Health

Chronicles

The deepest truths in health and healing are not found at the centre but where boundaries blur-where science meets compassion, where pain meets resilience and where hope takes root .
An online periodical that publishes stories from pro people health practice

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Editorial

What began as a spark at the Health Equity Conference at Christian Medical College, Vellore in 2024 has now grown into a continuing journey. Amidst conversations on health equity, grassroots work, and lived realities from across the country, an idea quietly took root — to create a space where such stories could be shared, preserved, and amplified. That idea became Health Chronicles.

What began as a simple idea — to bring together stories from diverse corners of the health landscape — continues to shape this second edition. We had envisioned a platform where individuals working in remote regions, academic spaces, field initiatives, and exploratory journeys could share their lived experiences. A space to reflect on their learnings, celebrate their successes, acknowledge their failures, seek support, and create opportunities for others passionate about meaningful work in health.

With this second edition, that vision grows stronger. We continue striving to amplify narratives of hope, unity, and resilience, reaching an even wider audience. We remain especially committed to engaging students in the health sciences who may sometimes feel disillusioned by the competitive race or the glamour of urban practice. Through these evolving stories, this magazine reaffirms its purpose — to illuminate the deeper realities of healthcare and inspire a more thoughtful, compassionate approach to Health for All.

Behind this edition stands a deeply committed compiling team that worked with patience, precision, and persistence. They carefully coordinated with contributors, followed up on submissions, organized diverse narratives, and ensured that every voice found its rightful place within these pages.

The final compilation of this edition was brought to completion through the dedicated efforts of students Vidisha, Geetanjali, Anshi, Jugnu, Bhavika, Nirtunjay, Anushka, Swati, Sarah, Sneha, Aakriti, Savithri and Priyadarsh as well who carefully assembled every section into a unified whole. Their meticulous attention to detail ensured consistency, clarity, and flow across the magazine. Through multiple rounds of review, formatting, and refinement, they transformed diverse contributions into a cohesive publication. This edition stands as a reflection of their patience, perseverance, and quiet commitment behind the scenes.

We extend our heartfelt gratitude to everyone who took the time to share their stories, reflections, and experiences with us. Each submission carried sincerity, depth, and purpose, and it was truly inspiring to witness the enthusiasm with which so many voices came forward. While we deeply wished to include every contribution, space constraints made it impossible to feature them all in this edition — and for that, we offer a gentle apology. Please know that every story matters to us, and we look forward to bringing many more of them to light in the editions ahead. With continued support and participation, we are excited to present even more engaging, diverse, and impactful editions in the future.

We look forward to be have more people connecting , sharing their stories and experiences. We hope to reach out to more and more people and share these amazing stories in the main stream. May this effort serve as a network for connection, support, along the way towards Health For All.

-Dr Priyadarsh

Touching Human Models: Rural Kandha Tribe Villagers' First Outreach Experience

- Krushna Chandra Ataka

Bissamcuttack, Dist. Rayagada (Odisha).

When I first brought human anatomy models to Thuapadi village, I did not expect how powerful a simple teaching tool could become.
That day, nearly eighty villagers—along with many schoolchildren—gathered around a small table where the models were arranged. Elders, parents, adolescents, and curious young faces
stood shoulder to shoulder, waiting to see something most of them had never encountered before.
Seventy-year-old Sitana Nanaka, a Kandha tribal elder, approached slowly, curiosity written across his face. He had lived his entire life in the village, raised children and grandchildren, and treated illnesses with forest herbs and traditional remedies—but he had never seen what the organs inside the human body actually looked like. In the community, bodies are cremated after death, and the inner structure of the human form remains unfamiliar.
When he gently touched the plastic model of the heart and liver, his eyes widened.
“So this is what is inside us?” he asked softly.
That moment stayed with me.
Using these models transformed our health discussions. What once felt abstract—disease,
alcohol-related damage, digestion, breathing—suddenly became visible and real. Villagers leaned in as we removed the liver from the torso model. I explained how years of heavy drinking can scar and harden it, leading to serious illness. The physical presence of the organ made the warning far more powerful than any lecture could.
People asked thoughtful questions:
“Can it heal?”
“How long does it take to get damaged?”
“What foods protect it?”
For me, as a health professional beginning my career in rural service, these conversations felt deeply rewarding. I realized that medicine here was not just about prescriptions—it was about trust, patience, and respectful exchange.

The children were the most enthusiastic. They pointed excitedly at lungs and kidneys, whispering to one another about becoming doctors someday. Watching school students learn alongside elders created a beautiful bridge between generations—science meeting tradition, curiosity meeting experience.At the same time, I learned the importance of cultural sensitivity. Many villagers rely on traditional tribal healing practices passed down through generations. Rather than dismissing these beliefs, I listened. We spoke about how modern medicine and indigenous knowledge can work together—how hygiene, nutrition, early screening, and timely referrals can strengthen what the community already values.

By the end of the session, nearly eighty people had attended to—patients and students alike—each leaving with new questions, new understanding, and perhaps a new way of thinking about their own bodies.
That afternoon in Thuapadi village taught me more than any classroom lecture.
It taught me that learning flows both ways.
Sitana Nanaka thanked me before leaving.
“We knew the body was complex,
” he said with a gentle smile,
“but today we saw it.”
For a young professional starting out in rural healthcare, moments like this turn work into purpose—and service into a lifelong journey.

प्राथमिक स्वास्थ्य केंद्र वेंटीलेटर पर है, पर अभी सांस बाकी है

-Utkarsh Gautam
Azim Premji foundation.
Barmer, Rajasthan.

सुनो, मैं पीएचसी हूँ।
मैं जानती हूँ,
तुम मुझे नहीं जानते हो।
मैं तुम्हारा सबसे नज़दीकी अस्पताल हूँ,
पर तुम मुझे क्यों जानोगे?
तुम तो बड़े अस्पताल जाते हो,
जहाँ महँगा इलाज होता है।
लंबी लंबी कतारों में लगना
तुम्हें अब अच्छा लगने लगा है।
मैं पीएचसी हूँ,
मैं जानती हूँ,
तुम मुझे नहीं जानते हो।
पर क्यों जानोगे तुम मुझे?
न तुमने अपने पापा को यहाँ आते देखा,
न तुम्हारे दादा यहाँ आए।
जब तुम जाओगे ही बड़े अस्पताल,
तो फिर पीएचसी को कौन पूछे गा?
मैं पीएचसी हूँ,
मैं जानती हूँ,
तुम मुझे नहीं जानते हो।
मेरे यहाँ तो
कम दवाइयाँ हैं, अधूरी सुविधाएँ हैं।
डॉक्टर भी यहाँ टिकते नहीं।
फिर क्यों आओगे तुम यहाँ इलाज कराने?
मैं पीएचसी हूँ,
मैं जानती हूँ,
तुम मुझे नहीं जानते हो।
स्वास्थ्य सेवा अब एक बाज़ार बन गई है,
यहाँ निजी अस्पतालों की भरमार है।
डॉक्टर भी व्यापारी बनते जा रहे हैं,
और समाज का खून चूसते जा रहे हैं।

मैं पीएचसी हूँ,
मैं जानती हूँ,
तुम मुझे नहीं जानते हो।
समाज हमेशा से ऐसा नहीीं था।
गांव गांव में वैद्य होते थे,
भोजन अच्छा था और इलाज सस्ता।
पैसा कम था, पर परेशानियाँ भी कम थीं।
बीमारियों का दबाव भी कम था।
जानते हो क्यों?
कयोकिं उपचार से अधिक ध्यान
बीमाररियों की रोकथाम पर था।
मैं पीएचसी हूँ,
मैं जानती हूँ,
तुम मुझे नहीं जानते हो।
पर अभी भी बहुत देर नहीं हुई है।
मेरी पीएचसी और उप-स्वास्थ्य केंद्र दूर नहीं हैं।
मैं बस इतना कहूँगी —
पधारो म्हारे देश,
और जानो कि मैं कौन हूँ।
मैं एक पीएचसी हूँ।
मैं जानती हूँ,
तुम मुझे नहीं जानते हो।

Beyond the tracker : The silent struggle of Anganwadi workers

— Rakesh Ghildiyal
Health Resource Person,
Azim Premji Foundation
Uttarkashi, Uttarakhand

Take Home Ration (THR) is a key component of the Supplementary Nutrition Programme under Integreted Child Development Services (ICDS), aimed at addressing malnutrition among children (6 months - 3 years), pregnant women, and lactating mothers. In a hilly state of northern India, especially in remote regions, frontline workers such as Anganwadi Workers (AWWs) are Responsible for distributing THR while also ensuring digital documentation through the Poshan Tracker app. But using technology, due to poor network, insufficient training, and too much paperwork, has made a potentially useful nutrition program stressful for both the workers and thecommunity.

During a field visit to an Anganwadi Centre (AWC), I witnessed something that left a deep impression on me. I was having a conversation with the AWW when suddenly a woman walked in, straight from working in the fields. The AWW quickly stepped out with her. They walked around here and there, and I stayed back. I was scrolling my phone. Moments later, I heard a loud laugh outside. The AWW and the women hugged each other, sharing a sense of relief and joy. When the AWW returned to the AWC, I asked curiously, “What happened? Why are you so happy?” She smiled and replied, “Her face has finally been captured in the Poshan Tracker.” For distributing THR, AWWs are required to capture the facial image of each beneficiary every month. However, due to poor mobile networks and frequent server issues, this has become an extremely difficult task. That woman had come to the AWC for the seventh time just to get her face captured. Even though THR distribution has been stopped since four months due to supply. Chain issues from the ICDS department, the face capture remained mandatory. If the AWW fails To complete it, she would be questioned by the higher authorities.

Once the face gets captured in the App, even when the beneficiary had not got any THR, they receive an automated SMS saying: "You have received THR for this month. If not, please complain on the given number." Strangely, the complaint number does not work.

Despite this, AWWs—through their rapport and trust within the community—continue to convince families that face capture is essential and that ration may arrive someday. Yet, whispers follow them. Some villagers say behind their backs: “The AWW keeps all the ration for herself.”

These comments are baseless and make AWWs feel demoralized and helpless.

Many AWWs, especially older ones (50+), are not comfortable using digital tools like the Poshan Tracker. They haven’t received sufficient training either. One 55-year-old AWW, who has served for 28 years, shared her experience: “When I raised this issue with my seniors, they told me—‘If you can’t do this, resign. Many unemployed people can take your place.’”In another remote village, an AWW had to take an entire family—husband, wife, and six children—two kilometers away from their home just to find network coverage. She did this for three consecutive days, and yet failed each time to complete the face capture. Finally, under pressure, she recorded a video explaining her challenges and the mental stress she was under. The department’s response was the same cold line: “If you can’t do the work, you are free to leave"

There are countless such stories around THR, that aren’t reaching people, but are marked as
"distributed" in official data. In one village, a drunk man hit a stone at an AWW, injuring her
head, simply because she kept asking his wife to visit the AWC for the mandatory face capture.
But THR is only one part of the load. AWWs juggle numerous responsibilities: working as BLOs
(Booth Level Officers), registering marriages, tracking immunizations, monitoring the nutritional
status of mothers and children, and much more. One AWW admitted with a tired smile:
“Sometimes I feel relaxed when the children don’t come to the AWC. It gives me time to finish
all the other work.” She added, “I know I’m not able to focus on their growth and learning. But
what can I do? No one ever asks me about that. All they want is portal data. And that data never
reflects the real story on the ground.”

These stories are not isolated; these are present in the everyday struggles of Anganwadi Workers
across India. While digital systems aim to bring transparency and efficiency, on the ground, they
lead to emotional distress among AWW and break the community’s trust. The voices of AWWs
must be heard and not dismissed. The system need to balance accountability with empathy.

The Evolution of Blood Vessel Anastomosis: From Ligation to Microsurgical Precision for reconstructive microsurgery.

-The History and Innovations of Blood Vessel Anastomosis

William R. Moritz 1, Shreya Raman 2, Sydney Pessin 1 , Cameron Martin 1 , Xiaowei Li 1 , Amanda Westman 1 and Justin M. Sacks 1,

What is now considered routine was once experimental, controversial, and frequently unsuccessful.

Early Foundations: Hemorrhage Control Without Restoration

For centuries, surgeons addressed vascular injury primarily through ligation. From ancient practitioners such as Paul of Aegina to Ambroise Paré during the Renaissance, tying off bleeding vessels saved lives but did not restore blood flow. While hemorrhage could be controlled, tissue perfusion was sacrificed. True revascularization remained beyond the limits of surgical science.

Early attempts at vessel repair emerged in the 18th and 19th centuries. In 1762, Richard Lambert described a brachial artery repair using a pin, though the technique lacked consistency and reproducibility. Later, Alexander Jassinowsky and J.B. Murphy demonstrated experimental vascular repair in animal models. These efforts, however, l were undermined by limited understanding of endothelial biology and thrombosis, leading to frequent occlusion and failure.

Visualization as a Turning Point

The mid-19th century brought a pivotal shift with improvements in optical technology. Advances by Carl Zeiss and Ernst Abbe enhanced microscope precision, while surgical loupes improved intraoperative visualization. Surgeons could now appreciate the layered structure of vessel walls, particularly the crucial role of the intima in maintaining patency.

Greater anatomical insight clarified why earlier repairs had failed. Intimal injury and turbulent blood flow were recognized as key contributors to thrombosis. This understanding set the stage for technical refinements that would define the next era of vascular surgery.

The Carrel Revolution

The early 20th century marked the first reproducible success in vascular anastomosis. Alexis Carrel , working with Charles Guthrie , introduced the triangulation method for end-to-end vascular repair in 1902. Carrel emphasized meticulous alignment of the intimal layers, dramatically reducing thrombosis and improving outcomes. His techniques enabled consistent vascular repair in experimental models and ultimately established the foundation for organ transplantation. For these contributions, Carrel was awarded the Nobel Prize in 1912. His work did more than refine technique—it redefined what was surgically possible. Vascular repair shifted from experimental curiosity to emerging clinical reality.

Anticoagulation and Clinical Translation

Despite technical advances, thrombosis remained a formidable obstacle. The discovery of heparin by Jay McLean in 1916 represented a major pharmacological breakthrough. As its anticoagulant properties became clinically applicable, vascular patency rates improved substantially. Heparin transformed anastomosis from a technically achievable procedure into a clinically reliable one.

By the mid-20th century, these scientific and technical advances converged. In 1950, Richard Lawler performed the first human kidney transplant using vascular anastomosis. In 1954, Joseph Murray achieved the first successful kidney transplant between identical twins, confirming that vascular reconstruction could support long-term graft survival. These milestones firmly established vascular anastomosis as the backbone of transplant surgery.

The Emergence of Microsurgery

Another paradigm shift occurred with the introduction of the operating microscope. Although microscopes had been adapted for surgical use in the 1920s, it was Julius Jacobson in 1960 who demonstrated their transformative potential in vascular repair. By applying magnification to small-diameter vessels, he dramatically improved precision and patency rates.

Microsurgery enabled anastomosis of vessels only a few millimeters—and eventually less than one millimeter—in diameter. This advancement led to the development of free-flap reconstruction, digit replantation, lymphatic surgery, and supermicrosurgical techniques.

Technological refinement followed: finer sutures, specialized micro-instruments, and enhanced optics expanded the scope of reconstructive surgery. By the late 20th century, vascular anastomosis extended beyond life-saving trauma and transplantation into quality-of-life procedures within plastic and reconstructive surgery.

Looking Forward

Today, vascular anastomosis continues to evolve. Sutureless coupling devices, bioengineered adhesives, and robotic microsurgery represent the emerging frontier. Yet the fundamental principle remains unchanged: precise approximation of viable intima is essential to maintain flow and prevent thrombosis.

From crude ligatures to submillimeter vascular repair, the development of blood vessel anastomosis reflects the synergy of anatomical insight, technological innovation, and pharmacologic advancement. Its history parallels the trajectory of modern surgery itself—where improved visualization, scientific understanding, and interdisciplinary progress steadily expand the boundaries of what is surgically achievable.

Unity, Passion and Diversity:

-Aisiri Bhat

MBBS Third year Student at GMC, Silvassa

It is so very hard for a Gen Z student to be able to witness all three of these complicated yet intertwining qualities in this materialistic world, but I am so very grateful for having gotten the opportunity to be able to capture all three of these entities at the very base level.

Being a newbie into the medical course, like actually a newbie, because I've just completed first year MBBS, like most others I knew literally nothing about the ins and outs of the Healthcare System the practical side to it or just how exactly it works but this was all about to change as I was ableto attend the RSP camp (Rural sensitization program), which is an initiative taken to expose the medical students to RuralLife, the Health Care System its facilities and also theproblems.

As soon as I set foot into the camp, I immediately felt a spark of togetherness and a sense of belonging with these people,the environment and just the setting in general. It was just around 30 of us from various corners of India withinnumerable differences maybe with respect to college,language, age, etc. with the only commonality being Healthcare and a desire for social service but I didn't feel like an outsider in any way.

Our first day to becoming sensitized to the rural healthconditions began by being taken to the health clinic at Bagdonda. There, after a brief overview on how things workover there, we were given the space to observe. It was over here that I alongside my peers were we able to grasp onto some of the most important qualities that all human beings should inculcate, especially the healthcare professionals.

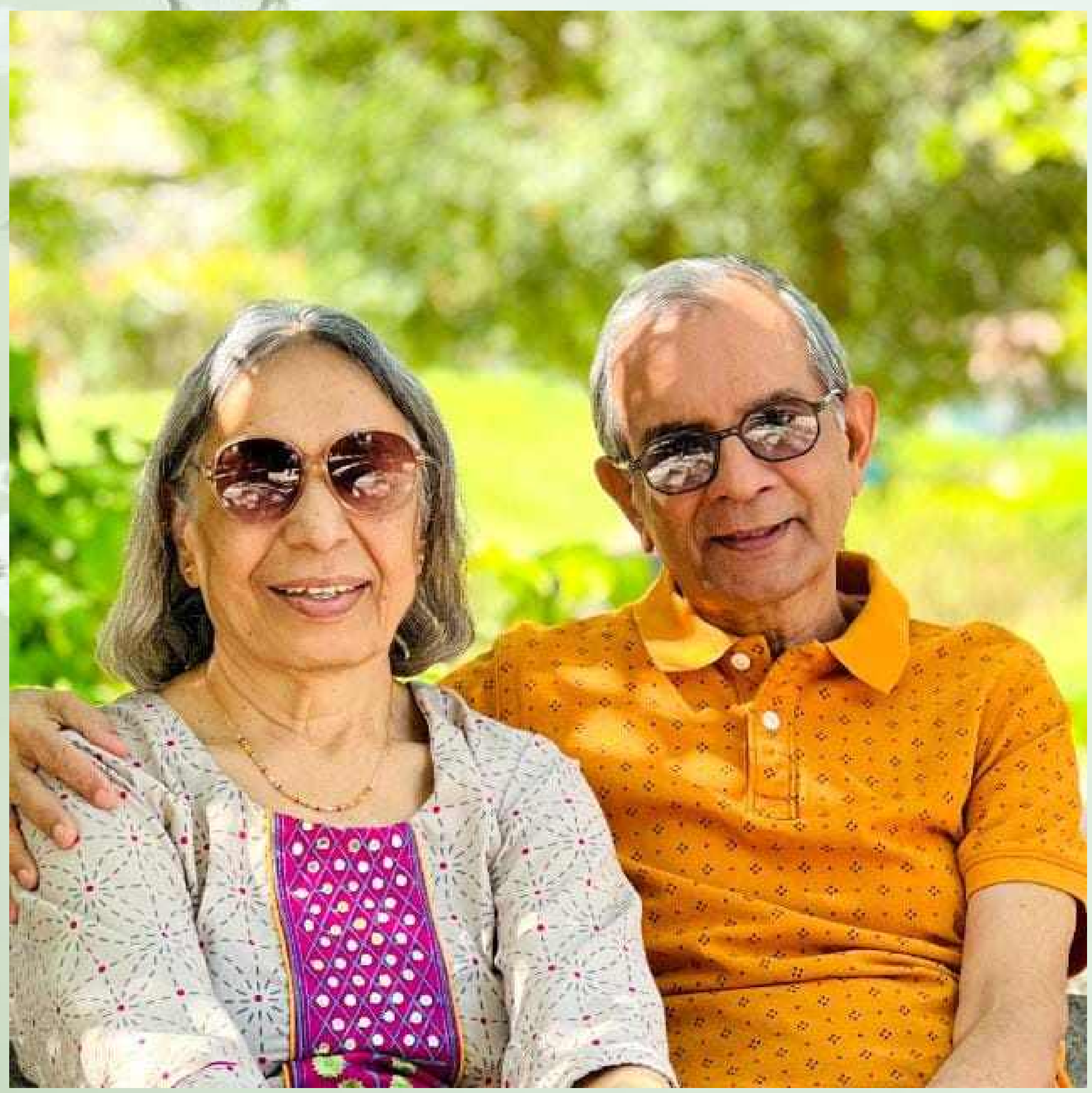
Selflessness was one major quality that was abundantly displayed by the villagers for they may not have a lot to offer but whatever they have, they share it with us with so much of love and warmth.

Throughout this 3-day walk through, the doctors and organizers here were living examples that if you are driven by your aspirations then you can always flourish and continue.
It is not easy to create awareness in places that have very minimum resources. It is so very hard to be able to instil a sense of hope in deprived regions. It is so easy to give up. I could go on and on about the many extreme challenges that are faced at these settings but still the drive to continue and maintain that same energy that you once upon a time had, the unwavering tendency to help and serve: These are just a summary of the things that I could grasp.
All in all, I honestly believe that these three days of attending this rural sensitization program is a huge milestone for me and I never thought that as an 18-year-old I would ever get thisexposure, so to actually get that especially in this education system when everything is so theoretical is something I'm really grateful about.

Aisiri Bhat
II Year MBBS

Service Beyond Profession

-Ashok Bhargava & Dr Lata Shah
(Our Journey As A Social Workers)



My family faced hardships when I was a child. It gave me firsthand experience of marginalized people's lives. Later when I was in college I went to work in the famine that struck Bihar in 1967 where I saw the death of a Dalit woman due to hunger. This event forced me to devote my energies and skills for social transformation. I didn't enter this field due to the attraction of any idol or ideology.

When raised in economic hardships, you are expected to earn money to improve your family's standard of living. Despite pressure from my family and relatives to take this path I chose to work for marginalised people, disregarding economic security..

Though individual efforts and initiatives are important, social transformation requires social movements. I was part of an organization called Tarun Shanti Sena which brought thousands of young boys and girls together to work for social change based on values like - democracy, secularism, national integration, world peace, social equality and economic justice. Lots of young members followed Gandhi's maxim “Be the change that you wish to see in the world.” They preferred inter caste marriage to break the caste barrier. Some of them even chose partners from different states, language, culture and even religion. We put gender equality in practice, declined dowry, declined to inherit parental property.

We raised our voices against the education system which failed to provide Life Skills and employment. Some of us burned our degrees many left their studies half way in order to learn from life experience. Medicos in Tarun Shanti Sena were under the impression that medical education is fine until one of them realised its shortcomings during his rural posting. A discussion on this topic gave birth to the Medico Friend Circle.

When Mrs. Indira Gandhi imposed an emergency in 1975 suspending fundamental rights of the citizens, we became part of the movement to restore democracy. Some of us who were arrested under MISA remained in jails for one to two years. Some of us worked with the marginalized people to restore their rights related to land, forests, health, education, livelihood, etc.

I am neither a leader nor an expert or professional. I enjoy working with my hands and problem solving with my brain. I like to work as a team member. Most of my learning and training were results of responsibilities, tasks and challenges I got involved with. It is different from formal education where one learns first and applies it later.
Spent 4-5 years in strengthening Tarun Shanti Sena and MFC as their national convener. I stayed in villages of Gujarat for almost 12 years where I got the opportunity to learn about health problems and behavior of marginalized people (Working as Village Health Worker). Working with children out of school gave an opportunity to understand "how people (children) learn?", pedagogy and epistemology.
Construction of dispensary buildings using local material taught me low-cost architecture. Investigation of jaundice in Ahmedabad gave the opportunity to learn some aspects of epidemiology and public health. Every learning helped in exploring and grasping other problems. Like working as VHW and understanding of "how people learn" helped us in designing the health education material and training programs for rural people when Lata and I got involved in it.

Lata started her social work in Arunachal Pradesh after completing her MBBS. After she worked with trust hospitals catering to the minorities and marginalized women. We joined together to prepare health education material in 1990. (See the the report “Ideal : A Decade of Learning”)
The role of a social worker is to facilitate empowerment of people among whom he/she is working. Going back to Gandhi's talisman, assessment of our work should be judged on: "Had he [she] gained anything by it? Did it restore him [her] to a control over his [her] own life and destiny?"
(Examples of people’s empowerment can be seen in the report.)
Whatever learning and experience we acquired during our activities of preparing health education material and training of health workers we shared with other colleagues in MFC through workshops.

We wanted to achieve health for all through strengthening the public health system but ended up in creating trust hospitals providing curative services. Not much has been done in preventive and promotive health. While working with village people we lost touch with the students and could not mobilise them for social change like we did in Tarun shanti Sena days.

My Journey
Lata Shah

I was brought up in a well-to-do middle class family in a small town in Gujarat. I never faced any hardship but was sensitive to the needs of poor people. Imbibing good values from parents and teachers I decided to become a doctor to serve the needy people. After completing my MBBS I went to Arunachal Pradesh in 1975 to work at a health project started by Tarun Shanti Sena. After coming back I did MD in Obst & Gyn and served in a trust hospital catering to the poor women of minority community for 10 years. Thereafter I worked with trust hospitals working among very poor communities of Banaskantha and Sabarkantha district of Gujarat. I conducted clinics in remote villages and major surgeries in trust hospitals.

I came to know that most women suffer from iron deficiency anemia and undernutrition. Women and village TBAs don't have necessary understanding of the reproductive system. I had to treat and operate several cases of prolapsed uterus which were the result of TBA vigorously pushing the uterus to expel the placenta fearing that it will ascend to the lungs. They believed that the uterus is open from the top. We produced a life-size model of the uterus to correct this notion.

Since 1998 I worked full time with IDEAL to prepare health education material and training of village health workers. Working with tribal women I found that they were very sharp and quick to grasp new information and could remember and recall important points without taking any notes. Their strategy of learning by doing was far superior than ours. (This common journey covered in IDEAL: A Decade of Learning)

A Journey of Growth, Grit, and discovery, a Research Journey!

- By Aakriti Roy, Sneha Tayde, Kapil Saini, & Chelsi Purohit

Here are some stories of student researchers, asking and seeking answers through some un-ordinary, yet interesting ways. STS - ICMR is a student short term internship/studentship. It encourages young students to engage and learn research.

<u>Idea and concept of their research:</u>

Aakriti, 3rd year MBBS Student, Sevagram
Aakriti's research journey began during a GTP camp discussion. A conversation about pesticide regulation in Tamil Nadu and its link to reduced self-harm cases left a deep impact on her. When someone said that many attempts are not always a wish to die but often a cry for help, the idea stayed. Later, discussions in Sevagram and guidance from a psychiatry professor encouraged her to explore deliberate self-harm along with self-compassion and perceived social support. What initially seemed abstract became real through patient interactions.

Kapil, 3rd year MBBS, Sevagram
Kapil found his research question during a community medicine field visit. Observing community-based rehabilitation for stroke patients made him realize how much support they needed. That exposure shaped his decision to study unmet needs among stroke patients.

Chelsi, Final Year MBBS, Silvassa
For Chelsi, research began at home. Her brother's delayed diagnosis of compound heterozygous sickle cell disease transformed her understanding of medicine. Under the Indian Council of Medical Research STS 2024 program, she studied variations in clinical presentation among sickle cell patients in western India. What started as a two-month project extended far longer — driven not just by academics, but by purpose.

Sneha, Final Year MBBS, Silvassa

Sometimes the most important journeys begin with the simplest decisions. During a research meeting, Dr. Priyadarsh asked us to choose from five topics, and I picked snakebite without much thought.What started as a simple choice soon grew into a valuable learning experience, shaping my understanding of research and guiding me to where I am today.

The Process: What Research Really Looks Like

For Aakriti, the journey from idea to execution was both structured and deeply human. With a supportive guide, she learned how to search on PubMed, review literature, and build a protocol with clarity. But the real challenge began when research moved from paper to patients. Identifying cases, reviewing files, and interviewing patients in Medicine wards after classes demanded consistency and balance. Gradually, she realized patients were not just answering questions — they were looking for someone to truly listen. Interviews often became safe spaces. Research, she discovered, was not just data collection but an ethical and emotional engagement with lived realities.

For Sneha, data collection began during final year postings — a demanding phase of MBBS. Over 6–7 months, she balanced ward duties while collecting cases from ICU, male, and female wards, often with friends covering her postings. Conducting 20–25 minute interviews taught her patience, discipline, and critical thinking. Research helped her grow from a student into a seeker of answers.

Kapil's journey began with finding the right mentor. Approaching faculty required confidence, but consistent guidance helped him refine his topic after field exposure to stroke rehabilitation services. Multiple proposal revisions, literature reviews, and ethics committee approval taught him persistence and methodological clarity.

Chelsi's study involved forty sickle cell patients under the Indian Council of Medical Research STS program. As the sole investigator, she interviewed patients, verified clinical data, and conducted analyses. Interviewing during pain crises was emotionally challenging, especially with stigma attached. Over time, trust developed. Patients began recognizing her, and one mother's words — "You will become a good doctor" — became the most meaningful outcome, beyond any questionnaire.

<u>The Challenges they faced during research:</u>

For Chelsi, final year meant eleven subjects, clinical postings, and constant examination pressure.
"At times it felt like — what's the point of doing all this?"
The most demanding phase was analysis. Data cleaning, learning statistical tools, interpreting outputs — nothing came easily. Days and nights went into refining the work. Close to the deadline, with guidance from mentors and biostatisticians, the data finally stabilized.
"We had smiles, we had tears... it was quite ups and downs."
That phase taught her discipline — and deep respect for data.

For Aakriti, the struggle was emotional. Entering psychiatry without much background, she had to ask deeply personal questions about self-harm, worthlessness, violence, and family conflict. Listening to repeated accounts of domestic abuse and alcohol-related aggression was heavy. Learning to regulate her own emotions — with support from a senior resident friend — became essential. She also realized that many research scales did not fully reflect rural Indian realities. Balancing methodological rigor with participant comfort, especially during recorded interviews, required sensitivity and constant reflection.

Kapil faced challenges in the field. Locating patients in villages without clear addresses, coordinating with ASHA workers, managing transport, and balancing academics demanded daily planning. He learned that logistics can be as important as research design. He also discovered that research tools are not always culturally perfect — some questions felt distant or sensitive, requiring careful communication.

For Sneha, balancing final-year postings with data collection in the Medicine ward and ICU was exhausting. Language barriers with Warli-speaking patients, hesitation during consent, and fear around certain components made interviews demanding. She later realized that seeking help earlier might have eased the process. Yet, the patience required to complete each 20–25 minute questionnaire strengthened her perseverance.

Research, some young seekers' guide to a beautiful journey.

A 40 KM Walk for Healthcare: A Reflection on Systemic Inequities

-DR. TIJO THOMAS

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He started his journey at 5 in the morning, walking 40 kilometers from his village to reach the health center. When I asked him, "Kentha kari asithilo?" (How did you come ?), he simply replied, "Chali chali..." (Just walked). It took me a moment to process that he had walked this entire distance for a basic health check-up. The realization hit me hard, and I felt an immense sense of responsibility as I prepared to treat him—a responsibility I hadn't felt so acutely before.

The man had been suffering from a high fever, cough, and cold for the past week. But beyond these immediate concerns, my examination revealed bilateral cataracts severely obstructing his vision. When I asked about it, he acknowledged his reduced vision but dismissed it as something he could live with. For him, even a simple cataract surgery was an unaffordable luxury.

This encounter left me grappling with a whirlwind of thoughts. How does our healthcare system fail people like him so profoundly? Coming from Kerala, where super-specialty hospitals are abundant and accessible, this was a bitter pill to swallow. The poor functioning of government hospitals is a grave injustice to those who depend on them. It's disheartening to see that even district hospitals often lack the capacity to perform basic procedures like cataract surgeries or thrombolysis for myocardial infarctions (MI).

Moreover, tribal communities and marginalized groups frequently face discrimination and neglect within these healthcare systems. This systemic sidelining discourages them from seeking medical care altogether. In a world where even government policies increasingly cater to corporate interests, how can the common person survive? Who will advocate for the poor?

As Rudolf Virchow aptly stated, "Physicians are the natural attorneys of the poor." Yet, in today's capitalistic world, the corporate-driven healthcare system has become the biggest culprit. It brainwashes budding doctors into prioritizing tertiary care and profit over primary care and social responsibility. This shift not only undermines the ethical foundations of medicine but also perpetuates the cycle of inequity.

This experience has reinforced my belief that healthcare is a fundamental human right, not a privilege reserved for those who can afford it. It is our collective responsibility to advocate for systemic reforms that prioritize accessibility, equity, and compassion. Only then can we hope to bridge the gaping chasm between the privileged and the marginalized in our Society.

The "Panini Generation": life in a blink of an eye

-Shyno Annie Jacob

Being a millennial daughter who has parents in and around 70, health is one the frequent topic I discuss with parents. As for many, this is one of the touchy topic too. Your concerns just get deflected as they feel like you are policing them. You are trying to figure out your
own life/ your spouse/ your kids and your parents at the same time. When you are staying away and is not able to reach in case of a need, a hospitalisation is a major toll on you trying to figure out the supportive bystander who can be with them, the finances in case you don't have insurance or not from a financially stable environment and most of all, the emotional load of managing it all. It's a physical, mental and financial struggle for an average middle class child.

In Kerala, most of the household has only parents, where trying to find a good caregiver who understands the need of the patient and the underlying physical and mental health conditions is a struggle irrespective of the financial situation you are in. Recently, I came across this ad in FB where they are offering help as an accompanying person if you need someone to take you to hospital. This need comes from the reality that most of the houses has none to accompany to a hospital appointment or to be a bystander in case of . hospitalisation. Just like it says, it takes a village to raise a child, it needs a community to take care of a patient or an older person. And that community is getting smaller and smaller with nuclear families and with migrations of next generation. With human expectancy increasing, we need to have proper system in place if we want to support this growing community. And the government need to make sure that it is accessible for all the walks of life. Hospital processes also needs to be more inclusive and practical for the current world problems. For example, in hospitals, expecting a bystander even for an OP appointment which might need an XRay or scan is also getting impractical these days with most homes having a single parent living alone.

Having an older set of parents who belongs to baby boomer generation, it's quite a challenge to communicate even when they are all healthy and in their best state physically and mentally. It adds an extra burden when they start declining physically. Physical stress and pain makes it more difficult to manage and communicate effectively and the emotional toll it has on both the ends is something our society hasn't been equipped to handle yet. And the current health system has no regard for the family members or the caregivers who are attending the patients. And most of the time, I find it cruel on patients too, making them isolated in spaces where they can meet limited number of people for a limited time. Most of them feel shame and guilty being dependent on others. We need heath care systems to address these issues, by taking care of mental health of the patients and caregivers too. Also, our public spaces and events needs to be more inclusive for our older population and for patients.

Public transportation, public spaces including park, events organized from government need to take care of the accessibility for our older and physically challenged population. We don't need system to isolate peoples into groups, in fact we need systems that work for all.

Last but not least, the financial issues that comes up with a disease is huge. With big corporates taking over the healthcare, even a daycare treatment in hospital is becoming a big financial burden for people who don't have an insurance. And for the majority of the population who does not come under State/Central governed pensions and insurances, this is added financial burden with the current inflation rate. This makes the parents more dependent on kids or someone else, making it difficult to access the healthcare on time and when needed. Delayed access to healthcare puts more pressure on all 3 levels, making it even more difficult and unmanageable at times.

Unless system intervene with processes to help the challenges for a growing community, it's going to put immense pressure on the earning population, who is also raising the next generation alongside. If the physical strength,financial resources, and mental energy
are getting drained, we cannot make use of the potential of our current generation who contributes to the society and generates tax for the government. They will not be able to raise a healthy generation for tomorrow and will not able to take care of their own health,repeating the cycle.
Coming from a nuclear family with or without a sibling who might be around if you are lucky to support your parents intertwined with societal and moral pressure to take care of your parents irrespective of how your relationship with parents is a moral dilemma many have.
Also, physical and emotional labor, as like in any other household related issues, falls on the females here, expecting them to perfectly manage and be the best care taker sacrificing your own mental and physical health, whereas mostly son is expected to manage the financial burden in an average Indian household. Unlike previous generations, who had multiple people to reach out to in case of a need, our generation is mostly running on a single person or single family system, and if something goes wrong, entire unit is suffering with no reliable system to fall back to.

Comparing to a decade or two ago, people in their 30s and 40s are also under long term disease management including for obesity and lifestyle diseases. They are the panini generation who needs to manage their parents and their kids along with themselves with no or minimal community support, probably the first of such kind in the history. Leaving no room for oneself amidst all these along withother struggles to focus on career and kids and self actualisation in the prime productive years of the life is not a sprint, but a marathon for an average of 15 to 20 years.

Dilemma's of Working in Periphery

-Sebin George Abraham
Community Health dept, CMC Vellore.

Regulations decided centrally cause dysregulations at the roots.
The regulations made and put in force by the government that are decided by the authorities are meant to align with the purpose.
But what if at the grass roots it doesn't?
Let's discuss a few dilemmas faced by a doctor working in the periphery:
The Community Health department has built trusting relationships in a tribal area, including the presence of village-level health workers who play an important role in improving access to health.
When an adolescent girl just below 15 years of age presented to us with non-specific complaints like myalgia, weakness, etc., we came to know of her marriage that had taken place a few months ago. On further probing, she revealed that she had a fight and was facing certain adjustment issues with her husband, though she loved him.

This marriage was not done in secret. Rather, it was held with all the regular customs, and for the community, it was not highly unusual to have marriages involving teenage girls less than 18 years of age.

Now the conundrum lies here.
As health professionals, we are bound to report the marriage under the Pocso Act. However, we risked breaking the ties with the community, which was built through decades of sustained fieldwork.

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The POCSO Act

The Protection of Children from Sexual Offences Act (POCSO Act) is an Indian law enacted in 2012 to protect children from sexual abuse, harassment, and exploitation.

Being at the crossroads, we do understand the community and their culture, but at the same time, we were legally required to report it or be penalised for not reporting.

The Supreme Court has recently directed the government that the POCSO Act should have a Romeo-Juliet Clause because many adolescent lovers face the music, because of the age cutoff, and also since it has been misused by disapproving families of such adolescents.

अंबु... अंबु... अंबु - पहाड़ों में सांसों की पहरेदारी की कहानी

दूरस्थ इलाकों में सेवा देने वाले स्वास्थ्य कर्मियों के संघर्ष और समर्पण की असल झलक

-Rakesh Ghildiyal
Azim Premji Foundation
Uttarkashi,Uttarakhand

"अंबु... अंबु... अंबु..."

एक मरीज को ऑक्सीजन की कमी हो रही थी। प्राथमिक स्वास्थ्य केंद्र के दो कर्मचारी अंबु बैंग (हाथ से चलाया जाने वाला बसन उपकरण) के माध्यम से उसे ऑक्सीजन देने का प्रयास कर रहे थे। भारत के इस पहाड़ी राज्य में चीन बॉर्डर से सटे इस इलाके में बाहर पुटनों तक बर्फ गिरी हुई थी ओर यहाँ पहुँचने के सभी रास्ते बंद थे। ऑक्सीजन सिलेंडर लाने के लिए एंबुलेंस जैसे-तैसे निकली तो थी, लेकिन भरोसा नहीं था कि वह वापस लौट पाएगी। अस्पताल के अंदर मरीज को जिंदा रखने की लड़ाई जारी थी। दोनों स्वास्थ्यकर्मी बीच-बीच में नंगे पैर जनरेटर तक भागते, जैसे-तैसे चालू करते, लेकिन कुछ देर बाद फिर जनरेटर बंद। और फिर वहीं दृश्य-

"अंबु... अंबु... अंबु..."

अगर बिजली होती तो ऑक्सीजन कंसंट्रेटर (एक ऐसा इलेक्ट्रिक उपकरण जो हवा से ऑक्सीजन अलग करके मरीज को शुद्ध ऑक्सीजन प्रदान करता है) की मदद से मरीज को लगातार ऑक्सीजन मिल पाती।

काफी देर तक यही संघर्ष चलता रहा। तभी एक कर्मचारी की नजर जनरेटर पर लिखे एक नंबर पर पड़ी। उन्होंने सोचा क्यों न फोन पर मदद मांगी जाए? फोन लगाया गया, किसी ने उठाया भी, लेकिन जवाब मिला- "एक एप्लीकेशन भेज दीजिए, फिर देखते हैं कि क्या कर सकते हैं।" और फिर वही कहानी-

"अंबु... अंबु... अंबु..."

कुछ देर बाद एंबुलेंस भी खाली हाथ लौट आई। लेकिन एक रास्ता निकाला गया मरीज को वहाँ तक पहुंचाया गया वहाँ सड़क बंद थी, पैदल पार करवाकर दूसरी एंबुलेस में बिठाया गया और जिला अस्पताल भेजा गया।

मरीज बच गया। पर इस पूरी घटना को बयां करने वाली सामुदायिक स्वास्थ्य अधिकारी तनुजा आज भी उस "अंबु अंबु अंबुवाले दिन को भूल नहीं पाती।

तनुजा पिछले दो वर्षों से इस प्राथमिक स्वास्थ्य केंद्र के एक उपकेन्द्र पर कार्यरत हैं और प्राथमिक स्वास्थ्य केंद्र से उपलब्ध करवाए गए सरकारी आवास में रहती है। आपात स्थितियों में तनुजा अपने काराजी कर्तव्यों से ऊपर उठ कर प्राथमिक स्वास्थ्य केंद्र के कर्मचारियों की मदद कर एक सच्चे पेशेवर की तरह नैतिक उत्तरदायित्व को बखूबी निभाती है।

यह इलाका जिला मुख्यालय से लगभग 80 किलोमीटर दूर है। वहाँ पहुंचने के लिए सड़क तो है, लेकिन कभी भूस्खलन तो कभी बर्फबारी के कारण सड़क अक्सर बंद हो जाती है। यातायात के साधन भी बहुत सीमित हैं- अधिकतर लिफ्ट मिलने की उम्मीद में निकलना पड़ता है, काना पैदल ही जाना होता है। जंगलों से घिरे इन रास्तों पर भालू और नाम के हमलों की घटनाएँ भी सुनने को मिलती हैं, लेकिन चलने वाला चलता ही जाता है। नेटवर्क की स्थिति इतनी अनिश्चित है कि तनुज के पास तीन अलग-अलग कंपनियों के सिम कार्ड हैं क्योंकि यहाँ कब किस कंपनी का नेटवर्क कुछ घंटों के लिए चले या बिल्कुल ना चले, इसका कोई भरोसा नहीं।

एक प्रतिष्ठित संस्थान से नर्सिंग की पढ़ाई के दौरान तनुजा ने सोचा था कि वह आगे मास्टर्स करके अध्यापन की तरफ बढ़ेंगी। सामुदायिक स्वास्थ्य अधिकारी का फॉर्म तो अस मज़ाक में भर दिया था। जज तक परिणाम आचा, तब तक शादी भी हो चुकी थी। तनुजा चाहती थीं कि उनके पति आगे पढ़ाई पूरी करें, इसलिए उन्होंने यह नौकरी शुरू कर दी।

नौकरी के शुरुआती दिनों में एक दिन तनुजा ने कुछ बच्चों को घुटनों तक बर्फ में 4-5 किलोमीटर पैदल चलकर स्कूल बाते देखा। तब उन्हें समझते देर नहीं लगी कि जिन पहाड़ो, नदियों और चर्फ को देखने के लिए लोग हजारों रुपये खर्च कर आते हैं- वहाँ का जीवन आसान नहीं होता। यही वह पल था, जब काम का कोई मकसद मिला।

दवाइयों से भरा बैग कंधे पर डालकर तनुजा सुबह अपने कमरे से निकलती हैं। उप-केंद्र यहां से 5 किलोमीटर दूर है। लगता तो है कि कोई गाड़ी मिल जाएगी, लेकिन इंतजार में समय न गंवाते हुए वह सुनसान सड़क पर पैदल ही चल पड़ती हैं जब तक कि कोई वाहन न मिल जाए। उप-केंद्र के पास चार गाँवों की जिम्मेदारी है, इसलिए वह बारी-बारी से लगभग रोज हर गाँव जाती हैं।
रास्ते में लोग अपने आँगनों से आवाज लगाते हैं-

"तनु, जरा BP देख लो।"

"मेरी दवा खत्म हो गई है, साथ लेती आना।"

और कभी-कभी हँसते हुए डांट भी लगाते हैं-

"तू नसों चाय पीने क्यों नहीं आई?"

तनुजा सबकी सुनती हैं, दवाएँ देती हैं और तब तक समझाती हैं जब तक सामने वाला संतुष्ट न हो जाए |

लोगों के दुख-सुख में साथ रहना, बीमारियों का फोलो-अप करना और अच्छे स्वास्थ्य की सलाह देना अब उनकी दिनचर्या का हिस्सा बन चुका है।

गाँव वाले भी उनका चहुत ध्यान रखते हैं; कभी देर हो जाए तो कोई कह देता है-

"अंधेरा हो गया है, में छोड़ आता हूँ।"

और कभी-कभी तो अपनी गाडी भी थमा देते हैं -

"आज तुम गाड़ी ले जाओ, कल दे देना।"

पर शुरुआत में सब कुछ ऐसा नहीं था। यह विश्वास जीतने में और समुदाय का हिस्सा बनने में उन्हे समय लगा। किसी की तबीयत खराब होने पर बार-बार फॉलो-अप करना, गाँव की संस्कृति के साथ खुद को जोड़ना यही आदतें धीरे-धीर लोगों के दिल तक पहुँचती रहीं। यहाँ के नवयुवक मंगल दल के साथ तनुजा रोज सुबह सफाई अभियान में भी जाती थीं। तनुजा बताती हैं कि नौकरी के शुरुआती दिनों में वह अपने उप-केंद्र के गाँव में ही एक कमरा किराए पर लेकर रहती थी। यह गाँव हिंदू धर्म के राजपूत समुदाय का है। पहाड़ों में यह धार्मिक मान्यता प्रचलित है कि ब्राह्मण समाज, राजपूत समाज के हाथों का पका चावल नहीं खाता। इसलिए जब भी गाँव में कोई धार्मिक अनुष्ठान होता और बाहर से ब्राह्मण आते, तो वे अपना भोजन स्वयं बनाते थे।

तनुजा भी ब्राह्मण है। जैसे ही यह आत गाँव वालों को पता चली, वे उनसे मदद लेने लगे। तनुजा भी पूरे मन से प्राह्मणों के लिए खाना बनाने लगीं। इस तरह तनुजा का गाँव की धार्मिक और सामाजिक प्रक्रियाओं में शामिल होना, उसे धीरे-धीरे स्थानीय संस्कृति से जोड़ता चला गया। यह जुड़ाव इतना गहरा हुआ कि समाज की वर्षों पुरानी कुछ परंपराएँ भी वह अपनाने लगीं जैसे मासिक धर्म के दौरान किसी के घर न जाना और मंदिरों से दूरी बनाए रखना। यह अनुभव शायद उनके लिए नया था, क्योंकि शहर में पली-बढ़ी एक लड़की के लिए ये परंपराएँ रोजमर्रा के जीवन का हिस्सा नहीं रही थीं। लेकिन धीरे-धीरे उन्हें यह समझ आया कि जिन लोगों के बीच रहकर काम करना है, उनसे जुड़ाव केवल दवाइयाँ देने या सेवाएँ पहुँचाने से नहीं बनता। जितना जरूरी स्वास्थ्य सेवाएँ देना है, उतना ही जरूरी लोगों की संस्कृति, सामाजिक विश्वासों और परंपराओं को समझना और उनका सम्मान करना भी होता है। यही समझ उन्हें समुदाय का हिस्सा बनने में मदद करती रही।

इन सब कार्यों को करते-करते वह धीरे-धीरे यहीं की लगने लगीं। आज तनुजा से बातचीत करके कोई भी यह नहीं कह सकता कि वह जीवन के 22 साल एक शहर में पढ़ाई कर यहाँ आई हों। स्कूटी और कार चलाने वाली तनुजा अब पहाड़ की पगडंडियों पर बहुत ही सहजता और निडर होकर चलती हैं। एक महिला होने के कारण उन्हें कई बार मनचले लड़कों की सीटी, देर रात के फोन कॉल और अनचाही निगाहें भी झेलनी पड़ती हैं लेकिन काम की तल्लीनता में यह सब पीछे रह जाता है।

पलायन की मार झेल रहे इन पहाड़ों में बुजुगों के लिए सामुदायिक स्वास्थ्य अधिकारी किसी वरदान से कम नहीं हैं। जो लोग चलकर उप-केंद्र तक आ सकते हैं, उनके लिए वहीं दवाइयाँ और जांच की व्यवस्था रहती है, और जो नहीं आ पाते, उनके घर जाकर हलवाल पूछना, BP-शुगर जांचना, दवाइयाँ देना यह सब तनुजा पूरी जिम्मेदारी के साथ करती हैं।

गर्भवती महिलाओं को वह अपना व्यक्तिगत नंबर देती है, क्योंकि उन्हें लगता है कि उननके 108 पर बात करने और पूरी जानकारी देने में समय ज्यादा लग जाएगा और जोखिम बढ़ सकता है। 108 पर तनुजा महिलाओं की जगह स्वयं बात करके जानकारी देती और जल्द सेवा की उपलब्धता को सुनिश्चित करवाती।

एक दिन तनुजा ने उप-केंद्र के बाहर एक लड़के को भांग के पौधे की रगड़ते देखा, और उसी दिन उन्हें लगा कि सिर्फ इलाज से काम पूरा नहीं होगा। अब वह समय समय पर स्कूल जाती है लड़कियों के साथ किशोरी स्वास्थ्य पर बात करती हैं और लड़कों के साथ नशे से होने वाले नुक्सान पर।

लेकिन यह सब इतना आसान भी नहीं है। तनुजा की पिछले पाँच महीने से सैलरी नहीं आई है। जैसे-तैसे वह घर वालों की मदद से अपना खर्च चला रही है। अपर बैठे अधिकारी भी कोई स्पष्ट जवाब नहीं दे पाते लेकिन कार्य फिर भी जारी रहता है। सिस्टम को बस डेटा चाहिए, चाहे जमीनी परिस्थितियाँ कैसी भी हों।

एक बार एक गर्भवती महिला ने 108 पर फोन किया, लेकिन बात करते-करते नेटवर्क चला गया। परिवार ने बड़ी मुश्किल से खुद ही गाड़ी की व्यवस्था की, लेकिन गाड़ी में बैठते ही महिला कर प्रसव हो गया। जच्चा-बच्चा सुरक्षित थे, फिर भी सवाल यह उठा कि प्रसव अस्पताल में क्यों नहीं हुआ।

असल में प्रसव किसी नियम या प्रक्रिया का इंतजार नहीं करता, लेकिन व्यवस्था अक्सर हालात को समझे बिना तय जवाब ढूँढती है। ऐसे मामलों में नेटवर्क जैसी मजबूरियाँ पीछे रह जाती है और पूरा दचाव स्वास्थ्य कर्मचारियों पर आ जाता है। इसका असर उनके काम के साथ-साथ उनके मानसिक स्वास्थ्य पर भी पड़ता है। तनुजा कहती हैं- "हमारी गलती बस यही थी कि उस वक्त हमें और हालात को समझने वाली कोई व्यवस्था हमारे साथ नहीं थी।"

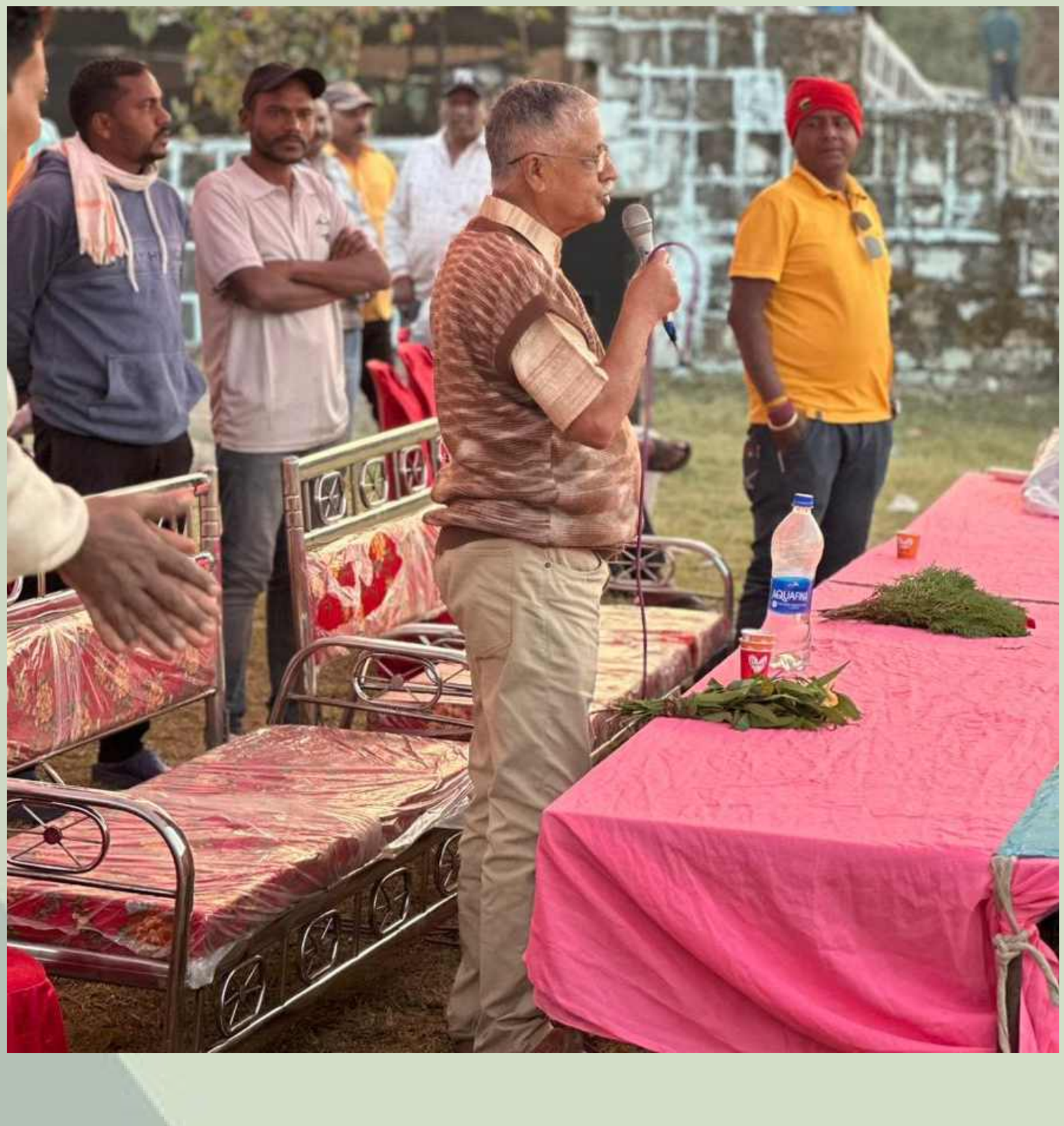
इन भौगोलिक परिस्थितियों में, पारिवारिक जिम्मेदारियों के कारण बहुत-से कर्मचारी शहरों में ही रहते हैं और काम पड़ने पर अपने कार्यस्थल पर आते है। सुविधाओं की कमी से जूझ रहे ये क्षेत्र सेवा प्रदान करने वाले कर्मचारियों के परिवार की सुरक्षा को लेकर भी चिंता पैदा करते हैं, इसलिए कर्मचारी दो मोचों पर एक साथ संघर्ष करते हैं एक अपने घर के लिए, और दूसरा अपने कार्यस्थल पर |

तनुजा आज हर चुनौती का सामना डटकर कर लेती है-चर्फ, जंगल के रास्ते, पहाड़, नेटवर्क की समस्या, और मानसिक दबावा यह उनकी 'आंतरिक प्रेरणा' ही है जिसने उन्हें अब तक यहाँ थामे रखा है। लेकिन यह कहानी हमें एक बड़े सच का सामना करने पर मजबूर करती है कि चुनौतीपूर्ण परिस्थितियों में काम करने के लिए जुनून जरूरी तो है, लेकिन यह चुनियादी सुविधाओं का विकल्प नहीं हो सकता।

किसी भी स्वास्थ्य सेवा की सफलता को केवल कर्मचारी की इच्छाशक्ति' के भरोसे नहीं छोड़ा जा सकता। हम यह उम्मीद नहीं कर सकते कि हर कर्मचारी तनुजा जैसा असाधारण त्याग करेगा। एक मजबूत स्वास्थ्य ढांचा वह है जिसमें एक सामान्य कर्मचारी भी निर्धारित प्रक्रियाओं और मजबूत सिस्टम के दम पर कुशलता से काम कर सके। सेवा तब तक ही टिकती है जब पीछे से व्यवस्था साथ देती है। अगर बिजली नहीं है, सैलरी नहीं है और नेटवर्क गायब है, तो वहां व्यक्तिगत जुनून भी धीरे-धीरे दम तोड़ने लगता है।

पहाड़ों में स्वास्थ्य सेवा का असली सवाल सिर्फ यह नहीं है कि एक फ्रंटलाइन वर्कर कितनी मेहनत करता है। सवाल यह है कि क्या हमारा सिस्टम इतना जिम्मेदार है कि उसे हर बार अपनी कमी छुपाने के लिए किसी कर्मचारी के 'सुपरहीरो' बनने का इंतजार न करना पड़े? तनुजा जैसों की सराहना होनी चाहिए, लेकिन सिस्टम को उनके व्यक्तिगत साहस के पीछे छिपने के बजाय, उन प्रक्रियाओं को दुरुस्त करना होगा जो सेवा को मुमकिन बनाती हैं। क्योंकि अंततः, सेवा तब स्थायी होती है जब उसे व्यक्ति के भरोसे नहीं, बल्कि एक मजबूत और संवेदनशील व्यवस्था के भरोसे चलाया जाता है।

THE SUPER DOCTOR
-Dr Saibal Jana



The Shaheed Hospital, stands as a unique legacy of collective courage and a powerful movement led by mine workers for dignity, health and self reliance. This hospital gave space to a number of super doctors to learn and grow here. One of such Super doctors, is Dr. Saibal Jana, serving his legacy here since 1980s in Shaheed Hospital.
In an interview with him, Dr Jana, shares his story.

<u>When you first came to Shaheed Hospital, what hopes did you have? What was your motivation for coming here?</u>

Before coming to Shaheed Hospital, we were actively involved in student organizations. We had a social service and survey organization, and there was also a Students' Association where we worked. We used to go to slum areas and work with marginalized workers. On Sundays, we conducted reading sessions, and on Thursdays, we carried out health education programs. So this kind of work had been part of our practice for a long time.

After completing our MBBS and finishing our housemanship training, our core group sat together to decide what to do next. Everyone had graduated and gone into different fields—some into medicine, some into surgery. We discussed whether we should pursue post-graduation. Ultimately, we unanimously decided that instead of immediately going for post-graduation, what was more essential was to learn practical skills and receive proper training. We felt that in our country, skill development and real training were more necessary than degrees.
Around that time, we heard that a ‘majdooro ka hospital’ (labourers’ hospital) was being built in Chhattisgarh. A friend asked if we would like to go there. The idea of working among workers attracted me. There was also a sense of adventure. Earlier, I had worked in places like Nagaland and had also gone to Delhi and JNU, but nothing felt quite right. So I decided to come here.

When I arrived, the hospital building was still under construction. I came with just a Jhola (small bag), thinking I would see what happens. Since I needed some income for my family, I joined a nearby Catholic hospital temporarily, where there was no doctor. I received ₹1100 per month. None of the others were earning, so we shared the money. We were also given a large quarter, and many of us stayed there together.

There were many challenging experiences. In one case, a pregnant woman was brought in critical condition with eclampsia. At that time, I did not know how to conduct deliveries. Dr. Mathai used to help us; he would say, “You teach me medicine, and I’ll teach you deliveries.” We tried our best to save the patient. We immediately made the labour room a makeshift OT. We called Dr. Kundu who did his housemanship in surgery and cesarean section was performed, but the fetus was already dead. Many workers came forward to donate blood. Despite all efforts, the woman passed away after three days. Her father later told me that although he was deeply saddened, he had never seen doctors make such sincere efforts for a patient. That left a deep impression on me.

After about eight or nine months, I returned and started working here (Shaheed Hospital) when the dispensary began functioning. Initially, the idea was to name it “Prasuti Bhavan” (Maternity Home), since the death of Kusum Bai was delivery-related. But after discussions with workers, we felt that focusing only on maternity would limit our scope. We decided instead to provide comprehensive health services—medicine, surgery, and other care as needed.

A health committee of about 109 workers was formed. Different groups took responsibility—some learned health work, some handled construction, some managed finances. Many workers volunteered to learn basic health skills.

When I came here, I did not know Hindi well, nor did I know much about the local conditions. I had studied Hindi only up to Class 5 and had never spoken it fluently, but I learned here. I always believe body language is more important than spoken language.
I had earlier worked in the floods of Andhra Pradesh and remote areas where telugu language was a barrier. We used to communicate though writting on paper and explaining like that. We learned to communicate through effort and sincerity.
We had only one guy named Vijay, who used to study in 8th class, and he was the only interpreter for a group of 75 health workers. Then while sharing our first day experience, only Vijay's group was satisfied with thier work, then we urged on expressing in our mother tongues itself, and it was really beneficial and when we had a meeting the next day, significant improvement was seen.

That's the story of how I came here.

I did not come here with some grand heroic objective. Through organizational work, I gradually understood that health work among workers is deeply connected with their lives and struggles.

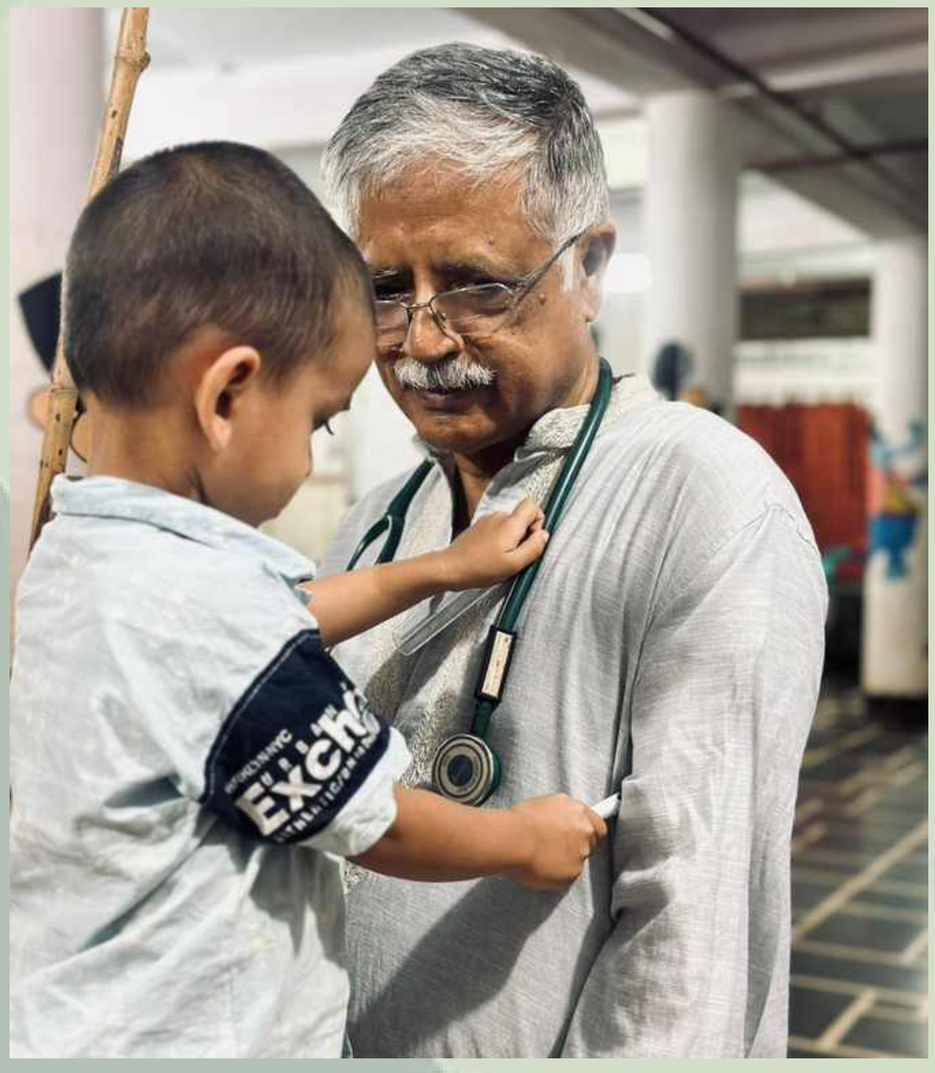
Once when there was a meeting with the workers, there was a problem that the workers who came here for few days did not have any place to rest, and there was not even single room unoccupied, and above all this ,it was chilly and cold outside. It is when Niyogi ji suggested to have them all stay in the OT. But then, we protested that they can't stay in the OT, although the OT wasn't actively working that time. Then Niyogi ji suggested to have them all stay in his own house! (It was a small kutcha house). But then we had discussions and made arrangements for the workers in the OT itself as it wasn't actively functioning at that time . After this incident we learned how to live with people, share their sorrows and joys, and stand with them.

<u>Sir, among all the ideologies and principles you have developed in your life so far, who has contributed the most to shaping them?</u>

First of all, my family played a major role—especially my father and my mother. My brothers were there, but the strongest influence came from my parents. The biggest inspiration they gave me was their trust. Whenever I wanted to do something, they trusted me completely.
After them, my maternal uncle and my grandfather also had deep faith in me. That trust and freedom they gave me helped shape my political understanding and my desire to live and work among people.
Many of my school and college teachers also contributed significantly. Even during my medical training, one of my professors invited me to their homes and told me:
“Do what your heart tells you. Practice professionally, but follow your conviction. Your attitude toward patients teaches even us something as well.”
My friends from student organizations also shaped my thinking. Later, Niyogi Ji had a profound influence on me. He was an extraordinary human being. His sense of humanity was so vast that it sometimes felt unbelievable—how could someone think so deeply and consistently about others?
He also had a spirit of adventure. In the evenings, he would say, “Let’s go walk through the forest,” and we would go exploring. If he found a new plant, he would name it immediately. He believed deeply in protecting nature and would encourage both us and the workers to plant trees.
One very important lesson I learned from him was this: never mix personal anger with political disagreement. We once had major conflicts with a mining officer. But when that officer was transferred, Niyogi Ji invited him home for tea and snacks. He told him:
“We represent the workers’ interests; you represent the company’s interests. That creates conflict. But there is nothing personal in it.”
That clarity deeply influenced me.

My wife also supported me tremendously. She never once asked me to leave this work or move elsewhere. During crisis periods, especially between 1983-87 . In 1987 ,Dr. Vinayak said he didn't want to work anymore, even Dr. Kundu wanted to go for higher studies and left, Dr.Chanchala after sometime also left. when several doctors left, we went through very difficult times. I was deeply depressed when colleagues moved away. It is when Dr. Goon who had come here just 3-4 months back, stayed here. He had worked in the Bhopal Gas tragedy. That time, Alpana (wife) also came from Calcutta. Dr. Goon and alpana stood by me. They encouraged me to continue and take the work forward. Up until the death of Niyogi ji, we three made a good team from 1988-1991 and managed the hospital. After Niyogi Ji's death, many doctors volunteered here but only for a short time.

Madam (Alpana) helped a lot during the period of crisis.According to our point of view treatment and taking care of people are both a different thing. So,later on as we all were doctors and there were no nursing staffs available so Alpana herself performed all the nursing duties and performed many deliveries using her expertise. She played a crucial role in hospital systems—especially nursing care, staff rights, duty schedules, and structured leave policies. Earlier, we doctors believed in working without rest. She insisted that nurses, especially women working night shifts, deserved proper leave and rest days. She professionalized many aspects of care and staff welfare.



What were some important cases in your life, which you remember?

Many incidents have shaped me.Niyogi ji taught me how to treat the labours with love and affection. One was a mentally disturbed(Schizophrenia) woman who used to call me “father” and Alpana “mother.” She later became pregnant under unclear circumstances.She was unmarried so we were thinking about who molested her. She delivered normally and was very happy with her baby. Along with the caring of child we were also treating her schizophrenia. But some months later, she was diagnosed as HIV reactive. There was an ART centre at Raipur so it was difficult for her to visit there as family members were not enough supportive. One year later she eventually passed away. Her life and suffering deeply affected me.

Another case was 3-4 years back, a two-year-old child with nephrotic syndrome came to our hospital. Initially, he responded well to treatment. Later he became steroid-resistant. We tried everything—AIIMS, CMC, Bangalore hospitals—but nothing worked. CMC performed his biopsy and at that time we came to know that he was steroid resistant. He remained with us for 2-3 years before passing away. Her mother used to record everything like the timings of his urination. We tried hard to save the child. One of my friend named Bipin whose wife was a pediatric nephrologist gave treatment to the child by inserting indwelling catheter and dialysis.But the child passed away. That case left a lasting mark on me.

Another case was of a small girl child. She was admitted in our hospital. At that time male and female wards weren't separate. The girl was from a small village nearby. She got well and left the hospital. It was the month of May and the OPDs were running too busy from 9:30 to 12:30 and 4:30 to 7:30. When I was leaving my quarter for my afternoon OPD I saw an elderly man standing at the gate.I asked him “Why are you standing here in this harsh heat ?”, He replied “I have brought Munga (drumstick) for you. The nurse told me that you are taking rest so I am not allowed to meet you so I waited here till your arrival”. That simple act of love from an ordinary person deeply moved me.

Another unforgettable case was of a young woman with severe heart disease. We had warned her not to become pregnant. She became pregnant and developed severe heart failure. She died. But the baby was still alive in her womb. With the family's consent, we performed a cesarean section after her death and delivered the baby alive. That was an emotionally overwhelming moment—removing a living child from a deceased mother.

The belief of people on us is of utmost importance.Once we all had a long meeting on whether we should perform an operation of a patient or not because his brother had requested us to do the operation here itself. So in morning we were urged to do the operation of patient with peptic perforation. Dr. Chanchala at that time was performing surgeries so she carried on with the surgery and I gave anaesthesia. But suddenly Dr. Chanchala had vasovagal and she fainted and I had to the surgery.

There were times when we had no surgeons available, and patients required urgent surgery. I gathered the relatives and explained honestly:

"I am not a trained surgeon, but if you trust us, we will try."

They would respond, "We trust you. Do what is necessary."

We performed intestinal obstruction surgeries, hernia repairs, emergency operations. I had to study a lot about all this topics because I never imagined to perform surgeries on patients.Sometimes we succeeded. That trust people placed in us—that is something I can never forget.

In bigger city hospitals, patients often lose that connection. Here, there is a sense of shared responsibility and emotional closeness.

What advice or message would you give to young doctors, and aspirants?

In India we have to strengthen the primary health care because many problems start from the primary level and later they become the problem of the tertiary level. We should deal the primary problems with our basic knowledge and for that availability of people is must. According to me, the course of MBBS is enough for learning new skills and handling both primary and secondary level cases.
Sometimes the problem is resolved, but in most cases it is not. So for that the government should focus on these problems. Nowadays specialization in respective departments of Medical fields is also in progress and the training of students at UG and PG level have become very important.
According to Aayushmaan Bharat, it is said that you have to be postgraduate or MD medicine to treat respiratory tract infection or diarrhea which is such a contradiction.
It is like two sides of the same coin,
1) To not pursue Post graduation and improve the skills and gain more knowledge and work as an MBBS doctor
2) To give NEET PG and pursue Post graduation degree.
But if, after attempting three times for NEET and not getting admission will disappoint a student. So it's better to work as an MBBS. In this rat race there are two possibilities either you will get admission or not.

Earlier Housemanship was a great practice, you would able to know about each and every department and would develop skills. But giving multiple attempts to pass NEET PG have hampered young doctors' learnings. According to me, Government of India should focus more on Rural health and the doctors should not get frustrated while doing their work, instead they should get respect and dignity for studying MBBS course of 5.5 years along with one year of internship. But today there's a belief that if you pursue post graduation only then you will get respect. Even if a student gains interest in any respective field but there are less chances that they would get admission for post graduation in the field of their interest. Nowadays legal proceedings have created a barrier for doctors as well.

Less than 50% students are nowadays able to do post graduation but the training is not sufficient for them.

When I passed out MBBS in 1976-1978 there were no degrees for the doctors in China. In recent days there are more fellowship degrees in foreign countries compared to masters. The people who choose theoretical medicine and research see their way to Masters (FRCS,FRCOG,MRCP) Fellowship membership). In our country we need to popularize it, so that there's an intensive training of students. Training programs should be such which are designed according to primary health care of our country. We should produce doctors who can handle everything at a hospital.

Those countries who progressed in health e.g Brazil, Cuba, etc, have a very strong primary health care. During Covid 19 pandemic, Cuba provided the maximum number of doctors to other countries and their degree was just MBBS.

Dr. Jana, in his interview focuses deeply on importance on primary health care, and care with compassion.

Upcoming Events

1. **Rural Sensitization Programme (RSP) by IDO, Telangana from March 13 - 15, 2026.**

https://docs.google.com/forms/d/e/1FAIpQLSeK7rTjmZ5J9FEX0ohRQVxNtp1jY03MqtJjo1Oj5WUeCdGboA/viewform?usp=sharing&ouid=112379857444749618724

2. **Go to the People (GTP) Youth Camp batch 6 in August by Yumetta foundation. https://share.google/1DCzccc2GJiT2lk0u**

3. **To share your stories and experiences related to health in the upcoming edition.**

Kindly forward to healthchronicleshfa@gmail.com
Whatsapp to:

Sebin : 9994495331
Priyadarsh : 8788915752
Sarah : 6354940349

Yumetta Foundation

YuMetta is a group of interdisciplinary professionals in Health, Education and Environment. It also involves socially motivated and active youths who are sensitive towards various issues around them. We believe in paying back to the society in our own capacity. YuMetta specifically wants to engage with the youths for their social sensitization, capacity building, empowerment and creating a new generation of social change makers.

This will be achieved by unique model of our "Go to the People Camp" concept in which youth will get a chance to meet other socially sensitive likeminded youths, role models and the youth will enhance their skills through learning by doing.

For more informtion website:

www.yumetta.org

RSP

Rural Sensitization Programmes are 3-day sensitization programs being organized to expose medical students, postgraduate students, and junior doctors to rural life and problems, models of community health, and to explore their role in contributing to health care in the country.

We now have these camps being organised in

- Tribal Health Initiative, Sittilingi

- ASHWINI, Gudalur

- Basic Healthcare Services, Rajasthan

- Jan Chetna Manch Bokaro, Jharkhand

-Bhansali Trust, Dangs , Gujarat

For more information, check website:

www.travelfellowship.org

MCQwave - an online MCQ solving platform

MCQWAVE is an online medical exam preparation platform designed especially for students preparing for competitive medical entrance and licensing exams such as NEET PG, INI-CET, FMGE, NEXT (National Exit Test), and CMS. It combines previous year questions (PYQs) with a large bank of high-yield, expertly curated multiple-choice questions (MCQs).

About the founders, Nirtunjay Prasad and Sandeep Choyal are UG medical students who built the platform with a mission to make high-quality medical MCQ preparation affordable and accessible. They emphasize personalized learning and community support.

https://mcqwave.com

Upcoming events on this platform,
Institutional Subscription, Extensive Test Series and PYQs, and HIVE!

FUN PUNS!

I find orthopaedics very humerus.

I lost my left ventricle...
Now I don't feel right.

I have a photographic memory...
It just needs better exposure.

I told my doctor I broke my arm in two places...
He said, "Stop going to those places."