Indian Grassroots Women Create Sustainable Change in Post-Tsunami Health Service Provision

The December 2004 Indian Ocean tsunami took away the lives of 12,000 people, displaced 650,000 and injured over 5,000 in Tamil Nadu, India.[1] It destroyed housing, sources of livelihood, schools, primary health care centres, drinking water supply systems and other community assets.

In the aftermath of the tsunami, Swayam Shikshan Prayog (SSP, "Self-Education for Empowerment" in Hindi)[2] engaged tsunami-affected communities in Tamil Nadu, especially grassroots women, to rebuild their communities and to address their specific needs in the health sector. Drawing on their experience following destructive earthquakes in the states of Maharashtra (1993) and Gujarat (2001), SSP convened a team of grassroots women leaders from these states to mobilise women in tsunami-affected villages of Tamil Nadu.[3] Realising that women's self-help groups (SHGs) were not formally recognised as key actors in post-disaster relief and rehabilitation, SSP partnered with local women leaders to assess whether relief processes were responsive to their needs.

The participatory assessment found that temporary shelters were insufficient due to excessive heat, the spread of contagious diseases and the lack of proper sanitary facilities, including toilets. Shelters proved particularly problematic for women (especially pregnant and nursing women), who lacked privacy and stayed at home while their husbands were seeking employment. As family caregivers, women also reported facing a higher level of post-disaster stress and trauma than men. Pregnant women were particularly vulnerable; inadequate nutrition and health services resulted in higher levels of anaemia and miscarriages. Government emergency health services at the village level effectively limited the spread of diseases but often only offered general health care, and did not serve women's unique health needs (e.g., gynaecological care). Women also often felt embarrassed to use government health services in the village due to lack of privacy and appropriate check-up facilities. Compounding this, from May 2005 onwards, these services were gradually withdrawn, as the 'emergency' period was coming to an end. Consequentially, women expressed the need to bring government health services closer to the needs of communities, particularly grassroots women.[4]

SSP responded by facilitating the creation of women-led local health governance groups (HGGs), called ASHAA, through mobilising women as health volunteers.[5] ASHAA approached the issue from two angles: driving grassroots demand for better health and health services and collaborating with health service providers in improving service quality and delivery. Within one year, 41 of the 80 worst tsunami-affected communities in two districts of Tamil Nadu[6] had formed HGGs, which are now federated. Reaching beyond the federation's 800 women leaders to all SHG members and larger communities, these groups have been running a community health fund since 2007; collaborating with government primary health centres (PHCs) and hospitals to organise health awareness talks and village-level health camps;[7] providing referral services; growing and distributing herbal medicines; and linking community members to PHCs, village health nurses, hospitals and government services. They also contribute to formal decisionmaking and planning arenas with PHCs through weekly planning meetings.

Aside from community health issues like seasonal illness and sanitation, ASHAA addresses women's unique health needs. They raise awareness on women's and girl's sexual and reproductive health (SRH), address other critical health issues (such as anaemia) and hold SRH camps where women and girls can undergo examinations and be referred for specialised care. Groups also educate pregnant women on maternal health and encourage accessing pre- and post-natal health care. Additionally, ASHAA leaders are trained to counsel those suffering from post-disaster trauma. The groups are also a platform to collectively address women's issues. For example, by working with its village government to close liquor businesses in the area, an ASHAA group from a village in Nagapattinam district addressed a post-tsunami increase of domestic violence against women in its community, which the group identified as indirectly caused by loss of livelihoods and which in turn they associated with increased alcohol consumption by men.

ASHAA's impact is well-recognised by communities, local authorities and service providers. Women now demand more knowledge and better services and ask critical health-related questions, including those associated with SRH. HGGs address demands for better health by collaborating with PHCs and government, thus increasing their accountability. As a result, communities increasingly use public over private health services, thereby decreasing health expenditures.[8] In the long term, by addressing critical vulnerabilities of disaster-prone communities, HGGs have strengthened community disaster resilience.

Endnotes

1 *Burnad, Fatima. "The tsunami exacerbates Dalit women's sufferings from caste discrimination." www.apwld.org/tsunami_dalitwomen.htm*

2 *SSP is a learning and development organisation based in Mumbai which has over 15 years of experience in mobilising women from disaster-prone communities to sustainably rebuild their lives and transform disaster recovery processes into development opportunities. Founded in 1989 by Prema Gopalan and registered as a society in 1998, SSP's operations in 10 of the most disaster-prone districts of Maharashtra, Gujarat and Tamil Nadu reach out to over 300,000 families.*

3 *The villages where the initial assessments took place were: Keelamoovarkarai, Poombukar, Koniyampattinam, Puthukkuppam, Madathukkuppam, Naickerkuppam, Melamoovarkarai, Savadikkuppam, Vanagiri, Sonankuppam, Singarathoppu, Akkarai gori, Sothikuppam, Rasapettai, Samiyarpettai, Pudukuppam, Indra Nagar, Pudupettai. The assessment began in January 2005 and refers to a process that took place over a series of peer exchanges that would be held throughout the year in order to encourage a process of grassroots sharing of expertise and capacity building.*

4 *It was also found over the year that there was an increase in incidence of child marriage in some of the villages. This was attributed in part to a well-meaning government policy which provided monetary support to engaged couples for the completion of their marriage (as many had lost all their assets and income during the tsunami), as well as due to reconstruction efforts funded by NGOs and government which intended to give each individual family a new home. This ended up being a misplaced incentive that encouraged some families to marry their girl children early.*

5 *'ASHA' literally means hope in several Indian languages. The acronym ASHAA stands for "Arogya Sakhis ["Health Friends" or loosely interpreted as "Health Guide"] for Health Awareness and Action."*

6 *Cuddalore and Nagapattinam districts of Tamil Nadu, two of the three worst tsunami-affected districts of the state.*

7 *Today the health department and primary health centres have begun holding village health camps regularly (typically 10 to 20 on a monthly basis), with the promotion and assistance of HGGs who mobilise between 40 to 80 people to turn up for each village check up. HGGs are also promoting and helping communities to access special health camps through a state preventative health program called Varumom Kappom Thittam wherein HGGs help to mobilise over 200 community members from four to five villages to attend each camp (one per group of villages per year). In the past one year, HGGs have independently organised over 30 health check-up camps in both districts and have also co-organised over 25 specialist health camps for those requiring further treatment in collaboration with PHCs and a local, well-recognised private medical institute.*

8 *ASHAA members have remarked that their health expenditures have decreased significantly (by approximately 72%) since joining the group.*

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