



RURAL SENSITISATION PROGRAM – 5

ASHWINI, Gudalur, Tamilnadu – May 3-5, 2019

The 5th rural sensitization program venue was at the Nilgiris and the program was conducted by ASHWINI (Association of health welfare in the Nilgiris). A total of 20 third year medical students from ESIC medical college, Chennai, and one student from St.John's medical college attended the program. It was an immense pleasure to listen and learn from Nandakumar Menon, Shylaja Devi, Stan Thekaekara, Premila, Regi George, Anand Zachairah, Ramadas and Rama as resource people, who spent their valuable time for the youngsters, to help imbibe the broader aspects of health.

DAY 1

Session 1 – Introduction

The introduction was a casual game, wherein all the participants were made to walk in two circles facing each other, while music was played. Once the music stopped, the ones who faced each other cross introduced each other. It was helpful for us to know everyone even before the program started.

Session 2 – Stan Thekaekera on SOCIAL INJUSTICE

We had a dynamic session by Stan Thekaekara, one of the founders of ACCORD (Action for community organization, rehabilitation and development, Gudalur), on the importance of a 'RURAL' sensitization program. He described the need for the young students to know the importance of exposure to a rural area, and why rural is different from urban in terms of resources, need and lifestyle.

He also emphasized that, “we live in an unjust society”, and that is the reason for many problems to address in both rural and urban areas. He threw very thoughtful questions like, ‘ What is being successful?, what is literacy? What contributes to the growing gap between rich and poor?’.

He gave a brief history of accord – about the land exploitation and the need for land rights in a tribal area. About the community health program started by Deva and Roopa followed by secondary care hospital by Nandakumar Menon and Shylaja Devi. He explained how each of the initiatives were started based on the needs of the society and governed by tribals themselves.

Stan ended his session by telling the students, ‘Three days are a challenge to yourself’.

Session 3 – Dr. Shylaja Devi

Stan had drawn an outline about three decades of work by ASHWINI, Dr Shyla spoke to us with facts& details with set of pictures spanning over the timeline - every milestone, every program, the teams, hospital, school, accord and all their initiatives.

She gave us a clear picture about the four tribes present in this area – Paniyas, Mulla kurumbas, Beta kurumbas and Kaatunayakkans. Their lifestyle, architecture, worship, language, work were shown to us through beautiful pictures.

Before we broke for lunch, we asked the students to write down their expectations from this three day programme.

- To become a good doctor
- To know more about tribal life, and to interact with tribals

- To have good food and accommodation
- To address the needs of the rural health
- To become a community doctor
- How to work with limited resources?
- To interact with the doctors who have worked here
- To become better in doctor patient relationship and to build trust
- To improve communication skills
- To find out whether a shift of urban to rural lifestyle is possible

Session 4 – Hospital tour

The students were taken on a hospital tour by the doctors associated with ASHWINI - Dhanya, Ajith, Royson and Shalini. The students were divided into four groups for the tour and were asked to observe, ask & find out the quality of care, cost effectiveness, acceptance by the community and teamwork.

Session 5 – On Education by Ramadas and Rama

After the hospital tour, we broke for tea and vada and came together for a vibrant session on education by one of the founder of Vidyodaya school – Ramadas.

Before he explained his understanding of education, he asked the students about the changes they seek in present curriculum – either school or medical college. The few suggestions given by students were

- Change in syllabus and methodology of learning
- From mark driven to practical and skill-oriented education
- More motivated teachers with different ideas and tools to reach students
- The pros and cons of reservation in entry to educational institutions
- More emphasis on co-education to know more about the other gender
- Life skills rather than the usual basic subjects in school

The group accepted the discrepancies in the education system and Ramadas went to explain the political and social dynamics behind it.

He spoke about the dream of Gandhi, when he established “NAI TALIM”. It is a school in sevagram, Maharashtra which was run based on the ideology that knowledge and work are not different. He gave this example when a child is taught to spin a mat, the number of subjects that can be learnt through it, the material (chemistry, botany), pattern (mathematics), hand skills, colors, designs, time management and also at the end, there is a product coming out of it as well.

And these days, education that way is compartmentalization of subjects, was the point raised by everyone. Being medical students with separation of subjects, we could relate really well, just like the mat, finally it narrows down ‘to taking care of the patient’.

He described how unfortunate it is, that privatization has taken over the right of a child to learn and its decided by social class, caste and economic status – the “social privilege” . There has always been a deliberate attempt to remove education from being a essential fundamental right. The system has been producing students who are taught not to question, not to be compassionate and to believe always in the competitive rat race.

It was an eye-opening session to understand the different layers of the education system.

He added how teaching in Vidyodaya has been different, where the students are taught to be proud of their tribal art culture and value system. Where learning is not only cerebral, but also skill and life based.

Session 6 – Discussion with young doctors

Young doctors who had worked in a rural area, Shalini, Royson, Ajith and Sangeetha discussed with the participants in smaller groups. The questions raised by students were on how to break the mainstream flow of MBBS students towards NEET, post graduation and superspeciality, how to convince the family to work in a rural area, why the satisfaction is more in rural experience and when to start working for the poor and needy.

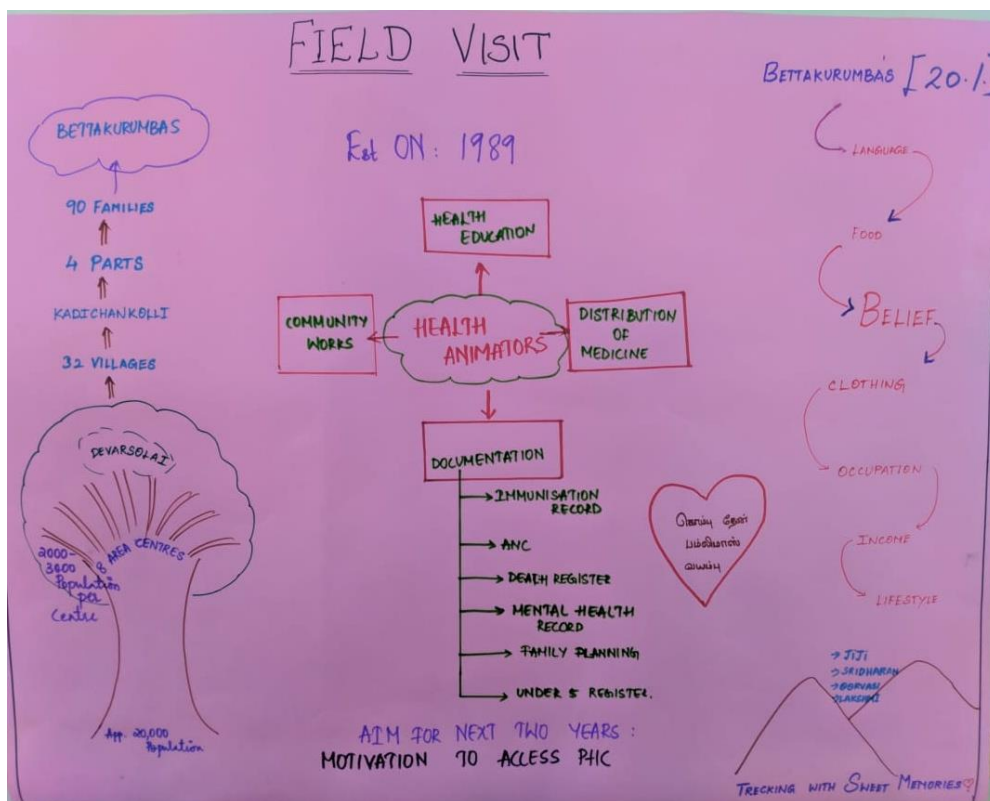
DAY 2

The second day started with Idli as breakfast and the canteen team was kind enough to give packed lunch for the field visits.

The whole day was spent in the field in four different groups. The students went to explore and experience the tribal villages to understand the broader aspect of health.

The groups came back by evening and the discussions started after tea break.

Devarshola- KADICHANGOLLI village



The group visited kadichangolli, a bettakurumba village. They were accompanied by Jiji, a community health coordinator. They met Sreedharan, Oorvashi and Lakshmi who have been affiliated with ACCORD and ASHWINI from the beginning. The students presented their observations and discussion went on like,

Health Animator

After discussing with Sreedharan, the students were able to understand who a health animator is. Health animator works with the community doing health education, documentation of medical records, orients health guides, volunteers towards their work and acts as a bridge between hospital and the community.

As ACCORD involved in land rights and the the senior health animators have been a part of it since then, they have great leadership qualities to address a village and to bring together the tribals.

Students said that they were surprised by the amount of survey that has been done to collect data for antenatal care, immunization, birth and death register, mental health follow-up, under 5 logistics and how all these data were rooted in the community.

Sreedharan added that health animators also encourage the villagers to access government primary health centers. The understanding of health, health systems and the community by the health animator Sreedharan was inspirational, as told by the presenting group.

Area centers

Kadichangolli comes under the area center, Devashola.Gudalur & Pandalur taluk constitutes of 8 area centers. Each of the 8 area centers comes under two health animators. The students said they saw a proper health system for the first time apart from community medicine books.

Lifestyle

They went back in history to ask about the health status of the villages before ACCORD and ASHWINI came. Sreedharan told, health and sickness were all about belief system back then.

Whenever a patient got any illness, it was always believed that it is an act of evil spirits and the patient would be taken to temples for prayers. After hospital and community awareness came, Sreedharan told the health seeking behavior of tribals have changed tremendously. Home deliveries which were a common norm in 80s is no longer seen, and people resort more to institutions for deliveries.

The food habits were mostly dependent on PDS rice and grains. The accessibility to vegetables is still a problem, because of less farming and low socio economic status.

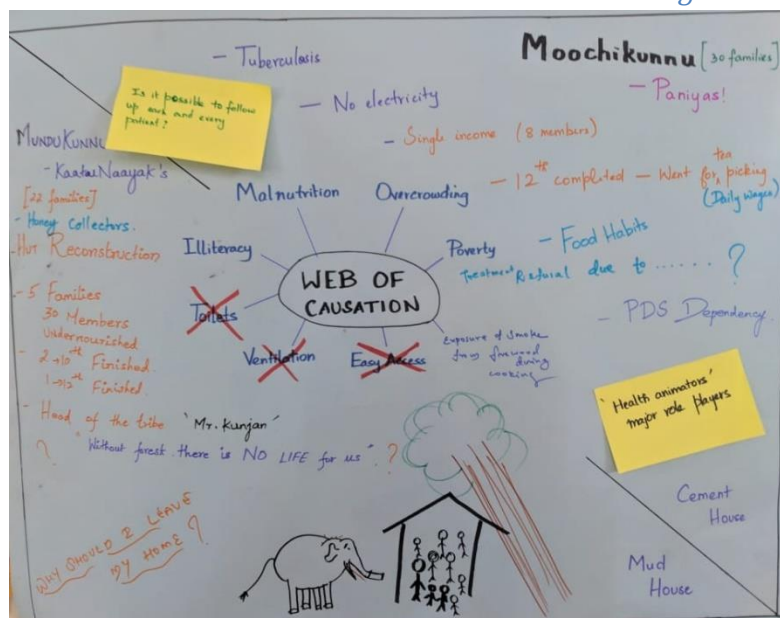
The villagers were seen going for daily wage labors to coffee or tea estate for 300-350 rupees a day.

Hospital vs Health System

Based on the presentation, the discussion went on to explain the difference between health system and hospital. The prime necessity of a primary health care, by a person from the community like Sreedharan was understood.

When the students were asked, “ We need more doctors or more Sreedharans?” . The students replied, “ Before this visit, we would have answered doctors. But after we saw the impact made by Sreedharan in the community, we now understand, trained grassroot workers from the community are more essential than doctors”.

DEVALA -Mundakunnu & Moochikunnu villages



The group that went to Moochikunnu, a Paniyas village were accompanied by Dhanya and Anand Zachariah. They were guided by Omana chechi & Kichan, the health animators of that area. They were able to meet two tuberculosis patients to know about social determinants of illness.

Health Animator

Every group, needless to mention, was impressed by the abilities and skills of a health animator.

Tribal Village

The students presented about the observations they made in Mundakunnu a kaatunayakan village, smaller houses, with a stream flowing nearby. The kaatunayakans are honey collectors. Out of all the tribes, kaatunayakans live very close to the forest.

They told, all the houses were extremely clean, contrary to what they had imagined about tribal hygiene. They could see, over crowding, where in close to 5 or 6 families of about 30 members staying together in a single house. Apart from malnutrition of children, they also noticed, alarming 'adult under nourishment'.

They were not very successful in farming and most of the time earning only to buy grains for food. The whole village was not electrified, and few houses were 'sharing their electric line' with their neighbors, a gesture difficult to find in cities.

Tuberculosis

The group met two TB patients, Girija from Mochikonnu (paniya). She was diagnosed with tuberculosis one and a half months back. Her younger child is also on prophylaxis due to her disease.

Malnutrition, Poverty, Overcrowding- were understood as web of causation for tuberculosis. The student who presented told, "Till now, I thought Mycobacterium tuberculosis only causes tuberculosis. Never saw the social determinants".

One of the barriers to compliance, as health animator told was hunger. Hunger during ATT, and less accessibility to food itself is a major threat for discontinuing medication.

Anand introduced a new term, "Malnutrition Associated Immunodeficiency Syndrome", where in there are enough data to support the fact that adult undernutrition causes a set of life-threatening infections. Also, when the BMI is less than 15-16, the chances of these patients dying due to the same infection is much higher. This triggered a question,

" Malnutrition causes TB or TB causes Malnutrition?"

Nutrition is a huge issue, because of their dependency on PDS system which gives only rice. And their threat to sustainable farming because of damage by wild animals. Frequent visits by elephants also complicates the issue further.

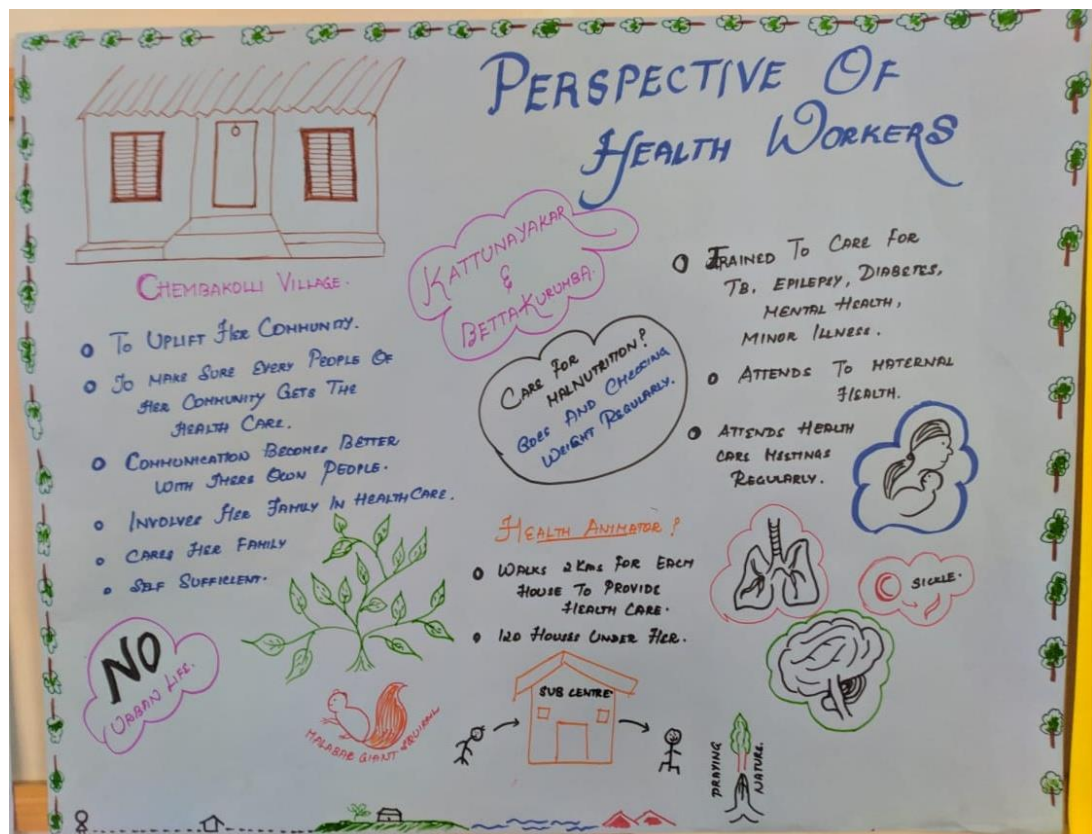
The group met an AMS (Adhivasi Munetra Sangam – ACCORD) leader and the Thalavar of the village, Kunjan who has been working for tribal rights for more than three decades.

He was asked, " Why don't you move to cities?". What he replied, moved the entire group.

" Without forest there is no life for us. Why should I leave my home?"

The day ended with a Ted talk, by a young obstetrician Dr.Taru Jindal, who had worked in rural hospital in Bihar. It was an inspirational video about her experience, the change she could bring in the system. She threw this crucial question to the youngsters, "At what age you start living, 25 or 55?".

CHEMBAKOLLI



The third group presented after a puttu-kadalai breakfast from the canteen.

The students were accompanied by Royson and Sangeetha and guided by Uma chechi, a senior health animator.

Area center

They first visited the area center at Srimadurai. They noticed the spacious building used for multipurpose work like, health, teaching, to hold meetings etc. They also told how honey collection and filtering were done at one corner of the area center.

The area center had drugs related to mental health.. It was a surprise to the students, since they assumed area centers will have only basic drugs like paracetamol and diclofenac. When the students asked the significance, Uma Chechi told they stock of most medicines especially ones that are not available in government PHCs

Village – a walk through the woods

The group walked for around 15 kilometers going to a number of houses as a part of Uma chechi’s health visit. Everyone told, they walked for more than how much they would have walked since birth in one stretch. They also noticed the ease at which Uma chechi walked wearing saree and normal slippers when compared to the students wearing sophisticated clothing and shoes.

The houses were at least 2-3 kilometers apart, with a hilly terrain making them realize the accessibility issues. Even a bike cant reach the houses, the question of how they reach the hospital during emergencies was brought up.

This is one of the very few villages where both kattunayakans and bettakurumbas live together. They met two health guides contributing to community health, a young mother who just delivered, the children were monitored for proper growth and development, one Tuberculosis patient on follow up and a patient with psychosis (on medication and was under control). The students were astonished by how Uma chechi knew every tree, every person and every path in the village, it was huge learning for the young GPS dependent generation.

Health Guide

Rukmani, a health guide spent some time with the students. She told how she is proud about doing health awareness to her own community. When she was asked, who will take over the health guide's job after her, she said her child will be more than willing to do it, since it's for the community.

Integration of systems and Cross Pathys

Rukmani, though works for the community through Ashwini, still believes in native system of medicine - their forest herbs and medicinal plants.

Also Uma chechi, like other health animators, is working on more accessibility to government hospitals for the tribals. This raised the discussion of how different health systems like Public, Private and NGO function? Shylaja explained how ASHWINI was doing 100% immunisation coverage to the community which now is being done by government and need not be duplicated but instead to focus on services that are not being provided by government..

Also the success of NGOs in community empowerment were explained by resource people as shift of accountability. In a government system, the accountability is to the system while in NGO like ASHWINI, the accountability is to the people they work for.

The respect, acceptance and acknowledgement for other systems, (AYUSH) are very crucial in addressing the needs of the community. Because it is a need to respect their beliefs and practices in a holistic approach to health and not always, allopathy holds answer for every illness in the community level.

PATTAVAYAL

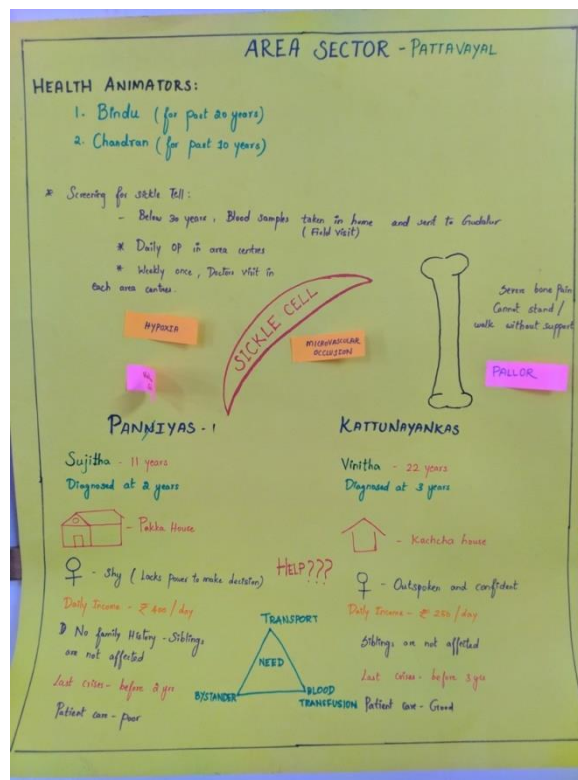
The final group that presented, went to Pattavayal accompanied by Ajith and Health animators Bindu and Chandran. They met Sujitha and Vinitha, patients with sickle cell disease.

Sickle cell Disease

Both the patients, whom the students saw were diagnosed with sickle cell disease and had a history of multiple sickle cell crisis.

They told, how both physical pain and social pressures, the families face during a crisis. The pain is excruciating as recalled by the patients. Also during the hospital admission, the family usually stops going for work. Since they are daily wage laborers, it takes a huge toll on the income and financial status. When the number of crises are more in a year, it adds to the suffering. And, repeated blood transfusions are another burden as well.

The concept of "Savings" and "Bank Balance" are not familiar for a tribal life, yet. So at the end of multiple hospital admissions, they end up having huge debts. And it continues for life since sickle cell is a life long disease.



Sickle cell - a History

Before we went into the discussion, Nanda Kumar gave an idea of the increased prevalence of sickle cell disease in tribal areas around the world. There is a theory that, the tribals area had more malaria than other places, and due to evolutionary adaptation, the RBCs resorted to sickle shape. And hence, the life cycle of malaria can be disturbed. There are enough evidences to support this theory as well.

ASHWINI has screened around 20,000 people from their community area and has found a 12% prevalence of AS trait and 1% of SS trait. The amount of work by the health animators and health guides in collecting the blood samples from the villages of hilly train surprised the whole group. Their willingness to work for the community was appreciated. Also hospital maintains *sickle cell register* for every patient diagnosed for proper follow up. And Shylaja says, sickle cell was the primary reason to go for a blood bank at the hospital.

Genetic counselling, Nanda Kumar added, is a failure in tribal communities. The tribals way of choosing partner for marriage doesn't go through multiple filters, and mostly decided by only the couple. It is difficult to advise genetic counseling once the partner has been decided already.

ASHWINI, now looks at amniocentesis for screening in addition to the neonatal screening they do. The ethics behind MTP – Medical termination of pregnancy was also discussed.

Housing

The students noticed the “not much used” houses built by the government. Though they are pucca houses, the tribals resort to use their traditional houses. Their relationship to the forest and why the identical houses built by the government doesn't serve the purpose was discussed.

Open air defecation has always been a topic of interest in every rural sensitization program. The question of, is there a need- the swach bharat, casteism behind cleaning toilets and importance of dry latrine in rural area were discussed.

Alcoholism

The observation of increased alcoholism In the families was raised as an issue. TASMAL, run by the government, has increased the accessibility to more liquor in the recent times. When both parents are

alcoholics, it contributes to two major issues – child neglect and young children becoming alcohol addicts. Unfortunately, it is not only in tribal areas, but a sad scenario of whole of Tamil nadu.

Session 2 – Reflections on Hospital tour

The students put together their observations from the hospital tour on first day in very creative charts.

COST EFFECTIVE CARE

COST EFFECTIVENESS

- ₹500/year for a family as a insurance.
- Treatment at low cost compared to other hospitals.
- Tribal people are provided health in low cost compared to non-tribal people
- Though the cost is low the standard of care does not decrease.
- Tribal people are treated with good care even though they can't pay the minimal amount.
- Even if the family doesn't pay the premium membership of ₹500, they are taken care off & treated.
- High-End treatment at Low Cost.
- All Patient details are Computerized
- Minimal Use of Electricity.
- For those people who don't have money to buy the printed X-ray sheets, they send it through computer to the doctor.
- No additional fee for referral
- Generic drugs are prescribed.
- Money doesn't matter if passion & will matters.

TEAM WORK

TEAM WORK / ACCEPTABILITY

- ஒரு மரம் மட்டும் காடு இல்லை
ஒவ்வொருவரும் உணர்வுகூர்மை
- A single tree does not makes the forest.
 - everyone is multitasking, so in the absence of one personal, the others can manage the department.
 - There is no need for doctor for minor illness. Nurses do their team work in taking care of patients.
 - Team work – Time saving – fun
 - Innovative ideas like transporting blood samples
↳ Also prevents spread of infection
 - Involving the people of the Community as a health workers makes health services more acceptable.
 - Acceptance of death by the tribes.
 - The whole hospital works like a Family.
 - Gender inequality & Respecting the beliefs & culture of tribal people without making them to change.
 - Multitasking, the whole village accepts to and belief the health animators
 - No hierarchy
 - Though they are divided by community but they are united by heart. "Working for passion, not just for profession"
- UNITY IS STRENGTH
- தாய் அறிவுதான் சக்தி
1500000

QUALITY OF CARE

MISCELLANEOUS

QUALITY OF CARE

- Sharing is Caring
- Clean Flooring
Pleasant smell!
cool atmosphere
- Friendly relationship with doctors and nurses across most of the clinics and medical units - visit not tedious, care hospitals take to does not go.
- Giving them what they Need.
- Every have the patience to cure the patient
- As nurses are also from the community, there is no restriction between patients & nurse. They feel very secure in & talking about their illness to nurses.
- Homely environment
BETTER DRUG AVAILABILITY
- Flexibility with patient's req.
- 24x7 availability
- well equipped
- Counselling centres for mental health care
- Separate blood bank and Sickle cell
- Modern Equipments are there which is not there in ESIC.
- The quality of care is far better than ESIC.
- Doctor - patient relationship is better on a more personal level
- No restricted visiting hours
- Eco-friendly & Patient friendly and STUDENT friendly environment
- Patients treated with respect & dignity!
- Patients Friendly - Easily accessible
- Low cost, high care.
- Quantity does not decides the quality here.
- NO USE OF PLASTERS

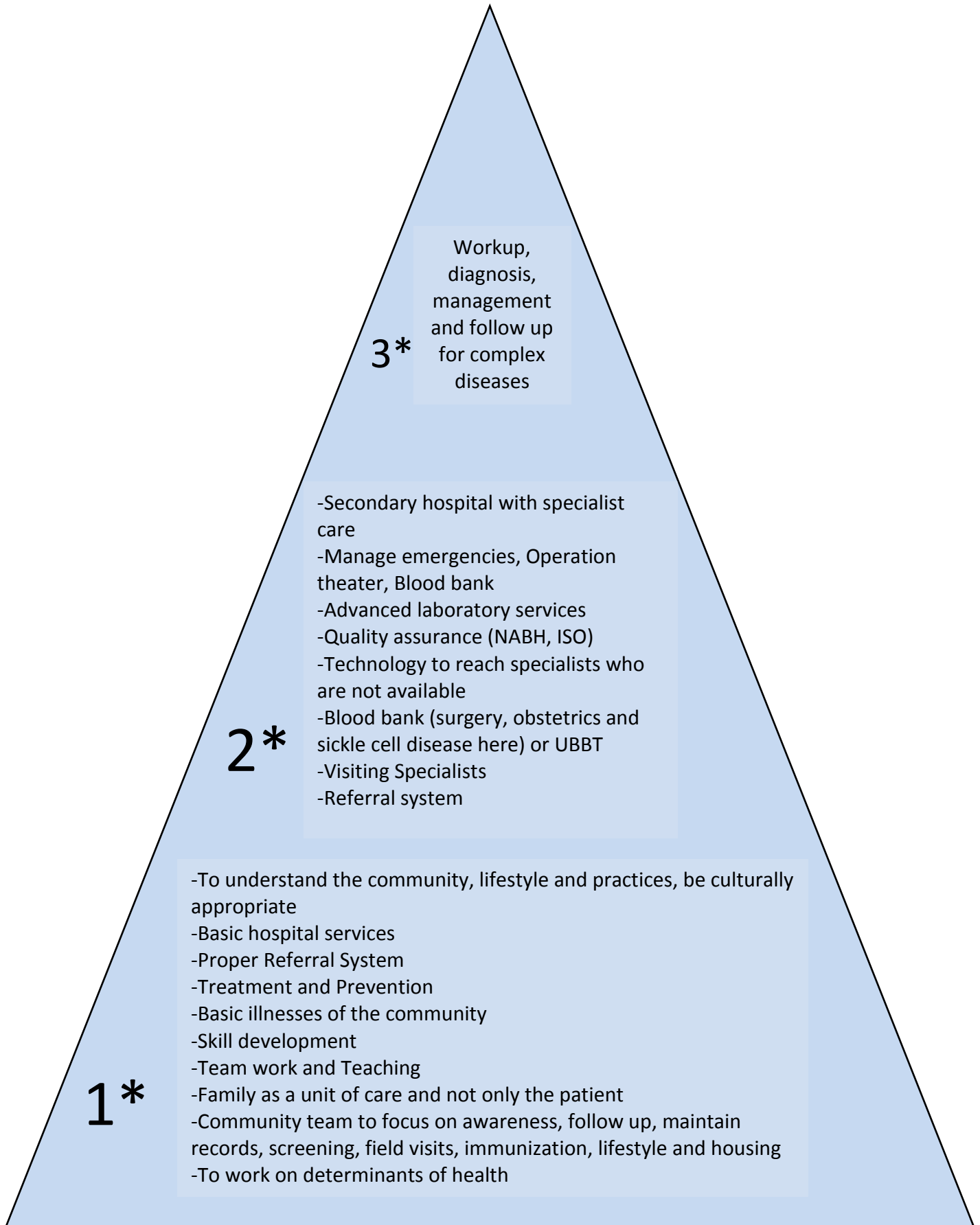
MISCELLANEOUS

- Anyone can do anything if they have real intention to care for people
- Minimal use of electricity
- Architecture is different (Home like architecture is very pleasant)
- Kind doctors & Peaceful surroundings
- Many unselfish people working towards people without expecting rewards.
- Degrees does not count much here.
- Separate lithoscope at each place, when many places does not have.
- Humanity before laws!
- No Separate Male / Female wards !!
- Empowerment of Tribal Community - Provides a chance for young students to explore the rural areas thro' R.S.P.
- Natural lighting !!
- No time limit for visitors
- Training given for health care workers
- No hierarchy / Peaceful Accomodation
- Provides young doctors a platform to practice.
- 8 digit number given to each family for identification. (Sangam No)
- Life makes some sense here 😊
- WE LOVE YOU!

Session 3- Primary, Secondary, Tertiary Care

The discussion was mediated by Anand and Ajith to make students understand about different tiers of health care. The group, with the three days of field visits and discussion, came up with what defines each level of care.

The session went on to give an idea, for the students for what they should learn to equip themselves in working for each level of care.



SKILLS FOR THE PRIMARY CARE

- Basic clinical skills and knowledge
- Trust of the community and winning their confidence
- Communication
- To work with limited resources
- Broad knowledge of all the specialties – being a family physician
- Humanity before law
- Ethical and responsible
- To handle emergencies, obstetrics, poisoning, snake bites,
- To do beyond what a doctor is supposed to do – multi tasking, paramedical works, finance, administration, training and motivation of team
- To be available 24*7 and work with dedication

The students also mentioned that they needed support from family and friends to venture into a rural primary care with addition to financial support. They said they would be happy to have a network of young doctors who are doing similar kind of work, to connect with and learn from. And above everything, good mentors and role models play a very crucial role in shaping the future in rural health care, as told by them.



Feed back

What they liked?

General experience

- Lit the fire up, Inspiring, Eye opener, Excellent, Awesome
- People with Dedication and concern for society
- Friendly & homely, No hierarchy which we have never experience in college, Calling by name
" Here we got inspired by many people. Everyone here is calling others by just name. It seems to be very friendly. We did not talk to our professors, HODs other than 'Good morning'. Here in canteen everyone was happy to share time with you all."
- No inferiority complex- " There is no inferiority complex or shyness among all."
- Understand life medicine

- Encouraged students & Increased self confidence to speak
"I liked the interaction with you people. I had never spoken before in front of even 10 people, but you made us speak individually."
"This camp actually made me speak out what I actually refused to."
- Got to know the other options other than PG, Exposure to other possibilities
- The work at grass root level
- Insight about the place and how to do service
- "Got to know new things, I was narrow minded."
- "Doctors too get to work in peaceful place."
- No technology...yet a beautiful place
- Now rural is also an option...Go rural
- Realized even one person can bring a change in the society
- People never spoke ever in class, spoke here and was happy to hear them all speak. Never knew my class mates too think this way...could see the other side of them.
- Liked plate washing after meals.
- "Would like to join your family"
- "Eagerly waiting for the next RSP!"
- "Camp was awesome, loved every moment"
- Changed perception - "It changed my perception towards the rural population, understood the need of health care in these places"
"It gave me an idea that a hospital can be run in a cost effective way."
I like- "First you made us understand what the rural health is all about and then the major role of doctors in providing health to all."
"Primary care physician is more important than specialist."
"I would love to work with these people if situation is favorable and opportunity is available."
"look forward to the day when I can join your family."
"I liked food, climate, everything even sitting with mats."
Group discussions- "Made me think", Liked the speakers and volunteers, Liked all the group discussions

Session with doctors

- Changed perspective about future
"It was a great experience to know the other side of the medical community and medical system in India especially in rural places."
"Learning from real life experience"
"For 4 months I was really in a stressed situation whether to do PG or work for bond. The first day evening session cleared my dilemma."
- Liked sitting and interacting with the doctors

Field visit

- Conversation with people in village, Interaction with tribal people
- "Health animators"
- Field visit topped the list
- Unexpected and the best part of my life.
- Trekking experience.
- "Experienced the inexperienced things."
- "Got to see the reality"

Stay and food- Perfect, Liked it all

What they did not Like ?

- Sometimes lectures were long
- More of a theory class

- More of discussion
- Travel sickness and long travel for the field visit

Suggestions

- Need more interaction with tribal people
 - Interaction with Patients in the hospital
 - Speak in Indian language (Tamil) than English
 - More sessions on health care in rural area
 - More students should receive this opportunity
 - Increase the number of camps
 - Increase the duration of camp to 4-7days
 - Increase duration of field visit and exposure to all different tribes
 - Session on basic life tips
 - Clinical aspect, Practicing Medicine, Handling emergencies with less resources
 - Break between sessions
 - To add coffee to the menu
 - Morning walk
-