Lessons learnt from the Adivasis of Gudalur, Nilgiris

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We narrate a few anecdotes and our experiences while working in Gudalur, Nilgiris, Tamil Nadu. We hope they will provide the readers with some insights into community health. And we write this in the hope that it will touch some reader somewhere.

Illiteracy is not equal to stupidity

Both of us, urban products, were growing up with the image that the average villager was poor, illiterate and ignorant. So, initially, when we went into Gudalur, it was with a slightly patronizing attitude – "*here are we doctors coming to help you adivasis*." However, during the initial months and years, as we visited their homes, ate their meals and listened to their stories we clearly realized that "*Illiteracy is not the same as ignorance or stupidity*." A story to illustrate this point *(See Box)*.

We realized that as doctors, we ONLY knew how to treat patients. But our patients knew how to grow their own food, build their own houses, understand the behaviour of animals and create lovely ornaments. They would not know how to read and write but each one was a farmer, an engineer, a naturalist and an artist, all rolled into one. After this, we stopped thinking of the rural people as ignorant and stupid.

Listen to the people; they have their reasons

As doctors we were taught to question patients about their ailments, diagnose and then treat. As products of CMC, Vellore, we were also taught the importance of explaining about the illness and the treatment to the patients. However, the general attitude that we imbibed was that we (professionals) talked and they (patients) had to listen. But the following theory proved us wrong.

During our initial visits to some of the villages, we noticed burnt-down huts. "*Was this due to some accident? Perhaps sparks from the hearth lighting up the thatch roof?*" "*No*", was the calm answer. "*These are huts where women have died during delivery.*" We were shocked. Maternal mortality and that too so many? This was unacceptable to us. Our initial assumption was that it was because the adivasis did not care for their women. What else could explain the fact that these women died just 15 km from the 100 bedded government hospital?

When we talked to the relatives and the elders, they were emphatic; "*we will take them anywhere, but not to a hospital. We have seen too*

Village meeting in Gudalur

Kullan refused to go to school

Nunjan, an adivasi, wanted to educate his son Kullan in a good school. So with great difficulty, he bought new clothes, a slate and a piece of chalk and took his son to the nearest private primary school. After enrolment, Kullan was sent to Class I along with the other new students - most of them children of farmers and traders. While all the other children were familiar with the alphabet, Kullan had no clue. He also did not know what to do with the slate and chalk since having seen these objects for the first time yesterday. Also the teacher was asking him something in a strange language (Tamil). The teacher got angry at Kullan's silence, slapped him soundly and made him stand in a corner. The next day, Kullan refused to return to school. On enquiry, Nunjan found out the trauma that his son had undergone. Consoling him, Nunjan accompanied his son to school. He then enquired from the teacher as to why his son was slapped. The teacher broke into a tirade of abuses: "Your son is ignorant; he is six years old and does not know the alphabet, he does not understand Tamil; he is a cretin; keep him at home. There is no point in sending him to school."Nunjan listened to all this patiently then called the teacher outside. Pointing to a nearby tree, he asked, "Sir, what is the name of that tree?" The teacher answered brusquely "how will I know the names of trees? I am a teacher, not a botanist." Turning to his son, Nunjan posed the same question. Not only did Kullan know the name, but also mentioned the illnesses which could be cured by eating the leaves of the tree, the birds which usually nest in this tree and the fact that the wood from this tree is useless for firewood purposes. After translating all this to the teacher, Nunjan gently asked him, "Do you still think that my son is a stupid, ignorant, cretin ... ? He knows how to treat cuts and wounds, he can collect honey, can identify edible mushrooms and can help in the construction of my house. Yes, he does not know the alphabets, but that is precisely why I sent him to you, so that he can learn your skills and knowledge. Kindly teach him these things." Humbly the teacher guided Kullan into the class.

many of our people walk into the hospital and end up being carried out – dead." Attributing this to the 'superstition' of the community, we decided to visit the General Hospital to look for ourselves. And our eyes opened.

One hundred beds, but just two doctors, one of whom was more under the influence of alcohol than the Hippocratic Oath. Labour rooms were staffed by *ayahs* because the doctors do not 'do' obstetrics and the nurses did not want to soil their white uniforms with blood. Labour rooms that could do with a good wash and a coat of paint.

Who monitors the delivering women? "*Oh, when the patient's attendant informs us about an impending delivery, the ayah conducts the delivery. Sometimes, if she is not fast enough, the baby ends up in the bucket below*," laughed a nurse. "*What about regular vaginal examination, monitoring the foetal heart rates, assessing the colour of the liquor?*" The nurses looked at us very strangely – obviously we were talking in some foreign language. In the wards, we saw evidence of such neglect: asphyxiated babies, mothers still mourning their still-born children, a very short woman who had ruptured her uterus and a maternal death in the mortuary. The doctors shrugged their shoulders, "*we are not gynecologists, the government has not posted a lady doctor here, so what can we do?*"

Now we understood the adivasis' superstition. It was not baseless. They had come to us with faith, but we had failed them. And then we chided them for believing in spirits and gods. We have seen too many such instances where the people have been right and we have been proved wrong. So now whenever people tell us something, however atrocious it may sound, we try and understand the story behind the statement. We have learnt to listen.

Health workers can make a difference, but only if ...

We were fresh out of CHAD, the community health department of CMC – Vellore, when we started our work at Gudalur. We were bought up on a diet of "Where there is no doctor," "Limits to medicine" etc. Village health worker and power to the people was the "in thing." Accordingly, we trained illiterate village health workers (VHWs) on basic preventive care – immunisation, antenatal check-ups and growth-monitoring. And then expected them to perform miracles! But they came back and told us that they were not being accepted as healers in their community (though they were selected by the community). On listening to the people, we found out that as a healer, the community expected the VHW to cure and not just pontificate about hand-washing or the importance of eating good food or that health is their right.

So we gradually trained the VHWs on the use of ORS, paracetamol, common antibiotics and other medicines. This increased their credibility tremendously. However, the downside was that they tended to forget the lessons and mix up the tablets and dosages. We tried many tools

like pictures, role plays, repetitions etc. Finally we resorted to regular supervision and that helped them retain their neo-knowledge. Every month, one of us would visit a VHW and accompany her on her rounds and OBSERVE how she was interacting with the community, passing on health messages and treating patients. This supportive supervision was an effective measure to ensure that a patient with fever received paracetamol and not mebendazole. During these visits, we also ensured that their supplies were replenished.

All this improved ANC coverage, immunisation cover rose from less than 5% to 80%; and diarrhoeal deaths became history. But as the VHWs grew in their knowledge, so did that of the local community. Soon the adivasi mother would come and ask for "MFI" for her pregnant daughter; or "amoxicillin" for her baby's "pneumonia." This was the effect of demystifying medicine to the community.

While we were happy, it also meant that if the VHW had to continue being respected as a healer, then her knowledge needed to be kept one step ahead that of the community. Maybe, we were wrong, but we felt that there were limits to which an illiterate woman and a full-time homemaker could be trained through monthly classes and field visits. Even the community echoed our concerns and thus was born the *concept of a medical assistant*. These were young tribal youth, who had at least reached Class X level and knew basic English, Maths and Science. We trained them over a period of one year to support the VHW in her work, especially the curative aspect. Today, these medical assistants do the work of a PHC medical officer, providing preventive and curative care for the population under their centre. They treat patients (from pneumonias to TB, from duodenal ulcers to amebiasis), refer the complicated patients to the hospital and babies to the government ANM for immunisation. They also supervise the VHWs, interact with the community and also with other departments like the ICDS, water and sanitation and even revenue officers.

From all this, we learnt that just training VHWs (ASHAs in today's context) and letting them lose into the community will not make much of a difference. For them to be effective, VHWs need to be SUPPORTED, SUPERVISED, and SUPPLIED (with medicines) regularly. And that MEDICAL ASSISTANTS can be a way out of the current crises of vacant PHCs.

Preventive vs hospital: Is it an either / or situation?

We trained during the height of the primary health care movement. While everybody talked about the eight

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elements of primary care, most health activists (us included) conveniently forgot one of the elements – "appropriate treatment of common diseases and injuries." We were heady with the preventive and promotive mantra. Curative care was bad, preventive care was the only answer. However, soon the community showed us the fallacy in our thinking. After two years of only preventive care, we were accosted with the community's reality at a meeting. A sage old man told us in no uncertain terms: *"You tell us that our pregnant women need to get a check-up so that they will not die during delivery. But at the time of delivery, you send us to the government hospital or a private hospital where the care is inadequate. You tell us that we need to immunise our children, but when they get severe pneumonia, you send us to the nearest hospital which we cannot afford or where they treat us like dirt because we are adivasis. Our people have listened to these messages many times. We also need to have our own hospital that will treat our people with care, with good medicines and will charge us reasonably."* We baulked at the idea of starting a hospital. *"C'mon, we are preventive people, we don't operate hospitals. It is against our ideology – Curative was bad!"* Also, hospitals are capital-intensive and take a lot of time and human resources. What will happen to all the field work?

But as more and more villages started raising this issue, we started considering it seriously. Remember, we had learnt to listen to the people. And with the grace of god, two doctors (Dr Nandakumar Menon and Dr Shylaja Menon) joined us and were happy to take the idea of the hospital forward. We rented a building and the Gudalur Adivasi Hospital came into being in December 1990. Of

course, it proved to be capital-intensive, it did affect the field work at times, it did take up a lot of energy and time of the doctors, but it also was a tipping point. Suddenly, the credibility of the health programme shot up. Women who earlier would never take MFI tables now started lining up at the GAH for their deliveries. Adivasis who were traditionally afraid of 'operations' were willing to undergo a Caesarean or a herniorapphe.

And, once again, we learnt that ideologies are not important. What is important is to listen to the people. And that CURATIVE AND PREVENTIVE CARE are both necessary for the people. And that the divide between curative and preventive is an artificial one created by us health activists. Washing hands prevents diarrhoea. ORS prevents dehydration. IV Fluids prevent death. Which is curative? Where do we draw the line? And when we look at successful community health programmes, be it Jamkhed or SEARCH, or CINI or ... all of them have a referral hospital to back up their primary care programme.

People can manage and monitor health services

Today, community-based monitoring is the buzz-word in NRHM. The adivasis taught this to us two decades ago. They taught us that though illiterate, they are capable of keeping tabs on the immunisation status of their village children; that they are able to analyse an infant death by raising the pertinent social and cultural factors that contributes to that death; that they are able to question an ANM as to why she did not bring the vaccines last Wednesday. Other than this, we also discovered that they are able to design a patient-friendly hospital; able to hold the doctors and nurses accountable to the community and manage a health insurance scheme effectively. Their leaders today negotiate with insurance companies, read the monthly computerised HMIS reports and berate the staff if his/her performance is below par.

And this is the most important lesson that we learnt – THERE ARE NO LIMITS to what a community can do as long as we believe in them and are willing to work with them.

We are grateful to all the adivasis of Gudalur who taught us more than we ever learnt from books, colleges and universities. ■

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routine that the government does not think they warrant an enquiry. NRHM and its host of schemes like Janani Suraksha Yojana, Madilu and whatever else are reduced to a mockery in the state. Pervasive and rampant corruption, gross neglect, callous attitude and irresponsible behaviour of health care staff seem to be the hallmarks of the health system that result in the deaths of innumerable mothers and infants. As per the investigation of the JAAK Racihur District Forum and their study conducted in 32 villages of 5 talukas, in the years 2006-08 about 96 cases of neonatal deaths (most of these deaths have occurred from 3 days to 3 months after birth) and deaths of 12 mothers have come to light. On 29th October, 2008 a mother, admitted in the Rajiv Gandhi Superspeciality Hospital (Raichur) in a very extreme anemic state, died soon after delivering her child. The child too died soon after. JAAK is now planning to create documentation of these cases for further advocacy.

JAAK Solidarity with Other Campaigns

Health as a social movement can be built only by building solidarity with other campaigns and social movements. JAAK has been actively collaborating with Free Dr. Binayak Sen Campaign, campaigns of National Alliance of People's Movements (NAPM) against SEZ, campaign to promote communal harmony, campaigns of people with disability for accessible and affordable health care and Novartis Boycott Campaign led by the Drug Action Forum – Karnataka.

Lessons Learnt and Way Forward

The so-called 'progressive' state of Karnataka has so far shelved NRHM and only after three and a half years, one is getting to see some things happening. While this is a symptom of the apathy in the entire system, mobilizing people towards this has given us some hope. People have started addressing issues of systemic failures in the district and the taluka levels. Dialogues of people with the PHC staff have happened. The letter campaigns, demonstrations, RTI and such other measures have raised the issues of state accountability. Positively, changes in staff attitude, Zilla Panchayat and Panchayat taking responsibility for repairs of PHCs and sub-centres are seen in many places. Most importantly, in some places, people have started cleaning up the sub-centres which were otherwise used to stock grains, to house animals and as sanitation place. ■

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