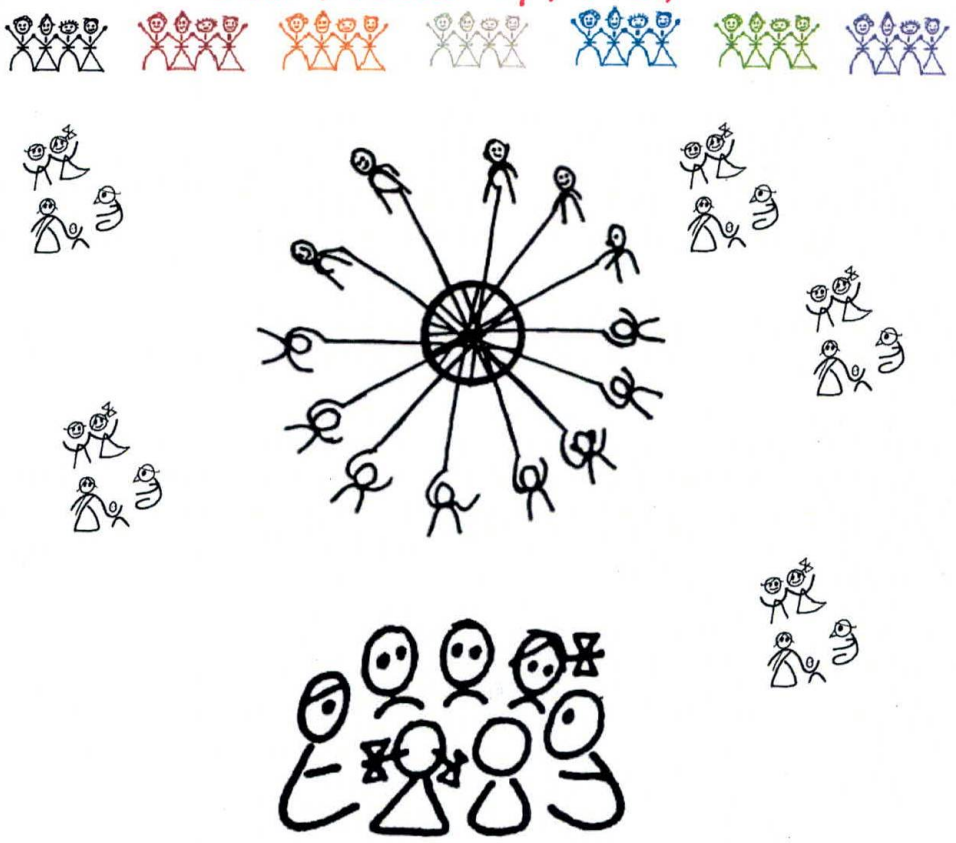
2015-16

Community Health Learning Programme

A Report on the Community Health Learning Experience

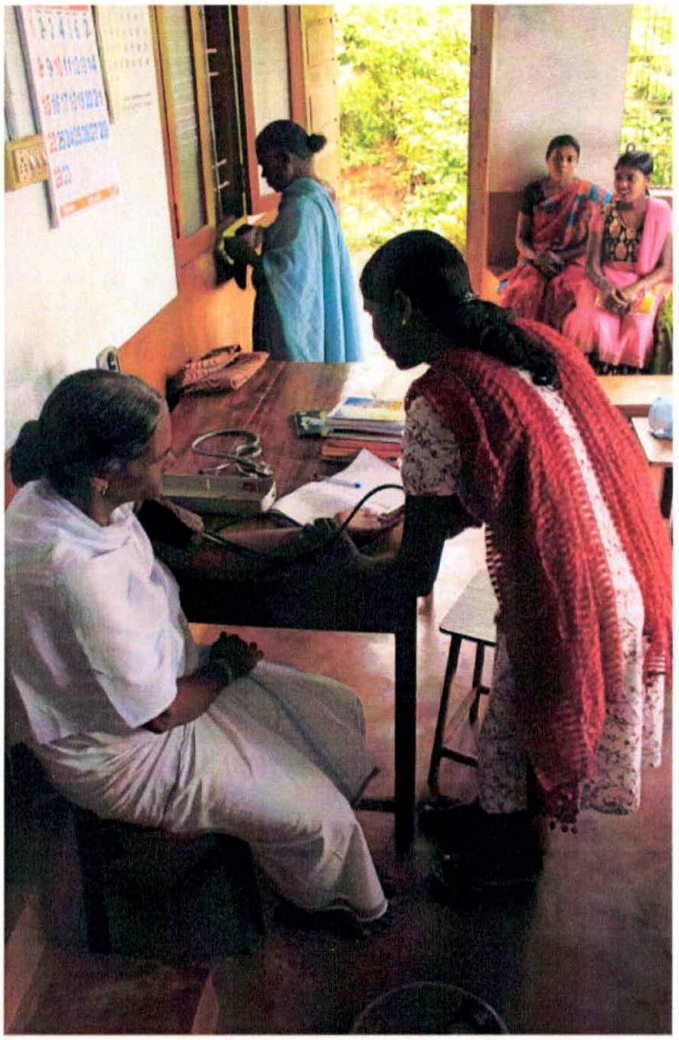
RAJEEV B R



School of Public Health Equity and Action (SOPHEA)

sochara
building community health

Society for Community Health Awareness Research and Action



Rajeev B R | CHLP Fellowship | February 2015-April 2016

Community Health Learning Programme Report

SOCIETY FOR COMMUNITY HEALTH AWARENESS AND RESEARCH ACTION

Contents

Cover Page photo: Adivasi health worker checking blood pressure of an elderly Mullukurumba woman at ACCROD's area centre in Ayyankolli village in the Nilgiris district.

Acknowledgements

I cannot express enough thanks and I am in debt forever to everyone in this journey. This journey would have not been possible without Samantha and Dr Eugenio at first place. Ravi and Thelma have been parent figures to me guiding, patting, cheering me every time I found myself in difficult situations.

SOCHARA is wonderful place with beautiful people with beautiful hearts. Friendly smiling faces always welcome people here. Mohammed's immense knowledge on demographics and public health, Chander's anti-tobacco and Kumar's social work experience with various organisations have been a source of inspiration and joyful learning.

Adithya's climate change sessions were eye openers, Rahul's google head was always welcoming us to discuss, Prasanna's proverbs and polyglot skills were much appreciated, Janelle's friendly and caring attitude, Krishna's communication techniques, Chandran's virtual skills and Prahlad's santitation sensitivity techniques were not just inspiring but moving. The smooth functioning of SOCHARA wouldn't have been possible without Hari Bhaiya, Tulsi Bhaiya, Joseph, Vijayamma, Kamalamma, Maria, Mathew, Vinay and Victor. They manage logistics efficiently. Special thanks to the librarian, Swamy who has well maintained this treasure trove. All these made the learning, a fun filled experience and I want to thank everyone.

At Gudalur, ACCORD and ASHWINI were very supportive. I would like to thank the Adivasi community for their love and support. My heartfelt thanks to Stan, Mari, Shyla, NK, Rahul, Ankur, Srikanth, Anna, Bhuvana and Vinoth who made Gudalur experience, a wonderful time. Special thanks to Mahantu who mentored and guided me. It would not be fun without Royson, Viraj, Mahesh, Jyothi and all the school children and teachers. I wish to thank Durga, who helped me writing the consent and information sheet in Tamil and also helped me in transcribing interviews. Gudalur stay will remain as a special memory.

This journey wouldn't have been a pleasant one without my co fellows. Finally, I want to thank my ever supportive family and friends.

Abbreviations

ACCORD- Action for Community Organisation, Rehabilitation and Development
AMS- Adivasi Munnetra Sangam
ANM- Auxiliary Nurse and Midwife
AMF- Adivasi Mutual Fund
ASHA- Accredited Social Health Activist
ASHWINI- Association for Health Welfare In the Nilagiris
ATLM- Adivasi Tea Leaf Marketing
AYUSH- Ayurveda, Yoga, Unani, Siddha and Homoeopathy
CHESS- Community Health Environment Survey Skill-share
CHLP- Community health learning programme
EAG- Empowered action group states
FRA-Forest Rights Act
HIV/AIDS- Human Immune Deficiency Virus/ Acquired Immune Deficiency Syndrome
IMR- Infant mortality rate
JAAK- Jana Arogya Andholana Karnataka
JSA- Jan Swasthya Abhiyan
LGBT- Lesbian, Gay, Bisexual and Transgender
LHT- Local Health Traditions
LMIC- Low and Middle Income Countries
NRHM- National Rural Health Mission
NHRC- National Human Rights Council
MSS- Mahan Sangharsh Samiti
PHC- Primary Health Centre/care
SOCHARA- Society for Community Health Awareness Research Action
SDH- Social Determinants of Health
TFR- Total Fertility Rate
UHC- Universal Health Coverage
VHSNC- Village Health, Sanitation and Nutrition Committees
VBVT- Vishwa Bharathi Vidyodaya Trust
WHO- World Health Organisation

Prologue- How I landed at SOCHARA

My introduction to Society for Community Health Awareness and Research Action or SOCHARA as it is popularly known, was rather unusual. My crony Samantha Lobo was at SOCHARA as a CHLP fellow in 2014. She accidentally discovered SOCHARA while surfing the internet for job opportunities after her return to India from Australia with a Masters in International Health. She explored and found it as a good opportunity for her to know more about health situation in India. She would narrate all the wonderful experiences at SOCHARA to me, but honestly, I never paid much attention to Samantha until I met Dr Eugenio Villar at the WHO headquarters in Geneva. There was the feeling of knowing SOCHARA very well, although I knew very little about it through Samantha.

Like the Kannada proverb goes "*Shankadinda bidrene theertha* " which means, 'It is considered holy water only if it is poured from the conch', I started to think about SOCHARA seriously even though Samantha had told me about it. Dr Eugenio Villar suddenly became the conch.

At the end of my internship at Global Oral Health Programme at WHO, I was given an option of continuing it for another three months. I wasn't sure of continuing it. There were numerous reasons. Foremost, I wasn't enjoying the work. The beautiful view of Alps and Mont Blanc from the windows of WHO building was like being on a paradise on Earth, but was far from reality. I wanted to work in policy area, but I realized soon, that one needs to have rich field work experience to understand the plusses and minuses of what works and what doesn't work at grass root levels and this knowledge is essential for policy writing.

Maria Niera, director of Environment, Sanitation and Social determinants at WHO, in a casual conversation told me in a witty tone, "*WHO is not for youngsters! Go back to your place and work there. There is a lot of scope for work there. Come back here when you have grey hair and a pot belly!*". It was a tight stroke on my head and enlightened my wisdom at once. Maria Niera put me in contact with Dr Eugenio Villar to learn more about social determinants. We would meet often over lunch and discuss issues ranging from politics to policies.

When it was time to leave Geneva, I met Eugenio to tell him that I would be gone. He suggested that I meet Dr Ravi Narayan and Dr Thelma Narayan. He told me about SOCHARA and its work and asked me to meet Dr Ravi. He wrote to Dr Ravi Narayan introducing me.

I came back to India and was still figuring out what I wanted to do. I wasn't sure, how to go about pursuing work in policy and health systems field. I lacked the direction in which I wanted to work. I wanted to explore all opportunities and wrote to Dr Ravi Narayan asking for an appointment to meet. He invited me to visit SOCHARA and explained me everything about their work since his student days. The other staff, I met also mentioned about the CHLP fellowship. Including Ravi, other staff also goaded me to consider it.

During my training in Dental Public Health, there was lack of contextual understanding of the entire public health. The course was for three years and I had hardly visited any PHC's. The only exposure was when there was dental outreach camp organised in a PHC. I had never met a health worker or even an ANM. My understanding of villages and their problems were from books, newspapers and scientific journals. I knew, I lacked the humanness in the training. I studied

about the national health programs of India, but didn't have a solid understanding on their implications at grass roots. There was a void in my training and When I heard about the programme modules from both Samantha and Dr Ravi Narayan, it was something I was looking for.

Besides, my staff at college were not friendly. Their understanding of social determinants was very poor and didn't encourage me either. Some of them were rude and hostile too. I would long for a mentor or guide who is friendly and non-hierarchical. During my training, I undertook an online offering course of "Health for All" by Johns Hopkins University. The course oriented me to community health. It was the first exposure to primary health care. The case studies which were used to explain in the course were success stories on how to bring about change in health status of a community. Jamkhed[1] and Gadchiroli[2] projects were used as case studies (Arolle & Arolle, 1974). I understood about a health worker and how they can be agents of change. Since then, I knew, I wanted that kind of exposure to real life situations and understand for the perspectives of the people living in affected areas. When I met Dr Ravi Narayan, he was talking about what all I wanted. I was presented with a training module which exactly what I was looking for.

My interest in humanities goes back to my childhood days. There are few incidents and experiences during my growing years which had profound influence on my leaning towards humanities. I was very much interested in Archaeology and History during my school days. I always took part in social project competitions where I would prepare models and charts on Egyptian, Roman civilisations and many others. I also won several prizes which further boosted my interest. It was in one of those times, I came across books on humanities in my school and public library. I read a lot about how cultures and beliefs in different societies and their influences on economics, political scene, etc. I had decided that I would study sociology then, but my family opposed this. They believed that, arts and humanity disciplines would not earn enough bread. My interest in humanities remained hard, but I chose dentistry as a career out of compulsion.

It was in my third year under graduation, when I was introduced to Preventive and Social Medicine, my childhood interests were revoked. I showed more interest in the social component of medicine. It gave a new dimension to my understanding of how health and development go hand in hand. For ex, the Great sanitary reforms of England which took place in the 18th century had influenced the public health movement across the western hemisphere and decreased the prevalence of communicable diseases (Park, 2014). Contrarily, communicable diseases still exist in India because the structural and socio-cultural determinants are not addressed adequately.

Indigenous cultures exist across the globe and they form a unique ecology. Their behaviours are in harmony with the environment they live in. The concept of self-sustaining and use of locally available materials make them more adaptable and amenable to the laws of survival. In such a context, they place health in the hands of their age old traditions which are yet to be explored. This is where my interest in public health grew much stronger.

My interest in culture goes back to my roots. My forefathers are from a small village called *Molkalmuru* in *Chitradurga*. It is well known for handloom industry. My forefathers weaved silk

[1] Jamkhed is a small town in Ahmednagar district of Maharashtra. Jamkhed project is a Comprehensive Rural Health Programme started by Drs Mable and Raj Arolle in 1970.

[2] Gadchiroli is a district in central India. SEARCH (Society for Education, Action and Research in Community Health) started by Drs Abhay and Rani Bang in 1985 at Gadchiroli.

sarees. Here, *Swakulasali, Pattasali* and *Padmashalis* and many other weaving communities have engaged themselves in the handloom profession for generations. All weaving communities belonged to the *shudhra* group of social stratification[3]. *Shudra* means one who is skilled in an art. The artisan strata include wide variety of occupations based on skilled handwork. Thus the artisans were the suppliers of basic essentials and products for the smooth functioning of society. From clothes to jewellery, iron to pottery; *Shudras* were the economical drivers and key contributors of industry and machinery during the pre-independent India. This class included *tantuvai* (weavers), *swarnakara* (goldsmith), *vaidyas* (healers) etc.

Molkalmuru silk sarees have a distinct style. Contrast colours of body and border, silver reinforced gold *zari*, bird figures such as peacock, swan, parrot, floral pattern, and mango and temple images are very unique to *Molkalmuru* style. There is rich history and culture represented in the sarees. Today, the saree industry is dying. With this, the salubrious culture will also be lost and all will be a thing of past. The motifs in the sarees not just had an attractive feature and also told a story. For ex, peacocks and mangos are very common here. It is with no doubt, the flora and fauna also were a part of daily life and thus adorned the sarees too. The craftsmanship means skills which are learnt hard way. It represents civilisation and a learned activity which is socially accepted. Sadly, with sarees gone and not much peacocks left, these all will be forgotten soon. It was not just about which figure showed up on the saree. It is about how the weaving community understood the nature around and expressing it in the form of art.

I also want to narrate another incident. This was when I was doing my Master's. My senior researched on *"Comparative Assessment of Knowledge, Attitude and Beliefs on oral health in Siddi tribals, Tibetan refugees and Local population"*. I had doubts about the reliability and validity of the results of the thesis. His methodology was fairly simple. He visited them only once and interviewed using a pre designed questionnaire. What puzzled me the most, was, how would one reveal any personal information to a total stranger? I believe, one has to understand the social dynamics of a community in all angles to win the confidence and then proceed to ask sensitive questions.

Through Samantha's experience at Kalahandi in Orissa, I got a clear picture of how the fellowship works. Field work would give me an opportunity to live with the community and observe them closely. Besides, joining CHLP was a calculated risk. The uncertainty of job and the stipend offered for CHLP was just enough for sustaining and meeting monthly expenses. *I took a while to decide about it. I considered other options of either work or studying further.* After much thought, I decided to apply for this fellowship. I appeared for the interview and later was selected and that's how I ended up at SOCHARA.

[3] Shudra is the fourth varna, whose mythological origins are described in the Purusha Sukta of the Rig veda, one of the sacred texts of Hinduism, and later explained in the Manusmṛti.

Learning Objectives

General

1. Learn community action from a community point of view
2. Understand community health in action
3. Learn the health system in India- principles, delivery, etc.
4. Understand the social determinants of health in India
5. Understand the cultural factors influencing health in India determined by knowledge, attitudes and behaviour.
6. Learn the quantitative and qualitative tools of measuring the health burden.
7. Understand the intricate networks through which community health functions

Research

1. Learn conducting a community mapping, ethnographic methods, focussed groups discussions, key informant interview method.
2. Understand health through anthropological view- human development, interactions and existence in harmony with environment.
3. Observe and learn the indigenous way of life.

Personal

1. Working in a team
2. Understand different cultures of fellow participants
3. Inculcate more good habits, learn from my mistakes, and become more integral.
4. Networking with various people from all areas
5. Learn new languages

BUILDING BLOCKS FOR FELLOWSHIP

The batch of 2015-16 consisted a diverse set of people from different backgrounds. There were full time and flexi (part time) fellows. Most of them were from social sciences background such as social work, anthropology, law and psychology. Few of them from bio- medical background such as medicine, dentistry and pharmacy. There were with journalism, textiles and management background too. People from different parts of India representing north east, north, central, south and western India were there too with one exception from United Kingdom. This mix of education, language, culture, etc was unique but posed many challenges in terms of understanding the subject, language barrier, culture shock to name a few. It was important to understand others and self at the same time to have a harmonious and cordial relationship with all the fellows and the facilitators of the programme. The need to learn intra and inter personal skills became imperative to understand oneself better.

Johari window was first conceptualised by Joseph Luft and Harrington Ingham in 1955 to help people better understand their relationship with themselves as well as others (Luft & Ingham, 1955). It is a framework to categorise our levels of knowing a person. The arena block represents traits of a person which are known by that person and others. The Facade block representing information about a person which their peers are unaware of.

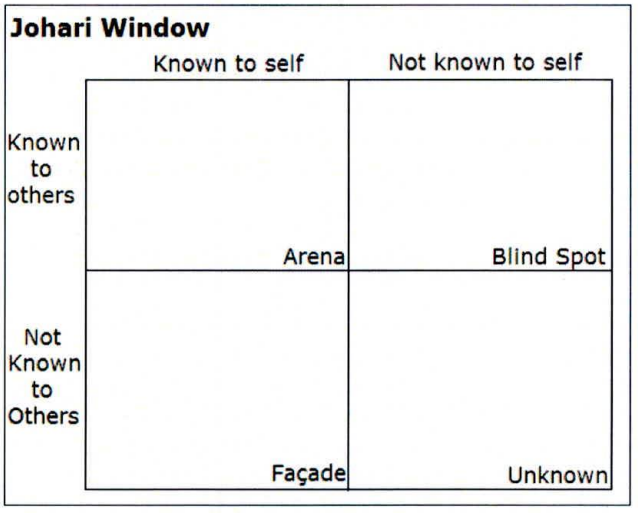


Figure 1: Johari Window

The blind spot represents information that the person is not aware of, but others are and Unknown representing the person's character that are not recognized by anyone including the person. Johari region is what is known about a person by others in the group, but is unknown by the person him/herself. It is the quadrant 2 - 'blind self' or 'blind area' or 'blind spot'. here are two key ideas behind the tool: to build trust with others by disclosing information about oneself and with the help of feedback from others, one can learn about oneself and come to terms with personal issues. By explaining the idea of the Johari Window, one can help team members to understand the value of self-disclosure, and you can encourage them to give, and accept,

constructive feedback. This can help people build better, more trusting relationships with one another, solve issues, and work more effectively as a team. The ultimate goal of the Johari Window is to enlarge the Open Area, without disclosing information that is too personal. The Open Area is the most important quadrant, as, generally, the more people know about each other, the more productive, cooperative, and effective will be when working together.

At the end of the Johari class, we were given a sheet of paper to write one good quality about each other. This exercise was to make the fellows think positively and reflect upon some good qualities observed in the fellows only within a few days of interaction. It was a test to examine the observation skills and also about knowing a person much more.

Communication skills were introduced during the first collective session. The two-day workshop on communications skills was an eye opener and team building and team work exercise. It opened up every fellow from their inhibitions, timidity, language barrier and inferiority complex to certain extent. Nearly 90% of the exercise was non-verbal and action oriented. There were improvisation exercises such as voice modulation, imitation, mime shows and role plays.

Figure 2: Communication skill workshop in progress

The sessions were modelled to train fellows to cope up with challenges that one might face in field. There were sessions related to role plays to communicate the message effectively with minimal props. Fellows were divided into two groups to come up with a health issue and conduct a role play highlighting a health issue and also capturing the nitty grits of daily life. Our group decided to showcase childhood morbidity and the effective role played by ASHA worker. We used common diarrhoea as a highlight to draw attention. It was a tedious job to have a consensus on what we do as a group and, to manage it effectively without falling apart with the group, was the lesson learnt. Some of the group members were difficult to convince and tried to subjugate other weak voices. Soft skills expose the dynamics of a group and, more over this exercise was apt at that time. We were preparing for the field and this exercise helped us in understanding the management of the community members with whom we have to work.

Figure 3: Fellows in imitation session during the communication workshop

Social skills like interpersonal skills are very vital for anyone who interact and work with people on a day to day basis. People skills is the ability to communicate effectively with people in a friendly way. It involves, understanding ourselves and moderating our responses, talking effectively and empathizing accurately and building relationships of trust, respect and productive interactions. Soft skills enable those qualities and attributes needed to succeed in community dialogue. They encompass an individual's ability to listen well, to communicate effectively, to be positive, to manage conflict, accept responsibility, show respect, build trust, work well with

others, manage time effectively, accept criticism, work under pressure, and demonstrate discipline.

In one of Dr Ravi Narayan's class, we were asked the names of our support staff- *Mr Tulsi Heera Adhikari* and *Mr Hari Ojha* or *Tulsi bhaiya* and *Hari Bhaiya* as we call them with affection. Dr Ravi tested us, whether we were good at soft skills. Also, we were subjected to another test. Hari bhaiya or Tulsi Bhaiya would get us tea twice daily, once at 10 30 am and at 3 pm. We were observed, whether we helped to serve each other or not. This was also, to check if we had hierarchical attitude. It was also to know how caste and class biased we were.

During field visits, this was an important people skill to bear in mind. People in the community would only entertain us when equality is established after the acquaintance stages of relationship are over. Being unbiased and displaying behaviour of trust, respect, equality is as vital to develop cordial relationship in order to bring behavioural changes in the community. The tea test, as what I love to call it, is crucial to establish the initial communication. During my field visits, I was offered black tea with copious amount of sugar which I detested whole heartedly, was offered at every house visited and any meeting that I attended. With very less chance to deny the *adivasis'* love and hospitality, I would drink it. Dr Ravi would tell us that, it was their way of judging a person if he or she is discriminator.

Our gender sensitivity was also checked by how many men cared to lift up the flappers in the toilet. Our cleanliness quotient was also checked if we cared about flushing toilets after use, dustbins used well, cared to keep the surroundings clean. All these exercises were to prepare for any challenges in field or in future. All of us got together and cleaned up the premises of SOCHARA twice. We called it *Shramadhan*[4]. Shramadan was popularised during the freedom movement by M K Gandhi. It is an altruistic act of gift of labour or in simple terms doing voluntary contribution of work for public cause. It was Gandhiji's call to the nation to do shramdhana at every level to uplift the self and others. Gandhiji wrote in *Indian Opinion*, that intellectuals should contribute to upliftment of their fellow labourers by earning a living through physical labour: "*Last but not least, it seems to us that, after all, nature has intended man*

Figure 4: Fellows doing Shramadan

[4] Shramadana means the giving of your time, energy and skills for the benefit of others without any personal gain or benefit.

to earn his bread by manual labour-'by the sweat of his brow". (Gandhi, 1910). *Shramadan* today has become an annual event on October 2nd celebrated as *Gandhi Jayanthi,* the birthday celebration of M K Gandhi. People exhibit sycophantic gestures to pose for cameras and media attention. It is sad to witness the actual *shramadan* is lost.

We all gloved our hands, picked up brooms to clean up the pile of garbage dumped by passers-by in front of SOCHARA. The place was a nuisance to eyes and nose. It was a painstaking labour subjected to heavy duty, stench of the garbage, directly exposed to micro-organisms and insects, potential danger of infections, etc. The act made us realise how difficult it would be for hundreds of *Pourakarmikas*[5] who clean up the city every day. The health concerns are many. The detritus also had sharp objects such as broken glass pieces, needles, blades and severed ends of metals. Dr Thelma Narayan had provoked us about having civic responsibility of knowing people around us. She asked if anyone us ever bothered to find out about their lives, or even their names. This *shramadana* did stir up interest about the municipal sweepers. Shwetha Gupta, co fellow who resided in the next building of SOCHARA found out the name of the *pourakarmika* of her lane. Her name was *Ramulamma* who came from neighbouring state of Andhra Pradesh and has been working for several years. *Ramulamma* complained that, they don't get paid on time. The contract labour laws are often criticised as anti *pourakarmikas.* (DNA, 2012) They prevent diseases in cities. Yet they have minimal job security measures. They contract communicable diseases quite often and do not have free access to medical care. They are underpaid and work involves manual segregation of waste without self- protection. The occupational safety and health measures are completely violated. The *pourakarmikas* put across their demand and held a strike too. (Ramani, 2015)

Figure 5: Newspaper column showing the demands made by Pourakarmikas

In another session, we were all given three green colour cards and were asked to write about our personal, professional and expectations of CHLP. I scribbled few thoughts into the paper. Although, in hindsight, when introspected, some goals and expectations have been met. While some of them have been re looked. Particularly, professional goals. I wanted to join the CHLP as a flexi and leave if I got admission for doctoral studies. But, I decided to finish the course, because the course provided a solid community exposure which I didn't want to jeopardise.

[5] Pourakarmika is a Kannada term referred to labourers who clean the roads and drainage in Bangalore city.

Values such as Equity, rights, social justice, inclusiveness, respect for local health cultures, solidarity and secularism were facilitated at different stages of collective. 2015 was of particular relevant to the values discussed. The political scene in India and also across the world was turbulent and many events were testimonies for violating these values. These values are intertwined and are moral characters which are practised at an individual, family, community, national and global level in an egalitarian world. All religions advocate theses values. They are integrated in a person as one grows. Values are decided by the society and evolve over time. These values conflict with greed, ego and selfishness. These values have been used as a weapon to influence critical mass in social movements. *Dr R Srivatsan,* a political theorist who was the convenor of medico friends circle[6], mentioned about Gandhiji's *Ramarajya*[7] concept as a utopian political independence thought. (Gandhi, 1937) Gandhiji adopted *seva*[8] for *Harijans*[9], *Mitratva*[10] for Muslims and *Satyagraha*[11] against the British.

Values relate to the norms of a culture, but they are more global and abstract than norms. Norms provide rules for behaviour in specific situations, while values identify what should be judged as good or evil. While norms are standards, patterns, rules and guides of expected behaviour, values are abstract concepts of what is important and worthwhile. A silent prayer offered for the victims of Chennai cyclones during the National Dissemination meeting was a norm but reflects solidarity. Values are generally received through cultural means, especially transmission from parents to children. Parents in different cultures have different values. For example, parents in a hunter-gatherer society or surviving through subsistence agriculture value practical survival skills from a young age. The *adivasis*[12] of Gudalur where I did my field observations showed immense community bonding and sharing. *Mari Marcel Thekaekara,* co-founder of ACCORD and a regular columnist at New Internationalist shares her views about sharing and caring among the *adivasis* of Gudalur. She mentions how a young Adivasi girl shared a biscuit with her siblings given to her (Thekaekara, 2015). Values such as these are a part of their lives and they don't seem to be puzzled by these gestures.

All these values are to be taught and learnt by self or through others at home, school, college, university, work place, etc. Community health learning begins with recognizing these values as an important part of our lives. Important to us is rights. Right to health is a fundamental right to attain highest possible standard of health. Community health emphasizes rights and entitlements as one of the axioms.

Secularism was by far the most argued topic in the past one year in print and social media. New terms such as "Sicklularists" have sprung up. In my opinion, secularism means to treat everyone and everything equal. Indian constitution upholds secularism. Accordingly, all religions, languages, people and cultures are equal. Secularism in India, thus, does not mean separation of religion from state. Instead, secularism in India means a state that is neutral to all religious

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[6] medico friends circle is a think tank founded in 1974 by a group of people inspired by socialism and left movements. The founders were followers of freedom fighter, Jayaprakash Narayan.

[7] *Ramarajya*- Gandhian idea of political independence, i.e., sovereignty of the people based on pure moral authority

[8] *Seva* is a selfless service offered to anyone in need.

[9] Harijans is a word coined by Gandhiji referred to Dalits who were considered untouchables.

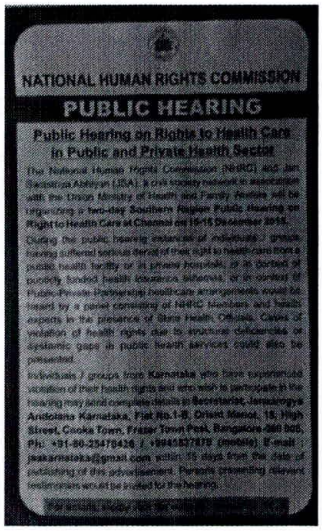
[10] Mitratva is Sanskrit term for friendship.

[11] Sathyagraha means "insistence for truth". It was a non-violent resistance which Gandhi used in his campaigns in South Africa and India.

[12] *Adivasis* or original inhabitants. I prefer to use the term instead of tribal. *Adivasis* also means indigenous.

groups. Romila Thapar, noted historian shares her views on secularism. "A secular society and polity does not mean abandoning religion. It means the religious identity of an Indian has to give way to the primary identity of a citizen. And the state has to guarantee the rights that come with this identity, as the rights of citizenship". (Thapar, 2015)

Denial of **Right to Health** is the most argued case in almost all LMIC. A national level public hearing on denial of right to health in public and private sector was organised by NHRC in association with SOCHARA, JSA, JAAK and other civil society organisations[13]. The meetings were held at four different places in India. The southern regional meeting was convened in Chennai and was to be held on December 14 and 15th, 2015. The deluge at Chennai forced NHRC to cancel the meeting.


NATIONAL HUMAN RIGHTS COMMISSION

PUBLIC HEARING

Public Hearing on Rights to Health Care in Public and Private Health Sector

Figure 6: Newspaper advertisement on NHRC meeting

According to WHO, "The right to the highest attainable standard of health" requires a set of social criteria that is conducive to the health of all people, including the availability of health services, safe working conditions, adequate housing and nutritious foods. Achieving the right to health is closely related to that of other human rights, including the right to food, housing, work, education, non-discrimination, access to information, and participation.

The right to health includes both freedoms and entitlements. Freedoms include the right to control one's health and body (sexual and reproductive rights) and to be free from interference (free from torture and from non-consensual medical treatment and experimentation). Entitlements include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health.

Vulnerable and marginalized groups in societies are often less likely to enjoy the right to health. Three of the world's most fatal communicable diseases - malaria, HIV/AIDS and tuberculosis - disproportionately affect the world's poorest populations, placing a tremendous burden on the economies of developing countries. Conversely the burden of non-communicable disease – most often perceived as affecting high-income countries is now increasing disproportionately among lower income countries and populations. Violations or lack of attention to human rights can have serious health consequences. Overt or implicit discrimination in the delivery of health services violates fundamental human rights. Many people with mental disorders are kept in mental institutions against their will, despite having the capacity to make decisions regarding their future. On the other hand, when there are shortages of hospital beds, it is often members of this population that are discharged prematurely, which can lead to high readmission rates and sometimes even death, and also constitutes a violation of their right to receive treatment.

The goal of a human rights-based approach is that all health policies, strategies and programmes are designed with the objective of progressively improving the enjoyment of all people to the right

[13] The word 'Civil Society Organisation' is deliberately used for substituting Non-Governmental Organisations.

to health. Interventions to reach this objective adhere to rigorous principles and standards, including: Non Discrimination, Availability, Accessibility, Quality, Acceptability, Accountability and Universality. (WHO Committee on Economic, 2009)

UNDERSTANDING COMMUNITY, SOCIETY, DEVELOPMENT AND HEALTH

Understanding a community is an arduous task. It involves careful observation of everything without making a value based judgment and reporting honest picture devoid of preconceptions. It is a hard assignment to be non- prejudiced. Our upbringing is always modelled on the basis of questioning and critiquing. The very essence of science is based on the strong foundations of questioning the way it is, and understanding things the way they function means getting down to a level where one sheds his or her hierarchical attitude and looks through the eye of the observant.

The concept of community is a sociological construct. It is a set of interactions, human behaviours that have meaning and expectations between its members. Not just action, but actions based on shared expectations, values, beliefs and meanings between individuals. Observation is the key here. It involves careful watch of the functioning of a system. Observation is the foundation of descriptive studying. The cognitive senses have to be working at their best to be accurate. Reporting as it is, is not as easy as it seems so. The observant should have an eye for it and write whatever appeared to the eyes, which means that, it is a skilful job and highly competent work. A thorough knowledge of what has to be done. Even while everything works well, acknowledging the grey areas in between apparent black and white is the real challenge. My understanding of the community is still in a nascent level and I think, I have made an attempt at understanding little bit of the black and white areas, although some of the grey areas were understood in due course with help.

Community is defined as *"a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings". (Kathleen M. MacQueen, 2001)* According to a research, community has five core elements—locus, sharing, joint action, social ties, and diversity which were was cited by 20% or more of respondents. *(Kathleen M. MacQueen, 2001)*

Community largely encompasses animate and inanimate objects. There is an objectification of characters such as our people, my place, etc. and that determines the identity of a person or a group of people. Society is a web of social relationships. It includes every relationship which established among the people. This social relationship may be direct or India organised or unorganized, conscious or unconscious. But community consists group of individuals. A definite geographical area is not necessary for society. It is universal and pervasive; but, a definite geographical area is essential for a community.

Community sentiment or a sense of "we feeling" is not essential in a society; community sentiment is indispensable for a community. There can be no community in the absence of community sentiment. Society is wider; there can be more than one community in a society. Community is smaller than society. There cannot be more than one society in a community. Society is abstract. It is a network of social relationships which cannot see or touched. On the

other hand, community is concrete. It is a group of people living in a particular area. We can see this group and locate its existence.

A collective is a group of entities that share or are motivated by at least one common issue or interest, or work together to achieve a common objective. Collectives differ from cooperatives in that they are not necessarily focused upon an economic benefit or saving, but can be that as well.

Class and Caste have differences have existed in India and elsewhere since time immemorial. Dr. Ketkar defines caste as "a social group having two characteristics: (i) membership is confined to those who are born of members and includes all persons so born; (ii) the members are forbidden by an inexorable social law to marry outside the group." Baba Saheb Ambedkar, the architect of Indian Constitution, argues that caste existed long before *Manu*[14]. (Ambedkar, 1979) He was an upholder of it and therefore philosophised about it, but certainly he did not and could not ordain the present order of Hindu Society. His work ended with the codification of existing caste rules and the preaching of Caste Dharma. At the outset that the Hindu society, in common with other societies, was composed of classes and the earliest known are (1) the *Brahmins* or the priestly class; (2) the *Kshatriya*, or the military class; (3) the *Vaishya*, or the merchant class; and (4) the *Shudra*, or the artisan and menial class. He further argues that, particular attention has to be paid to the fact that this was essentially a class system, in which individuals, when qualified, could change their class, and therefore classes did change their personnel. His thesis revolves around proving that some castes were formed by imitation, the best way, it seems to me, is to find out whether or not the vital conditions for the formation of castes by imitation exist in the Hindu Society.

This process of imitation is coined as "*Sanskritisation*"[15] by eminent Sociologist and Anthropolgist, M N Srinivas. (Srinivas M. , 1952) In today's times, there is a myth that caste and class practices are predominantly observed in rural areas, which is often the reason quoted for migration after job opportunities. Dr Ravi Narayan mentions that, class and caste practices are more obvious in urban educational centers. (Collective notes) The unfortunate death of Mr Rohit Vemula, a Dalit doctoral scholar is a typical example of urban caste practices. The 26-year-old PhD student killed himself inside the campus of Hyderabad Central University. Rohit was a member of the Ambedkar Students' Association, which fights for the rights of Dalit (formerly known as untouchable) students on the campus. He was one of five Dalit students who were protesting against their expulsion from the university's housing facility. The five faced allegations that they attacked a member of the Akhil Bharatiya Vidyarthi Parishad - the student wing of India's ruling Bharatiya Janata Party. They all denied the charge and the university cleared them in an initial inquiry, but reversed its decision in December, 2015. Rohit in his suicide note, he writes, (Vemula, 2016)

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[14] *Manu* is the name accorded to the progenitor of humanity, He is ascribed to the Sanskrit text, *Manusmriti which* is considered by some Hindus to be the law laid down for humans.

[15] *Sanskritisation* may be briefly defines as the process by which a 'low caste' or tribe or other group takes over the customs, ritual, beliefs, ideology and style of life of high and in particular, the twice born (dwija) caste.

"The oppressive attitude of bureaucracy and brahminical mindsets of a few... The value of a man was reduced to his immediate identity and nearest possibility. To a vote. To a number. To a thing. Never was a man treated as a mind. As a glorious thing made up of star dust. In very field, in studies, in streets, in politics, and in dying and living"

Swami Vivekananda said: "Caste is an imperfect institution, no doubt. But if it had not been for caste, you would have had no Sanskrit books to study. This caste made walls, around which all sorts of invasions rolled and surged but found it impossible to break through." The newly created Telangana state's movement started off as a Dalit movement and politically motivated campaign. Policy towards Dalits is often criticised as appeasement and vote bank politics rather than genuine desire for uplift of the backward classes. Despite the commonly held belief that casteism and untouchability are prevalent only in rural India with few traces of this practice in cosmopolitan cities, a report reveals notions of impurity and inferiority that still dictate the occupations and livelihoods of Dalits, particularly in the city of Hyderabad. (Mehta, 2015) Swami Vivekananda's words are true in this case. Caste has made an impregnable walls and these provide platform for vote bank politics.

Today's, class discrimination is not caste based, but it is the urban elite education based; opines Dr Ravi Narayan. (Collective notes) Rohit's suicide created a stir in nation. Politicking of his caste status also picked up instantaneously. Caste based reservations continue in government and educational institutions. There is a hidden discrimination of the scheduled castes and tribe students in educational institutions. It is much more obvious in government offices. Government jobs are called based on reservations. The Maharaja of Mysore, *Shri Krishnaraja Wodeyar IV* and his Diwan, Sir *Mokshagundam Vishweshwaraih* argued on caste based reservations. Sir M V had opposed caste based reservations. He stated in his memoirs, *"My idea was that by spreading education rapidly and adopting precision methods in production and industry, the State and its entire population would progress faster. By ignoring merit and capacity, I feared production would be hampered and the efficiency of the administration"* (Vishweshwaraih, 1951)

The new class of educated middle class urban elite have bought about a new dimension to caste and class issues. There is a feeling of threaten among a lot of educated mass. The identity crisis which is a result of heavy competition has led to class distinction. The most affected are the scheduled tribes, especially the *adivasis*. Their primitive traits, geographic isolation, shyness with the community at large have made them vulnerable to exploitation.

Social exclusion in today's times is no more related to caste oppression and women exploitation. The structural determinants which enable a person or group of people to go below the line of social mobility is a recognised fact. LGBT, minorities, debt ridden farmers, SC and ST, *adivasis*, migrant labourers, urban slum dwellers, people with mental and physical disabilities, drug addicts, delinquent etc. face discrimination and marginalisation at many levels.

According to the WHO's Social Exclusion Knowledge Network, Exclusion consists of dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions - economic, political, social and cultural - and at different levels including individual, household, group, community, country and global levels. It results in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities. (Jennie Popay, 2008)

Social exclusion will have direct consequences on the health inequalities. Both of them have underlying social and structural determinants governing the relationship. The WHO Commission on Social Determinants of Health (CSDH, 2006) framework for action on health inequalities highlighted the socioeconomic and political context and including: the labour market; the educational system; religion and other cultural systems; and political institutions. These give rise to patterns of social stratification based on differential access to economic status, power and prestige. Income levels, education, occupation status, gender, race/ethnicity and other factors are used as proxy indicators of these differential social positions. Based on socioeconomic position individuals and groups experience differences in exposure and vulnerability to health-compromising conditions. Socioeconomic position determines the level or frequency of exposures and the level of vulnerability (intermediary factors through which social inequalities generate health inequalities). The fundamental driving force for social inequalities and thus for health inequalities within the CSDH framework is 'power' embedded in social relationships and exercised through the formal and informal institutions and organizations making up the socioeconomic and political contexts.

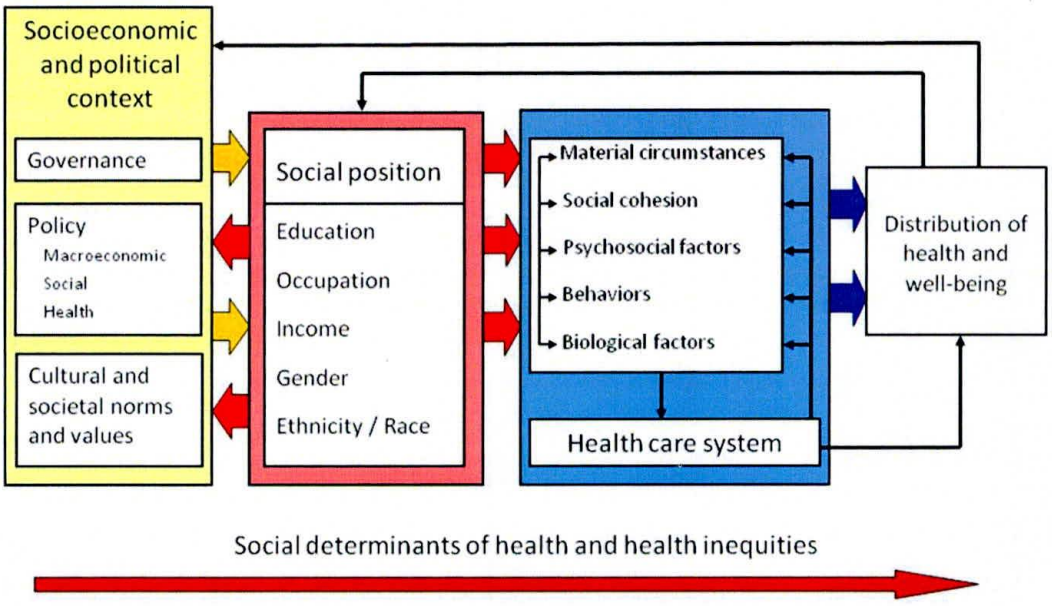

Figure 7: WHO framework of Health inequalities and social determinants

Power dynamics play a major role in health. Underneath questions of injustice and inequality is the question of power. Power is the degree of control over material, human, intellectual and financial resources, exercised by different sections of society. (Miller, 2006) Empowerment of women, oppressed, weaker sections is the common talk by sociologists, activists and social workers.

Empowerment is a strong social process involving power dynamics. When we say, women empowerment, it means giving equal power to women in all situations. It is a social, economic

and politically ascribed status delivered to women. At a family level, woman empowerment means the husband or the men in the family give equal status. It is the same at community level too. Community empowerment is a dynamic process where the oppressed or the weak are able to access entitlements and exercise rights.

It is a complex situation where the stronger section of the society is ready to accord the equality and equity position to the weaker. It is often mistaken and implied that, empowerment is enabling the powerless to become aware of their rights. But, it is forgotten and misled by civil society organisations, media and politicians. For ex, the 33% reservation for women in the Indian Parliament is perceived as instrument to gain equal status as men. In my opinion, empowering only happens when the men are ready to share the platform along with women, rich are ready to help poor, government is ready to structurally elevate poverty, etc. Nevertheless, women have achieved incredible success as change agents. Majority of the health workers are women. Had they not actively participated in the health care delivery, women and children related diseases would still have been in an upsurge motion.

Dr Ravi Narayan narrated a story about community empowerment which he was part of, Mallur Health Cooperative: In Mallur village in Karnataka, a health cooperative attached to a milk cooperative was set up way back in 1973. Encouraged by the success of the milk cooperative, the members persuaded doctors of the St. John Medical College to start a health care centre, which would be self-sustained, financed and managed by the community. The health cooperative provides services to nearby villages. During the first two years, members contributed at the rate of one-two paise per litre of milk sold by them. Subsequently, five percent of the profits from milk sale were given to the health centre. (ICMR, 1976)

Community empowerment is also a process where the community is aware of the issues around them and take right informed decisions to deal the issues. It encompasses the principles of health promotion. Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions. (Promotion, 1986.) The Lalonde report[16] from the Government of Canada, which contained a health promotion strategy "aimed at informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health".

Another example for community empowerment is the *adivasis* of Gudalur. ACCORD started working in 1984 with land rights movement. Within two years of their work, ACCORD with AMS was able to reclaim about two thousand acres of land from local land lords. The Adivasi community realized that they had poor access to health care despite presence of primary health care centres. The PHC staff discriminated them and ill-treated most often. They realized that they wanted a health care and, thus they demanded for health services to ACCORD. It was at that time, Dr Devadasan and Dr Roopa started the community health programme. The community health programme was able to reduce communicable diseases to a great extent. But, the acute conditions, emergencies couldn't be handled and mortality still continued. The *adivasis* realized

[16] Marc Lalonde, who was the Canadian Minister of National Health and Welfare in 1974, proposed a new "health field" concept, as distinct from medical care. The new concept "envisage[d] that the health field can be broken up into four broad elements: Human biology, Environment, Lifestyle, and Health care organization;" that is, determinants of health existed outside of the health care systems. It was one of the first documents which drew global attention towards social determinants of health.

that they need a hospital to handle emergencies. Thus, a *adivasi* community owned hospital came into existence. The Adivasi ownership changed the power dynamics in Gudalur. The hospital was open to non-*adivasi* too, but they had to get permission from the local *sangha*[17] to avail treatment. Until then, the *adivasis* were dependent on non-indigenous people for many things. With quality care provided at the hospital, non-indigenous people began to realise that they were dependent on *adivasis* for health. The power was now vested in *adivasis* or it was hard earned and also importantly shared by non-indigenous people.

Even 67 years after Independence, the **problems of *Adivasi*** communities are about access to basic needs. These include, but are not restricted to, elementary education, community healthcare, sustainable livelihood support, the public distribution system, food security, drinking water and sanitation, debt, and infrastructure. For them, equality of opportunity remains largely unfulfilled. In this context, it is important to stress that the values of *adivasi*[18] culture are transmitted in a manner that protects the right of the bearers of knowledge to determine the terms of the transmission without exploitation or commodification. Nor can the *Adivasis'* unhindered access to land and forests, especially in scheduled areas, be understated. Indigenous communities have, over the decades, witnessed the fragmentation of their habitats and homelands and the disruption of their cultures through predatory tourism. All this has left them shattered and impoverished. Entire communities across states have been dispossessed systematically through state action, and have been reduced from owners of resources and well-knit, largely self-sufficient communities to wage earners in agriculture and urban agglomerates with uncertain futures. Yet, we can scarcely forget that the rights of *adivasi* communities in India are protected by the Constitution and special legislations.

Indigenous communities across the world face extinction, social exclusion, exploitation, marginalization, main streaming, acculturation, etc. Scores of these largely self-sustaining traditional communities continue to this day in remote jungles, forests, mountains, deserts, and in the icy regions of the north. A few remain completely isolated from modern society. Their home is under threat. Most forests where the indigenous communities dwell are source of minerals such as coal, timber and other resources. These attract industries and apathy by governments cause conflicts. Some of them even give way to extremist activities and have resulted in naxal and maoist movements. The identity crisis particularly of culture, environment, religious, etc have led to the present conflicts.

The people of Mahan[19]are facing the threat of wipe out. Giant corporations like Essar and Hindalco are after the coal reserves below these forests. Over 14,190 lives and livelihoods were dependent on the Mahan forests, Madhya Pradesh. Their culture, community and lives are intertwined with the forests that the corporations threaten to destroy. Displacement from their natural habitat was devastating for the indigenous community.

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[17] AMS- *Adivasi Munnetra Sangam* (www.adivasi.net) is a conglomerate of village level groups called *sanghas* containing members from the indigenous communities.

[18] The term has vernacular and local synonyms such as *Girijana*lu (Hill inhabitants) in Andhrapradesh, *Kaadu Manushyaru* (forest dwellers) in Karnataka, *Malaivasi* (Hill inhabitant) in Tamil Nadu, *Adibasi* (same as *adivasi*) in Orissa, Chattisgarh and Jharkand.

[19] Mahan in Madhya Pradesh is one of the oldest Sal forests of Asia

Hindalco and Essar want to mine for coal in Mahan. The coal mining companies pose a threat to destroy the lives of the indigenous people of Mahan. The people of Mahan have come together to reclaim what is theirs. The MSS was formed in March 2013 to protect the forests and land from coal mining. Since then, the MSS has expanded to 11 villages. They have also organised rallies and public meetings to raise awareness of their rights in the region. The Forests Rights Act[20] (2006) entitles communities to decide for themselves. It recognises forest dwellers' rights and makes conservation more accountable. In Mahan, the people are fighting for their right to ensure this law is implemented and their rights are respected. With the help and support of Greenpeace international and other environmental activists, MSS was able to get a stay from the court on the mining activities. (Greenpeace, 2013)

Another success story of *Adivasi* struggle is Niyamgiri in Odisha[21]. State-owned Orissa Mining Corporation, which was granted mining rights for 30 years in 2004. It was granted a right to mine in the Niyamgiri forest area which is rich in bauxite deposit, to supply ore to Vedanta Resources. In 2013, a dozen villages in southern Odisha invoked their right to worship the Niyamgiri hilltop, warding off government plans to open a bauxite mine in their neighbourhood. The struggle ended up in the court. The Supreme Court passed a historic and exceptional referendum order in January,2014, to refuse final forest clearance to the proposed mine. Environmentalists world over celebrated the victory of the *Dongariah* and *Jarnia Kondhs* primitive tribal groups from one of least developed corners of the country. But the state government has gone back to the court to revoke the case. (MOHANTY, 2015)

Legally and constitutionally, Clause 5 of Article 19, specifically is concerned with protection of interests of scheduled tribes as distinct from other marginalised groups through limitations on right to freedom of movement [sub-cause 1(d)] and right to freedom of residence [sub-clause 1(d)]. This, with existing protections offers a core and express fundamental right protection to *adivasis* (as distinct from legal/ statutory protection) from a range of state and non-state intrusions in scheduled areas as well as from the perennial threat of eviction of *adivasis* from their homelands. (Kannabiran, 2015)

Stephany reports about Eco Village. Traditional indigenous communities offer the best example of sustainability. Worth mentioning is Eco villages. Ecovillages aren't about technology. They are locally owned, socially conscious communities using participatory ways to enhance the spiritual, social, ecological and economic aspects of life. Findhorn Ecovillage in the United Kingdom is one of the best known and has half the ecological footprint of the UK national average. It includes 100 ecologically-benign buildings, supplies energy from four wind turbines, and features solar water heating, a biological Living Machine waste water treatment system and a car-sharing club that includes electric vehicles and more. (Leahy, 2015)

Traditional knowledge and a holistic culture is a key part of the longevity of many indigenous peoples. The march of progress means that efforts are being made both to extract the resources on which these communities rely and to 'mainstream' indigenous groups by introducing Western medical, educational and economic systems into traditional ways of life. The traditional medicine

[20] The Scheduled Tribes and Other Traditional Forest Dwellers Act better known as Forest Rights Act passed in 2006 upholds the rights of forest dwellers across India's forest areas for democracy, livelihood and dignity.
[21] Odisha, previously called Orissa is a state in the eastern side.

practiced by the indigenous communities relies entirely on the forest for herbs and medicinal plant sources. It is well documented that, some of the modern medicines are derived from the traditional indigenous medicine knowledge.

It is important to preserve these biodiversity cultures and practices, especially local health traditions. The Karnataka knowledge commission was set up in 2000 to focus on the key components of the public health system in Karnataka state. The knowledge commission charted an actionable plan to revitalise local health traditions by state patronage and encouraging LHT's based home remedies and recognising LHP to strengthen local health traditions in primary health care through state and university accreditation mechanisms. (Karnataka Knowledge Commission, 2012)

Agrarian distress is another important social issue that is plaguing the country. There is an increase in the number of farmer suicides across India. Inflation, loans and debts, failure of rainfall, pesticide and insecticide issues, increase in the price of fertilisers and falling prices of crops, political treaties, etc are among the many reasons for this social issue.

The agrarian distress can be traced back to Green revolution[22] . The introduction of genetically modified seeds which yielded high production of crops. This genetically modified seeds also require heavy feed of fertilisers and pesticides. Heavy use of chemicals and continued high production of crops at a massive scale have rendered the lands untenable. Climate change and less rainfall have pushed farmers to edge.

With the liberalization of the economy in 1991, more banks started giving loans to farmers to buy heavy machinery including tractors and to dig tube wells. More agriculture based industries like Monsanto came in. The underlying agrarian crisis is a result of marginalization of agrarian economy in national policy since the economic reforms of 1991. The increasing growth of multinational companies' influence in the changing global political economy is apparent. This coincides with the quiescence of farmers' movement as compared to 90's which is reflected in the changing rural society and their attitudes. (Posaani, 2009)

Many activists and civil society organisations have been fighting against the lobbying of developed countries and supranational companies in imposing treaties and sanctions on developing countries. The commonly debated topic is the price fixing on crops based on the international trade as against the free trade. Vandhana Shiva, a noted activist has been in the fore front of agitation against Monsanto and other agriculture based companies who are trying to monopolise the agricultural market. Control over seed is the first link in the food chain because seed is the source of life. When a corporation controls seed, it controls life, especially the life of farmers.

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[22] Green Revolution in India was a period when agriculture in India increased its yields due to improved agronomic technology. The introduction of high-yielding varieties of seeds (hybrid seeds) and the increased use of chemical fertilizers and irrigation led to the increase in production needed to make the country self-sufficient in food grains, thus improving agriculture in India. The methods adopted included the use of high-yielding varieties of seeds with modern farming methods. Measures adopted were the use of high yielding varieties of seeds or hybrid seeds, expansion of irrigation infrastructure, use of insecticides and pesticides, consolidation of holdings, land reforms, improved rural infrastructure, supply of agricultural credit, use of chemical or synthetic fertilizers, use of sprinklers or drip irrigation, use of advanced machinery and the use of vector quantity.

The Agreement on Agriculture, negotiated during the Uruguay Round of the General Agreement on Tariffs and Trade, which determines the price of crops is criticised for reducing tariff protections for small farmers, a key source of income in developing countries, while simultaneously allowing rich countries to continue subsidizing agriculture at home.

In July 2015, as many as 90 farmers committed suicide in Mandya and Mysore districts of Karnataka. The relatives of deceased reported that lack of institutional credit as major problem. (The Hindu, 2015) This issue was also riased in the legislative sessions. Activists and the media rightly question loopholes in the National Crime Records Bureau data, pointing out that several state governments often report no farm suicides, contrary to local media reports. Suicides of farmers represent only the tip of the iceberg. Farm suicides, whether owing to purely agricultural reasons like crop failure, or the complex pressures on an Indian farmer, must be tackled seriously on the basis of a comprehensive examination of the causative factors, and the context.

UNDERSTANDING COMMUNITY HEALTH AND PUBLIC HEALTH

Community health is a process of enabling people to exercise collectively their responsibility for their own health and to demand health as their right. It involves the increasing of the individual, family and community autonomy over health and over organisations, means, opportunities, knowledge, skills and supportive structures that make health possible. (CHC Team, 1989)

Public health is more technical field. It involves epidemiological investigations to produce evidence based information. The social influences on public health include the current paradigm of individual responsibility and independence, as opposed to community-based values. Community health deals with translating the information obtained into a meaningful action. Meaningful action means, the information of the community, by the community and for the community. Community is involved in the decision making right from the conception of the problem. It is a political stand taken to emphasise the democratic values. Community is empowered to make their informed decisions.

Public health also works towards translatory reseach and action. For example, in case of Malaria, the preventive strategy is to provide insecticide treated nets. This is based on evidence based research results. One of the preventive startegies for HIV/AIDS is use of condoms by men. In both these cases, the preventive strategies are accepted methods of disease transimission. But, in reality, this strategy has met with many challenges and is proved to be partially successful. Use of condoms has many psychosocial factors associated with it. Some people might object to the use of latex or some aren't comfirtable using it.

In case of Malaria, particularly among the indigenous communities of Madhya Pradesh, it was observed that Malaria still continued to be prevalent despite governement providing insecticide treated nets. After careful observations, it was seen that the Bharia and other indigenous communities didn't use the nets. Most of these people were engaged in collecting *Mahua* [23]. They would go into the forest during April and stay there coinciding with the blossoming of *Mahua* flower. During these times, it was observed they wouldn't use the nets or some would use them to cover the trees to collect the flowers into the net. Malaria incidence peaked during April and was

[23] *Mahua*- Madhuca indica, a flower found in the forests of central India. It is used for making liquor.

mainly seen in those who ventured into forests to collect flowers. (Collective notes, 2015). It was clear about the causative relationship between Malaria peaking during April and the activites of the people. This discovery was possible bacause, there was an effort to understand the causality from the community point of view. This falls in the room 4 of *Johari* window. It was unknown to both people and the investigators why nets failed to prevent Malaria.

Community health focusses on this aspect of why certain thing fails and certain things work. It involves careful observation of the community from a sociological and anthropological lens to understand the community dynamics. It is that effort to make the community to feel that health is a fundamental right and they are entitled to basic primary care. It is a medium in which health is advocated by the community theemselves. The community is placed at the cetre of an issue and helped to solve the problem through action that is locally relevant with an ultimate aim of *'Health for all'*. Community health recognises that health is not just biomedical construct, but the cause of health issues are rooted outside the framework of medical personnel and infrastructure. It weighs heavily on the social and structural determinants of health.

Individuals recognised for their social skills are identfied from the community and are used as change agents. *Dais*[24], health workers, community leaders such as local health healers, village heads and indigenous community chiefs are engaged continuosly to communitise health. There is collective dimension and consensus building within the community to analyse the situationa and prioritise issues. Community health action emerges from contect of wider sociao-economic, cultural process of change and aims at an integrated approach to reduce duplication of the work, and establishes interactive communication to disseminate community health perspectives into masss education. A dialogue is established with key governement planners, policy makers and community members and feedback is valued to continuosly modify the strategies. Community health is a movement overviewing community empowerment especially marginalised groups, sharing of resources, networking, socio-epidemiological approach to priority setting to solves issues and linking with other social movements to garner support and stand in solidarity. (Community Health Cell-Red book, 2011)

Axioms of Community Health was facilitated by Mr Prasanna Kumar Saligrama and Mr Chander S J. The axioms or principles of Community Health is a summary of axioms derived from the reflection of SOCHARA team. The axioms are a result of analysis built on grounded theory to evolve alternative approach to understand and practice community health. The alternative approach to community health that emerged became known as 'social paradigm of health' and was rooted in the framework of rights and responsibilities. (Cell, 2011)

1. Rights and Responsibilities: In Gudalur, the *adivasis* demanded for health care and as a result of it, they have an excellent model of community health programme. (Fieldnotes, 2015) It is embodied in the Health Promotion concept. *'The process of enabling people, to exercise collectively their responsibility, to their own health and demand health as a right'.*
2. Autonomy over Health: Manikantan, who was a health worker and now working as lab technician at ASHWINI mentioned that, in his childhood, they had come across many deaths. Once he became a health worker, he realised it was easy to prevent many deaths through simple measures and vaccinations. He along with other highly motivated young *adivasis* worked at villages to improve the health status. When they realised that some

[24] *Dai* is the traditional midwife

deaths weren't preventable with the existing infrastructure and added discrimination at public health care facilities, they realised the need to have a hospital for themselves. This autonomy for self-care and taking health matters into their hands is what community health aims at. The community members explored the opportunities, used their existing knowledge and took support from others to make health possible. (Fieldnotes, 2015)

3. Integration of Health and development activities: Community health approach includes attempt to integrate health with development activities including education, agricultural extension and income generation programmes. Gudalur is a typical example of community development integrated with health activities. It all started as land rights movement and community health came later. ACCORD felt the need for a school based on alternative model and value based education, tea was grown in the land reclaimed, soap making and honey processing and selling in fair trade market. All these development activities complimented health. The health programme was a comprehensive approach oriented at preventive and curative services. The local indigenous healers are encouraged to be a part of the health system. Some of the *dais* were trained to be health workers. Community based health insurance was implemented to sustain health programme. (N Devadasan, 2004) *Adivasis* are organized into groups at village level to form *sanghas* for increased involvement and participation of the community through formal organization (AMS), health team, finance team, education team, etc. (Fieldnotes, 2015)
4. Decentralised democracy at community level: This value system pervades the interaction between the community and health action initiators. A non-hierarchical, participatory, people centred, team building and empowering ethos built in the system is the community health approach.
5. Equity and Empowering community beyond social conflicts: The system should be inclusive and equitable. It should reach out to the marginalized. The *Kaattunayakans* consider Bettakurumbas and Panniya[25] group as inferior, but the community health programme at ASHWINI is impartial and involves all sections of the society even the non-indigenous group. ACCORD, AMS and ASHWINI recognizes the cultural differences between the indigenous groups and have a sensitive approach to community health.

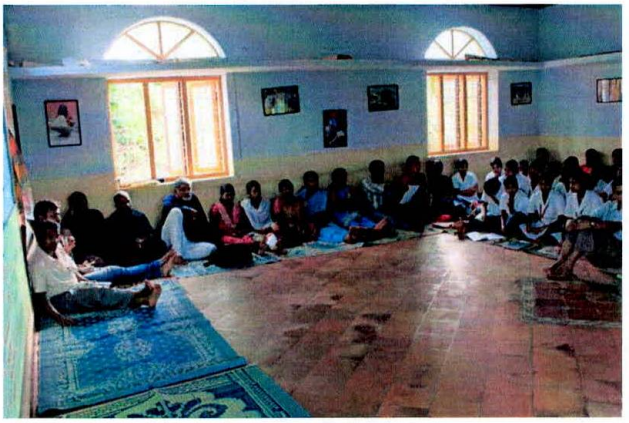

Figure 8: Adivasi team members meeting at ACCORD

[25] *Kaattunayakans, Mullukurumba, Bettakurumbas* and *Panniya* are the four indigenous groups present in Gudalur and Pandalur taluqs of Nilagiris.

6. Promoting and enhancing the sense of community: The efforts to imbibe the concept and spirit of community, to improve group dynamics and group inter-relationships are preliminary to evolve community actions.
7. Confronting biomedical model with new attitudes skills and approaches: Gudalur model works on the primary health care model. Although an effort to counter the compartmentalization of professional activities is carried out, it faces many hurdles. The non-hierarchical and participatory decision making systems allows people of the community to discuss and express their views.
8. Confronting the existing super structure of medical/health care to be more people and community oriented:
9. New vision of health and health care and not a professional package of actions:
10. Effort to build a system in which health for all can become a reality:

Figure 9: Panniya traditional dance at Putheri festival. The dance and music bring communities together and enhance sense of community

HEALTH SYSTEM IN INDIA

Health disparities in India. Inequalities are a part of all societies. Disparities exist across all aspects of life. Without the object of difference, monotony will take a pedestal. But where do we need disparities and where not, is an objective thought that reflects the values of any society. AS Humans, we are different in almost all aspects. We speak different languages, wear different clothes and eat varieties, like different movies and the endless list spirals. But there are few sectors where all of us unanimously agree to have no disparity and the one that takes utmost priority is Health.

Health inequalities or disparities have been existing since the first man and woman set their foot on this earth. We find disparity at all levels ranging from global to family. The most accepted reason for these differences are individual and community immunity governed by genetic makeup which are influenced by environmental factors like social, political, economic and cultural, behavioural factors.

In India, health disparities are universal. The main focus is always on the Empowered Action Group states and Assam. The health indicators of these states influence the national values and present a skewed picture. Therefore, this essay attempts at presenting the national and state level statistics in a disaggregated form.

India has a low sex ratio of 943 females per 1000 males which has shown slight improvement compared to the last decade (933/1000). The highest sex ratio is seen in Kerala with 1084 and least seen in Haryana with 879 females per 1000 males. Among the union territories, Puducherry has the highest ratio of 1037 and Diu and Daman has the least ratio of 618females per 1000 males (CBHI, National Health Profile, 2013). Among the EAG and Assam; Madhya Pradesh (920), Rajasthan (932), Uttar Pradesh (943) and Uttarakhand (997), Odisha (996), Chhattisgarh (974) are two extremes of the spectrum. The rural-urban divide is highest in Uttarakhand, rural sex ratio is 1032 compared to 919 in urban. The lowest ratio is seen in Morena district of Madhya Pradesh (833) and highest ratio is seen in Tehri Garhwal in Uttarakhand (1224). (AHS, 2013)

The birth rate of India in 2013 is 21.4 (21.2-21.6). The state with the lowest birth rate was seen in Goa (13.0) and the highest is seen in Bihar (27.6). The rural (22.9)-urban (17.3) divide is quite evident. (SRSBulletin, 2013) Whereas according to AHS; Uttarakhand (18), Odisha (19.6), Assam (21.2) and Bihar (26.1), Uttar Pradesh (24.8), Madhya Pradesh (24.5) continue to remain two extremes of the spectrum in all the three rounds. The rural-urban divide is highest in Uttar Pradesh and Madhya Pradesh. i.e. for Uttar Pradesh 26.4 rural & 19.6 Urban & in Madhya Pradesh 26.7 & 19.8 respectively. (AHS, 2013)

IMR has declined considerably to 42/1000 live births (2012) from 47 (2010). However, there is huge gap in rural (46) and urban (28). (CBHI, National Health Profile, 2013) IMR has further reduced to 40/1000 live births in 2013. Little improvement is seen in the gap in rural (44) and urban (27). Among the states, Assam and Madhya Pradesh show highest IMR of 54, whereas Goa shows the least at 9/1000 live births. The gender gap in IMR is not wide with 39 in males and 42 in females. A similar fashion is observed in rural-urban region. IMR in females (46) is more than males (43) in rural as well as in urban (Females: 28, males: 26). (SRSBulletin, 2013) Whereas according to AHS; Jharkhand (36), Uttarakhand (40), Chhattisgarh (46) and Uttar Pradesh (68) Madhya Pradesh (62), Odisha (56) continue to remain two extremes of the spectrum in all the three rounds. Jharkhand records the lowest IMR while UP records the highest. IMR in rural area remains significantly higher than that of urban area across AHS States. The rural-urban divide is highest in Assam, rural IMR is 59 compared to 31 in urban. More female infants die as compared to males. In Rajasthan, female IMR is 60 compared to 51 for males, the difference is the highest. In Baseline also, Rajasthan recorded maximum difference with female IMR as 65 compared to 55 for males. (AHS, 2013)

Health situation in India has recorded several gains in health since the new millennium. Life expectancy at birth has risen from 62·5 years in 2000, to 66 years in 2013. In 2013, the infant mortality rate was 40 per 1000 livebirths—down by a third since 2003 Between 2001 and 2013, the

maternal mortality ratio fell from 301 per 100 000 livebirths to 167 per 100 000 livebirths. The spread of HIV/AIDS has been contained, and, in March, 2014, WHO officially declared India polio free. In August, 2015, WHO declared India free of maternal and neonatal tetanus. Yet, 2014 ended with the tragedy of sterilisation deaths in the Indian state of Chhattisgarh and inflicted blindness through botched cataract operations in Punjab. 2015 saw similar tragedies as more than 100 people died in Mumbai from consumption of illicit liquor, and the number of dengue cases increased throughout the country, as compared to the previous year stark reminders of inadequate accountability, poor infrastructure, and low-quality health services in India's health-care sector. (Vikram Patel, 2015)

The new NFHS-4 data for 15 states shows that 37 per cent of children under the age of five in these states is stunted, a fall of just five percentage points in a decade. Bihar and Madhya Pradesh are the worst off, with 48 and 42 per cent respectively of children stunted. The proportion of underweight children has reduced equally slowly, from 39 per cent to 34 per cent, with Bihar and Madhya Pradesh the worst off again. The one success has been in the area of child wasting (low weight for height). The states for which data is available have more than halved their proportion of wasted children in the last decade, from 48 per cent to 22 per cent. The proportions of adult men and women with below normal Body Mass Index have also declined. (NFHS-4, 2015)

Aligning with the NFHS data, a survey conducted in Gudalur showed undernutrition is a serious problem for all the communities except the Mullukurumbas (Overall undernutrition prevalence [BMI <18.5] 41.54%; individual tribe prevalence: Paniya 56.22%, Bettakurumba 40.54%, Kattunayakan 60.00% and Mullukurumba 19.34%). (Srivatsan and Zachariah, 2015)

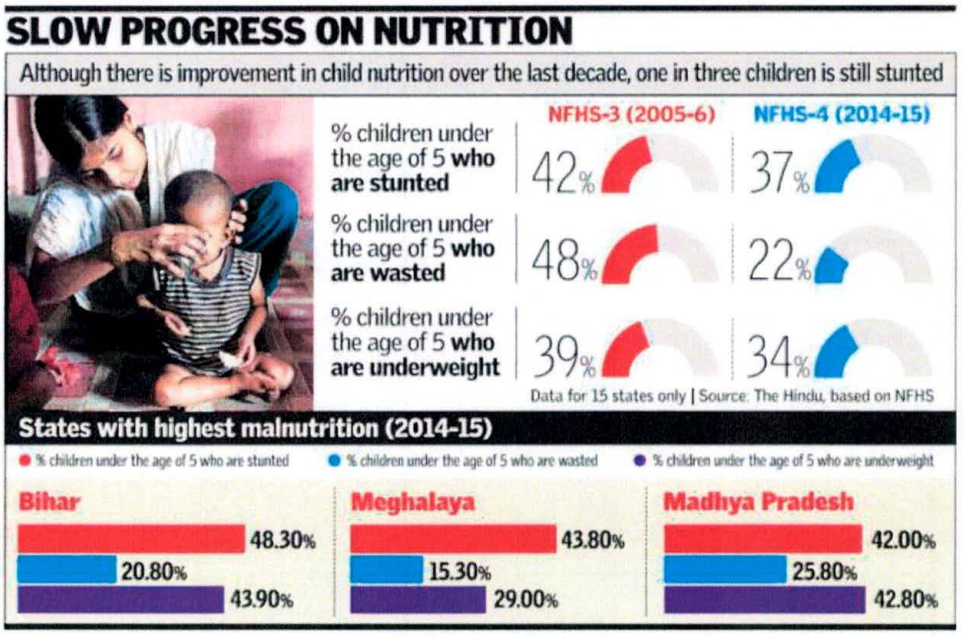

Figure 10: Newspaper article showing NFHS-4 results on Nutrition status in India

Data also shows that anaemia in women has increased in many states. In Meghalaya, the percentage of anaemic women in productive age has gone up from 46.2% during NFHS-3 to 56.2% in NFHS-4. Haryana follows a similar trend—from 56.1% to 62.7%. Awareness regarding HIV/AIDS among women has also dropped marginally in some states. The total fertility rate in Urban MP, urban Uttarakhand, urban Haryana now have below replacement level TFR. Rural Karnataka, rural West Bengal, rural Uttarakhand, are also below replacement, and all three states overall as well. Of the 13 states for which these factsheets have been released, only 3 states have above replacement level TFR: Bihar, MP, and Meghalaya. (NFHS-4, 2015)

The health situation looks bleak and gloomy. The Economic survey of 2015-16 shows certain loop holes. As per NFHS-4, the percentage of children fully immunized in the age group (12-23 months) is above 80 per cent in Sikkim and West Bengal. All the 12 states have more than 50 per cent children fully immunized. India ranks 143 among 190 countries in terms of per capita expenditure on health ($146 PPP in 2011). It has 157th position according to per capita government spending on health which is just about $44 purchasing power parity. India's performance on the indicator on treatment of diarrhoea needs improvement in terms of enhancing the coverage. (Economic Survey, 2016) Although, Diarrhea is the third leading cause of childhood mortality in India, and is responsible for 13% of all deaths/year in children under 5 years of age (Subitha Lakshminarayanan and Ramakrishnan Jayalakshmy, 2015), priorities are given to those diseases which can be prevented by immunization. This reflects on the political priority based on capitalistic attitude.

NRHM was launched in 2005 as the flagship programme of the Government of India to provide effective healthcare to the rural population of the country, undertaking architectural corrections of the health system, and improving access to equitable, affordable, accountable and effective primary health care. The Framework of Implementation detailing the vision, mission and strategies of the programme defined communitisation of the health system as one of the five pillars of NRHM.

A major challenge in most developing countries relates to providing basic amenities (such as education, health, water supply, roads, electricity, etc.) to their citizens, especially the poor and the rural populations. It is in this setting that Communitisation, which is a third way of governance offers an alternative approach in governance, one that proposes to improve public delivery systems at the grassroots. It calls for a 'paradigm shift' in the governance system: a shift to empower, harness, and strengthen the 'social capital' of communities at the grassroots. Communitisation argues that when the option to streamline the government system has failed and privatization is seen as an unviable alternative, 'then, there is a third way to leverage the funds, the expertise and the regulatory powers of the government with the social capital of the user community and combine the best of the public and the private sector system'. (Pandey, 2010)

Communitisation is a contract between the government and the community. In this contract, the community becomes the owner of the government institutions and assets and is granted powers and resources to manage the employees and maintain institutions. In other words, it is privatization of government-owned public institutions in the hands of the user community. It is 'empowerment, delegation, decentralisation and privatisation at the same time. Here, the government actively engages itself as active partner, assister, monitor and supervisor of the community. It follows the three T principle: Trust, Train and Transfer the power to the community.

Communitisation includes community involvement and active participation. Alma Ata declaration on PHC also emphasises on this aspect. The definition of PHC also mentions that "essential health care" that is based on scientifically sound and socially acceptable methods and technology, which make universal health care universally accessible to individuals and families in a community. It is through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination"

Communitisation is a new word introduced in the NRHM in 2005. The community action for health within the NHRM has many strategies for communitisation. The two key instruments towards communitisation under the NRHM were – the implementation of a Community Health Worker (ASHA) programme, and the institutionalization of community action through the formation of VHSNC and *Rogi Kalyan Samiti*[26]. Communitisation is an effort to bring people's health in people's hands. Community empowerment, accountability and responsibility are underlined within this concept of governance. Since health is a fundamental right, demand for quality health care has to be exercised by everyone. Communitisation aims at motivating community for fair health care.
Communitisation process involving community participation and active involvement can happen only when there is a supportive environment. For example, if the polices and laws are not socialistic and rather capitalistic, there is minimal chance for any sort of scope to improvement. The Ottawa charter[27] for Health promotion has rightly upholds the supportive environment which influences pyscho-social behaviour of the entire communities.

The trigger or stimulus for active participation comes often in situations of disaster at one end or when there is a mass provocation. Chennai deluge in December 2015 was definitely manmade disaster. Government's apathy and incompetence at many levels has resulted in such a catastrophe. But, the Chennai people themselves showed an extraordinary solidarity and have stood the challenge of selfishness, hate or any negative emotions. They came forward to help their own citizens. People of Chennai showed active community participation to find solutions in their immediate vicinity. Youth making makeshift boats using those materials which would float, helping people to get out of their homes, arranging food supply is nothing but taking responsibility on their shoulders.

Prime Minister, Mr Narendra Modi's signature campaign on cleanliness and sanitation- *"Swach Bharat Abhiyan"*[28] got a massive response from the community. Although, short lived, it generated a lot of noise and made people think about it. Leadership roles are crucial in bringing communities together. In one addressing, Modi asked the packed crowd, whether he need to tell everyone to keep their surroundings clean, reminding that responsibilities are not given, but actively assumed.
The above examples also touch a difficult issue of sustainability. Any programme to last long, needs a sustainable thought process, thinking, meticulous planning, flexible and more

[26] *Rogi Kalyan Samiti* is a decentralised democratically formed group at village level for the welfare of patients.
[27] Ottawa charter on Health Promotion is an international agreement signed at the First International Conference on Health Promotion in 1986 to achieve Health for All by 2000.
[28] *Swacch Bharath Abhiyan* or Clean India Mission is a national campaign by Modi's government to clean roads and develop infrastructure.

importantly adaptable to ever changing demands and environments. Timely reflections and reinvigorations are necessary to reflect upon failures and success.

Community is a group of people and with it comes a diversity of various kinds. And keeping all of them together on one path to reach a goal is not just an uphill task but most challenging. Community dynamics are certainly complex in a country such as ours. In such a situation, local self-governance plays a major role. It is a sad state that the present government has cut down the budget to Panchayat Raj and thus weakening the foundations of a very strong attribute of our Democracy. Ideally, the village panchayat system is itself a community empowerment process and a strong political institution. The VHSC will also be able to deliver the work if the system is supportive and encouraging. And, this support is provided by the village panchayat provided the system is integral, sensitive and responsive.

Communitisation was an effort to 'scale up' simple community health strategies of having community health workers, health activists and village health committees to the entire rural population of 750 million in 2005. These strategies worked very well at micro level through NGOs where there was presence of committed leadership and support systems. The scale up process was needed as all citizens have a right to better health and access to health care and therefore mechanisms were created to enable this. It was ambitious in scope and met with several challenges.

Some of the key challenges facing NHM are the incentive based work of ASHA. Complete commitment to the job is not reported since there is no job security. Also, the coordination between ANM and ASHA is crucial. Often times, ANM look down towards ASHA as subordinates. One brutal incident where an ASHA was gang raped during her routine home visits show the systems inadequacy in management and providing security. (Gangotri, et al., 2015)The crux of the success is dependent on the strengthening the overall health system. Financial constraints always slow down the process. The recent union budget allocation to health has proven this fact. Only 0.21% (Rupees 938 Crore) of the total infrastructure investments in India is in the health sector. (Saha, 2016)

Social Determinants, Equity and Public Health

Social determinants of Health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. (WHO-CSDH, 2008) The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

Health equity and social determinants are acknowledged as a critical component of the post-2015 sustainable development global agenda and of the push towards progressive achievement of UHC. If health inequities are to be reduced, both SDH and UHC need to be addressed in an integrated and systematic manner.

Figure 11: Social determinants of Health

Social Model of Health (Dahlgren and Whitehead, 1991) talk of the layers of influence on health. It describes the social ecological theory to health. The attempt to map the relationship between the individual, their environment and disease is explained. Individuals are at the centre with a set of fixed genes. Surrounding them are influences on health that can be modified. The first layer is personal behaviour and ways of living that can promote or damage health. –ex, choice to smoke or not. Individuals are affected by friendship patterns and the norms of their community. The next layer is social and community influences, which provide mutual support for members of the community in unfavourable conditions. But they can also provide no support or have a negative effect. The third layer includes structural factors: housing, working conditions, access to services and provision of essential facilities.

Dahlgren and Whitehead's model highlights a causal relationship between individual lifestyle 'choices', social networks, working and living conditions and economic, political and environmental factors, globally, nationally and locally. While the configuration of these different layers and factors can have both positive and protective influences on our lives, they can also undermine health and wellbeing, both for individuals and communities. For example, adverse economic conditions have implications for employment and training opportunities, public services such as health, social care, education, the wide range of services provided by local authorities, as well as the funding they provide to support local voluntary sector services. Where adverse conditions persist, they can have a significant and negative impact on: social attitudes, social cohesion and social mobility.

Social determinants were well established in academic circles and have been the subject of considerable study, but it was quickly discovered that the concept didn't work on the ground. The grantees—most of whom were dealing with real challenges at the community level, didn't necessarily resonate with this frame. For some it was so patently obvious that it became a truism.

A study was conducted to gain a deep understanding of people's thoughts and feelings about health differences across populations in the United States. The research was to find proxy word that could replace "the social determinants of health" as the leading descriptor for this area of work. While the testing showed that this phrase doesn't work for audiences, there is still not a neat replacement. But the research found a list of phrases that in context helped people understand the concept more clearly. These are the precise phrases that were tested and that scored well. The proxy statements use colloquial, values-driven language and relatable lifestyle references that engage audiences. These statements all focus on the solution versus the problem. Some of the statements implicitly acknowledge the notion of personal responsibility. (Robert Wood Johnson Foundation, 2010)

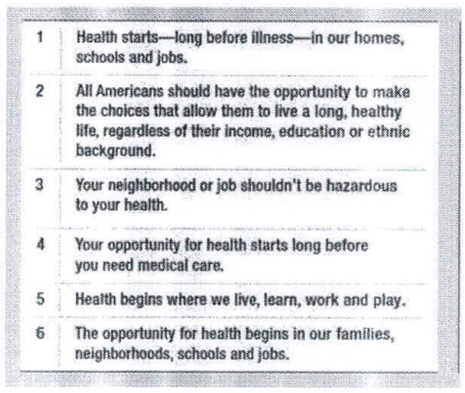

Figure 12: Proxy statements for Social Determinants of Health

SDH in India over the past two decades, five issues emerge as the most urgent to address: air pollution (both indoor and outdoor), child undernutrition, unimproved sanitation, employment conditions, and gender inequality. These priorities coincide with the major risk factors contributing to lost years of healthy life in India, as identified in disease burden analyses. Household surveys reveal the striking proportion of the Indian population exposed to indoor air pollution, which is particularly significant for women and young children who typically spend more time inside near stoves. Child undernutrition continues to affect a significant proportion of households in more and less developed states alike, and has failed to significantly decline despite national economic growth. Unimproved sanitation facilities also remain too common in India, most significantly in rural areas. India has made progress in reducing child labour, but many other aspects of employment conditions continue to be problematic – a lack of job security, insufficient safety measures, and inadequate compensation. Gender-based inequities persist in employment and governance, limiting women's power in households, businesses, and private and public decision-making. Caste-based inequities are also significant, with members of scheduled castes and scheduled tribes consistently worst off. (Krycia Cowling, 2014,)

HEALTH SYSTEMS

The world is witnessing an unprecedented change in this century, more than any other time in the recorded history of humankind. While the cost of living has become more affordable for people with middle and lower incomes, we are also confronted with challenges such as climate change, wars, pandemics, and, more importantly, a gap between rich and poor that is growing

unabatedly. Despite these serious threats to human life, the human development index has increased globally from 0.597 to 0.711 from 1990 to 2014. (UNDP, 2016) Indicators of development depend on many determinants such as economic, environmental, cultural, social, and political factors. Development and health status are not mutually exclusive; each has a complementary role in the process of human development.

Understanding health as a synergistic relationship between the physical, social, psychological, and spiritual elements that contribute to the well-being of individuals and/or groups in their physical and social environments and applying this into building health system is necessary. The role of responsive health systems is imperative in this phenomenon. In recent times, events which have drawn international concern such as the Zika virus pandemic; Ebola crisis; cyclones in Chennai and Western Pacific; Earth-quakes in Nepal, Indonesia, and elsewhere; and many other emergencies have rallied the world behind a new global thinking and sense of solidarity. At the outset of all these calamities lies a health system, because of which the events have been either successfully managed or the reasons why it occurred at first place have been analysed and suitable solutions are explored.

Two aspects of a health system that contribute fundamentally to its effectiveness include resilience and responsiveness. Responsiveness is the ability of a health system to be inclusive, whereas, resilience in the ability to withstand a shock. Resilience is a strong element of the health system, while responsiveness is more to do with ethos and values of the larger society. It is widely recognised that a country's health status is a direct result of the extent to which its health system addresses a range of diseases and serves all sections of society, with equitable distribution of services and social justice as underlying core principles. Weak health systems are characterised by lacking core capacity in governance, financing, health workforce, or information systems. (Margaret E Kruk, 2015)Some of the key features of a resilient and responsive health system are discussed here.

Any health system should have a sound information system. They are regularly updated about demographic, social, geographic, and meteorological indicators. A strong epidemiological surveillance system can itself predict impending threats. Systems thinking in public health will help predict such emergencies. It will prepare to quickly identify a medical emergency, try to isolate it locally, and coordinate with other sectors to direct resources of all kinds towards it. Natural disasters and wars offer salient examples of this need for responsiveness. The war in Syria and terrorism in parts of Africa, for example, have caused millions of people to migrate, a large number of whom require supportive health services. In addition to exacerbating fragile health conditions, this exodus has resulted in many deaths, especially among children. Such emergencies inflict catastrophic damage on both people and the environment and frequently result in disease epidemics. Being prepared for such untoward consequences makes a robust and resilient system, where there is little or no disruption of other essential services and investments in the social sector.

Health systems should be diverse and multifunctional in operations. The variety of diseases which often present in a community requires a platform, where a multitude of workers and facilities alike offer first point of contact to provide primary health care. This system must be optimally functional at all times, having constant interaction with, as well as winning trust and confidence from, the community it serves. Such a health system also provides care related to all diseases ranging from oral health to mental health.

A responsive, self-regulating health system must also be able to respond to health emergencies as well as continue providing services undisturbed in unaffected areas. Response to a crisis, be it a disease outbreak or other disruption resulting in a surge of demand for health care, requires both a vigorous public health mobilisation and a highly proactive and functioning health-care delivery system. The recent union budget in India is a bitter example of how political priorities are often made at the expense of such social investments, including education, health, water, and sanitation. India is one of the countries that spends the least on the healthcare sector, with public spending on health care at around 1% of GDP as compared to 3% in China and 8% in the UK. This reflects a low prioritisation of health by the government, as well as the potential for inadequate responsiveness of the national health system.

Human rights is also an important consideration in responsive and resilient health systems. Corruption, discrimination, and abuse of various forms by the staff of a health care system are the most commonly cited reasons for why people chose private over public services. Better governance which provides for a voice for all people, inclusive decision-making processes, and accountability are essential for people-centred systems. Political action is needed to ensure the above and a strong countervailing civil society is also required.

A functional and responsive health system is driven by an integrated network of actors and institutions in various sectors, including policy-makers, activists, community representatives, administrators, researchers, and educators, all of whom must be brought together in a collaborative effort to construct and maintain such a system. Enabling an eco-structure containing a triumvirate of technocrats, politicians, and civic leaders will help to come up with solutions that are locally relevant and which also will be resilient. Ecostructure is the set of expectations and norms about what everybody thinks policymakers are doing. Ecostructure determines how policymakers, citizens, and technocrats view themselves. Technocrats who become engaged in model building are building more than models – they are building shared expectations and a new eco-structure that fosters new engagement between politicians and civic leaders. Social mobilization and inter-sectoral action are essential for re-orienting health systems to be more people-centred.

Communitisation, a strategy used in National Health Mission in India, is an effort to 'scale up' simple community health strategies of having community health workers, health activists, and village health committees to the entire rural population of 750 million in 2005. These strategies worked very well at a micro level through non-governmental organisations, where there was a strong presence of committed leadership and support systems. The scale up process was needed as all citizens have a right to better health and access to health care and therefore mechanisms were created to enable this. By contrast, Indigenous people are a resilient community. They have a lot of sharing and caring exhibited by community bonding. These inherent features are often overseen. Particularly, their traditional healing is dependent on herbs which are easily available and locally relevant. Failure to recognise the local traditional health systems is not only unfortunate but also irresponsive and selective.

Research can evaluate and suggest new ways in which health systems and inter-sectoral collaborations can better respond to people's emerging health needs, be directly accountable to communities, and ensure the rights and dignity of all people who use and provide health care services. Participatory action research in particular can directly enable people to voice their

concerns and provide ideas for better health systems. In the case of the Zika crisis and the many uncertainties we are facing related to this emergency, we need collaborative research to understand disease transmission and thereby to find effective solutions. This situation, so far has no clear solution besides increased mosquito control and advice women not to become pregnant in the next two years - hardly a solution to a challenge with such serious effects. (David L. Heymann, 2016)

These crises also shed light on holes in our international health system. For example, one of the reasons why the Ebola crisis became a catastrophe was the lack of responsiveness of the global health system, supported by inadequate local and regional systems. The Ebola epidemic has illustrated that several preconditions for resilience were lacking. The first of these preconditions is recognition of the global nature of severe health crises and clarity about the roles of actors at all levels of the global health system. An important point here is that some of these disasters showed us shortcomings in the system and thus demonstrated the importance of more resilient and responsive systems worldwide.

Health-care systems are complex adaptive systems that must be able to respond to unexpected developments and demonstrate the capacity to adapt in normal times. A resilient and responsive health system should have a strong information system and at its foundation be diverse, self-regulating, integrated, and adaptive. Applying systems thinking in public health can help predict and respond effectively to unseen developments and strengthen a system's resilience to emergencies and unexpected strain. The importance of resilience and responsiveness to the challenges one open's the piece with, and how in order to meet these challenges, we must all work collaboratively toward systems that have these qualities.

ENVIRONMENT, SANITATION AND HEALTH

Environment Health is a trans-disciplinary branch of public health which aims at assessing and protecting against harmful external physical, chemical and biological factors to prevent disease and create health supportive environment at the personal, family, occupational, community and global level, and working towards the wellbeing of people and communities by enabling them to manage and improve their own community environment through an eco-sensitive perspective, and empowering them to demand eco-justice through action directed by evidence based on socio-political-economic cultural analysis with an equity, rights and social determinants perspective. (Pradhyumna and Narayan, 2012)

Environemntal health has been a public health concern since the times of Industrial revolution. Disasters such as volacanoes, forest fires and the man made disasters like Chernobyl and Fukushima nuclear disasters, Bhopal gas tragedy, etc have opened a new arena within the public heath. It predicts the overacrhing climate change along with deforestation, increase use of fossil fuels, wars, etc. It opens the truth of the unpreparedness of the health system to which these environmental disasters throw us at. The Bhopal gas tragedy is a testimony of irresponsive health system. There was limited knowledge of the health effects of the chemical exposure that occurred in Bhopal. The identity of the released chemicals itself was a subject of debate. Medical personnel also found themselves unable to handle this unusual situation, pointing towards the inadequate training and preparation for industrial disasters. The economically disadvantaged communities bore a double burden of disease - malnutrition and exposure to hazards of industrialization.

Therefore, there was an urgent need for a toxicological investigation to aid rational therapeutic care (treatment and rehabilitation) of the victims. The symptoms and signs of exposure in victims, pathological findings in organ systems during examination and autopsy, and analysis of chemical agents provided clues to answer the above questions. (Naryan, 1990)

In recent times, climate change has proven its tremendous impact and the torrential rains that created a havoc across the south eastern coast of India is one among the chain of events which was not just detrimental but devastating too and many more such events to come in our way. COP21 stands for the 21st Conference of the Parties to the United Nations Framework Convention on Climate Change held at Paris in December 2015. The key aim was the "stabilisation of greenhouse gases in the atmosphere at a level that would prevent dangerous anthropogenic interference with the climate system". The final destination is a world where temperatures rise not much more than 2°C above the level they were in 1850-1899 period. With the COP21 summit on climate change; global leaders, scientists, activists and the entire world focused their attention on this historic event. The decisions made here will predict earth's future. Many governments have pledged to reduce the green-house gases to reduce the impact on environment.

The implications of climate change for a global population of 9 billion people threatens to undermine the last half century of gains in development and global health. The direct effects of climate change include increased heat stress, floods, drought, and increased frequency of intense storms, with the indirect threatening population health through adverse changes in air pollution, the spread of disease vectors, food insecurity and under-nutrition, displacement, and mental ill health. The Lancet commission on Health and Climate change recommended policy changes to protect public health. The Commission recommends that over the next 5 years, governments: (Watts N et al, 2015)

1. Invest in climate change and public health research, monitoring, and surveillance to ensure a better understanding of the adaptation needs and the potential health co-benefits of climate mitigation at the local and national level.
2. Scale-up financing for climate resilient health systems world-wide.
3. Protect cardiovascular and respiratory health by ensuring a rapid phase out of coal from the global energy mix.
4. Encourage a transition to cities that support and promote lifestyles that are healthy for the individual and for the planet.
5. Establish the framework for a strong, predictable, and international carbon pricing mechanism.
6. Rapidly expand access to renewable energy in low income and middle-income countries, thus providing reliable electricity for communities and health facilities; unlocking substantial economic gains; and promoting health equity.
7. Support accurate quantification of the avoided burden of disease, reduced health-care costs, and enhanced economic productivity associated with climate change mitigation.

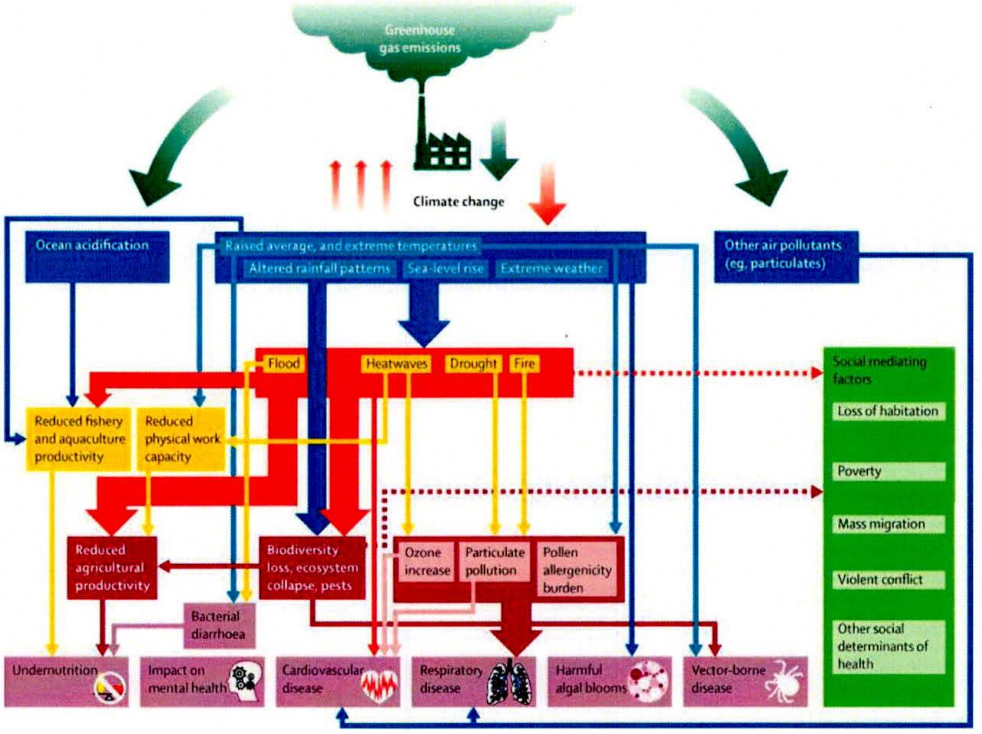

Figure 13: An overview of the links between greenhouse gas emissions, climate change, and health

A workshop on Energy and Health organised by CHESS facilitated interactions with coal impacted community in sharing of knowledge and skills of basic documentation of impacts on health and environment. Skills of health documentation through symptom survey skills; lung function tests, basic skills of environmental monitoring, dust samplings, etc. was shared to enable the communities to record health and environmental impacts. An overview of the policy, planning and governance surrounding energy and electricity in India major threw light on the energy challenges faced by India, namely - Huge Energy Poverty, Limited availability of natural resources and Ecological impacts of conventional energy use. Coal Bearing Act was explained by Mrs Sudha Bharadwaj, a legal activist from *Chattisgarh Mukti Morcha*. She explained how this act was more dangerous that the land acquisition act. She further spelled out that for mining, companies need to apply for a mining license, but if the company does not own the land, they are required to get consent from the owner to mine that area. The mining lease is not about acquiring the land, but about simply giving consent and collecting compensation. Hence, people do not realize that they are letting go of their rights over that land while giving consent. (Collectivenotes, 2015)

Environmental Sanitation and Public Health have been interrelated. The history of public health begins with the Great Sanitary reforms of England in the 19th century. Providing safe drinking water and sanitation have been the priorities of health committees, Alma- Ata declaration, Millennium and Sustainable Development goals. Environmental sanitation has two major problems- waste management and open defection besides many other water and vector borne diseases which are a result of inadequate safe water supply and sanitation.

The Garbage issue is becoming a universal problem. It is more accentuated in developing countries where waste management disposal is under strengthened. Bangalore's famed sobriquet as Garden city is tarnished with its piling garbage. The city generates 4000 tonnes of waste a day and now the BBMP is looking at a ban on plastic to reduce some of the burden. Since the garbage is being sent to landfill sites instead of the seven designated waste collecting centres, the city's garbage woes are unending. Gundur village, one of the waste collecting centre has seen unprecedented flow of garbage and resulting nuisance. The villagers staged several protests, but all in vain. The muck spilled out of dustbins on to city streets and festered in stinking piles in landfill villages, provoking protest after protest.

Recently, another opportunity was lost. On an invitation from Sweden, a team of officials headed by the then additional chief secretary *Ratna Prabha* visited the country to study its solid waste management system. Sweden is so efficient that it even imports waste from other European countries. It has 32 waste-to-energy plants, where 99% of garbage is incinerated to produce steam, which runs generator turbines, public transport and generates electricity, while only 1% ends up in landfill. These plants run in the heart of the city with zero pollution. The team recommended adopting Swedish technology to use the converted fuel for public transport buses and minimize burden on landfills. But after two rounds of discussions with Swedish counterparts, the ideas were dropped citing high cost. (Aiyappa, 2014)

Mobilising the citizens to demand the right for clean city is vital. The Residents Welfare Association in *Koramangala* [29]have mobilised and organised citizens to monitor the progress of their newly introduced 'no plastic' in their neighbourhood. Learning from others experiences, they encourage composting degradable waste within the households to minimise waste input to waste management system. The Karnataka High Court's decision on segregating waste at household itself is laudable. (Natraj, 2015) The waste management will definitely reduce a plethora of problems such as stray dog menace, dengue, malaria risk reduction, and many more. In this case, there is a strong community action for health observed. The residents action as well as the collective action by many civil society organisations' work which resulted in the legal framework has resulted in brought civic responsibility.

VHSNCs have been set up at the village/gram Panchayat level under the leadership of the *Sarpanch* (village leader) and the health worker in the village for carrying out activities leading to improvements in health, sanitation, and nutrition of the villagers. Each month, the workers of Ministry of Women and Child Development and the Ministry of Health and Family Welfare jointly hold a Village Health and Nutrition Day in the village. VHSNCs and Village Health and Nutrition Days provide an institutional platform for fostering convergence and addressing the social determinants of health at ground level. The VHSNCs set up at the village level under the NRHM have been known to carry out activities, such as sanitation drives, filling of pot holes, drives to control spread of vector-borne diseases, provision of nutritional support for malnourished children, purchase and installation of water purifiers at the *Anganwadi centers*[30].

One significant and internationally unique source of early life disease in India is open defecation, especially in rural India. open defecation in India is much more common than in even much poorer countries. India has the largest rural open defecation rate in South Asia by a very large

[29] Koramangala is a suburban neighbourhood where SOCHARA is located.

[30] *Anganwadi* centre means "courtyard shelter" in Indian languages. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition.

margin. According to WHO and UNICEF Joint Monitoring Programme estimates, 61% of rural Indians defecate in the open in 2015, compared with only 32 % of rural people in sub-Saharan Africa. Research suggests that rural Indian households reject the types of latrines promoted by the World Health Organization and the Indian government partly because their pits needed to be emptied every few years. Latrine pit emptying, which is routine in other countries, is substantially complicated by rural India's history of untouchability- work of disposing of human faeces is associated with severe forms of social exclusion and oppression.

Open defecation spreads germs into the environment, and therefore makes growing children sick. One form of this sickness is diarrhoea, which robs growing children of the food that they eat. Another resulting disease could be environmental enteropathy, a chronic inflammatory response of the intestines to repeated exposure to the germs spread by open defecation; it reduces the ability of children's intestines from absorbing nutrition. the consequences of open defecation for Indian children may be worsened by high population density and the problem of child stunting is worse in villages where a higher percentage defecate in the open. (EconomicSurvey, 2016)

The social and economic impact of sanitation issue in India is ignored and not considered on the policy process. The *Swacch Bharath Abhiyan,* which is the new name given to the older *Nirmal Bharath Abhiyan,* aims at building toilets. The government claims to have built over 80 lakh toilets in 2015 alone has failed to show the social impact of the issue. Poor access to sanitation also has mental health impact particularly on women. (Ganesh, 2014).

Community led total sanitation drive aims at recognising and acknowledging open sanitation as a public health issue by the community members. The walk of shame helps the community members to realise and practically understand the problem which in turn is expected to motivate the community for increased use of toilets. The problems often noticed is either with construction of toilets and maintenance of the toilets which means periodical emptying of pits. The use of appropriate technology to construct low cost toilets have overcome the first problem, but emptying the pits periodically is usually carried out by the *safaaikarmacharis*[31]-oppressed class. The behavioural and emotional factors hinder the successful use of toilets. There are efforts to convert the human waste into organic manure and its social acceptability has to be time tested. (Prahlad, 2015)

LOCAL HEALTH TRADITIONS

Local health traditions have been there since time immemorial. The dawn of medicine is traced back to the origins of humankind. But the question of when did it turn into an organised system of research, testing, conversion into practise, acceptability by the people and finally migration of knowledge to far off regions are all intriguing. If we have to agree that, there were local practised health traditions across the world, when did they evolve into an organised system with written records and thus maintaining the continuity? When did this system evolve into modern medicine? Another question is how did these local health traditions remain locally within the *adivasis* or other groups while others evolved and became popular.

[31] Safaaikarmacharis are a group of people, socially stratified, whose traditional occupation is manual scavenging of human waste.

Wendy Doniger, popular American Indologist argues that many traditions have evolved and polished over time including languages. *Prakrit* and other vernaculars came first and *Sanskrit* evolved from it as a polished form. She introduces interesting terms, 'Laukification' and 'Deshification'. (Doniger, 2015)These terms are opposite to 'Sanskritisation', used to describe the way that Vedic social values, vedic ritual forms, and Sanskrit learning seep into local popular traditions of ritual and ideology (in part through people who hope to be upwardly mobile, to rise by imitating the manners and habits, particularly food taboos, of Brahmins and in particular avoiding violence to animals). (Srinivas M. , 1952)

'The process by which the sanskritik tradition simultaneously absorbs and transforms those same popular traditions, is equally important, and that process is called oralisation or popularisation, or *Deshification*[32] or *Laukification*[33]. Cross fertilisation between the sanskritik and laukika traditions, have followed many areas and health has not escaped this transformation. What started as *lokaparampara*[34] in health also witnessed such sanskritik metamorphosis. And, as a result, we have *Ayurveda* which also must have evolved in a similar fashion when the elite sanskritik brahminical ideas seeped into local health traditions. The amalgamation of such another local health tradition is the Persian, Mongolian and Arab over centuries with the Hindu traditions was Unani. The distinctive feature of these local health traditions with that of what is claimed to be classical forms is that, lack of written texts. All these LHT have been passed since generations orally. There are no debates and discussions over texts and theories. These traditions are followed as told by their forerunners. It is interesting to note that local health traditions are popular among the Adivasi communities and others is because the materials used were locally available and easily affordable. Hence they became *Laukified* or remained as a L*okaparampara.* Ayurveda involved rigorous training and the materials used were expensive like oils, mineral salts, etc. which were often procured from far places. The elite could afford it and there was also a Brahmin whose superior position commanded authority. Hence, it might have become a classical tradition.

The traditional medicine into classified into *loka* (oral folk form) and *sastra* (codified classical form). (Shankar, 2001) This distinction of LHT and the classical health traditions into *Prakritik* and *Sanskritik* is again a dominant world view. The classification itself is systematic and based on the availability of texts, evaluation of backgrounds such as familial or ethnic, etc. The worldview of this classification is an elitist, brahminical and colonially influenced. The distinction between the *loka* and *sastra* are widely acknowledged and this classical view is viewed as a complementary relation, and over time, is replaced by mutual exclusivity. The historical analysis of how this distinction is necessary to understand the present political context surrounding LHT's legitimisation issue. (Unnikrishnan & Hari Ramamurthy, 2012)

Ausadhir nama rupabhyam
janatehjyapa vane avipascaiva
gopasca ye canye vanacarina[35]

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[32] From the 'local' or '*deshi*'
[33] '*Laukika*'-of the people (*loka*)
[34] *Lokaparampara* means Local tradition
[35] *Charaka Samhita*, Sushruthana, Chapter 1, verse 120

Charaka mentions that 'shepherds, cowherds and those living in the forest are knowledgeable about medicinal materials both by name and form'. This implies that forests are rich repositories of health knowledge. There was constant interaction between the two forms and over time the distinction grew big. The legislations passed post-independence gave rise to institutionalisation of medical system and legitimising only the registered and the class room trained practitioners leaving behind indigenous health systems. (Unnikrishnan & Hari Ramamurthy, 2012) This comes in the wake of arguing the scientific basis of the indigenous as well as the classical health systems against the western biomedicine. The western medicine in its modern phase is the paradigm for a scientific knowledge system which is based upon the various viewpoints such as sociology, epistemology, empirical analysis, etc. There is an argument that this view point is unlikely to be found in the Indian systems of medicine unless an unbiased criterion is established to call a knowledge system as scientific. (Balasubramanian & Radhika, 1989)

At a global level, WHO in its stewardship role has cleared the ambiguity between traditional, folk and indigenous medicines. It acknowledges that traditional knowledge eludes precise definition and description, containing as it does diverse and sometimes conflicting characteristics and viewpoints. Who defines Traditional medicine as 'including diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness'. (WHO, 2002) The support in the form of acknowledgment to legitimise LHT is necessary to push forward the agenda to revitalise LHT at national levels. The term local traditional healer was first mentioned in the draft National Health Policy on Indian Systems of Medicine in 2002. There have been few attempts to recognise LHT at both national and state levels. NRHM seeks to revitalize local health traditions to strengthen the public health system. A mission group on public health was set up by the Karnataka Knowledge Commission and it recommended an actionable plan to revitalise local health traditions by state patronage and encouraging LHT's based home remedies and recognising LHT to strengthen local health traditions in primary health care through state and university accreditation mechanisms. (Karnataka Knowledge Commission , 2012)

On other hand, there are attempts to comprehensively document and assess local health traditions with the objective of promoting best local health traditions. (Hafeel & Suma, 2007) The documentation of indigenous medicine by individuals and civil society organisations are an effort to preserve the biodiversity of these traditions. The way forward is to recognise these traditions and provide a legitimate platform. This is seen as one of the reason for erosion on LHT (Unnikrishnan & Hari Ramamurthy, 2012). Use of the LHT at primary health care level is beneficial particularly to treat common diseases, for mother and child care and also to treat snake bites. Manual for health workers are prepared by WHO and NRHM are helpful in delivering care to the marginalised and the economically weaker sections.

MY FIELD AREA

It all began when I was briefed during the orientation sessions about field areas that we have to choose to work for six months. We had to intern at a civil society organisation working towards community development and health. During these sessions we were also given assignments to read about various organisations involved in community health movements across India. Voluntary Health Association of India has published a series of books called *Anubhav* both in Hindi and English about such organisations. Each fellow had to pick up one book and read about it and present it to the fellows followed by discussion on the discussed organisation. This exercise gave us an idea about the community health movement in India and the challenges it faced.

Most importantly, it oriented towards the kind of work involved and idea about community health in various settings was instilled. I had picked up *Vivekananda Girijana Kalyana Kendra*[36]. My interest in *adivasis* grew much strong. Initially, I had decided to go to this organisation, but the logistics didn't work out. Dr Mahesh Matpathi, was working with the ACCORD as the community health programme coordinator and I had known him through Samantha. With more reading on ACCORD and consulting Dr Thelma Narayan, Dr Mahesh Matpathi and Samantha, I decided to go to ACCORD. Although practical reasons preceded over other reasons. It was easily connected to Mysore and Bangalore by road. The weather was pleasant and the nature surrounding it gave me a perfect getaway from the scorching heat and pollution of Bangalore. *The Shola Trust*[37], related to ACCORD was working with nature conservation and wildlife, which was also my interest. Thus, the primary area of interest- *adivasis,* and next wildlife and nature conservation, besides other practical reasons, I chose Gudalur as my field area.

Gudalur is a small town located in the lower *Nilagiri* [38]hills. It is located at a strategic meeting point of three southern states of India. The name suggests of *Koodal* which means Joining in Tamil and *Ooru* means village or place and thus *Koodaluru* could have evolved to *Gudalur*. It is a municipality town within *The Nilagiris* district of Tamil Nadu state. Tea industry dominates the region. The first tea plantations in India came up in this region. It is surrounded by protected sanctuaries- *Mudumalai* Tiger reserve and Mukurthi National Park.

According to 2011 census, Gudalur had a population of 49,535 with a sex-ratio of 1,032 females for every 1,000 males, much above the national average of 929. A total of 5,359 were under the age of six, constituting 2,719 males and 2,640 females. Scheduled Castes and Scheduled Tribes accounted for 27.66% and 3.65% of the population respectively. The average literacy of the town was 79.48%, compared to the national average of 72.99%. The town had a total of 12101 households. There were a total of 18,807 workers, comprising 551 cultivators, 1,759 main agricultural labourers, 206 in house hold industries, 14,488 other workers, 1,803 marginal workers, 90 marginal cultivators, 278 marginal agricultural labourers, 119 marginal workers in household industries and 1,316 other marginal workers. Gudalur has a heterogeneous community. It has a mix of people from various

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[36] *Vivekananda Girijana Kalyana Kendra* (VGKK) was started by Dr H Sudharshan. VGKK is working in the areas of education, health and sustainable livelihood of the *Soliga* indigenous group in *Biligiri Ranga* Hills of *Chamaraj Nagar*a district in Karnataka.

[37] http://www.thesholatrust.org/

[38] *Nilagiri* refers to Blue Mountains.

backgrounds. Hindus form the majority (59.83%), while Muslims (26.01%) were the second largest religious There are 14.1% Christians, 0.01% Sikhs, 0.05% following other religions and 0.01% following no religion or did not indicate any religious preference. (Census, 2011).

ORGANISATION

The story of ACCORD is nothing, but the story of the innocent indigenous people. It is a perfect example of community empowerment. ACCORD has been the reason for the success of the community empowerment. ACCORD,[39] a civil society organisation was founded in November 1985. It is the brain child of Mr Stan Thekaekara and his wife Mrs Marie Marcel Thekaekara and a young 19-year-old Mullukurumba Adivasi called Mr K T Subramanyam. The main objective of ACCORD is to fight against the unjust alienation of the *adivasi* lands and other human rights violations by organising them as a strong group.

ACCORD was born in November 1985 to support the *adivasi* community in Gudalur valley to organise themselves and assert their rights - especially land rights. Since the *adivasis* are a small minority here in Gudalur, ACCORD's core aim has been to support the *adivasi* community "enter mainstream society as equal partners and on their own terms in dignity and pride". The scope of work covers community organisation, economic empowerment, health, education, legal support, cultural revitalisation and advocacy with state and central governments. (Thekaekara, Mari Marcel, 1994)

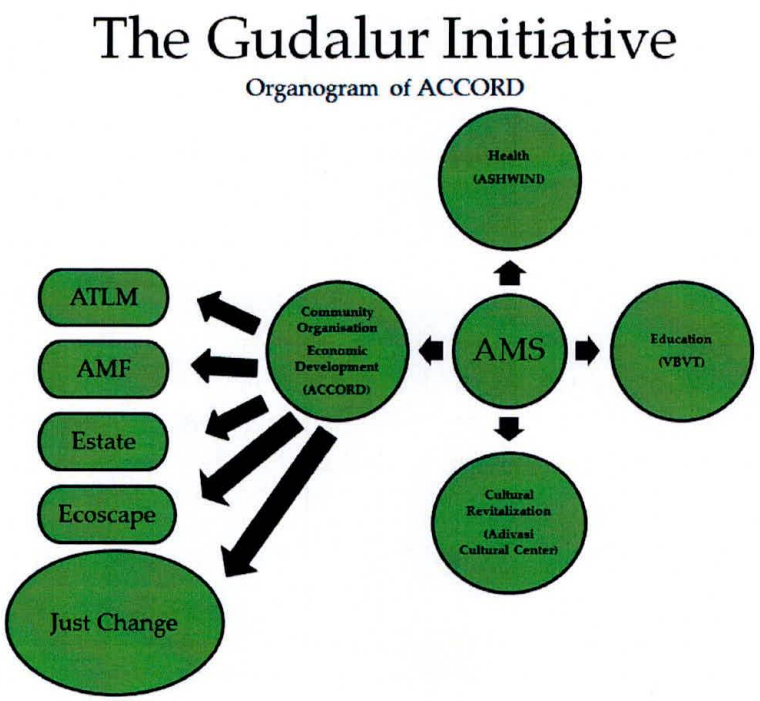

Figure 14: Organogram of ACCORD

[39] http://www.adivasi.net/index.html

The organogram above describes the position of ACCORD in the functioning of the work at the Gudalur valley. Unlike the other civil society organisations, ACCORD doesn't hold a superior position dictating terms and conditions. Rather, it plays a role of a supportive and guiding force for all the activities happening under the aegis of *Adivasi Munnetra Sangam*.

ACCORD'S history is an interesting tale. Stan and Marie were once travelling in the bus passing by Gudalur. An indigenous woman was ill-treated, her fellow passengers accused her of brave act of getting into a bus and sitting on a seat. Untouchability and social segregation was a common norm practised over the indigenous people. Moved by the shocking way of treating their fellow passenger, the couple decided to know more about problems of the indigenous people. Coincidently, Subramanyam, was also provoked by the treatment he and his community received, met Stan and thus the three musketeers set out to work with the community. During the 60's and 70's, there was heavy influx of migrants from neighbouring Kerala, settling as tea, coffee and pepper growers. The *Chettan* community were money mongers and started to exploit the indigenous people. They would lend money and if a person couldn't pay back, they would take over the lands of indigenous people. Thus, a large number of people lost their lands and other property to wealthy landlords resulting in the rampant alienation of *adivasis* from their lands and their human rights were grossly violated.

ACCORD's work is based on community led analysis, planning, implementation and evaluation. It mainly focused on community led institutions, thus avoiding hierarchical structure. Also, coordinated activities in fields such as community organization, health, education and economic development.

ACCORD's work can be phased at four levels. The phase I was mainly involved with human rights interventions (1986- 87) and saw the birth of ACCORD, AMS, land reclamation, prevention of atrocities. During the phase II, it focused around development intervention (1988- 94) like economic development of the *adivasis*, community health, building of hospital (ASHWINI). The third phase saw the development of community institutions (1995 to date) such as the *Mahasabha* leading to formation of VBVT, ATLM, Madhuvana Estate, AMF, initiating Just Change. Finally, now it is in the phase IV- forging ahead and ensuring sustainability.

ACCORD has right from its inception, always had two arms. The professionals or support team whose role is that of a catalyst and the *adivasi* team being trained to take the community into the challenges of the 21st century. ACCORD's task is to make the process of change continuous and irreversible. ACCORD began, by first supporting the creation of strong village level organisations called *sangams* which have been federated to form the AMS. Today the AMS, which is recognised by the State Government as the representative body of the *adivasis* of the area, consists of 312 village *sangams* clustered into 8 areas and covers a population of nearly 25000 people.

However, when the community felt the scope of the health work should be expanded to include curative care by the setting up a community owned hospital, they decided to create a separate organisation. ASHWINI[40] was set up in 1990 to provide curative services through the 40 bedded Gudalur Adivasi Hospital. Today ASHWINI through the AMS provides a 3 tier health care service. In 1995, based on the success of ASHWINI it was decided to institutionalise all their development

[40] www.ashwini.org

interventions. ASHWINI also provides midwife training under the National Social Service Scheme. It is recognised by the state government and the university grants commission.

The *Vishwa Bharathi Vidyodaya* Trust[41] runs the *Vidyodaya* School along with a residential school for dropouts under the government's *Sarva Shiksha Abhiyan*[42] programme. It also conducts a two-year teacher training course and has a large outreach programme. The Adivasi Tea Leaf Marketing Society (ATLM) is the collective that markets the tea leaves of the *adivasis* while another informal society has been set up to market the wild honey collected by the *Kattunayakans* under the brand called *BEE WILD*. The *Madhuvana* Plantation, a common property resource, is a 176-acre tea and coffee plantation meant to generate income for the various development interventions. All these work under the umbrella of the AMS and the board members are predominantly *adivasis* selected by the AMS. ACCORD is a community focussed movement, which is also led by the community.

In today's interrelated world, a holistic approach is essential. This also includes conservation and maintaining the community's symbiotic relationship with their ecosystem and environment. The recognition of the enactment of The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006, popularly called the Forest Rights Act, as a significant and landmark legislation which had huge challenges and implications both for the community and for conservation. ACCORD played an active role in supporting the community to ensure a proper implementation of the Act. 31 special *Gram Sabhas*[43] have been constituted in Gudalur and Pandalur Taluks in accordance with the Act. These councils are increasingly being recognised by the government as a vehicle not only for the implementation of the Act, but also for development programmes of the government. AMS is working actively to strengthen the capability of the *Gram Sabhas* to take on these challenges. Coupled with this, is the work on cultural revitalisation. Part of the price that the *adivasis* may end up paying to enter mainstream society is a loss of their cultural identity. In order to prevent this from happening ACCORD works with young people to ensure that traditional knowledge values and cultural practices are passed on to the next generation.

Ecoscape is a community based eco-tourism initiative started to empower the indigenous communities. The social entrepreneurship model allows local communities to self-sustain and also protect environment. It is located within the *Madhuvana* estate. Just Change is a fair trade enterprise linking communities and business. The tea and other produce like honey, coffee, pepper are traded with fishing communities and self-help groups in exchange of goods at a fair price. AMF is the process of setting up a community bank as well as a series of community enterprises.

Understanding the community

The focus of my observations were the indigenous communities. The predominant groups in Gudalur and Pandalur taluq are the *Panniya, Kaattunayakans, Bettakurumba* and *Mullukurumba*. These people live away from the rest of the society. They live in a small hamlets located deep in the forests or tea plantations. Social seclusion is quite evident with the indigenous communities. The trend of mingling and mainstreaming is evident. Many of the elderly and adults whom I

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[41] www.vidyodaya.org

[42] ***Sarva Shiksha Abhiyan*** is the Government of India's flagship programme for achievement of Universalization of Elementary Education

[43] ***Gram Sabhas*** **means Tribal Village Councils**

interacted have all confided about shyness to talk to strangers and have expressed fear of non-indigenous people in the 70's and 80's. Some of the people whom I visited in the villages, shied away from talking to me. The indigenous groups are classified as semi primitive, hunter-gatherers. They are spread across Gudalur, Pandalur and the neighboring Wayanad district of Kerala. The anthropometric features of these people are distinct and they can be clearly distinguished from the non-indigenous groups.

Panniya, the majority population among the indigenous groups were traditionally bondage labourers. They were enslaved by the landlords in their farms and plantations. Now most of them are engaged in manual labor. Although, the bondage labour continues sporadically, but is usually not prominent. They speak a dialect of Malayalam. The term Paniyan originates from the Malayalam word *pani* meaning work; pannikkar means worker or labourer. The term paniyan is used to address males, whereas the females are referred to as panichi.

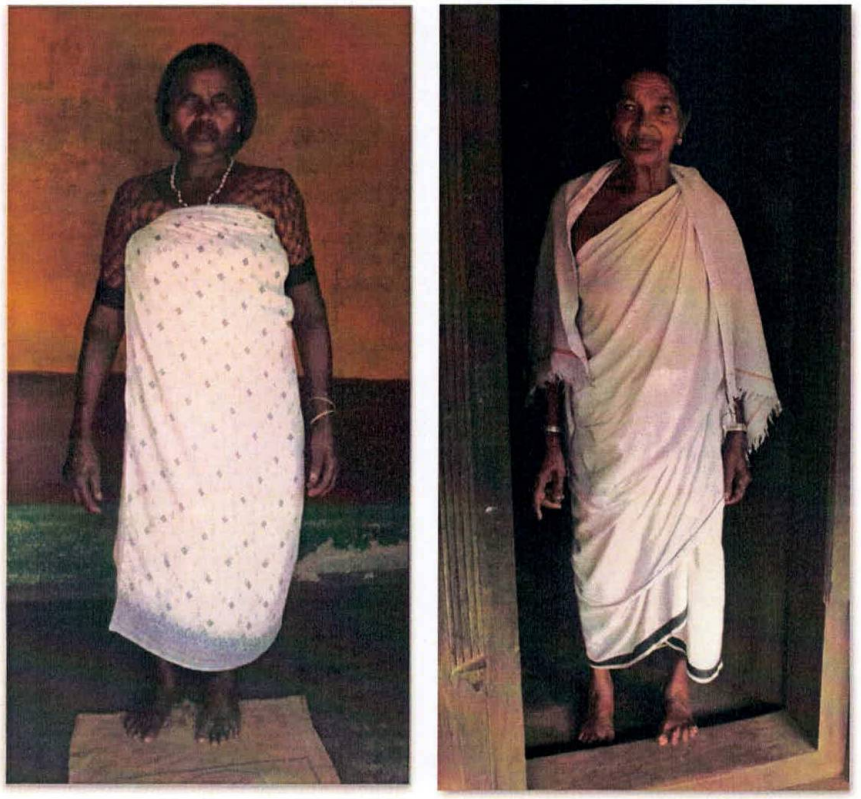


Figure 15: Panniya (left) and Mullukurumba (right) woman

Kurumbas : They are the pre-Dravidian ancient inhabitants of the Nilagiris. Kurumba is not the name of a single tribe. Rather it indicates a common name applied to different ethnic communities in and around the Nilagiri area in Tamil Nadu, Karnataka and Kerala. In the Mysore plains they are considered as a shepherd caste. Their name probably originates from their early occupation of tending sheep (kuru) as a pastoral people. Five different groups called Kurumbas have been identified in the Nilagiris—each of them being a distinct ethnic group differing from the others in language, religion, traditional occupations and other cultural features.2 They also inhabit different parts of the Nilagiris. The Alu or Palu Kurumbas live in the higher ranges, the

Betta Kurumbas (also called Kadu Kurumbas) and Jenu Kurumbas (also called Kattunayakans) in the lower heavily forested areas, and the Mullu and Urali Kurumbas in the lower ranges and foothills. Only the latter two groups of Kurumbas live in Pandalur taluk and in Wayanad district of Kerala.

Mullukurumba are settled agriculturists. They are economically better off compared to the other groups. They speak a dialect of Malayalam. The word mullu means arrow or thorn, but can also be related to the word mula (bamboo), which grows profusely in this area and is an intrinsic part of their culture and occupation. The Mullu Kurumbas are bow-men and hunters. Traditionally, the Mullu Kurumbas were a forest people dependent on food gathering, hunting of small game, extensive fishing carried out mostly by women, and slash and burn agriculture. Today they have become settled agriculturists cultivating either their own land or work as labourers for big landowners and coffee and tea plantation owners. As marginal farmers they cultivate both dry and wet lands. In dry fields they raise spices such as pepper and ginger and crops like coffee and plantains. They cultivate paddy in the swampy wetlands.

The Mullu Kurumbas speak a Kannada dialect called *Kurumba bhasha* with an admixture of Tamil and Malayalam words. They live in uni-ethnic settlements in the Wayanad district of Kerala, and there are 10 settlements of theirs in Pandalur taluk with 8-12 households in each settlement. Their houses are neat, clean and aesthetic with a colour wash to the walls and designs. They are arranged in a planned manner around one or more quadrangles at the centre of which is a temple house, called *deiva perai* or *koil veedu* (god's house). This is of the same design as the other houses and its walls are decorated with various designs drawn and inscribed by the men at the time of its construction. A separate shed for husking harvested grains is also put up near the temple.

Figure 17: Mullukurumba women sowing paddy

Bettakurumba were traditionally elephant trainers. Some of them are employed by the forest department to herd elephants.

Kaattunayakan[44] are the most primitive among the four groups. They live near the borders of the forest. Traditionally, they were hunters and gatherers. They are known for their honey collection skills. They speak Kannada corrupted with Malayalam. They were also involved in shifting cultivation.

The *adivasis* of Gudalur have lived in these hills for time immemorial. The *Edkal* inscriptions at Wayanad provide a valuable evidence that the *adivasis* were here since 3000 BC. *Mullukurumba* group were skilled warriors and hunters. They had helped *Pazhassi Raja* of Waynad in many of his war campaigns. *Mullukurumba*s supposedly helped the British to build the road between Sri Rangapatna and Calicut passing through Sulthanbatteri and hence were given lands to cultivate as a pay for their service.

The *adivasis* in the Gudalur valley have been exploited by the British officials, local landlords, forest department and by the government staff too. Large-scale migration of non-*adivasis* into Gudalur can be traced back to the mid-19th century. At that time, much of the area was under the control of the *Nilambur Kovilagam*, a royal family from neighbouring Kerala, who leased out land for the establishment of first coffee and tea plantations primarily to the British. The emergence of this plantation economy required labour from the plains. The next significant wave of migration was in the 1950s when the post-independence state launched the "grow more food" campaign to contain the effects of famine. During this time, smallholders from the neighbouring state of Kerala were encouraged to cultivate food crops and develop the agricultural economy of independent India. The last major wave of migration into Gudalur was after the Sirimavo–Shastri Pact in 1964, a pact that resulted in the repatriation of over five lakh Tamils from the plantations of Sri Lanka to various parts of South India. (Karthik & Menon, 2016).

Along with this, the nationalisation of the forests and the resultant driving out the indigenous and non-indigenous communities out of the forest alienated the people in their own homeland. The indigenous community which is less than 10% of the population faces economic and social challenges. All these have further driven them to poverty and displacement. The atrocities against the *adivasis* were more commonly acted by the local landlords. They would occupy the lands belonging to the *adivasis*, fence it and claim it as theirs.

In one such incident, land belonging to the *adivasis* which had a sacred grove was occupied by a landlord. Group of men including young K T Subramanyam, a *Mullukurumba* youth approached Mr Stan Thekaekara for help. Stan and the group of men removed the fence and built huts in the land reclaiming their position. The landlord later set fire on the huts and sought police action against them, resulting in jailing of the men. They were later released on bail, but the struggle continued.

There were gross human right violations on the *adivasis*. They were already economically and socially exploited, but now, there was final extermination from the society and stripped of their

[44] Kaattunayakan means master of the forest

basic human rights and values. The *adivasis* realised that they were unorganised and dependant on the landlords. They lacked unity and a collective spirit to fight.

Figure 18: Panniya family standing in front of their demolished hut

The land rights movement started with organising the village members as *sanghas.* It is a three tier structure organised at village, area and taluq level. This came to be known as the *Adivasi Munnetra Sangam.* In 1988, these sangams federated to form a registered society- AMS, a peoples' movement bringing all the five tribes together. Today the AMS covers close to 20,000 *adivasis* in over 200 hamlets. The interventions helped many families to reclaim land and today nearly a 1000 families own small plots ranging from half an acre to two acres. On December 5th of 1988, all the *adivasis* marched in Gudalur town. An unprecedented display of solidarity and unity was seen. It was for the first time; the outside world got to know about the sheer numbers of the *adivasis.* Until then, it was acknowledged as few people of *adivasis.* This historic day is celebrated every year as *Adivasi* day. (Fieldnotes, 2015)

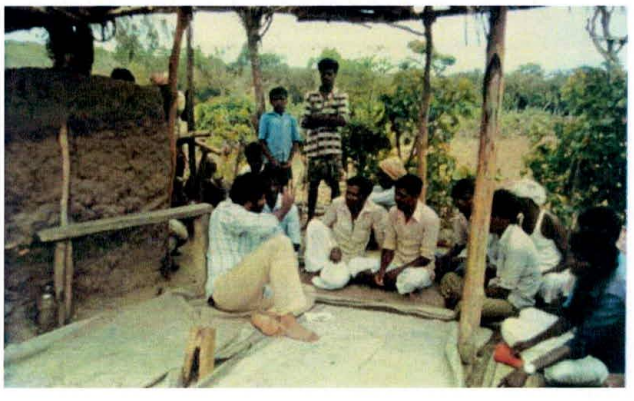


Figure 19: One of the Sangam meetings

Figure 20: Demonstration on the court road in Gudalur on 5th December 1988

COMMUNITY HEALTH PROGRAMME

At another level, the health of the *adivasis* was alarming. Malnutrition was rampant; many women died in childbirth; children as well as adults died of preventable diseases like dysentery and tuberculosis. People preferred to stoically await death at home, rather than go to an unfriendly, alien hospital far away.

There were a series of catastrophic incidents in Theppakad, where three maternal deaths occurred in a single village, which were all preventable. The *adivasis* by now were all an organised group realised the need for health care. The provocation came, because the existing health systems wasn't accommodative to them. They were ill-treated in PHC's and widespread discrimination existed even within the health care providers. The *adivasis* were sensitised to the health issue and asked ACCORD for health care services.

Two young doctors, Dr Devadasan N and Dr Roopa, joined ACCORD to fight the health battle. With patience, they trained a cadre of *adivasi* village women as "health workers".

Chemban Manikantan who began working as a helper in the mobile clinic as a part of health out-reach programme of ACCORD. He along with *Parashu Shridharan* and others underwent health guide training under Dr Roopa and Dr Deva. With the help of AMS and ACCORD, an area centre in Devala, where health related work was carried out. His initial work was limited to identifying Anaemia cases and giving the patients few Iron capsules. He remembers, carrying a small box containing essential medicines and distributing it in the community. His duty was to refill the health kit from the cupboard. He then underwent more training to diagnose and treat common ailments. He would also maintain growth chart of children, immunisation schedule in every community. Manikantan added,

"The health condition very was poor, there were no check-ups for pregnant women, no one got vaccinated, TB was high, Pregnant mothers would die often and many were weak and also had Anaemia".

He remembers about three maternal deaths within a month in Theppakkad. When enquired, it was found that, the *Bettakurumbas* were fearful of visiting health facilities coupled with besides poor access to health care.

The severe and serious cases in the community had to be taken to distant either Sulthan Batthery, Mysore, Coimbatore or Bangalore. The *adivasis* felt it was very stressful and taxing on their pocket. A The young doctor couple trained young *adivasis* to become health workers.

The focus of the work in the villages was the health of the most vulnerable group – namely pregnant women and under five children. A weekly mobile clinic would visit the villages covered by the health worker to cater to more serious patients and also to upgrade the skills and knowledge of the health worker. An important step had been taken towards the objective of encouraging people to access health services.

Figure 21: The first health worker team

After almost three years of gruelling, often frustrating effort, the tide slowly turned. Infant and maternal deaths were no longer accepted as commonplace and inevitable. And patients seeking curative care began pouring in. The problem now was that there seemed nowhere to treat the more serious cases. The government hospital was overcrowded and impersonal, private hospitals prohibitively expensive.

Fortunately, in 1990, another doctor couple joined the team. Dr Nandakumar Menon, a surgeon, and his wife Dr Shylaja Menon, a gynaecologist had just returned after 10 years in the United States, wanting to start a hospital for the poor in rural India. They joined ACCORD. ASHWINI, another society, was started to cater to the health needs of the community. They started a clinic

within the ACCORD office. Youngsters from the different *adivasi* tribes with some schooling were trained as nurses, accountants and other support staff. Manikantan recalls, the initial trainees were, *Ambika, Sita, Janu, Uma, Meenakshi, Janaki and Padmini.*

Dr Deva and Dr Roopa were against duplicating the work of government, i.e. starting a hospital and providing institutional care. Dr Shylaja adds,

"*It was a lesson learnt that, health care lies in a spectrum and there is no demarcation between community services and organisational care*"

They decided to jump into action and started their work at Gudalur. They started a modest hospital at a rented building. So modest, that the operation theatre was just 6*6 feet. They would spend most of the time at field raising awareness about health and hygiene. She narrates,

"*there was a man who would stand outside the hospital all day and they got suspicious and when they enquired about his presence, he was a patient waiting to see a doctor, but was scared to go in*".

This was the situation and they realised they had to deal with more complex issues. They also had a condition to start the hospital. They also want to treat non indigenous people, because it was about helping poor people irrespective of their caste and creed. AMS agreed to it, but had its doubts in the beginning. She adds,

"community participation can be demanding sometimes because they would ask for what they are informed. The logistics, man power, finance would be a challenging task to manage and hence they stressed to include the no- indigenous people to be included for availing the services. Also, the nurses realised that it was important to show others about their achievement. It was a matter of self-esteem"

Figure 22: Doctors and health workers on their field visits

The 20-bedded *Gudalur Adivasi Hospital* was set up to complement the community health work. The secondary care hospital is efficiently managed by the *adivasi* team with the help of a few professionals. Soon afterwards, a process of active decentralization was set up, with the establishment of 8 area centres each covering between 20 and 60 *adivasi* villages, so as to bring health care to the door step of the villagers. Also the health care expanded. The eight area centres (Devala, Ayyankoyil, Devarshola, Erumad, Paattavayal, Sri Madurai, Ponnani and Gudulur) which were already functioning as administrative centres of AMS were supported with health centres. Volunteers from the community enrolled for the health workers training. They would receive training of 15 days in the field and at hospital for a day. They were taught to identify symptoms of Anemia and fevers, ANC measures and first aid techniques. The senior health workers now supervise these area centres.

The area centres are run by trained *adivasi* nurses called "Health Animators", who are more skilled in curative care than the health workers were. People come to the sub-centre for all their basic health needs. What the Health Animators cannot handle at the area-centre is referred to the Gudalur Adivasi Hospital. The health animators also visit each village on a regular basis. They treat minor illnesses, take health education classes, and continue, in collaboration with the old health workers, to monitor pregnant women, children under five years of age, and persons with chronic diseases like TB, asthma, etc

Figure 23: Cheeru, a healthworker carrying essential medicines and other supplies in her backpack and visiting a hamlet close to Gudalur

Figure 24: Omana, a health worker at Devala area centre in a conversation with Gudalur Adivasi Hospital team regarding a screening outreach programme

HEALTH STATUS

The health trends in the Gudalur Adivasi population is quite inspiring in some conditions and rather displeasing in other cases. Everyone agrees to the fact that, communicable and preventable deaths related diseases with commonly prevalent in the 80's when ASHWINI started. The common diseases were TB, Malaria, Anaemia, Diarrhoea, Pneumonia, etc. In 1986, the situation was comparatively worse than the national averages. Deaths from Anaemia, Tetanus and Diarrhoea were common. There was high incidence of Eclampsia. Antenatal check-ups were less than 2%. Primary Immunisation was less than 5%. High incidence of Maternal and Infant mortality was seen because of the above reasons. The cultural and social factors played a major role besides economic and political determinants.

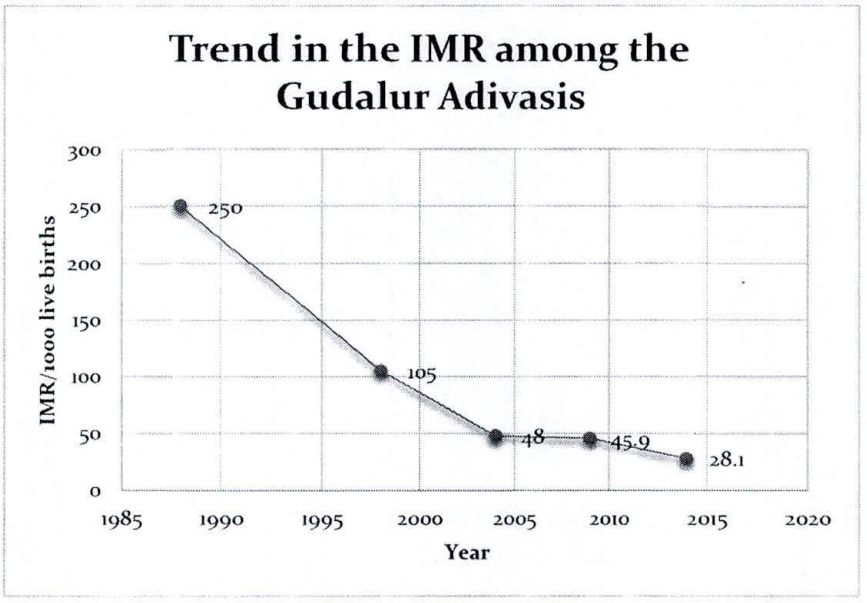
Table 1; Comparison of death rates between Gudalur Adivasis and the National data

	National data (2005)	Scheduled tribes (2005-06)	Gudalur *Adivasis*(2009)
U5MR	42.1	95.7	55.1
IMR	36.1	62.1	45.9
MMR	16.3	NA	1

With the communitisation of the primary health care and the development activities complementing the health care, health indicators such as IMR, MMR, etc. have shown remarkable improvement. Graph 1 and Graph 2 shows the trend in the mortality rates. MMR has been considerably low compared to the national average and ST data. (SRS, 2011)

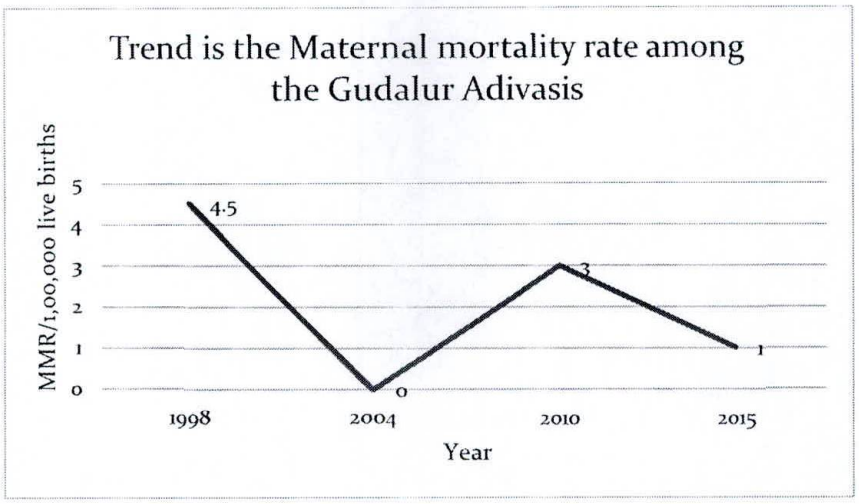
Sickle Cell Anaemia is another common disease observed in the *adivasis*. Dr Shylaja opines that, it is because of inbreeding. When asked about counselling the indigenous people about it, she adds, "*It is not difficult to change the attitudes and cultures of the people. One of the health animators knowing the consequences, married her cousin and had a baby with sickle cell disease*". Manikantan observes that, the *Panniya* and the *Kaattunayaka* group are more vulnerable to sickle cell disease than others because of increased practice of consanguinity. Sickle cell disease is also seen in the *Chettys*[45] and *Badagas*[46].

While the other disease prevalence and incidence decreased, Hypertension, Diabetes Mellitus, Cardiovascular stroke, Mental illness, etc increased. These diseases are also attributed to developmental activities. A recent study was conducted with a goal of understanding the risk factors of common diseases among the Gudalur *adivasis* in relation with development. I was found that development stress may be affecting the tribes differentially causing differences in ill-health. Among the *Mullukurumbas* this may be due to access to better food, changes in physical activity, overweight and alcohol leading to diabetes and hypertension combined with smoking leading to one pattern of cardiovascular risk leading to more heart attacks. Among the *Panniyas, Bettakurumbas* and *Kattunayakans,* development may be leading to lack of or access to poorer foods and alcohol leading to hypertension and undernutrition that be leading to another pattern of cardiovascular risk profile with increased risk of strokes. (Zachariah & Srivatsan, 2015)



Graph 1: IMR trend in the Gudalur Adivasis

[45] Chetty's are the local landlords
[46] Badagas are an indigenous group living in the higher Nilagiris hills



Graph 2: MMR trends in the Gudalur Adivasis

Sickle cell anemia is another cause of concern among the adivasis. The prevalence is 14%. (ASHWINI, 2015)ASHWINI has been implementing a well-designed and comprehensive Sickle Cell control programme for more than ten years among the adivasi and Chetty population of about 30,000 in the Gudalur valley, Nilagiris district, Tamilnadu. It is managing the Sickle Cell Disease Center for the Nilagiris district and has done lot of work to begin addressing this issue on a local and national level. ASHWINI's strategy of controlling the disease with a combination of clinical and community-based team members to implement a successful management system for adivasi populations is worth documenting and sharing with other organisations working with adivasis.

Malnutrition is another area of concern. Anecdotal reports of malnutrition are misleading. *Chemban* from Ponnani village in a meeting mentioned that, although the quantity of food the *adivasis* ate was less few decades back, but they were healthy in contrast to the present situation where quantity has increased but quality has reduced. While, *Madha* of Ayyankolli village told that the situation was bad. They didn't have enough food to eat previously, but the government fair price shop provides them enough grains now. A study on the malnutrition of the under 5 children conducted among the community have shown around 104 children under "Severe", 462 children under "Moderate" and 668 children under "Normal &G1". (Klatz, 2015)

The current adults remember that in their childhood they had a wide food basket which was primarily obtained from the land and forest. This included range of cereals, millets, tubers, leaves and fruits from the forest, a variety of hunted meat and fish from the streams. Although there were periods of starvation, the food quality was better. Today their primary food source is rice given through the public distribution system. Most of the food is bought with scanty amounts of vegetables and fruits, minimal protein and fat. Although physical activity has reduced from their childhood, the most members interviewed are still very active.

Zachariah recently surveyed the risk factors for non-communicable diseases and found the influence of development and health status i.e., the development of small towns in the vicinity and the entry of urban concepts, processes and organizations like health care, education, wage

labour, and development/community health groups have all led to changing health profiles among the adivasis. (Zachariah, Anand, 2015)

The Mullukurumba tribe which is socioeconomically better off has higher rates of diabetes, obesity and hypertension. All the other three tribes have almost non-existent diabetes, moderate rates of hypertension and high rates of low BMI (chronic energy deficiency). The villages which were more developed had higher rates of diabetes, hypertension and obesity. The villages which were less well developed had higher rates of hypertension and low BMI. From this, it can be inferred that the, villages and tribes have different cardiovascular risk profiles based on their development parameters. Review of community mortality statistics showed that the foremost cause of death in the community was heart attacks and strokes. The overall rates of deaths due to strokes and heart attacks are equal to urban Kerala. (ASHWINI, 2015) In Mullukurumbas, the main cause of death was heart attacks probably secondary to obesity, diabetes, hypertension and less physical activity. In the other three tribes the chief cause of death was stroke probably due to wide-spread hypertension.

To bridge the gap in provision and accessibility of the health services, a community based health insurance scheme is followed at ASHWINI. The AMS members pay Rs 22 per year per person a premium. This has resulted in increased utilisation of services and mobilise resources within the adivasis. The geographic reach and the total number of subscribers are challenging, but it has made the health care services affordable to the Gudalur adivasis. (N Devadasan, 2004)

Mental Illness is on a rise in the Gudalur *Adivasis* in the last decade. An analysis of the mortality rates was conducted in 2004 and revealed that suicides were the second most common deaths after cancer. A baseline survey was conducted. This was done to assess the burden of the disease in the community and to start discussions about the topic. Village leaders, health workers and youth groups were involved in the discussions. 184 villages were covered in the survey. Meetings were held in each of these villages and a survey form was used to collect data regarding number of people with abnormal behaviour, mental retardation, alcoholism, substance abuse and suicides. Peoples' attitude to the causation and treatment of mental illness was also studied.

More than 60% of the surveyed were completely or partially ignorant about issues concerning the mental health of the community. About 12% of the people had strong misconceptions and wrong beliefs about mental illness. This fact is more striking, when we consider that the survey was conducted only in sangam villages. Adivasi members in sangam villages are expected to have comparatively more exposure to health issues than the non-sangam villages, due to continuous interaction of ASHWINI's health team with them.

The most important result of this base line study was that it triggered lots of discussions in the villages on mental health. The community members came together to discuss various new issues like mental health, suicides, depression, alcoholism, epilepsy etc. 67 new patients were identified during the course of this base line study and people felt that they need to be followed up or some sort of treatment should be started. (ASHWINI, 2009)

The spread of addiction to alcohol and *ganja*[47] during the course was highlighted in many occasions of the community mental health programme.

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[47] *Ganja* is the local name for Tetra hydro Cannabis

Figure 25: All team meeting in which alcohol de-addiction was discussed

Mental illness, in Stan's opinion is caused by the erosion of the values and ethos at family and community level. Indigenous communities who are known have high community bonding and sharing attitudes are also facing mental issues is because of losing these value systems. Therefore, the community based approach to treat these illnesses would be an appropriate measure.

Alcoholism is the newest health issue which has a mental, social and economic impact on both the individual and the family. The government outlets where liquor is easily available have made a huge impact. The exploitation of the *adivasis* by luring them to alcohol for cheap labour is also reported. The government policy on producing alcohol is, at first place, the cause of alcoholism. There is a political stand and the vested interest of the industry.

Figure 26: Mental health care provided by missionary hospital

The health infrastructure in Gudalur and Pandalur are adequate. There is a mix of both public and private health care centres. Primary health centres are located for every ten thousand populations. The government schemes such as Muthulakshmi Reddy scheme for mother and child health attract people. With the availability of better public health care facilities and the monetary benefits given through the government schemes, institutional deliveries have increased. There is

still a tendency for home deliveries among the *adivasis,* although the numbers have reduced. There were 45 home deliveries among the *adivasis* in 2014 (Fieldnotes, 2015). The NRHM has introduced a new health worker in hilly and Adivasi region called *'tribal coordinator'* who job is to convince the *adivasis* to avail more services at PHC.

In one of the discussion with a facilitator, who claimed that ASHWINI's work is not supplementing, but duplicating the work. (Collectivenotes, 2015) The records of health indicators at ASHWINI are used by the health officials to add up the numbers to show an upward health status. But undermining the actual situation. This is refutable. The claims are observatory and from the field experience, the health records are used by the officials to actually note the health indicator status. The district health survey found out that 0.6 women in 2013 had home deliveries. (DLHS, 2013)When the number of the home deliveries among the adivasis of Gudalur is extrapolated to the entire district population and compared to the district survey, the numbers are comparable.

Several civil society organisations are carrying out health care in this region. The Nilagiris Waynad Tribal welfare society hospital is located in Ambalamoola in Pandalur taluk of Nilagiris district in Tamil Nadu. It is a private non-profit hospital. The hospital was functioning on the model of PHC with selective primary health care. It was also the district monitoring center for TB. Besides, numerous for profit private hospitals, Christian missionary hospitals also are providing services.

One of the Christian mission hospital was exclusively rendering mental health services in the region. It was run by the Catholic health association of India, a charitable catholic missionary hospital located in Pattavayal in Pandalur taluk. Selective secondary care was provided by ASHWINI and few other hospitals. The nearest tertiary care centres were located in Calicut and Mysore. Crossing the forest to reach Mysore during night times is prohibited and hence, most of the times, patients are referred to Calicut Medical College.

Figure 27: Demographic details in a PHC

The Integrated Child and Development Care is provided by Anganwadis, better known as *Balawadi.* A visit to a *Balawadi* in Erumad village in Pandalur taluq to check the number of *Adivasi* children availing the services revealed a good picture. But according to Mrs Cheeru, an Adivasi health animator at ACCORD mentioned that, it wasn't feasible with the young nuclear Adivasi families because of their work schedule. Most parent are labourers at estates and the timings are not compatible with the *Balawadi* timings. Hence most parents take their children along with them to the work site. The occupational health needs to be explored in this region.

RELIGION AND CULTURAL ASPECTS

Cultural aspects of the Gudalur *adivasis* are unique. Many cultural facets describe the way of life of the adivasis at Gudalur. Each of the indigenous group have their unique dressing style. Men, irrespective of all groups, wore a piece of white cloth tied around their waist. *Panniya* women tied a white cloth about a meter or two, around their chest covering their breasts. They also tied a small piece of cloth around their waist to secure the bigger cloth creating a big pocket. They wrapped their upper body with another piece of cloth. Blouse are a recent addition. So are sarees. The women have curly hair greased with coconut oil. Most women cut their hair at shoulder level.

Marriage is often consanguineous, but it is fast eroding. The inbreeding explains the reason behind high prevalence of Sickle cell anemia among the *adivasis*. Marriage between groups is not permitted, although cases of such union have taken place. Mr Velan, education animator at Ponnani once told me that, they resent such activities and who ever goes against the norm are excommunicated. Madhavi, a *Kaattunayanaka* health guide mentioned that, they go to *Mullukurumba* houses, but wouldn't go to a Bettakurumba and *Panniya* house. The latter are considered low. She said that they wouldn't have marriage alliances with any other *adiavsi* groups. When probed further, she mentioned that *Panniya* women don't follow the monthly menstrual rituals and this is absolutely unacceptable to them.

Panniya religion is animist. Ancestal spirits and male and female deities are worshipped. The spirits are invoked for good actions by their shaman called *'Attali'*. Their chief goddess is *Katta Bhavathi* (goddess of the forest). Devil worship is also prevalent. Most of the *Panniya* songs invoke their ancestral spirits and deities. *Panniya* stories depict the relationship between *Panniyans* and their non-Adivasi masters, the problems with their wives over affairs in their master's household, and their relationship with animals around them. Sanskritisation is also happening to some degree where Hindu gods and goddesses are worshipped together with other castes and tribes, which implies an acceptance of the Hindu caste system with its hierarchies.

The *Kattunayakans* worship nature in the form of animals, birds, the sun, the moon, even shelter and the shade. They still worship rocks, hills, snakes and animals claiming their origin from them. They have implicit faith in charms, sorcery and black magic. Deities are *Mari, Mastideiva* (male) *Hethappan* and *Mala Deivom* and they also worship Siva by the name of *Bairava*. They celebrate festivals like Onam and Vishu. Their oral tradition flows through music and dance along with songs and tales about forest trees, wild life, famous temples and about acceptable behaviour in kinship relationships. Musical instruments used are *the thambattai, kuzhal, pipi, kulalu, mard, parai, tempte, pukiri, kadimai and tavai*. Their council, headed by the *muttam* (headman), is called Nyaya. Every settlement also has a headman called *karanvar or modale*.

Parvathi, education coordinator once told me while walking to a village to meet a healer, that they didn't worship any Hindu deities like *Ganesha or Shiva*. They only worshipped *Kaavu*[48]. *Kaavu* is a sacred grove worshipped by the *adivasis*. It consists of tree or a group of trees. The surrounding area is maintained neatly and sometimes smeared with cow dung. It has been well documented that sacred groves often play a key role in biodiversity conservation, especially in

[48] Sacred grove

highly modified landscapes. They maintain some habitat heterogeneity, sometimes acting as 'stepping stones' for long range dispersal of numerous species. This is especially true for a region like Gudalur, where communities have lost a considerable part of their ancestral domain to both the state (in the creation of forest plantations, particularly the Tantea corporation) and immigrants into the area who have appropriated their lands and converted it into monoculture plantations.

Velan said that, usually a white liquid seeping plant or tree is revered in the *Kaavu*. Over the years, there has been increased identification with Hinduism or sanskritisation has seeped into their names, folk traditions, celebrations and also marriages. The *Brahmin* priest is invited to conduct a marriage of late which was not followed in the earlier days. There have been increasing number of religious conversions mainly to Evangelical order. Vishnu, a school teacher at VBVT told me that, people who never understood their own religion go into others.

Figure 28: Sacred grove at Naduvattam village

PHYSICAL INFRASTRUCTURE

In terms of physical infrastructure, the situation is fair. Topographically, the lay of the land is mix of hills, valleys, rivulets. The scene is dominated with tea plantations. The condition of roads here ranges from below average to good. The roads connecting between major towns and villages and those particularly the interstate roads are asphalted and maintained well. But those connecting small villages are average, and are not maintained well. The local public transport is fairly good considering its price. There are few buses in a day connecting hamlets and villages. There are numerous private jeeps and auto rickshaws operating between short distances. These are often overcrowded and suffocating to travel. They ply between all villages and hamlets every few minutes at a price higher than public transport service. There are few bus shelters. People stand at a designated point on the side of the road. The plight is pitiable during monsoons.

Electricity supply is fairly good in all areas except in section 17 land, but the government has provided solar lamps. Section 17 land is a litigated land which was earlier leased to the British by the *Nilambur Kovilagam* royal family. After the land reforms in 1970's, the land fell into petty hands and the presently in court. The area is now termed section 17 by the revenue department and is devoid of basic services since it is under litigation. Tele-connectivity of mobile phone services is good and land line telephones are decreasing. The broadband services and the internet connectivity are above average.

Figure 29: Thatched bus shelter near Gudalur

Adivasis live alongside the non *adivasis*. But most live separately in groups. Their houses are of substandard quality, although the hill area development board of the state government are constructing house of fair quality.

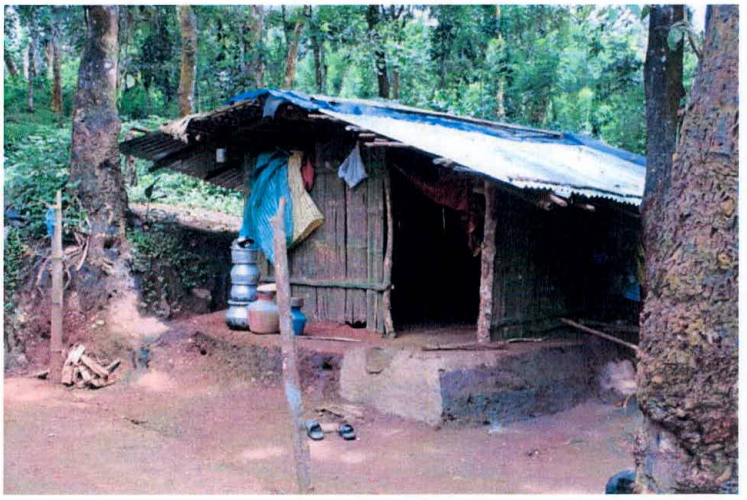

Figure 30: Kaattunayaka hut

AGRICULTURE AND FOOD PRODUCTION

Gudalur *adivasis* are historically hunters and gatherers. *Kaattunayakans* engaged in shifting cultivation, while the *Mullukurumbas* grew paddy and millets. Full-fledged agriculture only began with civil societies involvement in land reforms in 70's and 80's. Tea was encouraged to grow, because it was onetime investment and economically sustainable.

Traditionally *adivasis* depended were self-sufficient for food. The forest gave them a lot - a wide range of fruits, tubers (roots), leaves, wild vegetables and of course meat. They also grew a range of traditional vegetables – like different kinds of greens, yams, pumpkins, beans etc. But over the years as they became more and more part of the mainstream society and less dependent on forests they have slowly shifted from a highly nutritious and varied traditional diet to a less nutritious diet – with rice as the staple. And as they became more and more dependent on cash they increasingly spent less time on growing their own food and instead buying from the shops. Thereby shifting from a varied and protein rich diet to a carbohydrate rich diet. A recent survey found that the food basket has shrunk. (Zachariah, Anand, 2015)Today their primary food source is PDS rice. Most of the food is bought with scanty amounts of vegetables and fruits, minimal protein and fat.

Similar trend was recorded by Dr Denis Burkitt, the popular epidemiologist from Ireland who did primary work in Africa. He noticed that diet in Uganda was rich in fibre based vegetables and tubers as compared to the diet back at home in UK. This research laid the foundation to our understanding of diet based diseases and the usefulness of diet. (Collectivenotes, 2015)

Figure 31: A Public distribution system shop displaying the picture of rice sold at the outlet in Ayyankolli village

EDUCATION

According to Planning Commission, the school drop-out rate among STs in Tamil Nadu between classes 1-8 is 71.60%. (Planning Commission, 2000) In the Nilagiri district, it is about 74% between the 8th and 10th standards. This was higher than that recorded in Karnataka and Kerala. In the Nilagiri district the drop-out rate of the tribal girl child is much higher than among the STs of other districts. The literacy level among the Adivasi communities in Pandalur taluk is the lowest in the district with high drop-out rates at the upper primary and high school levels. In Gudalur block there are 9 Government Tribal Schools, 21 government primary schools, 15 government middle and higher secondary schools, and 10 Christian missionary schools from the primary to the higher educational levels. The fees charged by the private schools are on the high side with the tuition fee being more than Rs 5000 per year. Additional expenditure on the uniform, transport costs, books could be further taxing. The accessibility is another issue. The percentage of Adivasi students passing the 10th standard exam is also very low. One of the important reasons for low enrolment of girls in the Adivasi areas is the lack of relevance of formal education for their roles and responsibilities in their own culture.

VBVT is providing value based alternative education to the *adivasis* and non *adivasis*. The school is modelled on alternative pedagogy. The education system here stresses on cooperation and group work, creating a possibility for children to work at their own pace, co-curricular activities are given equal importance and firm value-base is inculcated. Rahul, the English teacher at Vidyodaya school has successfully organised many camps for the children. The main aim was to expose the children to different cultures, activities, problems, etc. in a place they have no access or opportunity to go. Variety of activities like sports, village walk, chat with village elders, talk by senior AMS members, discussion and debate about social topics and reflection about it through t-shirt painting, etc. are organised. These camps also include sports activities which encourage team spirit. Stress was laid on Frisbee. This activity garnered enthusiasm and was used to grab the children's attention towards education.

Figure 32: Children on a transect walk in the forest during the camp

ENVIRONMENT

Gudalur's dense malarial forests were opened up in the late 19th century with colonial zest, as mentioned above, first for coffee, then tea plantations, when the *Nilambur Kovilagam* leased out large tracts of land to wealthy British planters. An enormous labour force was required to clear these forests and transform them gradually into the uniform rows of well-pruned tea bushes interspersed with silver oak trees that still dominate the landscape. The repatriation of Sri Lankan Tamils during the late 60's and 70's resulted in converting nearly 27,000 acres of forest to tea plantations to provide employment and livelihood.

With the forest cut for agricultural purposes, the green cover declined drastically. Further, the last remaining forest was declared Mudumalai Wildlife sanctuary. With further encroaching the forest cover above 1500msl, the sholas too were not spared. This caused much more ecological imbalance. The Sholas are a mosaic of mountain evergreen forests and grasslands. They are found only in high altitude (>1500 metres asl) regions within the tropics, and are limited to the southern part of the Western Ghats. They are characterised by undulating grassland patches, interspersed with thickets of stunted evergreen tree species, and are home to a host of endemic and endangered plants and animals. They are also vitally important in keeping water cycles alive. They retain most of the rain they get over the monsoons, and release it slowly through the year via a network of streams and rivers, that eventually serve the needs of a huge number of human settlements across south India.

With sholas encroached, the water table has reduced further. The remaining rivulets also began to dry with inadvertent planting of Eucalyptus trees along the rivulets. These trees are known to suck the underground water leaving behind a dry top layer of sand. This resulted in decrease in fauna because of shortage of water. Villagers recall witnessing herds of deer decades back near the water bodies.

Figure 33: Encroaching Shola grasslands

The government policies such as ban on the use of hydraulic excavators and tube well diggers are implemented well but selectively carried out to benefit the government work. River *Ponnaniyer* meandering through the Nilagiri forests passes through the Ponnani village. Recently, the village municipality used a hydraulic excavator to clear the weeds along the river. With it, rich biome and invaluable water plants also were removed. Worse, the fish depending upon the algae were not spotted. Fish from the river was an important source of protein for the indigenous people here. Unscientific practices not only harm the environment but also affects the people depending on it. Reckless environmental destruction and its consequences are detrimental to humans and affects health directly and indirectly.

Figure 34: River Ponnaniyer now flowing lifeless

Indigenous communities across the world have played a significant role in conserving their natural world. Their lifestyles, cultural practices and spiritual belief systems, intentionally or otherwise, have resulted in a relatively harmonious balance and stability through centuries. The hunting traditions among the Adivasi are rooted in ecologically conscience. They have rules governing hunting.

They wouldn't hunt cats, domesticated animals, pregnant and younger ones also spared. Dog usually accompanies the hunting team and to help them find the catch. The hunting is carried at special occasions and a strict calendar based on the reproductive season of animals is followed to avoid the animals which cannot be hunted. There are more lessons to be learn from them. (AMS, 2013)

Another concern across the world is the human animal interaction which is heading towards conflict is basically due to the encroachment of the forests. Wildlife trespass into human settlements often in search of food. This either results in killing of animals or wildlife preying on

domesticated animals and sometimes on humans. Reports of human-animal conflict appear regularly in newspapers.

Figure 35: Adivasis going on a hunt (ACCORD Archives)

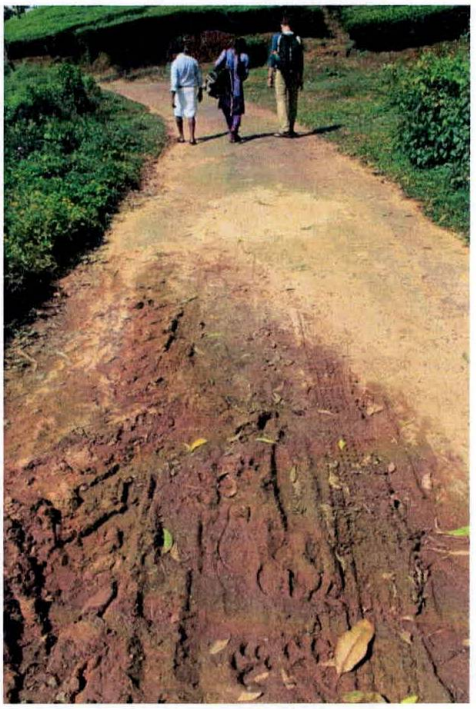

Figure 36: Co-existing with Animals-Leopard pug marks spotted during a village visit

Exploring perspectives of local traditional healers on oral health among the indigenous population, South India: Reflections on qualitative research orientation and communitisation of this initiative.

ABSTRACT

Background: The indigenous concept of health and disease is based on holistic approach where illness, wellbeing, culture, environment, etc are intertwined. Rural India faces roadblock to oral health care in terms of Accessibility, Availability, Acceptability and Affordability (4A's) especially in the indigenous areas where health seeking behaviour among the indigenous communities is driven by cultural ethos and influenced by local beliefs. The health system operates on biomedical model which causes cross cultural conflicts that may mediate with 4A's.
A preliminary study was conducted as a brief project of community health learning programme to understand the perspectives of local traditional healers on oral health and explore the convergence and divergence with the current dentistry framework to support further integration of health systems.

Methods: This study involved participant observation for six months focusing on the determinants of oral health in the indigenous groups in Gudalur, South India. Observations in homes, community facilities, within the region were supplemented by in-depth interviews and focussed group discussions with ten local traditional healers. The transcripts of the discussion revealed overlapping symptom conditions and were categorised into themes-culture, health conditions, local health traditions, social position and relations, difference with western biomedicine, access to herbs, etc. Grounded theory helped analyse observations and interviews.

Reflections: While the results are still analysed, this paper focusses on two challenges that the researcher faced in this evolving study. Researcher is a dentist with a training emphasised on biomedical, evidence based, epidemiological western framework who is trying to learn qualitative participant observation research. The research is focussing on communitisating the research with the support of local organisation to bring about participant action.

Results: Cultural practices such as prayers, rituals and offerings along with herbal therapies play a major role in healing. Changing social, economic, political, cultural and environmental determinants have increased the prevalence of oral diseases. Some of the causes, diagnosis and treatment for common oral conditions are both contradictory and some supportive to western biomedical framework. Those supporting factors support integration by complementing or supplementing the health system.

Conclusions: Researcher is undergoing a paradigm shift from patient to person centred health care, subject to participant research and biomedical to social care. Community based health systems inclusive of local health traditions make a responsive people centred health systems.

BACKGROUND

Oral health is an integral part of general health. (WHO, The World Oral Health Report 2003. Continuous improvement of oral health in the 21st century-the approach of the WHO Global Oral Health Programme. , 2003) Oral health, like the rest of the body parts and their functions, contributes to the overall quality of life of an individual. Oral diseases affect majority of the Indian population. 83% of 6-19 year olds are affected with dental caries. (FDI, 2009)Prevalence of Edentulousness is 19% in the age group of 65-74 years and the age standardized incidence of oral cancer is 12.6 in India. (WHO, The World Oral Health Report 2003. Continuous improvement of oral health in the 21st century-the approach of the WHO Global Oral Health Programme. , 2003) Oral health delivery system is still following the inverse square law in India. (AIIMS, 2001)Rural India faces roadblock to oral health care in terms of accessibility, availability, acceptability and affordability. According to Central Bureau of Health Intelligence statistics, India has 5278 dentists working at Government hospitals. (CBHI, 2013) There is no data available on the number of dental surgeons working in rural area. The Dentist-Population ratio is 1:10,120.85 and the only 59% of Indian population is served by Dentists. (CBHI, 2013)

The NRHM seeks to revitalize local health traditions and mainstream AYUSH including manpower and drugs, to strengthen the Public Health System at all levels. However, there is no mention about local health traditions in the joint Government of India and WHO workshop draft on effective utilization of manpower. (Prakash, Duggal, & Mathur, 1999)Although, the draft acknowledges AYUSH as a part of oral health care delivery system in India. Deprofessionalisation of medicine is a recognized modality of delivering health services for effective primary health care practice. Besides, medical doctor, the role played by multitude of social workers, accredited social health activists, practitioners of Indigenous medicine, etc. is indispensable.

Local health traditions have been catering to health needs of the people since time immemorial. Particularly worth mentioning is their role in lives of *Adivasis'* or indigenous people. Tribal concept of disease and treatment, life and death is culturally varied. (Gupta, Shrama, & Sharma, 2014) Traditional system of medicine also includes the local health traditions and sometimes referred to as folk medicine. This system depends upon remedies found in nature, otherwise available locally. Local health healers form an important part of the health care system within the indigenous communities. World Bank recognizes their significant role in a health system. Traditional Healers are usually informal, unrecognized by the government, and do not interact with the rest of the health system. Yet they can be a formal part of a system. (World bank, 2013) WHO notes that Traditional Healers are especially significant in developing countries because they are more accessible and affordable. In addition, they are more socially accepted as compared to formally trained health workers from the urban areas. (WHO, 2003)

The *adivasis* living in the Gudalur region belongs to different groups, each one with their own identity, culture and occupation. The four *adivasi* groups – *Mullukurumba, Bettakurumba, Panniya* and *Kaattunayaka* make the major *adivasi* population in Gudalur. Development activities and exploitation over decades have caused much trouble to this minority group. However, government and other civil society groups are working for their betterment in many areas including health. One of the civil society organization working for *adivasis* is ACCORD. ACCORD is actively working for the past three decades for *adivasis'* land rights, education, health, and housing and cultures all of them revolving around community empowerment. ASHWINI was

born out of such demand from the community to meet the increasing needs of the health. ACCORD began realizing that the input of the medical systems is making traditional healing practices slowly disappear. ACCORD has engaged in mobilizing the traditional healers in *adivasi* communities to a forum where in they can share their experiences between themselves. Health seeking behaviour among the *adivasis* is driven by cultural ethos and influenced by local beliefs. The utilization of institutional healthcare services is sought after the alternatives of traditional healing/ black magic/ sorcery are exhausted. (Gandhi, Verma, & Dash, 2015)One study has documented the high prevalence of Periodontitis (gum diseases). (Philip, Chithresan, & Vijayalakshmi, 2013) Another study reported that, *Panniyas* might have favourable compliance for oral health promotional programs. (Vivek, Jain, Sequeira, Battur, & Tikare, 2012)

However, no qualitative studies have been done concerning their beliefs and illness behaviour related to oral problems. Gandhi noted in her observation that many *Adivasis* would visit to health institutions only after visiting a local traditional healer. (Gandhi, Verma, & Dash, 2015) Therefore, some ethnographic knowledge is needed to understand how and why modern health services are perceived and used in a society. This data is lacking in oral health especially in the Gudalur *adivasi* community. Thus the aim of this study was to describe the beliefs and illness behaviour related to oral health problems in the Gudalur *Adivasi* community from the perspective of their traditional healer.

Aim and Objectives:

Aim: To describe the beliefs and illness behaviour related to oral health problems in the Gudalur *adivasi* community from the perspective of their traditional healer.

Objectives:

1. To document the understanding of the oral health conditions and the views of oral health by local traditional healers.
2. To document the information about causes, prevention and treatment of the most common oral conditions from the perspective of the local traditional healers.
3. To understand the perspectives of the causes of the oral health problems.
4. To explore the convergence and divergence with the current dentistry framework to support further integration of health systems by the host NGO.

Review of Literature

A report on stakeholder's workshop on "AYUSH Interventions in Public Health" documents the work carried by ACCORD and ASHWINI hospital in Gudalur. ACCORD began realizing that the input of the medical systems is making traditional healing practices slowly disappear. Hence they are currently documenting the local health traditions. Accordingly, the region houses different specialists of traditional healers who are traditional bone setters, etc. Efforts to mobilize the traditional healers in *adivasi* communities to a forum where they share their experiences between themselves. The need to document the existing practices and also take up an initiative in traditional medicine in the existing institutional community health programme like, training community health workers from the community itself, to identify and prevent illnesses like diarrhoea, to provide immunization and nutrition to pregnant women and children, to improve health awareness among the adivasi community. (FRLHT, 2008)

A study exploring the health seeking behavior of the *adivasis'* belonging to the *Panniya, Kattunayakan and Bettakurumbas* is examined. The pattern and determinants of access and utilization of healthcare services amongst these tribal and the determinants of the out of pocket expenditure were analysed. Despite public provision of healthcare services, healthcare seeking behavior was predominantly driven by ethos and belief system. The utilization of institutional healthcare services was sought after the alternatives of traditional healing/ black magic/ sorcery were exhausted. The probability of utilization of public health services among *Panniyas* and *Kattunayakans* was less as compared to the *Bettakurumbas* due to trust wedge emanating from historical psychological trauma inflicted upon *Panniyas*. Similarly, for *Kattunayakans* their culture which is embedded in ethnomedicine and symbiotic relationship with forests explains the trends. Also, the penetration of NGO's providing culturally compatible health services to indigenous people was exacerbating the underutilization of public facilities. The preference for traditional healers over qualified health personnel was not explained by differential in expenditure but due to cultural factors. (Gandhi, Verma, & Dash, 2015)

Methods

The study involved ethnographic observation for six months focusing on the determinants of oral health in the indigenous groups in Gudalur, South India. Purposive representative sample with an effort to get at least one from each *adivasi* group. The participants were selected using convenient or snowball sampling method drawing mostly from the healers known to ACCORD through their outreach.

Persons who identify themselves as local traditional healers. Traditional healers are defined according to World Bank as "Traditional healer services refer to the application of knowledge, skills, and practices based on the experiences indigenous to different cultures. These services are directed towards the maintenance of health, as well as the prevention, diagnosis, and improvement of physical and mental illness. Examples of traditional health service providers include herbalists, faith healers, etc. (WHO, Report on WHO Traditional Medicine Strategy, 2003) Other inclusion criteria were, persons who are living and practicing local traditional medicine/folk medicine for substantial time period[49], local traditional healers who belong to any of the Gudalur *adivasis- Mullukurumba, Bettakurumba, Panniya and Kaattunayaka*n and local traditional healers know to ACCORD through their outreach.

Ethical clearance was from the SOCHARA Institution, Scientific and Ethical committee, Bangalore and permission was obtained from the AMS.

The data was collected between October 2015 and November 2015. Observations in homes, community facilities, within the region were supplemented by in-depth interviews and focussed group discussions with local traditional healers. Local traditional healers were identified through networking and snowball sampling method. Oral or written informed consent was taken after explaining the intention of the study in local language[50]. Local traditional healers were interviewed in depth based on the themes (Annexure 1). Few local traditional healers were invited for a focused group discussion to examine both internal consistency of the information provided

[49] This was fixed for about 10 years

[50] Tamil was used as local language here. The *adivasis* were fluent in Tamil, although it was not their mother tongue.

by the interviewees and understand the new dimension of their understanding of health institutions and the process of referral to ASHWINI or any other health institution. The interviews and discussions were tape recorded for ease of interviewing and later transcribed and analysed.

The emerging themes were analysed using deductive inductive methods to identify perspectives of oral health by the local health healers. Data collected was thematically analysed to understand the oral health and illness behaviour, causes, diagnosis, treatment patterns through local health healer's perspective and also to explore the convergence and divergence with current dentistry framework to support integration of health systems. Grounded theory helped analyse observations and interviews.

RESULTS:

Ten local health healers took part in the interview. The age ranged between thirty-two and sixty. There were two females and eight male participants.

Table 2: Demographic details of the interviewees

SL NO	AGE	SEX	INDIGENOUS GROUP	PLACE	OCCUPATION (S)
1	NA	Male	*Panniya*	Thondiyalam	Agriculture, AMS member
2	NA	Male	*Panniya*	Ponnani	Health guide
3	32	Male	*Bettakurumba*	Kummamoola	Agriculture
4	46	Female	*Panniya*	Thondiyalam	Housemaker
5	60	Male	*Kaattunayaka*	Ayyankolli	NA
6	48	Female	*Kaattunayaka*	Ayyankolli	Traditional Dai
7	49	Male	*Bettakurumba*	Theppakadu	Daily wage labourer
8	NA	Male	*Kaattunayaka*	Chembakolli	Agriculture
9	52	Male	*Bettakurumba*	Theppakadu	NA
10	50	Male	*Kaattunayaka*	Chembakolli	NA

The transcripts of the discussion revealed overlapping symptom conditions and were categorised into themes-understanding oral health, health conditions, local health traditions, social position and relations, difference with western biomedicine, access to herbs, etc.

Understanding Oral Health

The local understanding of the anatomy and physiology of oral structures are elusive and extraneous. Nevertheless, in the colloquial, terms such as mouth, teeth, tongue, jaws, bone, etc. are used with reference to oral health. *Vaayi* is the term used for mouth, *pallu* for teeth, *naakku* for tongue, *elumbu* for bone are used in the local dialect of Tamil. The vernacular terms are given more importance here, because they express the emotion and the proper meaning attached to disease or condition or even a structure.

Oral Hygiene

Oral hygiene refers to cleaning and maintaining of the teeth only. The cleaning and brushing of teeth is a daily routine and is carried out in the morning everyday by all. Tooth paste and tooth brush have come into their lives only recently. Until then, *aduppu kari* (charcoal) from a variety of trees other materials was used. Some of the *adivasis* still follow it.

When I was a small boy, I brushed my teeth with nellu ummi (paddy husk) M1

Others spoke of using *kari* from *Nilagiri* (Eucalyptus), *Thega* (Teak wood), Silver oak, *Maanga Maram* (Mango tree), *Saathu, Kaathaadi maram, eeti maram, Idala maram* and mixing it with salt and stored in a box. Karimathi (), *Nugge maram* are not used because it will cause *vaayipunnu* (mouth ulcers).

The detailing of the ingredients of the dentifrice is given importance and followed. For ex, salt is used along with charcoal. The following quote illustrates the reason behind why salt is added.

What we should think is, what should be used when. Why we use salt is because, if there is a germ in the tooth, then that will be gone. That is why we use salt. Even in paddy husk, we use salt along with it. M1

While everyone acknowledged the use of toothpowder and toothpaste by the members of the community. Toothpaste is equated to Colgate and is vernacularly used by most people. There is a transition from the use of homemade charcoal to commercially available dentifrices.

Earlier, there was no toothpowder or Colgate. Only in the last 40 years, our Adivasi people have started using Colgate heavily. Most people now don't use charcoal. M4

Adverse Habits

The use of *vetthalai pak* (betel quid)[51] is traditionally accepted as a norm in the *adivasis*. Some people consume it only after meals to ward off the smell of the breath. Most of the elderly folk chew regularly and continuously. Tobacco is also chewed along with the quid. This habit is now a thing of older adults and of the elderly, while the younger ones prefer commercially available tobacco sachets. The habit is simply learnt by doing. Children pick it up by observing their elders.

People chew a lot of beetel and tobacco leaves here... They have got into the habit. Even the children do it. M4
If parents were educated, and if the children were chewing, "You shouldn't chew it" No one tells them. They say, "It's a child only" and would praise them...whatever parents do, children also learn. F2

The relation between chewing beetel quid and oral hygiene is illustrated by the following quote

[51] Beetel quid – Areca nuts are placed and lime paste is smeared on the Beetel leaf folded neatly into a quid.

..... *Some people chew vetthalai pak nicely, its pashe (paste) will stick to the teeth. If we use charcoal and brush it properly, then there won't be any problem.* M1

The awareness about the effects of adverse habits is there. The knowledge about diseases and their causation is aware.

They say people using Hans[52] *will get vaayi cancer (oral cancer).*M7

Alcoholism is also recent development. *Adivasis* drank locally made *naati saara* (country liquor). Although, occasionally[53] consuming alcohol is a cultural norm, many interviewees revealed that, many *adivasis* consume alcohol heavily. Increase in capital and earning potential are believed to be one of the reason.

If one has hundred rupees, then he will immediately buy a quarter. Today, 95% of people drink alcohol. This wasn't there before. M1

Nutrition

There is a general consensus that the quality of food was better then, although the quantity was less. Food security was an issue then and often *adivasis* starved. The access to forest, meant that they hunted and dug *Kelangu* (tubers).

we ate kelangu,... there were five to six varieties of kelangu available. ..we call it kaattukelangu (forest tubers). M1

Whoever ate Noorkelasu[54] *in those days, they lived for 100 years. In Kannada, it is said that, noorekelasu tindavarige nooraysu anta (who ever ate Noorkelasu lived for 100 years)...if we have any worries and we eat kavalekelasu*[55]*, all worries will go. In those days, they were named for a reason. Bendikelasu, a tuber named so is also there. We roast the tuber and eat it.* M4& F2

Also, everyone complained about the use of *Vazham/Eruvu*[56] which has caused a compromise in the quality of the crops. The eating habits were distinct. Food was cooked in earthen pots as compared to the use of Aluminium and stainless steel used in today's times. Food was consumed on a plantain leaf or *naakele*[57]

Diet during illness was followed. The self-control over food and strict diet to be followed during illness is additional therapy by itself. One healer said,

Suppose, If I have sorangu (rashes) and if it isn't going, I shouldn't be eating katharikaayi (Bitter gourd) and karuvadu (dry fish). If I eat them, it will aggravate. If I don't' eat them I will be fine. We should be knowing what to eat and what not to eat. M1

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[52] commercially available chewable tobacco

[53] during *Putheri* (harvest festivals) or when someone passed away to forget the pain of death.

[54] *Noorukelasu* is a root tuber consisting of numerous long slender tubers attached to one common stalk. The numbers give an impression of one stalk containing a hundred tubers, hence the name. (*Nooru*= hundred in Kannada)

[55] *Kavalekelasu: kavale* in Tamil means worry and *kelasu* means tuber

[56] *Vazham* in Tamil and *Eruvu* in Kannada is the same as chemical fertilisers, pesticides and insecticides

[57] Naakele (Naak=tongue, ele=leaf) is a broad tongue shaped leaf used to eat food over it.

Conditions or Symptom Complexes

Pallu Vali (Tooth pain)

Tooth ache is the most common complaint with which people presented to the healers. Dental Caries is also understood as the reason behind the Tooth ache. *Karumolagu* (Black pepper) and *Nelli Pattam* (Gooseberry bark) and *Lavangam* (Clove) are used to reduce the pain in the teeth by most healers.

*Vaai Kola (*Mouth swelling*)*

Swelling in the oral cavity is also a common complaint told to the healers. Healers explained the associated symptoms as trismus and inability to chew. Two healers mentioned that the swelling is commonly seen during the winter season.

...vaai kola (swelling), pallu vali (tooth pain),.. in January, when it is cold M2

Sothu Pallu (Tooth Decay)

Dental caries is not seen in all, but healers notice a rise in dental caries among the children, compared to their childhood times. They identify it as a black discolouration on the tooth. It progresses to a level, what they describe it as, *'eating away the entire tooth'* The reason for dental caries is observed as eating sweets. M5

Some people chew beetel quid even while sleeping. This way teeth will turn black and disappear soon M3

While another healer describes the cause of dental caries as

.. in some people, there will be gap in between teeth. There will be Sali (calculus) in the gap which causes sothu (decay).... But, in some people, there could be some problem in the elumbu itself, or if there is less raktham (blood), if there is less koluppu (fat) which can lead to many diseases. M1

Loosu Pallu (Shaky teeth)

Weakening of gingiva and periodontal tissues are considered as the result of improper hygiene. The awareness of brushing teeth twice daily was noticed in one healer.

That is because of eating vetthalai pak, and also not brushing teeth properly, and not brushing before sleep. People only brush their teeth in the morning M3

Vaayi punnu (Mouth Ulcers)

Ulcers in the mouth occur because of using charcoal of few trees.

Vaayi Cancer (Mouth Cancer)

Cancer of oral cavity is seen commonly among women and noticed often. They reported,

It begins as Vaayi punnu and grows to become a cancer and complain of inability to eat. The reason for its occurrence is chewing a lot of vettalai pak, smoking cigarette and beedi[58] M4 & F2

Cancer is also seen in those who don't eat *vetthalai pak* or drink *saara*. In this case, it could be because of *raktham sambandham pattadhu* (Blood related).M4

Pallu edukkuradu (Removing tooth)

When it came to extracting teeth, there was apprehension and fear associated with extraction of teeth. This fear let them to leave the tooth in the mouth and wait until fell off. This belief has evolved to getting the teeth extracted because of the belief that rotten teeth will spread to others teeth.

..no one was taking the tooth out.....When it becomes bad it would fall on its own. Scared to take out. Now they have started doing it and feel if they don't take out the bad one it will spread. M5

Mobile teeth were removed off by themselves and was seen as a pain reliever.

If there was loose tooth, they will only make it much more loose and remove it out. If they knew how to remove it, they will grab it and remove it slowly. Then there will be a little relief. M4 & F2

Local Health Traditions

The local health traditions are presented with respect to the healers' perspective of their position in the society, acquiring the knowledge, practise methods, elements of preaching and rituals, future and continuity of the tradition, people's attitudes, differences between western biomedicine and their system and how they see other traditional systems.

Social Position

The vaidyar (healer), didn't just treat diseases. He/she was given importance within the and commanded *moraippu* (respect) and the position claimed obeisance not only in the family, but also in the *paadi* (village) and the confines of the village boundaries.

Vaidyar had his own moraippu (respect)....in the paadi (tribal village), he is like an elder... as the times changed, those kattupaadu (rules) are no more. M1

The social position is localised to the area. This meant that, his or her position was also relatively higher than other *adivasis* and also other community members. The position also was applicable

[58] *Beedi* is Indian cigarette filled with tobacco flake and wrapped in a *Tendu* (Piliostigma racemosum) leaf tied with a string at one end.

to other communities like those of *Chettis*. The *vaidyar* also sometimes was a *karnavar*[59] and would be invited by *Chettis* for both happy and mourning ceremonies to perform rituals.

People respect a lot. In ours, even the chetti community also, respect the karnavar. We have a temple in Ponnani.. Vishnu temple. The Chettis also have a share in the temple. We also take part in theirs. M2

Learning

Medicine part of the healing was learnt by observation and this tradition is practised for generations. It is often familial and passed on from *Paattan-paattan* (ancestors) time. However, there has been no written records. All the healers learnt it from their parents or grandparents since their childhood, except one healer who started learning few years back although his parents and their parents were practising it.

Practise

Practise of medicine is similar to that of modern doctor. They usually don't go to a different place and treat. Whoever comes to them are treated. The assurance of healing is not offered, although the confidence in the healers by the community members cannot be validated. There is a mutual understanding between the healer and the patient and the relationship is personal.

if someone like that comes to asking for me, I will give them some medicines. Then I will say, "If it doesn't cure, then come again! If it doesn't heal, come for the second time." And if it doesn't heal by then, I will ask them to see another person...there are chances that, they will get well and some people no matter who gives, there won't be any healing. M1

When it comes to paying for the services, it is more of a personal offering and above the service provider and consumer relationship. The patients would offer whatever they can and there is no compulsion. Often, the service is returned in kind. The vital part here is the custom followed. Like in the case of this healer, the

"Nanga,...Hoovu kaayi, ondu kottevu. Kottadu, hecchi hetthana ninga kottaadadhu ninga kaanalu bandide. Ee koosu ulla kaala ganta, iduvulla guna kododu neene, hecchi hetteva"[60]

With our treatment, they have a child, we ask them to bring the child to us and offer the child to god. Once they offer, they can give whatever they feel like. We keep the child in front of the God and ask them to pray, "because of your medicine, that is herbal medicine, we have a child now"
If they wish they can keep kaanike (offering) or something at that time. Some people give sari to my wife and a shirt and a tundu (dothi) to tie around for me, and some people give us nelavelakku (lamp stand) and keep it over the ground. But we won't take it in our hands directly from their hands. It is kept over the ground and we take. M4

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[59] *Karnavar* is a religious head in the *Adivasi* community
[60] Kaattunayaka language

Prayers and elements of preaching

Prayers are an integral part of the healing with the healers. The rituals and timing of the prayers varies from one healer to other. Some offer prayers to their *daivam* (god) in their house before heading out to get herbs, while some offer in the forest before cutting the herbs. Two healers advise the patients also to visit a temple except one healer who doesn't pray.

I don't offer any particular prayers, but I think of the god and pray in my mind that this medicine should work. Personally I don't do anything openly like offering prayers to kavu (sacred grove), but I just pray in my mind. M3

There are no particular days to give or not give medicine. But the timing of the taking medicine was important. One healer said,

there are no restrictions to give medicine on new moon or some days like that. but you must take before the sun rises. It is a practice. M5

Future of LHT

The tradition is passed to the next generation. Not many youngsters show interest, only few have picked up. The practise is taught to their children. The learning is mostly by observation and following the instructions. There is a belief that it is an ancestral property and a common consensus about not letting it go off. Secrecy is maintained by some healers about disclosing the information about herbs and preparation.

when the medicine is being prepared none should see it. If they see it, they will also give it. That's the reason many wont teach. M5

People's attitude towards LHT

Healers think that although *adivasis* acknowledge LHT, the usage has come down after the hospitals have started providing good care. Deliveries are more at hospitals these days because the government schemes and monetary benefits. Sometimes, *adivasis* come to the healers after the hospital care wasn't satisfactory.

Differences with western biomedicine

There healers differ with western medicine. They believe that, western biomedicine's effect is short lived while traditional medicine takes time to show its effect but it provides a long lasting effect. There is also a consensus about going to hospital for few ailments. They would only ask the patients to see a doctor. There is a concern about the inadvertent use of western medicine even for small illness which can be treated at household level.

In our community people are aware that they should go to the hospital. Herbal medicine is also important. But now for everything people go to the hospital. We have many herbal medicine. First they have to use this and then go for that. M5

Social Issues and Challenges

Right to denial of Health

Discrimination and ill treatment towards *adivasis* at PHC's and other government hospitals was one of the reason why they hardly visited them. The doctors wouldn't see them or are made to wait for long time.

the doctors wouldn't even see an Adivasi patient. They would ignore us since we were adivasis'. M1

Social situation

The situation has changed. There is a consensus that their lives have changed after ACCORD's intervention. The awareness about their rights, education, health has improved. The shyness to talk to others outside their community has reduced. Many believe that their culture has also changed. The knowledge on basic arithmetic while dealing with finance and commerce has also improved. They have realised their entitlements. But there is a concern that development activities have also bought other issues such as ill health, alcoholism, etc.

there used to be no dress. But now we have lots of food and lots of materials like oil, soap. It is not like the old times. We have food. But no health. F2

Access to herbs

By far the, biggest challenge faced by healers is the availability of herbs. Access to herbs is challenging with the given situation. Restricted entry to the forest, abuse by the forest officials, loss of forest cover and subsequent rise in tea plantations, use of chemicals in the plantations, lack of space to grow herbs are some of the reasons quoted by the healers.

We don't grow the herbs. When we need medicine we get it from forest. we have to go without being seen. Now it is difficult. M6

Health guide experience

Some of the healers have also worked as health workers. The healing experience with health worker training is additive and has brought positive developments. It becomes an important mechanism to deliver health services because a *vaidyar* or a *karnavar* held a high position.

*When I was here (as a health guide), lot of people used to come here with their problems, even if it was their family problems like marital problems. They would come and ask, "there is a problem, please do something". I go and perform rituals. Then they will feel better.*M2

DISCUSSION

In the course of understanding the cultural and social construct of oral health among *adivasis* from the perspectives of local health healers, Positionality of the investigator should take precedence. When interpreting, the investigator's positionality that of urban, middle class, western biomedical trained, evidence seeking, different cultural background can and will have an impact on the interpretations. The interpretations are often, a subjective attempt to objectively

describe the situation. Personal is political. Personal descriptions and statements are political. It states a person's stand on an issue.

The concept of health and quality of life is abstract and difficult to define. It becomes even more complex to translate it into an action, particularly for those who look for solutions to the problems. Health refers to a multidimensional complex and it is well acknowledged as having no defined boundaries. This is in contrast to the existing health care delivery system which is reductionist and compartmentalised. Health, however can be defines as "an individual's subjective experience of his/her functional, social and subjective wellbeing". Consequently, it refers to our experience of our bodies and ourselves and the consequences of that experience for the conduct of daily life. As such, it is a sociological and psychological concept which applies to people and the populations. It belongs to the socioenvironmental paradigm and commits us to the development of ways of measuring perceptions, feelings and behaviours.

Kalachaaram[61] is the 'explicit and implicit collection of ways, both general and specific, established by humankind, of thinking, feeling, and acting, more or less differentiated in groups integrated by each of the other groups, somehow distinguishable in time and space and internally between them'. (Turin & Satriani, 1978) In such socio environmental paradigm, it is important to consider the cultural influences of health. Particularly that of local health traditions which are a cultural construct in the *adivasis*. The lack of primary health care services and environmental and sanitation strategies that take into account the cultural differences of the *adivasis* in our country is evident. This could be because of the insufficient organised health system within the indigenous communities and also because of limited financial support and lack of definite strategy that is culturally defined. (Eder & Garcia Pu, 2003) At the outset, indigenous health systems are resilient and responsive. They are inclusive, locally relevant, and use naturally available materials. The concept of well-being among the *adivasis* is limited to basic essentials of life and being content with that. Health forms an integral part of all the dimensions of well-being and not considered as separate entity.

The practitioners of healing among the *adivasis* are everyone in the community. Although, there are few people who spend more quality time on learning, practising and disseminating it to the next generation, the harbingers of this tradition are everyone. Mothers at homes, men at field, elderly through their experiential learning, etc, all of them practise it. The *vaidyar is a sanskritised* term referred to the healer, they are known as *pacchamarandukarar*[62]. The healers are mostly seen as possessing a technical or practical capacity, But, at the same time, some of their knowledge is linked to belief and directly related to the natural settings around them. As, Kleinman termed them as "non-professional specialist or expert who offer some form of alternative or non-orthodox therapy" to their respective village community. Hence they may be few in numbers but their influence affects every villager in the close knit isolated community. (Klienman, 1985)

Oral health in indigenous groups are studied less. The beliefs and illness behaviour related to oral health problems were studied in the *Orang Asli* indigenous group in Malaysia. The traditional healer who is called *Tok Halaq's* role in prevention and health promotion was crucial. (Saub & Jaafar, 200 I)

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[61] *Kalachaaram* is the Tamil and Malayalam equivalent of culture

[62] Pachamarandu is herbal medicine and the practioner is called Pachamarandukarar

To understand this phenomenon of health culture among the *adivasis,* a grounded theory is essential. Going into the field with a pre-set of questions to find answers for, defined aims and objectives wouldn't work to understand health traditions which are intertwined in a complex process which result in the well-being of the group rather than an individual. The treatment is aimed at an individual, but the diagnosis and prognosis is from the collective analysis of the community in which the individual lives. The environment in which a community lives, the structural and social determinants are given importance in the entire process of understanding the disease to curing it.

The earlier health concept was holistic and comprehensive. There was no reductionism. Oral health is not distinctly seen from the rest of the body health. At delivery level, the indigenous communities, marginalised, people in hilly regions are inadequately reached to the health system. Local health traditions form the fourth tier in the health system. People often seek healers help for common diseases. Our initial aim was to find out how much importance was given to oral health through a key informant interviews. There was an attempt to understand the oral health conditions and the views of oral health by local traditional healers. This preliminary analysis also aimed at understanding the convergence and divergence with the current dentistry framework to support further integration of health system.

It was anticipated that it would be difficult to gain their cooperation since they are generally shy and secretive towards outsiders. While few were very easy to approach. Hence, a lot of time and patience was taken to build their trust and confidence. This took a couple of visits over several weeks to be establish a good rapport. Taking the help of the local *Adivasi* coordinator from ACCORD as a guide and interpreter ensured that our intention was well explained. As a result, full cooperation from the community as well as the healers was obtained without reservations. They shared their experiences and views willingly without restraint.

Scambler noted that symptoms that present in a "striking" way (such as toothache in this study) are more likely to be interpreted as illness and more likely to receive prompt attention than those which present less dramatically. However, given the quantity of symptoms and illness experienced by people it is apparent that most are treated by self-medication. Most families have some knowledge of how to treat common illnesses. This also applies in treating toothache in the *adivasi* community. (Scambler, 1991) Dental caries, tooth pain and swelling in the oral cavity were the commonly noticed symptom complexes. One possible reason could be due to the fact that dental caries and toothache was the most easily recognized and can significantly disrupt one's life routine.

As far as dental caries was concerned, although their belief on how the tooth become rotten was remote from the scientific explanation, nevertheless its rationale may be related to the maintenance of environmental cleanliness and hygiene in general. This may be considered as a Positive belief that is quite harmless to oral health. However, there is a need to try to relate this belief to include personal hygiene in addition to the established belief of caring for the environment. This could be used as the basis of health education messages for health promoters to reach the *adivasi* community.

For periodontal disease, anecdotal reports on its high prevalence among the adults has to be explored. Although, there is knowledge about improper oral hygiene and it causes, the proper knowledge about prevention and promotion is lacking. This could be due to the low impact of

periodontal disease on their routine life as compared to toothache due to caries. This is also coupled with the availability and affordability of oral hygiene aids such as tooth paste and toothbrush. There is an increase in the use of these aids, but the availability is still out of reach for the entire community. From the healer's perspective, the use of herbal twigs to clean teeth is still prevalent and this has to be explored further.

The oral hygiene is only limited to cleaning teeth. There was no mention of other hygiene measures such as gargling, tongue scraping, etc. The extensive use of beetel quid and tobacco is another cause of poor oral hygiene. It is not surprising that oral cancer is commonly encountered in this community with the common habit of betel quid chewing laced with tobacco, lime and betel nut. These are known risk factors for oral cancer and pre cancer lesions. Since betel quid chewing was extensively practiced in this community. The awareness of oral cancer is important. Self-examination on how to detect early signs of oral cancer should be taught to the healer and the community in general. It is recommended that a survey of oral cancer/pre-cancerous lesions be carried out in this community to ascertain its incidence.

In a community where modern health facilities including dental treatment are not easily accessible, alternative care should be made available, especially in cases of emergency pain relief. The healer could play a role in primary oral health care. They could be involved in promoting healthier oral self-care practices. Some form of basic health education and training could be organized in the community.

Finally, the health promotion strategy should turn to improving the environment in which they live to enable them to practice a healthier lifestyle. For instance, to get water to clean themselves up more often was difficult enough, let alone to brush their teeth several times a day and before sleeping. There were other more pressing basic needs to be fulfilled such as getting adequate food, clothes and a better housing condition. Buying toothbrushes and toothpaste must be very low in their order of priority. Hence the relevant agencies need to improve the overall economic, educational and social needs of the Gudalur *adivasis*. These will definitely lead to a better health and hence their overall quality of life in the long-term.

CONCLUSION

Researcher is undergoing a paradigm shift from patient to person centred health care, subject to participant research and biomedical to social care. Community based health systems inclusive of local health traditions make a responsive people centred health systems.

REFLECTIONS

To understand the local health traditions in an open mind requires plenty of unlearning. This process could be bit more frustrating and compelling oneself to not be judgemental. Nevertheless, complete unlearning is not possible because of the strong attitudes, though process and the world view with which an investigator starts the study.

During the course of this exercise, I faced several challenges. First and foremost, obtaining the permission to conduct the research from the community members was taxing. They had to be briefed about the objectives and purpose of the study. Meanwhile, the ACCORD has asked me to assist the community members in forming a research committee to look into the ethical considerations. With the help of Dr Ravi Narayan, I used the guidelines for social science research (CEHAT, 2000) to form a committee that looks into giving permissions for conducting research on *adivasis* of Gudalur. I charted out the guidelines in the Tamil and to make the process simpler, the colloquial was used to explain them about the process of questioning and reasoning.

After the preparation, the first application to the committee was this present research. I had to sit through three such meetings to get the final approval. I had to explain the committee members how this research is going to help my understanding of local health traditions and the overall culture of the *adivasis*. I explained them painstakingly, in simple terms how the knowledge generated from this study can be utilised to engage the healers within the existing health system. The final approval came after I promised that the data in the form of audio tapes and also a report of the study will be submitted back to ACCORD and ASHWINI. Although this process was hard, it involved the community to decide if they wanted the study or not. The Cuenca declaration on 'Research for People's Health' envisages active community participation.

"Research should bring about social action by the mobilization of people and communities as participants and collaborators. Biomedical research should be integrated with social research."
"Research should involve dialogue between investigators and representatives of communities as well as the people directly" (Research for People's Health , 2005)

One of the challenges was meeting the healers. My idea of healer was influenced by movies where the healer would be grinding some leaves and always busy collecting herbs from forests. However, this false imagination was deleted from my mind, after I started visiting villages in Gudalur. Healers are people with other duties or occupations. *Pacchamarandu* is only given when asked. Rest of the time, they are busy in their daily chores. Finding suitable time to meet them with the help of animators[63] at ACCORD was a little hurdle. The animators had to be free and take me to the healers. Once, I had to meet a healer at one of ACCORD's area centre. He used to work as a health animator earlier, but relinquished to become a diviner. One of the animator at the area centre didn't get along with this healer. The healer wasn't very comfortable talking to me during the interview process because of the presence of other animator.

The ethical issues of getting the permission was one learning experience, but other ethical issues were further challenging. Getting to healer's house and meeting them was one step success, but convincing them to talk about LHT was another practical challenge. One of the healer was very

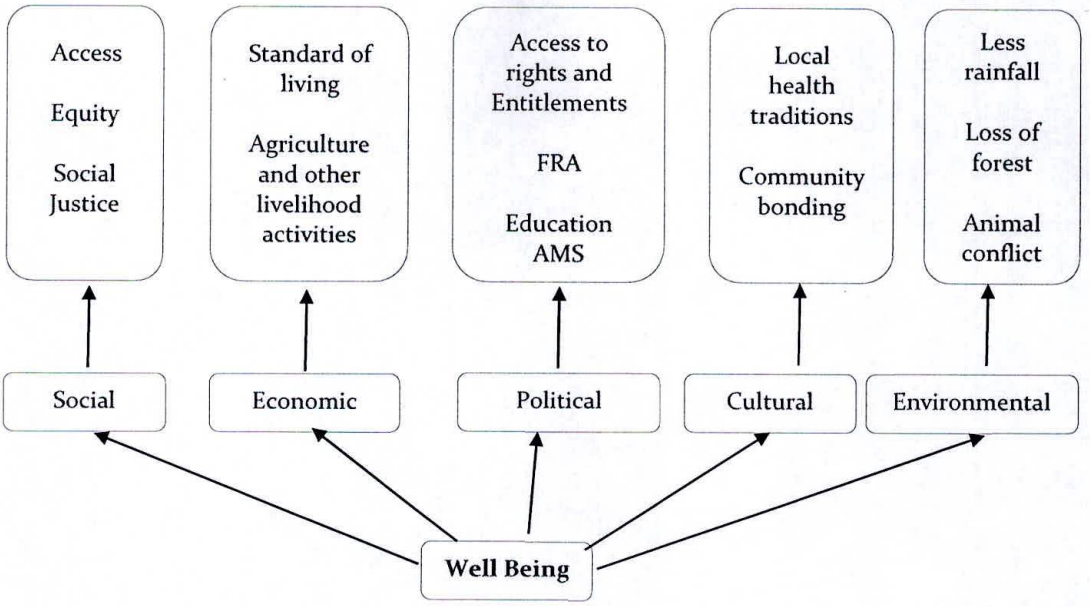
[63] Animator is a term used in ACCORD office for the Adivasi coordinators working in different fields. There are health animators, finance and education animators likewise.

timid and hesitant to talk to me. Her husband goaded her, but was futile. With much convincing, I managed to talk to her, she showed signs of disinterest, uneasiness and was lackadaisical. I had to stop interviewing her against her will.

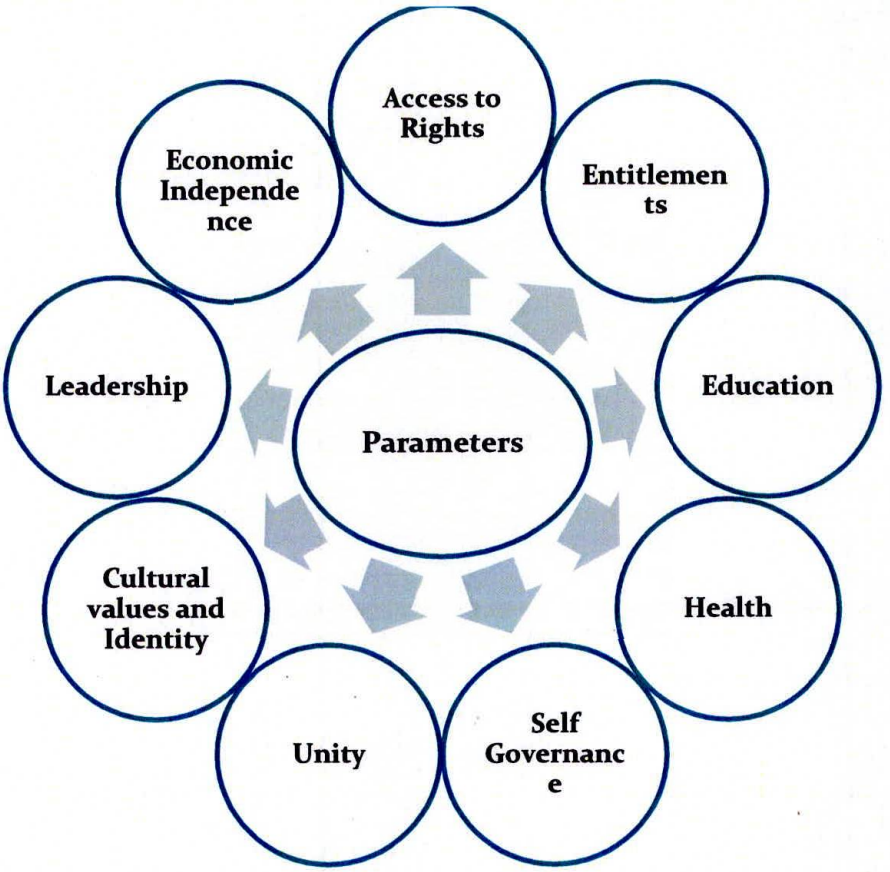
There were fruitful outcomes of the study as well. In one of the group discussions, a healer was curious about my next plan after data collection. He suggested, that I should talk to the school authorities at VBVT and convince them to organise children's camp with healers. They should be taken on forest transect walk to identify the herbs and explain the use of it too. His went on to say, *"we should teach our children and make sure they also know it (herbal medicine)"*

While the results are still analysed, this study focusses on two challenges that were faced in this evolving study. The positionality as researcher, dentist, training emphasised on biomedical, evidence based, epidemiological western framework who is trying to learn qualitative participant observation research were disturbing in terms of making value based judgements. The research is focussing on communitising the research with the support of local organisation to bring about participant action. Many questions of how to mobilise the community to turn towards locally available and relevant health tradition will be a daunting task.

Social, Economic, Political, Cultural and Environmental Analysis of Gudalur Adivasis



Development Parameters (Axioms) of ACCORD



Pedalling forward the Community Health Journey

In October 2015, I pedalled for a social cause on a fund raising venture. The funds were collected for the Gudalur Adivasi development activities. The week long ride[64] was more than a fun or leisure ride, it was a great learning experience. We stopped over at organisations involved in some sort of community development. What was supposed to be an adventure filled joy ride, turned out to be a moving experience. I learnt a great deal of community health more than I ever did in the last few months of classes and field work at SOCHARA and at ACCORD respectively. Every place I visited had an interesting tale to narrate. Everyone, I met had a story to tell. Every event that unfolded, bewildered me and awakened to the reality.

I cycled nearly 400kms from Bangalore to Gudalur in Lower Nilagiris on my mountain terrain bike. The ride would start off early morning by 6 am passing through the countryside, enjoying the green waves made by the wind as it cuddled the blades of paddy, ragi and sugarcane and the forests of rural Karnataka and Tamil Nadu. The ride would finish for the day by noon at a school or at a not for profit organisation involved in activities such as rural employment, youth development, revival of traditional economies, alternative education, community health programme, tribal development, women empowerment, etc. The cycle ride was unique in many ways. First of all, it was not a race and participants could cycle at their pace. If it was difficult, one could load the bike on the truck behind and relax in it. The ride was a fund raising event. All the money raised would go into various development activities of Gudalur *adivasis*. Most importantly, the ride passed through the beautiful countryside of South India and offered a chance to meet interesting people and know about their inspiring work.

On the first day, as we biked past Bangalore's deafening motor vehicle traffic and chaos on Mysore road, the overwhelming stench of drainage was strong enough to clip my nose tightly with my fingers and I rode as quickly as possible to avoid any more assault on my olfactory sense. The huge stream of Bangalore city's drain used to be once upon a time a river, called River *Vrishabhavathi*, and only now the water is replaced with nitrate and phosphate rich sewage. What was once a life supporting river is now dead and carries the litter of urban civilisation. It reflects poor governance and passive participation of the civil society. I felt helpless held myself responsible too for being the passive part of governance. We passed through the first green patch as we moved away from the city. The board read "Kumbalgodu forest". I couldn't see any variety of flora. Neither shady humongous trees nor wet forest floor! It was a perfect parade of an infantry of eucalyptus trees planted under the afforestation scheme. What a disappointment! I felt angry at what mankind has done to the nature which has given us surplus and yet the greed doesn't subside. The rest of the ride was through the scrub and arid deciduous forest of Saavanadurga with its huge monolith hill and ruined fort on top in the backdrop.

We met young architects of a rural architectural firm called Andagere architects. They were reviving traditional rural economies like blacksmithery, country tile making and using the products in their work thus creating livelihood.

We stayed at Hosa Jeevana Haadi (New path in life) in Melukote on the second day. It was founded by Sri Surendra Koulagi and Smt. Girija Koulagi, a couple inspired by Mahatma Gandhi

[64] www.madcycletours.in

and Jayaprakash Narayan. The Trust has been striving to create a non-violent and egalitarian order of society. Its core area of work is welfare, education, rural industry, environment and agriculture. Surendra Koulagi, now a nonagenarian, whose age doesn't seem to mellow down his zeal. We met his son, Suresh Koulagi, a pleasant looking man who manages the activities of the trust. Mr Suresh's spoke about his life journey that took many interesting turns. He said, "*I once read One Straw Revolution by Masanobu Fukuoka after graduating as engineer. That book changed my life. I decided to come back to my village and work here*".

Figure 37: Participants riding through Bandipur forest

According to him, the greatest problem the country is facing today is, youth of the nation are feeling disempowered and diffident and the haughty misconception that urban area provides more happiness. His tone expressed apprehension about today's education system leading to individualism. He added, "*Youth want to earn more money by quick means without much effort. Most of them want a comfortable air conditioned rooms, but none want to till the land, sow grains, reap yield. The capitalistic market based economy is luring away the creative minds of the country. Very few are interested in handicraft skilled work like sericulture, carpentry, weaving*".

The next day we were heading towards Mysore- the cultural capital city of Karnataka. A small stretch of the route, about 10 kms, was on the mound of the left canal of *Krishna Raja Sagar*a Dam. It was by far the most picturesque landscape. Quietly flowing water on one side and bright green carpet made up of paddy fields on the other side. The air smelt of the water filled with algae and fresh foggy soil. Few small and yet quaint villages dotted the otherwise emerald fields. The scene was very romantic, reminding me of poems of the Kannada poets Kuvempu, Da Ra Bendre and English poet Wordsworth, etc. This lustful decor has to be enjoyed and words fall short of describing the countryside grace.

A grand welcome at Mysore by the Green Hotel staff just added merry to the wonderful day. Garlands, lemon drizzle cake, samosa, tender coconuts kept coming in. Green Hotel at Mysore is one of the best social business initiatives. The Green hotel initiative is on the model of sustainable tourism was started by Dame Hilary Blume. The profits of the hotel are used for economic and environmental issues in and around Mysore. Their pragmatic solutions have helped thousands of people through their eco-friendly business- charity model. That evening we visited *Dhwani*, a slum dweller's women federation. The women self-help groups have made a tremendous progress in housing, community development, education and health. One-woman in her forties trained as a midwife told us that she has delivered more than 250 babies successfully. Each one has been through their own ordeals and their cheerful smiling faces gave me hope. Their success story narration was filled with emotions, hardships, toil and sweat.

After a day's break and relaxing, we visited another organisation outside Mysore called Rural Health and Literacy Programme. We celebrated Dasara with the children of *Ashadeepa* and *Ashakirana.* These two home for children for both boys and girls respectively, are alternative schools aiming at providing vocational training alongside education. Children sang, danced and shared their innovative experiences on recycling garbage from the kitchen. The guava fruits from the farm grown by the children were sweet and toothsome.

We were already four days past and deeply involved in the journey. The ride got more absorbing. We passed by meadows, hills, shrub forests, dried lakes, canals, ruins, etc. Train of milkmen carrying churns on their motorcycle backs, migratory birds enjoying the tropical heat, perplexed villagers' faces became our norm. Dawns were chilling with roosters crowing almost everywhere. Men hurrying into their fields, women folk sweeping muddy floors and the perfect protein and carbohydrate diet breakfasts were a big hit. As the day faded, gloaming golden sky was idyllic. The Indian countryside is diverse and offers more than one can imagine.

On the way to Sargur, we broke for breakfast under a tamarind tree at Puttegowda's farm. Puttegowda was growing Okra, Tomatoes, and *Avarekaayi* (Hyacinth beans) in only two acres of his four-acre plot. He complained about water shortage and hence couldn't grow in the rest of the farm. This was shocking to me as we passed through *Krishna Raja Sagara* reservoir which was about 30 kms away. What was supposed to be an irrigational project hasn't served its purpose and that fact baffled me. With rainfall, less than the average this year, agrarian distress escalated. As predicted, the monsoons failed and resulted in heavy economic loss which had its repercussions felt long afterwards too. Farmers committed suicide and this caused an uproar in the state legislative sessions. Agrarian distress can be devastating on the families and it is rightly called, "Indian agriculture is a gamble with monsoons" and that made sense to me. Sympathising with Puttegowda's plight, I felt heavyhearted.

It was a joy ride from Sargur to Chikkayalchatti. The first half was around the Berambadi state forest and later half through the plains before we entered the Bandipur Tiger Reseve. As we were passing the last village and the patches of fields along the kutcha road, I spotted women standing still in the fields with an expression of disgust, nervousness and anxiety. My involuntary smiling face wasn't received well. I sensed some discomfort from these women because of our presence. A little away about 10 metres, a woman in her early 20's stood up quickly in shock. She was near the edge of the field. I also spotted a pitcher next to her and that was the clue. All these women were attending to their nature's call. I felt embarrassed. Their loathing faces were strongly repulsive. It must be awful to them. Open defecation, sanitation and safe drinking water is a big public health

problem in India. I recalled Mr Prahlad's view, an environmentalist working on sanitation at SOCHARA. He opines that, women go out to defecate because many do not have toilets at their houses, but also because it is the only time they get to venture out their fortified houses, gossip on mundane things with the other women folk. The kutcha road turned into a terrain soon afterward and my focus shifted to the safety while balancing the bike on the gravel road. The distant Nilagiri hills were visible. The blue hue of the mountains created a mirage. The day was welcoming the dusk with warmth. The eerie silence, green meadows, chirping birds, blue mountains and the early night sky was like taking a short ride into a beautiful medieval painting.

Chikkayalchetti is a small charming village of only five houses. The village headman, also the priest at the only temple in the middle of the village around which houses are located, hosted us and his family cooked the Mysore style food. Ragi balls with coconut chutney, rice with sambar was served while we sat in rows on the floor. The villagers were very warm and kind. The bon fire under a huge Banyan tree was perfect for the chilly night. All of us sat around the fire and the topic of the chit chat became horror stories. David's horror comedy jittered everyone and all of us laughed at ourselves. I retired to the sleeping bag around the fire and stared at the starry sky. I hadn't seen a starry twinkling night sky in years and was trying to recall the last time I was amazed to such an incredible wonder. I slowly passed into slumber.

Next day was to the final destination- Gudalur. The entire stretch was in the forest. First, Bandipur and then Mudumalai. It was complete uphill and total highway ride. We had to be extra cautious of the reckless motorcycle and car drivers. The forest road was laid with tarmac with few potholes the size of a small crater at frequent intervals. At one point, I spotted two forest officials on either side of the road handpicking plastic litter and loading it into their sacks hanging from their waists. They looked like tea pickers on the higher hills. I couldn't stop admiring them and applauding their effort. Environmental pollution has become universal in India even in protected areas. *Swach Bharath Abhiyan* doesn't seem to have any effect so far. We further passed though Bamboo forests and finally made it to Gudalur after seven days of cycling through Indian countryside.

Thighs aching, joints biting, spirit dying, alas, I made it to the final destination. It seemed impossible in the beginning but the team spirit and the wonderful support team helped me reach my goal. Most importantly, the people we met made a remarkable impact. Learning from everyone's experiences and listening to their tales brought goose bumps over my skin.

Community health is the outcome of every action done towards wellbeing of an individual, family and the community. The farmers complained about the lake which was dried, and they say, they have never seen the lake bed in their lifetime. Climate change is here for sure. How will the farmer be happy when there is no water to grow crops? The mental agony of the elderly when all their younger ones want the comforts of the urban space. How do we address the problem of open defecation when the problem is not with the ability to afford toilets but rather the complex social construct driven by paternalism and oppression of the weak?

Hive of activities always engage the village folk throughout the year. Women, young, old, everyone is involved. Men fight over lands and their heads held high egotistically. There are all sorts of things happening. There is much more bonding and community relations are stronger. India lives in her villages. As I start to think seriously, I understand the concept of rural self-governance without any unequivocal note. Mahatma Gandhi talks about village life in Harijan,

"My idea of village Swaraj is that it is a complete republic, independent of its neighbours for its own vital wants, and yet interdependent for many others in which dependence is a necessity" (Gandhi, M K, 1942) I agree on Mahatma Gandhi's statement without ambiguity. The village life contradicts capitalism and sadly the market economy has invaded rural life and has shaken the foundations of

Figure 38: Visiting a Khadi weaving centre in Melkote

the solidarity.

On a travel note, this has been my favourite travel journey so far in my life. I have been asked quite often about my favourite destination and now I proudly announce it as rural India. I want to visit again and again to know more. The whole ride was organised with great care. Responsible tourism is what I believe in and this ride truly lives by it. Before the ride, I was a cocky nonchalant person with 'know it all' attitude. I admit now, I know little as much as a tiny shred of a cotton fibre of a warp in the vast textile that is made rich with intertwined weft weaved by, of and for mankind.

There sprouts a wisdom once in a lifetime or perhaps twice to get out of the self-made cocoon and to see the world as it is. To see it without prejudice and premonition. In that journey, everything appears natural with no fancy sparkling notions attached. The world is a stark truth. Things that we often tend to oversee because of ignorance becomes apparent. People and places appear more connected and that wisdom helps us to see the reality of what they are made up of and what it takes to be there.

Oral health is one of the health areas which have considerably received little attention in India and elsewhere. Oral health in India is a neglected public health problem. The exact burden of oral diseases and its effect on body is not known in the Indian context

ORAL HEALTH POLICY: RATIONAL BASIS

Oral health is integral and essential to general health. Oral health is necessary for well-being of an individual. Quality of life of an individual is determined by oral health. The ability to perform essential functions such as chewing, speech, smiling, etc. is very much determined by optimally functioning oral cavity and related structures. The inter-relationship between oral and general health is backed by vast body of evidence. Periodontal diseases are the sixth complication of Diabetes Mellitus. A number of common risk factors affect non communicable diseases including oral health. Many systemic diseases manifest orally before the actual symptoms show up. Thus early detection of oral signs and symptoms of systemic diseases such as microbial infections, immune disorders, etc. is crucial for reducing premature mortality. The need for oral health policy is imperative. The whole role of knowledge translation into a policy process and therefore the decision making authority, is a socio-political issue which is complex and challenging. The need to collect data about the prevalence of diseases and its risk factors should be the first priority.

GUDALUR EXPERIENCE

Dr Pramila Nair, a senior paediatrician was convinced about oral health neglect and its detrimental effect on general health. I spoke to her about the evidence between Pregnancy related Periodontal diseases and Pre term low birth weight and miscarriages. She conveyed the message to Dr Shylaja. Dr Shylaja decided to have a compulsory oral health check-up included in ANC for all pregnant women among the Adivasi people. Although, this is a small step in preventing morbidity and mortality, it is still a major advancement. If health policies work at organisation level, I'm optimistic that can work at national level too. This demonstration can prove the relationship between oral health and general health.

Once I was talking about oral hygiene practices to children at VBVT. One boy from the group shooted a question at me, "*we cannot afford toothbrush, yet you are asking me to brush our teeth using toothbrush and toothpaste*". It was a slapping question. It also made me re question the approach towards finding solutions to the bigger problem. Healthcare should be acceptable, available and most importantly affordable. The health education modality is always routinely focussed on brushing techniques, oral hygiene measures, and diet. It has never focussed on grabbing the attention of the public to sensitise on this issue.

LONDON CHARTER

In May 2015, I attended the International Centre for Oral Health Inequalities research and policy meeting at London. The meeting had a series of talks about social inequalities in oral health,

evidence based actions and policy implications. The attendees were asked to contribute to the London charter based on their personal experiences. The London Charter addresses the social determinants of oral health primarily and also calls for action. (Watt, Sheiham, Listl, & Peres, 2015) I suggested addition to the agenda, on Community involvement which is outlined in the principles of Primary health care. There was emphasis on "Communitisation" which involves community empowerment, community action and active participation. The success of National health mission in India can be attributed to the concept of communitisation. The use of health workers (professionals complimentary to dentists) can be a useful tool in reaching out to the community can be used to scale up the services. The shift in the paradigm even in dentistry is now gearing up to the oral health shift and the discovery of social determinants of oral health has contributed to our understanding of oral health from social justice view point.

FORUM FOR ORAL HEALTH ACTION IN INDIA

A network of likeminded community dentists was formed and named it Forum for Oral Health Action in India. medico friends circle was an inspiration for the initiation for this network. There are three members and expects to have more members on this network. This first work undertaken by this network was collecting evidence for denial of right to oral health in public and private care. A draft of 'Oral Health Equity in India' was also prepared. This evidence was to be presented at the National Human Rights Commission meeting at Chennai, but was cancelled due to the deluge.

The next work undertaken by the forum was filing a Right to Information application on the irregularities in conducting National Oral Health survey. Our complaint is based on the newspaper article titled "Rs 3.5 crore dental health report rejected over 'flaws' after seven years of work" covered in UK's leading newspaper Daily Mail on 23rd November 2015. (SHARMA, 2015) The article reports a huge corruption scandal on the conduct of the National Oral Health Survey. It also acknowledges that the report would be a guiding document for the oral health policy in India. In summary, Ministry of Health and Family Welfare sanctioned 4 crores to the Dental Council of India to conduct the survey called, called "National Survey on Availability of Dental Health Manpower and Disease Prevalence in Urban and Rural India". DCI in turn to a private agency to conduct the survey. After much delay, the private firm submitted the report and DCI found irregularities in the validity of the report.

Reflections of the Community Health Learning Programme

Everything that happens, happens for a reason

Community Health Learning Programme happened for a good reason. I am not sure, if coming to SOCHARA was serendipitous or coincidental. I was looking for a guru, also a mentor, friend, guide and who will help sort out my confusions and help me in choosing the right path. I remember the road outside Fireflies intercultural centre, when we were there for CHESS meeting. The road was curvy, lined with trees with shedding leaves. It was dusty, rugged and less travelled road. I realised that moment that, I had chosen a less travelled road. I knew, I would find my way out. I trusted SOCHARA.

The environment at SOCHARA is very friendly and non-hierarchical. People, here are highly motivated and very dedicated. Their experiences speak about them. Some of their stories inspire to take risks and move a step ahead of peers. Truth is told in a subtle yet blatantly. The message is delivered clearly. Speaking of truth, we were also made to analyse any given information in all viewpoints and then understand the truth in a logical manner. This realisation of truth, made me think with an intellectual mind to minimalise the grey areas and to see as much black and white areas as possible. SOCHARA's work reinforced the belief that things can work and good work will be recognised. It is a luxury to be here. The space created to experiment and voice out opinions and views, loudly, was radical compared to my previous learning centres. This is a parallel world with lots of good people. In fact, SOCHARA is called as 'University without walls'.

Community health journey is a hard one. It aims at building an egalitarian society with just and equity as core principles. Capitalism is encountered at every milestone. Market based economy is challenged to overcome inequalities. The role of rights and responsibilities of both community and individual are emphasised. The life skills required to manage intra and interpersonal skills which in turn are important aspects of community health are taught with simulation exercises. Outreach concept to reach the much bigger community which is the core value of public health is the objective to reach 'Health for All' goal. To reach this goal, one cannot work in vacuum and therefore networking becomes necessary. SOCHARA with its vast network of organisations in India and abroad and also with the government has demonstrated a way to solve health issues governed primarily by social problems. It gives the required strength and belief in the system and reinforces the fact that, it is possible to get things worked. During the course, we met inspiring people and had chance to know their work. They were all engaging public in the political process. Most of them were 'Scholar activists' who have an excellent combination of skills, competencies and activism.

Reflecting on the readings and observing the current scenarios then, I understood that sanskritisation has taken a political stand. It has given way to turmoil. The whole beef fiasco, lynching of Muslims, Hindu reconversions, the suicide case of the Dalit scholar, targeting university students across India, anti-nationalism debate and many other disturbing events reveal an authoritarian process of exercising power. The political stand one can take is particularly debated and accused. The neglected health issues such as alcoholism, mental health and oral health have deep rooted invisible political relations. Mr Keshav Desiraju, former union health secretary, during the annual dissemination meeting said, *"to be a woman, destitute and diseased is*

a deadly combination in India". When we try to look at this statement carefully, one can easily notice that, health is a political process and needs strong political commitment.
If at all there is any learning that happened, I must confess, unlearning happened to a great extent. There were unlearning of dominant attitudes and ignorant behaviour. Sharing and caring with fellows made me more gender, language and community sensitive. An important and crucial habit that, I am still developing is 'value based judgement'. I learnt this as part of ethnographic understanding of *adivasis*, which later, I started implementing in my life too. To remain neutral in understanding a process or culture or an individual reflects on how we perceive things. It is the most difficult exercise. Getting into others shoes and see the world through their eyes makes one see the entire situation so different to that of the former understanding.

The community experience at Gudalur was powerful and had a tremendous influence on me. Learning from the community, their lifestyle, attitudes, worldview left a mark on myself. They have solutions to everything and considering that in problem solving is crucial. Lao Tsu, the Chinese scholar said,

Go to the people
Live among them
Learn from them
Love them
Start with what they know
Build on what they have:
But of the best leaders
When their task is done
The people will remark
"We have done it ourselves."

It left a sound advice for practising in my field work. I learnt a vast amount of knowledge, particularly working knowledge. I used many opportunities to speak up. The words were carefully used to express the views and concerns emphasising sensitivity in practise. Being political or apolitical is a conscious decision made on an everyday basis and I have come to terms in my political stand which is basically centrist based on Gandhian, Marxist, Socialist, and a little bit of Capitalist ideas. I could have been more organised, should have taken notes regularly and should have written my reports on time, which I regret. Nevertheless, better late than never. I will try to improvise. My reading and writing has improved, but still needs more precision and less word mongering.

On a philosophical note, there was a lot of reflection and reinvigoration into my thought process. Community health is based on facilitating and fulfilling basic essentials of life. It is to lead a simple life, yet not to forget to celebrate the journey of life. When you also leave selflessness, there is self -realisation and the higher power acquired makes happier and shows direction to a meaningful life.

Years ahead, I would like to work closely with marginalised communities. I also want to learn more about health systems, health policies and engage in participatory action research to make health available, acceptable, affordable and adaptable.

Academically, discerning between public and community health was possible. Public health is technical knowledge based completely on sound epidemiological and statistical theories that are logic and scientific. To a great extent, it doesn't consider the social part of the issue. The boundaries in which it works provide a solution that is often deduced in an arithmetic fashion. For ex, providing condoms to prevent HIV/AIDS. Community based clinical trials based on epidemiological principles have proved the effectiveness of condoms in preventing the spread of HIV/AIDS, but this knowledge doesn't throw light on how successfully it is compliable with the users. The cultural and social factors affecting the human behaviour are not given much importance in public health. Community health attempts at this lacuna. Community health is a process of enabling people to exercise collectively their responsibility for their own health and to demand health as their right. In case of HIV/AIDS, the community affected by the disease is also considered to solve the issue. The affected persons are also consulted to find solutions at all levels of prevention. They will be an important part of the entire process from identifying the problem

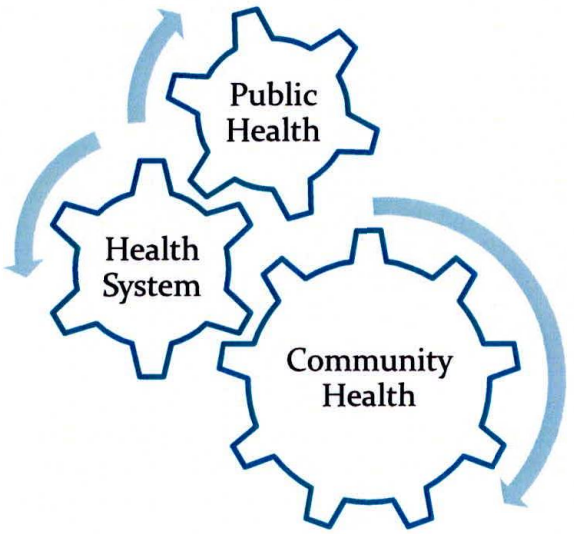


Figure 39: Relation between Community Health and Public Health

to finding the solution. Health systems is at the outset having both these arms of approaches to solve health issues. It bridges these with a community oriented policy. The NRHM is modelled on this Communitisation process of enabling the people through highly motivated people from the community to advance towards health for all goal. It is now adopted as a policy. The roots of this approach was by various demonstrations across India to show community health's success by a cadre of personnel ranging from technical (medical, nursing, public health) personnel to non-technical (health workers, health activists, teachers, anganwadi workers, dais, socialists, anthropologists, policy makers, bureaucrats, politicians). Health policy is the tool to implement the strategy which is effective and also for the benefit of the community. Community health is a social process dealing with the larger social determinants that are the actual causes of health issues. It is a political struggle for a better society.

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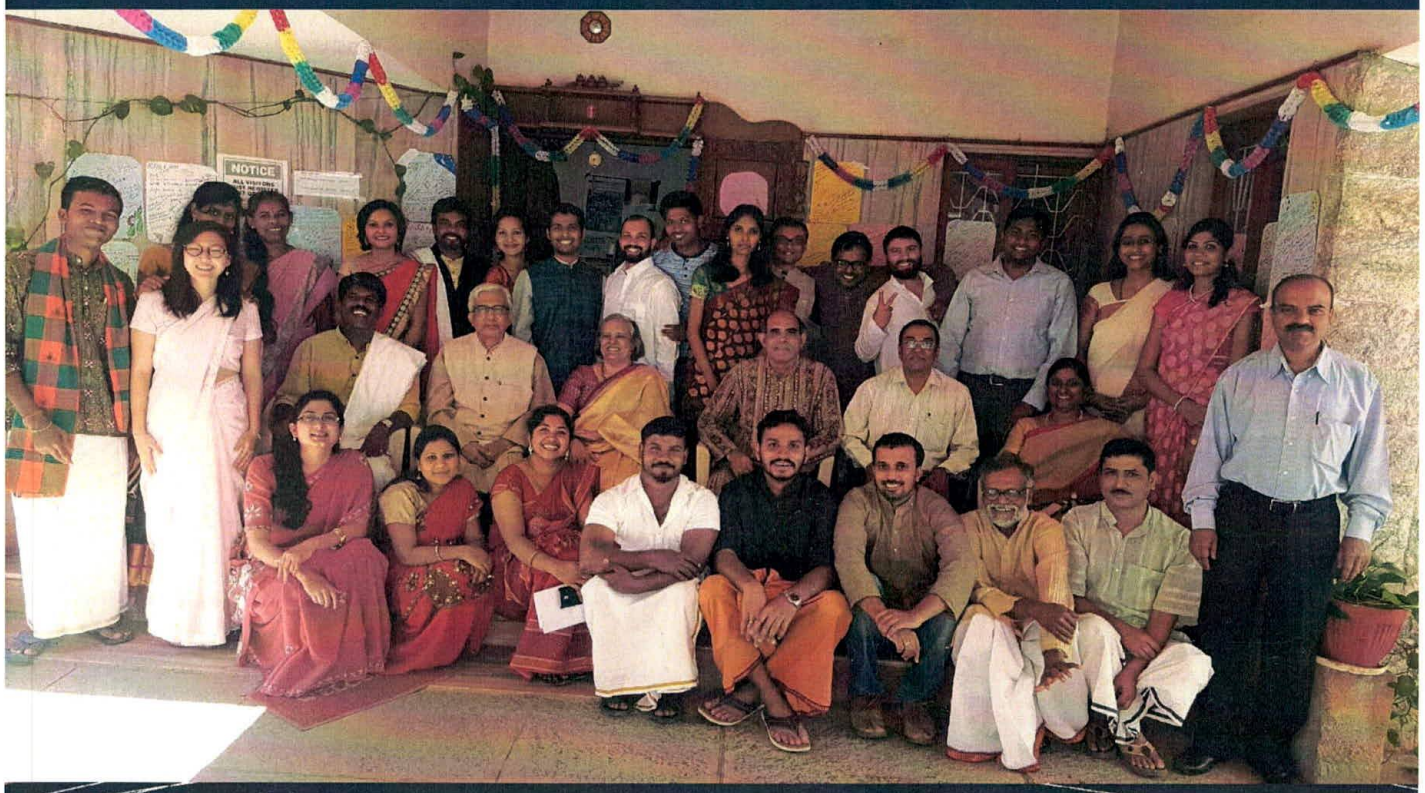

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