CHAPTER VIII

SUMMARY

The distribution of Brugia Malayi infection is found to be confined in certain localities. In India the largest endemic tract as observed earlier, exists along the coastal region of central Kerala with its greatest concentration found in the Taluks of Cherthala and Ambalapuzha with in the Alappuzha district. The high prevalence of the disease in these taluks has a history that ranges over a century. In a census report as early as 1901, Dr. Subramania Iyer, who was the Census Commissioner of the earst while princely state of Travancore, has highlighted Cherthala for its highest prevalence of filariasis, mentioning Ambalapuzha as following close behind. Dr. Subramonia Iyer’s report records one in 27 of the population as having filariasis. It is to be noted that what came under the census report was the cases of the overtly manifest chronic cases as in those days any kind of tests and examination to detect dormant disease condition was quite unknown. Control measures regarding filariasis were introduced as early as in 1933 , based on the scientific studies of MOT Iyengar. Considering the peculiarities of the breeding cities of mansonioides he had suggested a simple, indigenous, biological control measure. This consists of pistia clearance and was found as a very effective vector control measure. A study by Dr. Sweat in 1937, after a thorough survey and assessment, proved the measure to have achieved a
remarkable high degree of efficacy. But this measures we could not be sustained as potent weapon against filariasis, because interest of the people in the programme could not be sustained for long. As the planning and implementation of the programmes had a vertical orientation, it ended up as government programme to which public acquiesced when the pressure was on and left it the moment such pressure was lifted. In most cases people put the vegetations back as soon as the Govt. team left the place. This happened so because they were not given to generate any confidence regarding the purely governmental programme.

The above attitude of the people can be understood in terms of the socio cultural atmosphere prevalent at the time. A 1955 report also shows one in 23 having swelling of legs or arm as a manifestation of the disease. A very long co-existence with the disease, spread over several generations had instilled a kind of knowledge, which was at variance with and in contradiction of real scientific knowledge. This native ‘knowledge’ told them that filariasis was a non-fatal, non-curable, non-controllable disease. There was neither any awareness of any cause of the disease or of control measures in the ‘knowledge’ as there was nothing one could do about it. The native wisdom prompted tolerance verging on acceptance and resigned itself to the fatalistic conclusion that it is the will of the almighty.

In the relatively uninformed society of those days, the false believes and misconceptions that they cherished were dependable direct deduction from their own experience and they developed a practice that was in full logical, correspondence with those ‘beliefs and concepts’. In this ‘knowledge’ pistia was
good and useful to them in many ways. It provided manure, it kept the water bodies clean and cool, and prevented rapid evaporation. On the other hand they could not feel the same kind of faith when government agency told them that removing pistia would prevent the proliferation of mosquitoes.

Neither did they feel the necessity of keeping away mosquitoes. So the villager was content to remain with his native knowledge and pistia rather than accepting and pursuing what “scientific” people proclaimed. This even lead to a kind of social acceptance. There was no social stigma attached to the disease as is found at present. This social acceptance of the disease can be seen reflected in many folk ditties of the areas and even in some of the well known poems.

The eminently popular Malayalam poet Vayalar Rama Varma opens one of his poems with these lines;

"Randu kalum malapole manthulla
Kundunni Menon Nadannu pathukkave"

[Kudunni Menon stalked in slow grandeur clad,
Riding elephantine hugeness of his feet.]

Another folk piece sings

[Welcome to the swollen footed guest of honour. We spread the grass mat of honour for you]

"Mantha bandhuakkara Va Pullupayeliri"

[Welcome, elephant footed in - law - We spread the grass mat of honour for you]

Again the lines

"Manthanannengilum Chinthikkavendedo,
Manthenikkreeswran thannathane"

[No disdain need you show nor
look down on my gait.
These swollen feet mine
Are sure gifts from the Lord.]

show both the acceptance and the belief that it is Gods divine dispensation.
This can be viewed as the operation of a simple of mechanism of social integration. Since, a sizable number of population was affected with this non-fatal, and non-curable disease, it was neither necessary nor possible to isolate them from the society.

This was the state of the society that prevailed in those days. The society had an immune and isolated existence where in interaction with other societies was limited to the bare minimum. A typical Kerala village of those days had a closed - in existence. In a place like Cherthala, one could live on to the end of ones tenure seeing and interacting with people of ones own area, many of whom had contracted filariasis which was taken for granted and nobody cared to even think of doing something about it.

As time rolled on, and as the mobility of the people increased with improving education, transportation and other such elements, social contact grew more, varied and heterogeneous. These aspects of having to interact with people of other societies and other areas left its mark on the people. These other societies had not had any experience of having lived with filariasis for generations and they looked down on the disease with revulsion, which the home society, left to
themselves, would scarcely have developed. In the eyes of the outsider the elephantine legged Cherthalite became a laughing stock as well an object of repulsion. The gravity of the problem was driven home as matrimonial ties with other communities and areas became increasingly common. Gradually the social stigma got attached to the disease. The attitude of the people towards filariasis changed. They began to desire to get rid of it. But this did not generate any interest in the scientific knowledge regarding the disease that was available. This was the case even with the highly educated segment of the society. Most people cherished myths of varying degree of falsity regarding the disease. Nor did any attempt from the people was seen in fighting and preventing the disease.

The surveys VCRC conducted prior to the launching of the programme, revealed that only 12% of the people really knew that the disease was spread by mosquitoes. This was the case despite of the very high level of literacy in the area during the period. This was so even when 87.12% of the people strongly desired to avert the disease. All the same this did not persuade them to adopt any preventive measures. The social stigma attached to the disease co-existed with the deep-rooted misconceptions regarding it.

It was a programme functioning on active participation of the people that VCRC had designed. The major element that blocked access to the community involvement was the lack of scientific information regarding the cause of the disease. An opening to break into the strong resistance block settled through centuries of experience was the need of the hour for the VCRC programme.
Involving voluntary organizations was the opening VCRC found. The present study has proved beyond doubt that this was a great success. An action plan co-ordinating and orienting different organizations of a given area, has been proved to be an efficient tool in combating other health problem as well.

Health education programmes channelled through these voluntary agencies have been found to be highly successful in transferring informations to the people and activating them to join the fight against disease. The study has also found that the tools and means adopted in the programme was remarkably in tune with the economic, cultural and political structure of the concerned society. The information that was confined to a meager 12% before the launching of the programme has now reached 94.5%

"The primary relationship" characteristic of the rural society was found to have contributed considerably to the success of the programme. The social bond that rests on mutual trust and co-operation were seen to have had enhanced the faith in and acceptability of the disease eradication measure. As these voluntary agencies intimately knew the native pulse, they could help in modulating the programme to the tastes and needs of the society, without compromising the scientific and technological foundation of the control programme.

The presence and involvement of Government agencies also were found to be inevitable. For the people of Kerala who are highly concerned about health, it is very important that there should be authenticity and authority in the field of treatment. The health level index of the state being on a par with highly developed countries, is a corollary of the high level of education here. Accredited programmes
in the field of science at the governmental level may harness community involvement to make such programme immensely more cost efficient and effective.

The religious and communal organisation of the state were also found to be of great use. But a thorough evaluation of their role could not be effected due to certain peculiarities of their areas and manners of operation. The Christian church was however, found to have more of the community presence.

A disease like filariasis with much social implications can be handled and controlled only through the active involvement of the people. The strategy in harnessing such community involvement in the programme under study, was found to have incorporated a deep and sound understanding of the structure and variety of the society.

In short, a programme that imparts information in a manner in which the common man can assimilate it, that involve people in whom they can place their trust, that uses techniques that they can handle for themselves for the greater part and that is made to function in their area involving them, can for certain be successful. This should be the case with any programme involving community participation in real terms. Cost wise also this could be very advantageous. Governmental thinking and planning ought more to be turned in these lines.

**MAJOR FINDINGS OF THE STUDY & RECOMMENDATIONS**

Voluntary organisation in the villages are very effective in channelling disease control programmes. The following special features of organisation and programme were found to be vital in making them effective.

a. The social infrastructure.
b. The primary relationship with community.

c. Better understanding of the community.

d. Social obligation and commitment

e. Simplicity of the technology involved in the control programme.

2. Voluntary organisation that functioned in different locations, improved their efficiency when co-ordinated and operated centrally.

3. A well informed community can participate successfully and meaningfully in disease control programmes.

4. Health education campaigns should be in tune with the social and cultural background of the community.

5. A horizontal level of health education involving the community members are better than vertical level followed so far.

6. Genuine supports and involvement of an authentic agency is the most important factor in a successful participation programme.

7. Disease control programme with simple and practical technology, promotes community participation better.

8. Involvement of reliable and acceptable members in the programme facilitate participation.

9. Proximity of services enhances participation levels.
10. Collective programmes - reduces resistance, increases social responsibility and inspiring the collective conscience, aids in the promotion of community participation.

A scientific evaluation of the tools and means adopted by the VCRC in fighting filariasis in Cherthala has revealed that it was by reason of the VCRC being able to function, in tune with the pulse of the people and their culture, that made it possible for them to harness the participation of the people in full measure.

Apart from being very effective in filariasis control and cure, the programme has imparted a new trust and faith in Government programmes which has set the people to work in full alignment and co-operation with government agencies. The people strongly feel the necessity of putting up a strong peoples united front against epidemics and other health hazards. The most important aspects of the experiment is its cost effectiveness. The Government ought to build on from the strong foundation now created. The peoples planning programme now running in the state or other similar programme now running in the state or other similar programmes could be fruitfully aligned in the line of the VCRC programme and has to be kept in going till targets are fully achieved. The faith that has now been created in the people has to be sustained.