists from the region invited them to work there;

and it was one of the poorest and most inaccessible regions in the country. They approached the district administration for support and the district administration allocated an abandoned colony in the village of Ganyari that was about 15 kms from Bilaspur on a short-term lease. The colony had to be renovated and work started in December 1999 without any publicity. The doctors went around talking to different villages about the clinic as well as the program. In four to five months, 10 villages were selected. Soon more than 250 patients started using the clinic at Ganyari in a day.

Today the work of the organization is centred around the clinic in Ganyari as well as their mobile clinics that visit remote villages in the north of Bilaspur regularly. JSS has a steering committee which meets once a month in Bilaspur and usually once a week for project planning, financial management and administrative decisions. Most decisions are consensual.



The JSS team and staff on the first functional day of the new OPD building

Their clinical practice offers exposure to health care that is caring, rational, empathic and sensitive. More than 30,000 people have availed of the clinic's services and 70 per cent of people benefit from the treatment. The low cost of treatment and drugs allow people to escape loans. They also create, seek, use and market low-cost technology products to decrease expenses. Further they demonstrate that rational and economic health care is possible to other health care systems, particularly public care.

From a group of 10-15 people in 10 villages, the group working on community health now numbers 70 with work in six areas. In each village, JSS encourages the villagers to choose a woman as a community health worker. This is usually done in a village meeting by consensus. Further, this selection is written into a contract with the woman. The poverty in the region is so extreme and the education system so poor that literacy is a luxury. Literacy is thus not compulsory, and all material produced in their training and work takes this into account. These community health workers monitor the health conditions in the village, take preventive actions like preventing malarial larvae growth, follow-up on patients who use the clinic's service; test purity of drinking water and so on.

JSS has extensive patient records that indicate illness and nutrition patterns in the area. These feed into the constant reflection to evolve further work. For instance, they found that the maximum number of malaria cases that they handled were in the months of November to January and not just post monsoon as it was originally thought; and much to their relief, that chloroquine efficacy in treating malaria was high in the region. But, the occurrence of multi-drug resistant tuberculosis (TB) strains is very high. This they attribute to indiscriminate usage of antibiotics caused by poverty. TB requires treatment for six months consistently. Poor people,

especially those that migrate, find it difficult to access health care.

In the course of work, the doctors observe, there is no day that passes by normally without encountering some form of human destitution. All that can be done is to keep one's eyes open. In a situation where most of the people are undernourished, curative treatment becomes futile. Looking back, they say that when they decided to enter this 'war zone', little did they expect to be on the losing side.

They draw attention to the severity of malnutrition in the area. One patient was an adult woman weighing 19 kgs. In these situations, any curative effort without structural changes is difficult. This state of affairs is compounded by an indifferent, unreliable and expensive public health care system. The other significant alternative is the private practitioner, who is even more unreliable and expensive. The area has the usual diseases of poverty – falciparum malaria that can be fatal and tuberculosis. Water-borne diseases have increased with the deterioration in availability of clean drinking water. In addition, there are also illnesses like heart disease, cancer and cholesterol requiring high-quality tertiary care; contradicting the myth that poor can manage with primary health care. Given the stress of rural poverty and migration, their vulnerability is likely to be higher. In some sense working in such extreme conditions render certain things easier – diagnosis, for instance, since the conditions are so full-blown, making it is easy to identify the disease.

Being part of the system as well as running it causes many kinds of challenges. The OPD of the clinic thus has to run irrespective of administrative, financial or advocacy requirements. The expansion of work has meant greater attention in keeping focus, with less time to interact with each other and the outside world.



OPD consultations at the community health centre



Dr Yogesh Jain with a tribal patient

The possibility of burn-out and fatigue is something each doctor has to address. The clinical practice cannot economically support the clinic. Most of the patients find it difficult to pay even the subsidized costs. This forces JSS to look to other funders including the Sir Dorabji Tata Trust (SDTT) which is currently supporting JSS with a grant of Rs. 12.50 million – and the time taken for obtaining this funding is usually at the cost of the time spent in the clinic.

Further, the organization is finding it increasingly necessary to undertake health advocacy about the larger social issues within which health care is embedded. The systemic requirements of the latter often impinge on the severe discipline that the former requires. It is here

that the financial and institutional support provided by SDTT becomes invaluable. This support helps subsidize the treatment that they provide and also allows them to acquire technology that they need. In looking forward, they expressed concern about the necessity of continuous support over time; and their ability to keep raising this. “Nothing will sustain you in the humdrum other than the poetry of the toil-worn person.” The doctors at JSS have never taken more than two weeks leave from work. In the final count, they explain that practising medicine is hum-drum. The initial excitement of creativity in the first two years is no longer there. What enables them to continue daily is the grace, dignity and power that their patients assume in accepting their realities, however, bleak.

