

**THE AROGYA HEALTH INITIATIVE**  
**Revitalization of indigenous health traditions**  
**among the Sahariya tribal community**  
District Sheopur, Madhya Pradesh



*A 'safed moosli' plantation at the herbal nursery in village Paira*

**PROGRESS REPORT**  
**March 2005**



**SAMRAKSHAN TRUST**  
DISTRICT SHEOPUR, MADHYA PRADESH

## PART I: INTRODUCTION

### 1. Name of the project

The Arogya Initiative

### 2. Project location

Village Agraa, *tehsil* Vijaypur in the Sheopur district in Madhya Pradesh.

### 3. Project Duration

One year

### 4. Project start date

May 01, 2004

### 5. Proposed end date

April 30, 2005

### 6. Objectives

The two major goals of the Arogya initiative were:

1. That people should increasingly use indigenously found herbs and plants to prevent as well as home remedies for common ailments; and
2. That the herbs found in the area should be exploited in a way that ensures their conservation for future generations

### 7. Strategies

The strategies to be used for achieving these objectives included:

- **Processing** of herbs to prepare medicines that can cure common ailments, and **Dispensing** of these medicines by a qualified Ayurveda practitioner
- **Popularising** the usage of herbs for first aid and home remedies through training of the community, especially women and traditional healers
- **Exhaustive documentation** of the medicinal herbs found in the area and the traditional ways in which the local people have been using them

## PART II: WORK PROGRESS

### I. Processing and Dispensing

■ The Arogya dispensary was inaugurated in village Agraa on 11 August 2004. Two Adivasi women from Agraa, Bajjanti and Teejo bai, broke a coconut at the door of the clinic, and *prasad* was distributed among all people present on the occasion (including children, women and men from nearby villages, as well as the entire Samrakshan team).



■ The dispensary combines standard allopathic treatment with Ayurvedic treatment, and is run by Dr. Balram Raje, BAMS, who joined the Samrakshan team in June 2004 as the Arogya coordinator. Dr. Raje is assisted in his work by Roshanlal Adivasi, who belongs to the Sahariya tribe and lives in village Agraa.

■ The initial focus (May-August 2004) of the Arogya team was on establishing a functional allopathic clinic, to provide the community with a quality and low cost alternative to spurious medical practitioners and deal with most common

ailments on the basis of sound professional diagnosis and quality medicines. In the second stage (September-October 2004), the team focused on setting up the Ayurvedic section of the Arogya clinic with facilities for preparation packaging and dispensing of Ayurvedic medicines.

■ The clinic has been established on rented premises, located centrally in the main market of village Agraa. As such, it is easily visible to and accessible for people from numerous other surrounding villages, who come to Agraa to buy ration and other essential items or for consulting with medical practitioners.

■ The clinic is divided into 3 parts: Out Patients Section, Indoor Section and Medical Store Room. Basic equipment and facilities are available in the Out Patients section for proper diagnosis, basic first aid and dispensing of oral and injectable medicines to patients. The Indoor section has facilities (including a stretcher, basic surgical instruments for minor operations, and saline drip) for more detailed examination and treatment of patients.

■ The clinic is also equipped to carry out basic pathological tests including blood and urine tests for diagnosis of common ailments like jaundice, typhoid, malaria, diabetes and tuberculosis.

■ The clinic has facilities for sterilization of instruments, cotton and bandages, and uses only disposable syringes to contain chances of spread of infectious diseases.

■ The Ayurvedic section has facilities for preparation of medicines through processes like boiling and grinding. Using these facilities, it is possible for the doctor to prepare and store bulk quantities of basic Ayurvedic remedies for easy and quick dispensing among patients.

■ Allopathic medicines dispensed at the Arogya clinic are purchased from wholesale stockists in Gwalior, and are made available at cost price to the community. Since the cost of these medicines is fully recovered from patients, the facility can be sustained without any external support. Moreover, the sale price of these medicines is around 40 per cent lower than that being charged by local shops, making it far cheaper for the patients to access quality medicines.



■ Initially, a stock of essential medicines was purchased by the clinic using project funds from ICA, but now the clinic is able to replenish its stock through its monthly income.

■ For keeping proper records of the Arogya clinic, the following books are maintained:

- **Treatment record register:** for recording patient details like name, age, sex, residence, ailment and line of treatment
- **Patient card:** to be kept by the patient, for use during follow-up treatment – these cards entitle the patient to free consultation for a period of 15 days
- **Medicine sale receipt book:** for recording the quantity

and price details of medicines dispensed to each patient

■ Raw material for Ayurvedic preparations is procured either through the herbal garden set up at the Samrakshan campus under the Arogya initiative, or procured from Gwalior (in case of material that is difficult to produce or procure locally at present).

■ The Ayurvedic preparations being dispensed at present from the clinic include *Drakshasava*, (a proprietary medicine for stomach disorders); powders of *Arjuna*, *Hadjuri* and *Sitawari* for diverse ailments including cardiac disorders, bone-setting, urinary tract infections; and Ayurvedic tonics and syrups for use in cough, colds and malnutrition cases.

#### **A Helping Hand**

☀ *The young son of Bajjanti, a widowed tribal woman from village Agraa, was suffering from severe stomachache and recurring fever. After proper diagnosis, and with support from the Arogya coordinator, the child was referred to the Jayarogya Hospital in Gwalior, where a stone of 40 grams was removed from his urinary bladder.*

☀ *Three villagers, Angad (village Ladar), Chaitu (village Ladar) and Kapoori bai (village Palpur) who were suffering from chronic tuberculosis, have begun regular long-term treatment at the Arogya clinic. This is remarkable since a very high proportion of tuberculosis patients in this area do not get full treatment, partly due to ineffective medicines supplied by the state run PHC, and partly because of the high cost involved in private treatment.*

☀ *Two patients, from villages Palpur and Jakhoda respectively, suffering from mental disorders are undergoing treatment at the Arogya clinic.*



■ From the date of inception of the Arogya clinic till the end of February 2005, on an average nearly 100 patients used its facilities each month. The numbers fluctuated seasonally, and in periods of high vulnerability to disease, this number went up to more than 150 patients each month, from nearly 25 villages of the region. Of these, nearly 90 per cent of the patients belonged to the Sahariya tribe, and the most common ailments were anaemia, tuberculosis and malaria. Children below 15 years of age formed around 50 per cent of all patients, and were found to be suffering mainly from malnutrition-induced diseases.

## II. Documentation of Indigenous health practices

■ A format has been developed for collection of data on indigenous health practices, using which detailed information is being collected on parameters like name of village, name of the information provider, method of treatment using specific medicinal plants, and possible variations in the method.

■ So far, almost 30 villages have been covered in the primary data collection phase, and around 150 formulations have been documented, which are unrecorded in the Ayurveda tradition and are unique to this region. Thus, the first phase of our proposed documentation exercise has been completed, and the information collected during this phase is being sorted and compiled to enable proper follow up in the next phase.

■ Detailed photodocumentation and video films of all species featuring in the above document is under preparation, and will support the main compilation on indigenous health practices of the Sahariya.

## III. Training of women in use of medicinal plants for home remedies

■ Women were selected as the main target group for training and capacity building related to use of home remedies for treatment of common ailments.



■ On 17-18 August, a training programme was organised at the Samrakshan campus, in which around 70 women from 5 villages were invited. An external resource person was invited from a Jabalpur based organization called Shodh. In the 2 sessions of this training, information about 15 species of medicinal plants and their usage for home remedies of common ailments was provided to the trainees.

■ A herbal garden has been prepared on the Samrakshan campus, in which nearly 25 species of locally available medicinal plants are being cultivated to familiarise the target community with the appearance and usages of these plants, as well as to ensure easy

and timely availability of these herbs when required.

■ The Arogya team is targeting 250 women belonging to 20 self help groups (SHGs) mobilized by Samrakshan in 12 villages. The team conducts one training session each day, and the target is to familiarize the women with 24 formulations to treat nearly all common ailments found in the area over the next few months.

■ A number of the trainees have already started using these formulations at home, and we often receive requests from them to access different medicinal herbs from the herbal nursery at our campus for this purpose.

## PART III: THE WAY AHEAD

### Main problems faced and lessons learnt

■ In our documentation work, the biggest problem arose in identification of local healers or *jaankars* and in gaining their confidence to elicit information from them about the indigenous healing traditions of the region. The Arogya team has gained experience over the past few months and become adept at gaining the confidence of these healers to gain valuable learnings from the experiences.

**Lessons:** In view of these experiences, we have learned that the targets for organizing and training the local healers will have to be revised and pushed back. These people are reticent and

are geographically scattered over a large area, and consequently, it is very difficult to organize trainings and interactive sessions with them. Moreover each healer usually specializes in only a few formulations, and they do not tend to view this knowledge as a potential full-time income source. Their knowledge is held in sacred trust, and we have learned that Samrakshan should not aim to break this tradition and venture to commercialize it, since there are distinct advantages to the existing system in view of rising threats of piracy of intellectual property.

- In our training work, we initially faced a number of problems in terms of getting trainees together, and then holding their interest throughout the training sessions. The main reason, we learned, was that we were organizing trainings for randomly selected groups of women, who did not necessarily relate to or bond with each other. This made them reticent during training sessions, and thereby reduced the interaction between the group and between the trainees and the Arogya team.

**Lesson:** We discovered that these problems could be taken care of if the Arogya trainings were linked with the ongoing SHG programme of Samrakshan. Since the SHGs are formed on the basis of affinity, and since these women meet anyway on a designated day of the week for savings and microcredit activities, the Arogya team could work in synergy with the SHG team to conduct its training programmes. This method has worked quite well, and results are obvious in the form of greater interaction as well as voluntary follow up information seeking by the trainees.

- Another important lesson we learned was that issues in preventive health and personal hygiene should be added to training agenda, since a number of common ailments can be avoided if these issues are addressed right from the beginning.

**Lesson:** We therefore propose to add modules in personal hygiene and preventive health to the training programmes in Year 2 of the Arogya initiative.

- Among the most serious problems faced by the Arogya team is that the dispensing, documentation and training activities are placing unreasonable demands on the time of the coordinator. As a result, at any given point of time, at least one of these activities tends to suffer, and usually, the one that gets neglected most often is the clinic. Consequently, the degree of outreach and follow-up of patients is less than satisfactory.

**Lesson:** There is an urgent need to enhance the human resource support the coordinator through recruitment of a multipurpose health worker (MPW), who is trained to assist the coordinator in dispensing medicines and adequate follow up of longer-duration cases. We hope to address this gap in Year 2 of the Arogya initiative.

- The clinic was unable to reach out to critically ill patients and provide proper follow up support to patients in distant villages due to poor road connectivity and our inability to inform far-flung villages about this facility. We have tried to address this problem through distribution of pamphlets, word-of-mouth publicity, and spreading information about the clinic during documentation visits by the Arogya team.

**Lesson:** The Arogya team will have to acquire a low-cost mobile dispensing unit in the future to address these issues. At this juncture, we feel that the team will be in a position to take up this activity not earlier than Year 3 of the Arogya initiative.