CHAPTER VI

Health, Healthcare Seeking and Notions of Well-being

Health Development as Marginalisation

This chapter analyzes the Paniya’s and Kurichia’s perceptions of health and illness and their experiences of various healthcare services. It is not about the mortality and morbidity patterns but about conditions that produce ill health and loss of well-being. Adivasi views and experiences illustrate how their conceptualisation of well-being is quite different from the dominant biomedical/developmentalist notions and how the latter marginalises the former. However, health seeking by the Adivasis is partly influenced by biomedical developmentalist notions and partly by their culture and the necessities of their living conditions. According to Bury (1998), the powerful mechanisms of modern practices of healthcare with its objectifying processes and rise of professional expertise had separated key areas of knowledge from the ‘life world’ of people to rationalise, colonise and homogenise everyday life. While the Adivasis struggle to avail themselves of modern healthcare facilities, they continue to rely on their cultural resources and make efforts to reaffirm and recreate their knowledge and continue to offer a critique of modern healthcare practices. Even though Adivasis are constantly in tryst with the capitalist commoditisation trends in their everyday life, the present mode of development and progress are alien concepts especially for the Paniyas as they are people living for the present without amassing wealth for the future. The Paniyas and Kurichias have no definition for ‘development’ in their culture but they always connect a healthy and self-reliant life as a preferable condition. Adivasis consider health as one of the most important assets in life, and for marginalised groups like the Paniyas it is the only asset for their survival and livelihood. Exploring the experiences of marginality and their everyday struggles is important in delineating the health and illness of the Paniyas and the Kurichias.

The first section of this chapter discusses the conceptualisation of health and illness of the Paniyas and the Kurichias and the conditions that produce ill health. The latter part explores their experiences of seeking healthcare through different systems of medicine, the developmentalist state and its approaches to Adivasi health as well as Adivasi
The cultural constructions of modern medicinal practices of the Paniyas and the Kurichias and their own systems of belief and practices are given importance in understanding their world views and the factors affecting their health and illness. More than a conventional biomedical approach which dominates the current discourse on health and illness, the material, cultural, ecological and political factors affecting the health status of the Paniyas and the Kurichias are given importance in this analysis.

**Conceptualisation of Health, Illness and Well-being**

In the study area, the Paniyas and Kurichias perceive health as their most precious asset and grace from god. As people who live for the present without accumulating much for the future, health becomes the most precious resource for their everyday life. The concepts of health, illness and healing for Adivasis are much broader in perspective than the biomedical concepts. When they talk about health and well-being, the Adivasis are not only concerned with the direct causes and effects of health and illness, but are also concerned about the loss of rich sources of food items, conversion of paddy fields and the loss of rich reservoirs of food, pollution of food, air, river and soil and destruction of fish in the river. They also give importance to their rituals, customs and values which help preserve unity in the community and consider their neglect as the cause of the wrath of ancestral spirits and gods, which results in ill health. When they attribute the main reason for their illness to the wrath of the gods, sorcery or the evil eye, they also include lack of food and unhealthy food habits and lifestyle changes due to the alienation from their habitats as causes of ill health. The displeasure of spirits and gods are not brought on merely by disrespecting cultural and normative systems but also by the inability of the Adivasis to protect their natural environment. As Eder and Gracia Pu (2003) point out, the indigenous healing practices are not centred on the biological aspect alone, but are concerned with reordering the social, environmental and spiritual balance. According to this perspective, the individual is not diseased but is in a state of imbalance. So the treatment also takes into consideration the family, community and combines characteristics of physical, social, environmental and spiritual therapies.

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25 Kurichias use the word *Thambai* and Paniyas use the word *Padichavan* for God. But while talking with me they used the word ‘daivam’ as I am not familiar with their traditional usage.
In the study area, the Adivasi’s traditional belief is that different deities and ancestral spirits are responsible for causing health and illness. According to their belief, mistakes committed while propitiating their ancestral gods is one of the main reasons for illness and they adopt ritualistic healing practices thus reinforcing cultural practices and traditions to please their gods to get rid of the illness. Elders among the Paniyas and Kurichias believe firmly in the ‘supernatural’ basis of ill health. For instance, one Paniya mother stated, “My son is sick as we could not attend the traditional rituals of my father’s kaakkapolai.”26 A Kurichia elderly woman said, “If boys touch the girls during theendari (menstrual cycle), boys will get sick as their ancestral gods will get angry with them for violating their tradition and girls will get sick if they do not follow the traditional norms”. Paniya and Kurichia elders also mentioned the use of herbs for healing along with rituals. Thus, supernatural causes are also treated with natural remedies.

The Paniyas and Kurichias reported that they perceive and give importance to the bodily causes of illness and use many herbs in their healing practices. At the same time, they perceived their healing as a divine mission unlike other systems of medicine and its commercial trends. Elders reported that initiation into this healing mission and their gift and abilities to be healers is revealed by god through dreams and practical expertise through apprenticeship. Nair (2002) reports that after death, the mentor’s soul gives divine sanction to his successor for practising their medicine. He notes that the involvement of the dream in the initiation of practising medicine often prompts it to be labelled as an inefficient and irrational practise. However, one Kurichia vaidyan, Vellan, negated the involvement of the dream in the initiation of Adivasi healers. Even though he negated the revelation through the dream, he stressed the need to protect it as sacred and consider it as god’s gift. Majority of the Paniyas and Kurichias still emphasise the need for knowledge revealed through dream for initiation as a healer and it becomes a strategy to keep their wealth of knowledge within the healer’s family or community.

However, educated members in both the communities are in a transitional stage of disowning their belief in supernatural causation due to its being labelled a superstition by

26 Ritual on the 7th day after death when the spirit of the dead joins the ancestors.
dominant cultures and modern medicine. At the same time, it has been observed that when misfortune hits, they resort to ritual and spiritual healing centred on ancestral worship along with medication. For instance, the death rituals are strictly followed by youth in both the communities. Thus, the critique of traditional and spiritual healing put forward by some of them has to be interpreted as attempts to negotiate the demands of modernity. Badami (2011), in his study on agency and identity in Paniya health, points out that their negation of traditional medicine and use of modern medicine is an attempt to avail themselves of development aid, an opportunity to renegotiate their marginality and to project a new identity. However, their pragmatism in choosing different methods of healing and following a pluralistic approach in health and healing cannot be interpreted as an instrumentalist approach to health. Rather, it can be seen as an internally consistent world view or cosmology that is integrative and not structured along the binaries of natural/supernatural causes and ritualistic treatment versus herbal treatment. The dominant biomedical discourses and the ethnographies of medical anthropologists impose binaries that are neither observed in Adivasi life nor are analytically useful in understanding their world. The science of medicine forces people to disown the experiential wisdom on health and healing gained by Adivasis through ages by labelling it ‘primitive’. However, nobody can ignore the Adivasi healing principle as it is re-emerging in different forms of healing like Nattu Vaidyam (indigenous medicine), ‘energy healing’, pranic healing, shamanic healing and so on. Generally, all the Vaidyars among the Paniyas and Kurichias have a strong belief that it is god who has entrusted the gift of medicinal knowledge to them and they do it as a service to both god and humanity. One of the traditional practitioners said, “We do not claim that we are healers”. He added his logic, “We give medicine only for deenam (ill health) and not for Ayus (life). If we give medicine for Ayus, only birth will happen and death will not take place”. This reveals how much they align themselves to the cosmic principle of life and death as a natural process and their limited role as ‘care givers’ not as ‘life providers’ in contrast with the hegemonic discourses of ‘medical power’. Some of these points will be elaborated in the discussion on tribal healing practices.
Conditions of Health and Well-being among Paniyas and Kurichias

The deteriorating health condition of Adivasi communities is a growing concern in Wayanad. According to the Centre of Excellence study (2006), poverty, genetic issues leading to sickle cell anaemia, high consumption of tobacco and alcohol, low nutritional intake, unhygienic surroundings and excessive exposure to chemical fertilisers and pesticides are the main causes for ill health among the Adivasis.

The major health problems among the Paniyas reported by people, primary health centres and Asha workers in the study area were general anaemia, underweight, tuberculosis, gynaecological problems, sickle cell anaemia, cancer, chicken pox, jaundice, meningitis, pneumonia, repeated infections, bronchial infections, body aches and scabies. Rare incidents of high blood pressure, diabetes and heart attack among the Paniyas were also reported from the study area. The main problems reported during the field work period among the Kuruchias were rheumatism, high blood pressure, diabetes, heart diseases, paralysis and rare incidents of cancer. However, an epidemiological sample study conducted by Mahadevan et al (1995) reported that there were no ischaemic heart diseases and diabetes mellitus among the Kurichias and this was attributed to the relative longevity among their elders. Even though fever, cough, cold, stomach ache, headache and other respiratory diseases are common in both communities, the Paniyas face frequent attacks unlike the Kurichias. As reported by the PHC staff, anaemia and tuberculosis is less among the Kurichias compared to the Paniyas, but more than that among the non-Adivasis. At the district TB centre at Manathavady, 77 Paniyas and 7 Kurichias were registered for Directly Observed Treatment (DOT) in the year 2008. In 2009, 57 Paniyas and 3 Kurichias were registered for DOT treatment (computed from District TB centre files, Mananthavady).

Anaemia was reported as the most prevalent sickness among Adivasis and especially among the Paniyas by the health personnel in the study area. Sickle cell anaemia was reported among the Paniyas but not among the Kurichias. The number of sickle cell patients among the Paniyas in Wayanad is 161.27 Even though sickle cell anaemia is reported as a genetic disorder, Devi’s (2006:20) question seems relevant in the Wayanad

27 Collected through RTI from the office of Arogya Keralam, Wayanad.
context, “Is it perhaps possible that malnutrition for generations has imposed this condition of perpetual anaemia on the Adivasis?” Food security ensures that all people have access to sufficient, safe and nutritious food to maintain a healthy life. But in 2001, more than 30 starvation deaths were reported among the landless Adivasis in Wayanad and the Government interpreted it as undernourishment deaths (Jacob 2006). According to Nair (1995), tuberculosis, scabies, worm infestation and malnutrition are reported more among the Paniyas than among the Kurichias and he attributes the difference to the resources available to them. However, according to Adivasi understanding all illnesses are interlinked and a biomedical interpretation is not sufficient to understand Adivasi health and illness. Poverty, exploitation, unemployment, alcoholism, food availability and change in diet practises are closely related to their health and illness.

**Poverty and Ill Health**

Wayanad has the highest level of poverty among the Adivasis at 60.4 per cent (Chathukulam and John 2006). However, there is difference in the extent of poverty among different Adivasi groups like Paniyas and Kurichias their daily food intake and thus in their health conditions. For Paniyas it is observed that there was inconsistency in daily food intake. Ruha a Paniya woman said,

> If we have money to buy from the market, we prepare food; if not we remain hungry. If my neighbours have, they give some rice gruel. After my husband’s death we survived because of my brother’s and neighbours’ support. They also lack money and how long will they be able to support my family?

While staying with them I noticed that drinking black tea without sugar at regular intervals during the day has become a habit even for their children and they use this to tackle their hunger when food is not available. Kurichias had regular meals, three times a day, and there was more variety and nutritional value in their diet which perhaps contributed to their relatively better health.

The relationship between poverty and anaemia is well understood. But this abstract understanding does not convey the subjective experiences of anaemia under conditions of poverty. A Paniya woman, Nelly’s, experience is not an isolated one from the study area. Nelly with symptoms of shivering of hands, breathing difficulty and giddiness was admitted to the Government district hospital. Her face and legs were swollen and she was
pale. According to the hospital report, her haemoglobin level was 4.3 and she needed four bottles of blood. With one bottle she improved and the haemoglobin level became 6.9. Her mother, Ruha was happy to stay in the hospital because they get free food there. Ruha was a sick widow, and there was no possibility of her giving Nelly good food at home during the treatment. Ruha did not know about the seriousness of Nelly’s condition because the doctor did not explain it to her. But she was aware that it was mainly due to lack of food at home and that she was not able to feed her five children properly. Nelly narrated the history of her illness:

I dropped out of school after Standard VIII and then onwards I was working in a brick kiln till my father’s death. Father’s sickness and the burden of feeding six members in the family fell on my shoulders. I became very weak and I could not continue my work. My mother is sick and Kantha my elder sister had difficulty in breathing and her whole body was swollen and she was undergoing treatment. No person in my family is healthy enough to go for wage labour. To support the family our younger ones in school going age started working and one was hospitalised due to chest pain. My mother applied for a widow’s pension in 2009 but it is not sanctioned even after one year and she has applied for it again.

It was observed that Nelly was not healthy for the whole year and she was hospitalised thrice within a year and she could not do the follow up as suggested by the doctors. During heavy rain and wind she was staying in the temporary shed made with plastic sheets in Karakkuni, Edavaka panchayat where Adivasi Ksema Samithi (AKS) promised to give 10 cents of land if they lived there continuously and attended party meetings. Party leaders warned that if they left the shed, others would occupy their land. So without even considering their health condition, they stayed back during the season of heavy rain and wind. As they had no regular employment they did not have enough food and from there, Nelly was taken to the hospital again.

One of the Assistant District Medical Officers, with many years work experience in the district hospital, Mananthavady where many Adivasi patients visit, reported:

The Adivasi’s blood situation is very poor and they cannot stand even a small post partum bleeding. And this cannot be corrected by giving iron tablets during pregnancy period. It will create gastritis if they do not take proper food. Even though they include leafy vegetables in their food, the total nutrition content is not enough for them. Most Kurichias have land and they have enough food to eat. Their health condition is better than that of the Paniyas and anaemia is less among them.

28 A left party oriented Adivasi organisation engaged in land struggle and land acquisition for Adivasis by occupying and erecting huts in surplus lands, revenue lands and vested forests.
Swelling of face and body, weakness, pale colour of lips, eyes and face due to lack of blood were common among Paniya adolescents as well as pregnant women. The PHC staff in the study area also reported that almost 75 per cent of the Paniya women approaching them for healthcare needs were suffering from anaemia and underweight. A visit to the district hospital in 2009 revealed that there were many pregnant Paniya women waiting for blood transfusion to treat anaemia as there was no stock of blood in the hospital blood bank. Their stay in the hospital for long in turn affected their children’s health and education. While visiting Yarah, a pregnant woman from Kunnil Paniya colony in the district hospital, she introduced me to three other Paniya pregnant women, who were also waiting for blood transfusion to treat their anaemic condition in the same ward. Soumya, eight months pregnant was waiting for two weeks for one bottle of blood, Santha for 25 days for one bottle, Ammini for ten days for five bottles in the district hospital. There was no dearth of analysis or understanding among the medical officer and the PHC staff about the ‘real’ cause of Adivasis acute anaemia. Yet, all they could offer was only intermittent blood transfusion for the Adivasi bodies weakened with inadequate food and excessive labour demands.

The Paniyas are fully aware that lack of facilities and poor living conditions due to poverty are the main reasons for their repeated infections, scabies and skin problems in their colonies. Because such illnesses are comparatively less among the Kurichias, the PHC staff immediately conclude that it is due to the unhygienic practises of the Paniyas and praise the Kurichias for their hygienic practises and better health. The Arayal colony is situated at a 100 metre distance to the PHC and the Paniyas reported continuous incidents of scabies and infectious diseases among their children. In their colony, there was no place for waste disposal and they reported experience of water scarcity during the dry season. Except for four or five houses out of forty, they had no latrine facility also. As Zurbrigg (1984) points out, the overriding emphasis on individual factors like germs, unhygienic behaviour and lack of particular nutrients in disease causation is ideologically compatible with the structure of western capitalism which overshadowed the earlier traditions of understanding health as primarily determined by social and economic conditions.
Labour, Exploitation and Violence

Focusing solely on poverty will not unravel the health issues of Adivasis without addressing the underlying structures of exploitation and violence at different levels. Reducing work opportunities have increased the indebtedness of the Paniyas and have recreated bondedness and exploitative labour relationships. Kodagu labour, wage labour while experiencing ill health, multiple pregnancies, sexual exploitation and increasing alcoholism among men make Paniya women more vulnerable to health problems. Kurichia women are more protected at the cost of their sexual freedom.

Unemployment, indebtedness and the resultant bondedness in terms of money or employment again lead to the vicious cycle of poverty, malnutrition and ill health. Many Paniya people take advance wages during lean seasons of employment and in return are forced to go to Kodagu for hard labour. The ‘Kodagu labour’ is a form of bonded labour and is often compared with their history of slavery. For the money advanced to them, they owe labour in return, thus falling in the trap of bondedness and slavery. Paniyas who worked in Kodagu from the study area reported that no safety measures are provided in Kodagu and they are vulnerable to all kinds of physical, mental and sexual health problems due to the unhealthy and exploitative conditions. Women face more vulnerability due to lack of staying and toilet facilities. Women and men stay together in sheds and they fall in love and have sexual relationships, but in many cases men do not take the responsibility of looking after them. Men and women are forced to handle all kinds of pesticides and chemicals without taking any precaution. The New Indian Express reports,

‘There is a small pool of pesticides at every ginger farm. Workers, including children are forced to work without gloves and masks.... They end up as cancer and TB patients as they got to dip ginger suckers in the pool prior to planting them exposing them to the pesticides...’(The New Indian Express, 8 December 2008, page 5).

Out of the four selected Paniya colonies, three colonies reported the death of Paniyas in Kodagu or after coming back for lack of proper treatment at the work sites as the hospitals are at a distance. For instance, in Arayal colony Paniyas reported that Raja, who came back from Kodagu, vomited blood and died the same night. These deaths are counted as natural deaths and no action is taken by the state authorities. The Kurichias seldom go to Kodagu and therefore do not face similar health risks.
Mani, a counsellor from the Kurichia community working at the TB centre in Mananthavady reported,

It is really pathetic to note that the TB patients undergoing treatment were taken for wage labour by the non-Adivasi ginger cultivators to Kodagu to make profit. Since there is no other way to give them regular medicine, the TB centre at Mananthavady entrusted the medicines to the person (agent) who takes them for ginger cultivation on behalf of the employer. One TB patient in Edavaka panchayat is taking medicine for the third time and he goes to Kodagu while taking medicine. Now tablets are not working, so he is taking injections.

Mani called this inhumane and brutal as they make profits by playing with the life of the Paniyas. He mentioned that even for healthy people, the Kodagu migration and work is very hard. From Arayal Paniya colony, women too reported that TB patients went to Kodagu for wage labour in between treatment and due to irregular intake of medicine, the tablets were no more effective and they had to switch over to injections. Due to labour scarcity, Paniyas were forced to go to Kodagu for work even after knowing about the unsafe and exploitative work conditions there.

As described in the earlier section, Paniya women are forced to work while facing acute health problems like anaemia and infections as they assume the responsibility as caretakers. This led to serious health problems. Further, it is observed that if there is shortage of food women remain hungry after feeding the husbands and children. While distributing food, preference is given to the man who goes for wage labour and women who sit at home and indulge in household work due to lack of employment opportunities remain on an empty stomach. Very recently, a thirty year old woman died in Valli colony and she was suffering from acute anaemia. First, she was infected with TB and she completed the full course of DOT treatment. As Eva, a tribal promoter from the area conveyed, the strong medicines cured her from infections but lead her to acute anaemia and death as she could not eat healthy food while taking the medicine.

Child labour and the resultant health problems were rampant among the Paniyas as described in the case of Vitha’s family. For instance, in Kunnil Paniya colony, a Standard VI dropout, Vitha was admitted in the hospital for blood stain in the sputum, chest pain and anaemia. Her neighbours reported that it was due to hard work to support her family. Her mother’s pregnancy and delivery in the intervals of one and a half years forced Vitha to take on the responsibility of housework while her elder sister (18) went for daily wage
labour whenever it was available. Their mother, Urha with eight children gave birth to the
ninth child when the youngest one was only one and half years old. Urha was interested
in undergoing sterilisation, but the doctor discouraged her due to her severe anaemic
condition and weakness after delivery. Her husband suffered from back pain and was not
able to go for wage labour and the only option was to send her children for work and they
also became anaemic. Thus, multiple pregnancies lead women to health risks as well as
their children to child labour.

Paniya women experience various kinds of exploitation such as lack of employment
and more importantly sexual exploitation due to their economic dependence on non-
Adivasi people and thus they experience the double vulnerability of exploitation and ill
health. Ellan Mooppan said that their women were sexually exploited by the government
employees in the past (in 1970s) and this trend is continued by the non-Adivasis even
today. Ellan Mooppan exclaimed,

The people who were appointed by the Government to serve us started exploiting us. What
can be done if the fence itself starts eating the crop!

However, Paniya women’s free movements and sexual freedom is misinterpreted as the
reason for their sexual exploitation. A Kurichiya youth commented,

Paniya women have no shame to dance on the roads. Such indecent behaviour is the cause
for so many ‘unwed mothers’ among them.29

In Arayal colony since they do not have even a big yard to dance during their festivals
and ritual practices they danced on the road in front of the colony. Paniya women
experience comparatively more freedom than Kurichia women and other non-Adivasi
women. Their intermingling with the opposite gender is not controlled strictly in their
colonies. During their festive occasions, men and women dance and they express their
sexual attractions while dancing through gestures, comments and songs. However, the
dominant culture decides the appropriateness of other cultural practices and the tendency
is to homogenise the practise of control on women’s sexuality in the guise of
safeguarding them from exploitation. It appears that the constructions of Paniya sexuality
and identity are based on the power relations existing in the society. The patriarchal

29 According to KILA survey report there are 392 ‘unwed mothers’ among Adivasi women in Wayanad.
notions and the demeaning constructions about their sexuality in a way helped to exploit them without assuming any responsibility and their sexual freedom is depicted as a reason for their exploitation. Being ‘unwed mothers’, women experience social stigma as well as double vulnerability as they face lack of support to bring up their children and unemployment. It is reported that their children go for paid domestic work to survive and get into the vicious cycle of exploitation.

However, there are few reports of violence against Kurichia women. An elderly Kurichia said,

Unlike your (researcher’s) community, dowry deaths and violence on women are not reported among Kurichias. We still hold on to our traditional values regarding these matters and respect our women.

While the Kurichias attributed the reason for less exploitation of their women by non-Adivasis as strict sexual restrictions, a non-Adivasi neighbour of Tulsi tharavad shared that Kurichia women were not exploited like Paniya women by outsiders as Kurichias were experts in using the bow and arrow. Their history as warriors and their skill in using their traditional weapon gave them special power and saved their women from exploitation. However, there were rare incidents of exploitation of Kurichia women. Two incidents were reported among Kurichia women from Thirunelli panchayat.

The brutality of non-Adivasis did not spare even blind women from sexual exploitation. A blind Paniya woman from Arayal has undergone sexual abuse and her children also were born partially blind. During a visit in 2009, I observed that one blind Adivasi man married this blind Adivasi mother and they were struggling to live. One day I saw him picking up food from the hotel waste bin with the help of the hotel owner. The anganwadi helper said that there were seven ‘unwed mothers’ in that colony of 42 families and that their life was miserable, but they were hesitant to talk about their experience. The label, ‘unwed mothers’ hides the severity of violence and social suffering Adivasi women experience through sexual exploitation. Without addressing the sexual exploitation and the violation of a person’s integrity, the State and authorities gave them a special label ‘unwed mothers’ as if it were the women’s fault and tried to transfer the stigma to Adivasi communities to alienate them further.
During the interactions with sexually exploited women in Arayal colony, their aversion towards the non-Adivasi community was visible on their faces and they seldom spoke to non-Adivasi outsiders. However, fearing the stigma and dishonour attributed to sexually exploited women by non-Adivasis they were hesitant even to accrue the benefits promised by the Government for unwed mothers. In an initiative by the People’s council for social justice, a factual study was arranged on February 7 1994, and out of 300 sexually exploited women identified in Thirunelli panchayat only three victims appeared before the study group (Local Support Team, Paniyasadas 2010). The sharing of their experiences started with an appeal not to make them actors in the political drama in the media for political gain (ibid, cited in Mangalam Daily, February 8, 1994). Even though the State Assembly Judicial Committee headed by Balan vaidyan recommended that the victims be given full financial support to prove the parenthood of their illicit children through DNA test, nothing worthwhile happened other than settling three cases by reconciliatory discussions (ibid).

It appears that these inhuman sexual assaults on them create alienation which affects their mental as well as physical health. They reported the continuation of these sexual assaults in recent times (during 2000s). Ippy from the Paniya community said,

Duni an anganwadi helper from the Paniya community in Valli colony was sexually exploited by a Muslim, who is married with three children. He started living with her as her husband but after having a child he went back to his previous wife. As Communist Marxist party insisted he did register the marriage but deserted her and later again with party insistence he gave her compensation. After this traumatic experience when the girl started going to the anganwadi for work he exploited her again and she gave birth to a second child. He started visiting the colony again during late evenings. One day, the entire colony caught hold of him and started beating him but immediately the party people and other non-Adivasis got involved and called the police to keep him safe in the police station. Next day he was released.

The Paniya community was furious about visiting Duni in the late evening. At the same time they were not against visiting her during the day time as he was supporting her for daily expenses when the children got sick and she had nobody else to depend on. Duni was infected with TB and she was undergoing treatment in 2009 (Field notes, March 2009). However, people who practised the values of sexual freedom are now forced to restrict their children due to the experiences of continuous exploitation and labelling by the same community who exploit them. According to them the reason for restriction was, “It can become a bad model to the younger generation in our colony” and I felt that it was
a typical non-Adivasi construction. It appears that these experiences contribute to their feeling of fear and alienation and affect their psychological and physical health in manifold ways.

With the influence of non-Adivasis, the freedom and support that Paniya women enjoyed in their natal family is reducing. For instance, Nimi from Kunnil colony reported that when she came back to her natal home leaving her husband’s house, her family insisted that she go back as their jenmi’s wife advised them to do so and she took poison to escape from their compulsion and scolding. She was hospitalised and after recovery they never insisted that she go back. The Paniya elders said that if a woman comes back to her own house leaving her husband, there was no stigma attached to it. With the influence of the non-Adivasis, the Paniyas too started worrying about a deserted woman’s stay in her natal home, adapting values from the dominant culture. And the suicide attempt reveals the mental trauma of the Paniya women undergoing these value conflicts.

On the contrary, the Kurichia community’s sexual restrictions were appreciated by their own community as well as by the non-Adivasis. However, in Kurichia tharavads if women break the sexual norms, they become outcasts and even very recently (in the year 2010) there was an incident of a woman from a Kurichia tharavad eloping with a person from another caste. They reported that this couple could not enter the tharavad again and that there would be no further support from the tharavad for their living. Even though this practise help to keep the Kurichia culture intact, it can create harmful effects including illness to the girl, her family and the community as peaceful coexistence is disturbed for a long period. The paradox is that severe restrictions on women seems to help Kurichia women from outside exploitation and Paniya women’s freedom makes them more vulnerable.

Before the age of marriage itself women undergo violence. Yarah, a student of Standard VI had a love affair and to escape the scolding from school teachers and from the dehumanising comments of her peers, she ran away with the boy even though she had not intended to marry so early. She came back after one year as her husband and father

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30 When teachers caught Yarah for her love affair, non Adivasi peers started teasing her saying, “We have studied in this school till Standard VII but nobody in this school has created such a bad reputation”.
in law harassed her after drinking alcohol and she was then three months pregnant. In between her haemoglobin went down to 3.8 but with blood transfusions she could survive. She was suffering from severe infection in the genital area and even passing urine was very painful to her. At the age of 15, she delivered a baby but the baby died after one and half months due to weakness and malnutrition. While undergoing the pain and trauma, she burned all the hospital documents and discharge sheets as a symbol of her anger towards the system which was insensitive to her and nobody at home could stop her from doing that. She was a very intelligent girl and expressed her desire to study but again she returned to her husband’s house, when the husband’s family members came over for a compromise. In 2010 she was pregnant again and had come back home to escape her husband and his family’s harassment. It appears that the pre-conceived norms about sexuality and sexual behaviour of the non-Adivasi community see the Paniya children’s sexual attractions and their free expressions as intolerable and in this case Yarah escaped the shame and control by running away from school. Her father became more addicted to alcohol with this incident and was irresponsible in family matters for a while. There was no person/institution that she could turn to for help.

Increasing alcoholism and drug use among Paniya men also affect their women’s health in manifold ways. Paniya women are victims of ill health and violence as their men spend their daily wage for alcohol instead of buying food items. Sexual exploitation and wife beating by Paniya men were reported by Paniya women. Thus, a double alienation is being faced by Paniya women which has serious health implications. In the case of the Paniyas, alcoholism destroy their values of special respect for women in their communities. One old woman, Thapi from Kunnil Paniya colony reported,

Even though we slept under trees in the past, we were peaceful. In recent times, men’s drinking habit has increased and women cannot even sleep peacefully.

The Adivasis were described as people who live in the culture of self sufficiency and thus had less anxiety about the future (Kalathil 2004). However, there were women among them who lived in constant anxiety as their men folk were addicted to alcohol. There were Paniya men who used ganja for momentary enjoyment leading to ill health and strife in the family. In one Paniya colony in the study area, women reported that non-Adivasis make money by selling illicit liquor and ganja in the colony. While women could prevent the man from selling liquor to the colony, they could not prevent the sale at his own
house, which was near their colony. However, selling ganja was more secretive and when women found it in their men’s shirt and pant pockets, they destroyed it. In Arayal colony, Ellan Mooppan reported that the Paniyas were preparing illicit liquor in the colony itself with the help of non-Adivasi people. The non-Adivasi perception in the area is that Paniyas will go for wage labour only to those employers who distribute alcohol at the work site. Unlike other Adivasi communities, the Paniyas do not have a culture of liquor consumption and the non-Adivasi migrants in the area started distributing it to them to exploit maximum work.

Women in all the Paniya colonies in the study area reported that Kodagu labour makes their men more and more addicted to alcohol since the employers distribute it in the workplace. In Kunnil, Raven an alcoholic brought three girls one after another and he did not look after them after having children. In such cases, the community gives some support but during pregnancy and the breast feeding stage they face various health problems. His first wife, Nimma lost five children and second wife Dhuni lost one child due to poor health and premature delivery. His third wife also lost her child during delivery and Raven’s family members and relatives reached her home and convinced her family members that Raven would not look after her. Now his first wife also went back to her natal house with her sixth girl child who survived. Dhuni, the one who is staying with him is unhealthy and she has two children. At times she was agitated towards her husband for not looking after them and for harassing her after drinking alcohol. However, Kurichia’s experience of alienation and addiction to alcohol was much less compared to that of the Paniyas. They prefer to go for wage labour in their own locality if there is dire need and keep away from Kodagu labour.

After knowing about the brutal treatment of labourers at Kodagu, opting for the same also indicates the alienation that Paniya people experience in their own locality. For instance, one youth in Arayal colony expressed that he would prefer to work in Kodagu to working in his locality. Paniya youth facing alienation and becoming addicted to alcohol is a common phenomena. Lampan from the Paniya community reported,

When I was a youth we used to gather in small groups and play thudi and dance and relax. But today we have no gatherings like that. Today Paniya youth drink alcohol and sometimes spend all night in watching TV and the community bond is diminishing among us.
As Lampan reported, various kinds of cultural alienation make their people alcoholics and drug addicts. Alcoholism has increased among the Paniyas especially among their youth due to the alienation and strife they face in the colonies and they become victims of physical and psychological illnesses due to addiction. According to a newspaper report,

‘Joggi, a native of Thirunelli, who recently returned from a ginger farm said that hooch packets reach the farms as early as six in the morning. Workers, both male and female, start the day at the farm with a pouch of hooch. Drunk always, they lose sense of time and thus they work without confining to a time schedule’ (The New Indian Express, December 8, 2008, page 5).

The traditional social organisations of the Paniyas and Kurichiyas are becoming weak, since the Mooppan and the religious functionaries are considered to be part of a ‘primitive culture’ according to the dominant cultural constructions; besides, they are becoming less acceptable to the youth. Paniya elders reported that their youth started disobeying their Mooppan. However, they learn through association and education that assimilation to the dominant cultural practices is considered part of modernity and progress. But it was observed that their traditional authority is not completely eroded in performing their cultural rites such as funeral, marriage and puberty rites. However, they are aware that they are alienated from their material, cultural and spiritual grounds by dispossession of the land and nature which was the base and binding force for centuries.

**Depletion of Food Sources, Change in Diet Practises and Loss of Health**

Whenever the Paniyas and Kurichias were asked about their health, they connected it with the availability of food and change in food consumption patterns. They affirmed that food is medicine more than any other medicines produced by pharmaceutical companies. They believe that through regulating food substances and by consuming pure food they can improve their health. According to Antony (1995) the food practises of Adivasis depend on their culture, ecology of the habitat and their income.

The Paniyas believe that their older members were healthier than the present generation and many elders among them stated that it was easy for them to carry 100 kilo sacks with ease when they were young. They explained that it was because of the type of food intake which itself was medicinal in the past. They had plenty of leafy vegetables, wild roots and fruits available in forests and common lands, which were not contaminated with chemicals and fertilisers. As a result, illness such as swelling of the body due to lack
of blood and anaemia were less compared to the present. If anybody suffered from due to swelling and lack of blood, they were provided with leafy vegetables such as *Vayalchully* (Hydrophyila Auriculata), *thazhuthama* (Boerrhavia Diffusa) and *thaal* (leafy stalk of colocasia) which are medicinal and very effective for healing. *Ponnamkanni* (Alternanthera sessilis) leaves, pumpkin leaves, *churli* (Diplasium esculantum) leaves, colocasia leaf and stem, *thakara* (Cassia tora) leaves, different varieties of *cheera* (Amaranthus dubius), bamboo shoots, bamboo seeds etc. were very common in their diet. In one colony they reported that they followed *ragi* (Eleusine indica, millet), *thina* (Setaria italica, a kind of millet) and *chama* (Paniculam sumatrease, a kind of millet) cultivation in the fallow lands available for cultivation and that supplemented their diet. However, they have lost their traditional food sources, which resulted in the deterioration of their health. Thanan Mooppan from Valli Paniya colony stated,

> During slavery we used to get paddy as wages and we husked the paddy and made rice gruel for dinner and what was left after dinner was given to the children the following morning. Whenever wild tubers, bamboo shoots, field crabs and fish were available, we used to add these to our meals. Pumpkin was plenty and we used to boil and eat it when there was no rice. Today we have to buy everything from the market and our younger generation prefers market items to tubers and leafy vegetables.

In complete contrast to the idea of Paniyas being the healthiest people during slavery and early independent period, during the field work they were found highly malnourished and susceptible to many illnesses (photo 23).

It was observed that during the lean season, the Paniyas may not have anything to eat the whole day. When they have money, they buy rice and fish, tomato or dal-gram from the market to prepare curry and if money is not enough then they eat rice with chilli and salt. Non vegetarian items are bought by Paniyas only when they have regular work. Once when two Paniya girls went to the paddy field to get some crabs to make curry to eat with rice, they found that their toil was futile. And they said that from the 1990s, crabs have become very rare in the paddy fields as paddy cultivation had changed to banana and ginger cultivation. Also their traditional sources of fish – ponds, streams and rivers, are alienated from them or do not give them any catch. According to a study by Aerthayil (2008), fish which is a major source of protein for people in Kerala is not affordable to the Adivasis in Wayanad in recent times. Vellan Vaidyan from Kurichia community said,
Adivasis were healthy as they ate wild food from forests and leafy vegetables from their surroundings. We have *Nadibalam* (physical stamina) because of the food we ate. If somebody hits me with a 50 kg weight nothing happens to me. Non Adivasis eat meat and bakery items excessively, which creates all kinds of illness.

The Kurichias also reported that their elderly people were very healthy and lived longer lives than the younger generation. The pharmacological analysis of the leafy and root vegetables they used in the past found the beneficial influence of cardiac protection, slowing down the aging process and prevention of diabetes mellitus (Mahadevan, Subramaniyam, Viswanathan 1995). The Kurichia elders too reported that their traditional food habits in the past were ‘pure’ and nutritious. *Ragi* (*Muthari*) was a common food item for them. The Kurichias reported that until the 1970s, they ate *ragi* at least once a day and for children *ragi* was used as a supplementary food from the second month onwards. A regular intake of *ragi* maintained their health and infant mortality was very less among them (ibid). Mahadevan et al (1995) observed that their healthy food habits might have contributed to the proper growth of elderly Kurichias, but the change in food habits may have adversely affected the health and longevity of the future generation.

According to Aiyappan and Mahadevan (1990) the discontinuation of *ragi* cultivation and its regular use severely affected the nutritional status and health of the Kurichias particularly in Wayanad as they used it as a staple diet for centuries.

*Ragi* cultivation was traditionally followed under shifting cultivation. They reported that fallow lands and forest lands were used for *ragi* cultivation but were not available after the new Forest Acts for conservation and land reforms here implemented during the 1960s and 1970s. The Kurichia women reported that their vegetable cultivation had reduced and *ragi* cultivation had stopped due to conversion of their remaining land into coffee, pepper, and cashew nut gardens. For the Kurichia community, this loss and change was not that drastic as majority of them had paddy fields and they continued to grow food for daily consumption. In all the four Kurichia settlements in the study area, they have stopped the habit of eating *ragi* and shifted to eating rice. In the study area, one *tharavad* continued the cultivation of *ragi* in a small patch of their paddy field till 2009 and in the other *tharavads* in the study area, they stopped it with the prohibition of *punam* (slash and burn) cultivation and privatisation of land and forests about two to three decades ago. The Kurichias were self reliant in growing food crops and unlike other communities, the Kurichias generally did not buy *ragi* even though it was available in the
market. One Kurichia ASHA worker working among their own people reported that ragi is rich in iron content and has less starch which protected them from illnesses like diabetes in the past, but diabetes patients were increasing among them from the last two decades.

The food habits of the Kurichias and Paniyas differ depending on their habitats, which has immense implications for their health. The general health of the Kurichias is reported to be better than that of the other Adivasi population in the area. The diet of the Kurichias contains more variety and richness compared to that of the Paniyas. However, they too explain the reason for their illness mainly in terms of the changes in their food habits and the use of ‘contaminated’ food items from the market. In the morning, they eat traditional dishes in Kerala like idly, dosa, puttu or kanji (rice gruel) with vegetables. They have seasonal supplementary items in their diet like tapioca, yam, elephant yam, colocasia and pulses cultivated in their own land. For lunch, generally they use boiled rice with vegetable curry, butter milk, pulses and fish according to the availability. For dinner, rice and vegetable curry is common among them. In tharavads as well as nuclear families, they work hard and eat sufficient food (three meals a day). However, during the field work period, blood pressure, diabetes, heart diseases, stroke, paralysis, and cancer were reported in their settlements. The Kurichias reported that tubers, fruits, milk, milk products and wild meat supplied them with plenty of vitamins and proteins, and after the 1970s, all these became rare in their diet, due to loss of cattle, grazing lands and forest lands when land got privatised and forests were reserved.

Today the Kurichias and Paniyas have started depending on the market for their daily food. While the Paniyas depend on the market almost totally due to the lack of land for growing vegetables and paddy self cultivation by the Kuruchias gives them better self sufficiency in food. However, both communities suffer from the loss of roots, tubers, wild fruits, honey, mushrooms and berries which were available in the forest and common lands. The Kurichias reported that they were non-vegetarians and wild bear, rabbits, birds and fish were common in their diet before independence and during the early period of independence. All the Kurichia elders interviewed claimed that hunting and eating wild meat was part of their culture and ritual practice which has stopped due to strict prohibition of hunting. Wild animals are no more a dependable source for their food and
this change also has implications for their health and nutrition. The Adivasis were well aware of the health issues and their interconnectedness with the broader social and ecological issues but they used the healthcare system as a quick remedy to deal with ill health.

**Experiences of Healthcare seeking**

Among Adivasis, the spectrum of healthcare varies between Allopathy, Ayurveda, herbal medicine, Adivasi medicine, ancestral worship and ritual healing. There were differences in their preference and actual use for a variety of reasons.

There were Paniyas and Kurichias in the study who reported that they preferred Ayurveda and Herbal treatment as it has similarities with their tradition and were not harmful to the body. However, majority of them opted for allopathic treatment expecting immediate cure which they needed as daily wage labourers or subsistent farmers. It was reported that for rheumatic complaints, majority of Kurichia women in the study area went to the Ayurvedic hospital for treatment as they work in their own paddy fields and cash crop gardens and they can afford rest and more time in the hospital, unlike the Paniya agricultural labourers who had to keep to the timings of the employer. Urha, a Paniya maintained,

Those who work to earn their everyday meal cannot afford Ayurveda and herbal medicine as it takes time to cure even though we have affinity towards that. Also Ayurveda hospitals have only few medicines in stock and other medicines are very costly and we have to buy them from outside. We know that ‘English medicine’ is harmful for our body but we go for it as it gives instant relief. We can take the medicine and go for work. But for small ailments like headache, toothache, urinary infection etc., we know effective herbal medicines and we treat ourselves without seeking help from English medicine.

The study by Centre of Excellence (2006) observed that the government hospitals were most favoured by the Adivasi population due to affordability as well as quality of healthcare, besides, occult practises are diminishing among them. Similarly, Dilip (2008) points out that for treatment of diseases like cancer and other tumours, Adivasis prefer government hospitals over private hospitals which are expensive and demand continuous visits and long stay. He opines that economic constraints are important in Adivasi
decision making and choice of hospitals. Similarly, the Paniyas and Kurichias in the study area reported that only people with a high economic status can afford private hospital for serious sickness which demands long stay. However, they said that their faith in the services of the PHCs and the district government hospital, especially in the general outpatient section is diminishing. If they have a choice, they even borrow money from neighbours and go to the doctor’s private clinic for better diagnosis and better care for ailments like fever, dysentery and scabies. One Kurichia from Champa settlement said,

It is better to get healed with one meeting instead of going many times. So if we have money we depend on private practise. Their timings are also suitable for us because during the day we work on our land. We are ready to pay if we get better treatment.

It appears that even Adivasis who perceived healing as a divine mission for centuries are forced to depend on the commercial hospitals competing for profit as they find the timings more suitable and it provides better personal care. However, the reality observed was that very few can afford the cost of a private hospital even in the case of one time consultancy for common illnesses. For serious illnesses which need hospitalisation and prolonged treatment, surgery and diagnostic tests, they cannot even think of going to a private hospital. Sarada, an Adivasi promoter appointed in the district hospital for helping Adivasi patients reported,

From my colony all are approaching the government hospital for treatment. Many of them prefer private hospitals but they have no money to pay. Most of them opt for hospital medicine as they want immediate healing as they are all wage labourers.

Ippy from Paniya colony said,

We prefer to go to the district government hospital as we get food three times a day. When I was young, there was no free provision of food and even though hospitalised, five of my children and my husband died from TB. There was no food to give them and I used to give them hot water from the tea shop in front of the hospital.

However, there are Kurichias and Paniyas who criticise these free provisions by saying that distribution of bread and rice gruel in hospitals will not help but they have to equip them to cook rice daily to become healthy. The Paniyas and Kurichias believe that as the treatment is free in government hospitals, the doctors provide minimum care. Also they

32 In Valli Paniya colony also it was observed that an eight year old boy got fever and they waited till evening for his father to bring the wages to take him to a private clinic. Meanwhile the child’s grandmother did the traditional healing of cleansing him. Water, silver coin and ash were used for cleansing and the grandmother acted as a shaman possessing the impurity in the sick body.
tested and reported that the free medicine they received from the hospital decayed faster than what they purchased from the medical shop. However, it appears that their choice for a different healthcare system was more practical and contextual rather than their degree of faith in each system.

**Material Factors Affecting Healthcare**

Factors like poverty, distance to the hospital, inconvenient hospital timings and lack of facility in PHCs to provide emergency care are constraints experienced by the Paniyas and Kurichias while seeking healthcare.

An anganwadi teacher in Kunnil Paniya colony said that a six month old child was very serious due to pneumonia and that with the help of an ASHA worker, the child was taken to the hospital at the last stage. When asked for the reason for not consulting the doctor early, Urha from Kunnil Paniya colony said,

> Many children were having Ancham pani (measles) and we thought this child also had the same problem and neglected the weakness in the beginning stages and her father did spiritual healing every day.

Since the anganwadi was close to the colony, the teacher reported the serious condition of the child to the ASHA worker and the child was taken to hospital. At the hospital, the doctor informed them that there was little chance of cure even if they took the child to the Medical College hospital. Then child’s father (Nellan from Kunnil colony), said ... “Give me the child. Let her die in my lap”. Even though the people gathered around him criticised him for inaction he explained his disposition later... “That time I did not have even 5 paisa with me. And the only possibility before me was that”. He was very clear that his action was not due to lack of interest in the child’s life but the acceptance of the inevitable, under conditions of extreme poverty.

However, the anganwadi teacher and the people around him collected some money and they were sent to the medical college in hospital ambulance. Nellan told me later,

> Even though the medicine and treatment is free in the medical college we have to pay for using toilet, bathroom, and hot water and to drink a cup of tea. Also when the child started recuperating she started asking for toys seeing the other children playing and I did not have money even to buy tea for her. There was no way to get some money to survive as my family members and relatives were also sick and some of them were admitted in the district hospital. Remembering how they had sent me to the medical college by collecting money
from the people in the hospital premises, I went out of the medical college and told everybody around that I had no money to survive till the child gets alright. Some people gave money and I managed there till the child was discharged. By that time my brothers could bring some money for us to go back even though they managed it with much difficulty.

This describes the plight of the Paniyas who depend entirely on wage labour to meet the expenses and of course he could not do follow up even though the doctor advised him to return after two weeks. The aid they get from the Government is not enough to meet the necessities if they do not have a material base to survive. In that family, there was only one girl of 18 years to fetch food for the entire family of ten members, as the mother who had an infant to breastfeed and the father who was physically weak were not able to go for wage labour. Their family is caught in a debt trap due to continuous health problems and the girl who dropped out in Standard VI was sent to a nearby panchayat for paid domestic work. Further, if the PHC staff or ASHA was vigilant they could have visited the village early when many children were infected with measles in the colony and the child could have been attended to early.

Even though the PHC was just 100 meters away from Arayal colony, the two wells in the colony were filled with waste thrown by children and they were not in a usable condition and no action was taken against this. A dead rat was found in a well, the water from which the colony people used for bathing and washing. Dhara, a Paniya woman said that they could not clean the well as they could not hire a pump to remove the water and that the non-Adivasi neighbours were not ready to lend their motor pump to the Paniyas. The other well was not used for drawing water by them but leaving it like that could lead to serious health problems (photo 24). Dhara reported that the public tap was also damaged for two weeks and they experienced scarcity of water. When I visited the colony in 2006, I found that there was no public tap and the scarcity was severe. The PHC field staff were unconnected with the life of the people, their feelings, their views about illness and treatment and reported that the Paniyas’ lack of cleanliness and alcoholism was the main reason for their sickness. This indicates that they attribute the responsibility of the sickness to the Paniyas without assessing the material, social and cultural context in which they live. However, this approach leads to lack of cooperation on the part of the Paniyas and their disregard for PHC healthcare services. In effect, the PHCs were unable to enthuse and elicit participation from the Paniyas as its functioning seemed irrelevant to
their basic health needs. It was observed that Paniyas do not demand for better care and most of the time it appeared that PHCs were thrusting healthcare on passive beneficiaries.

The absence of doctors in PHCs and their neglect of Adivasi patients, especially Paniyas, were also reported as reasons for the Paniya’s lack of interest in approaching PHCs. A pharmacist who worked in Arayal PHC reported that doctors were not ready to stay in the village and that they were not regular; in 2006, after 36 years of its functioning, one doctor was ready to stay there. In the absence of the doctor, the compounding only helped them in risky situations. It was also observed that when non-Adivasi staff were appointed in interior areas, they take long spells of leave and went home on grounds of familial responsibilities and more the lack of facility. During my three visits to the Arayal PHC on working days, the field staff meant for Arayal Paniya colony were on leave and when I enquired, the Adivasis said that she often took leave as her family stayed in another district.

Further, most of the PHCs lack the basic minimum facilities for attending to their recurring ailments. For instance, in Arayal PHC the pharmacist reported,

Treatment for tuberculosis was offered in PHC for a short period. The lab technician was transferred to a medical college in Alappuzha district without a replacement. Even the microscope was taken away from the PHC. The TB patients in this area have to travel a distance of 26 km to the district TB centre for a routine sputum examination. If TB checkup was introduced in that PHC, it would be of great help to the Paniyas who stayed in the PHCs as well as in interior places of Thirunelli. Even though DOT treatment was found helpful, there was no mechanism to control the spread of the disease in the thickly packed houses in the colonies. Late diagnosis and lack of facilities for hygienic practices, spread the disease to other colony members.33

The pharmacist who worked in Arayal PHC reported that when P.K Kalan, an Adiya Adivasi leader was the Block president they got a fund of Rs. 4 lakhs and used it immediately to set up a gynaecology ward in Arayal PHC. But it never functioned as the Government did not appoint a gynaecologist. An inpatient section needed repairs before it

33 The colony atmosphere is very congested and it is observed that sick people, children and others sit together to watch TV, as only one or two families owned a TV, which perhaps was the only source of entertainment for them. It was also observed that in the same way chicken pox, scabies, anchampany (measles) etc. spread to other children in the colony.
could be used. P.K Kalan said that he recognised the need to get pregnancy care in Arayal PHC for the Adivasi women in the interior areas of Thirunelly as the hospital was 26 km away. In an emergency, the Paniyas found it difficult to get a taxi to reach the pregnant women and serious patients to hospital as they may not be having ready cash to pay the taxi fare. However, the then Health Minister decided that there was no need for an inpatient section in the PHCs and did not appoint a gynaecologist. It appears that Adivasis are excluded even in the PHC services due to lack of political will to cater to their urgent needs like pregnancy care and facilities for delivery near their settlements. Even though the state exhorts women to have institutional deliveries, it does little to ensure that institutional facilities are accessible to pregnant Adivasi women.

Even though the economic condition of the Kurichias was relatively better and they were more vigilant in attending to their health needs than Paniyas, the distance to the government hospital and the lack of referral service in the PHC affected them. Swathy (35) from Thirunelli panchayat, Champa settlement said,

In August 2007, my mother (85) was taken to the PHC for pain in the legs and as she fell down while changing her clothes. With support she could walk to the PHC. She had high blood pressure and she used to take medicines regularly. The doctor gave her five tablets from his quarters and after taking the tablets my mother became weak and in the night she was paralysed and lost her ability to walk and talk.

Even though the case was serious, the doctor did not refer the patient to the district hospital. When they took her to their house for further checkup, his comment was “... let her lie down now, and you take care of her. She has looked after you for long. Now it is your turn to look after her...” This comment made them furious and they lost faith in the PHC doctor, and took her to the district hospital 26 km away. When they reached, the doctors in the district hospital could not do much as it was at the last stage. After 15 days of hospitalisation, she regained her speech partially but they could not cure the paralysis in her legs. Swathy said that they suspected the reason for paralysis was an overdose of medicine and carelessness on the part of the PHC doctor.

Even though the Allopathic system hegemonises the other systems with its universal cause effect relations, Adivasis still perceive the complex nature of health and illness. One retired post man from a Kurichia tharavad affected by stroke and recuperating with Allopathic medicine, daily practise yoga and control of food talked about their lifestyle...
changes and stress in life as causes of illness. He continuously spoke about the period of 
change to nuclear families and the stress they had undergone in their *tharavads* during 
property division among the *tharavad* members. There was no consensus among them as 
it was a sudden transition. The property laws favoured the nuclear family set up and thus 
the change to nuclear families was in a way forced on them. The existing joint families 
still face ongoing strife due to unsettled property divisions during the 1970s and that may 
have implications for their health too. The general sickness noticed among the Kurichias 
during field work were blood pressure, diabetes, heart problems and rheumatic 
complaints, which were not common among them till thirty to forty years back. The 
cultural alienation they had undergone was tremendous during their transition from joint 
families to nuclear families. However, in modern health institutions in Wayanad, the 
Paniya and Kurichiya culture, the historical transition they have undergone and their 
subjective experiences on health were not given importance. According to Good (1994: 
73), “the person is a cultural construct, a complex and culturally shaped way of 
experiencing self and other, and cultural “work” is required to reconstitute the person who 
is the object of medical attention”.

In PHCs, separate health records for Adivasis in general or for different groups of 
Adivasis like the Paniyas and Kurichias were not available as it was not demanded by the 
state government. As Haddad et al (2010) too point out the Paniyas, a particularly 
vulnerable tribe, due to their historical enslavement and their poor living conditions have 
greater health needs compared to other Adivasi groups in Wayanad but no distinction was 
made between Adivasi groups in social policy. Further, modern health services lack 
sensitivity to the experiences of diverse groups like the Paniyas and Kurichias and follow 
a mechanical approach that was conceived in the colonial past. Panickar and Soman (nd) 
argue that the difference in the socio economic level is related to the difference in health 
values, understanding and information concerning diseases, preventive planning, cultural 
expectations concerning health services and feelings of social distance between oneself 
and health practitioners. Rather than the socioeconomic factors, as Kleinman (1977) 
argues, culturally constructed health beliefs and practises affect the health seeking 
behaviour and the healing process of different cultural groups. However, understanding 
people’s subjective experiences of the structural and cultural factors are important in 
understanding their choices and health seeking behaviour.
**Object vs. Subject in Healthcare**

In the biomedical system, the patient becomes an object to be treated than a person to be explored with varied experiences of health and illness for correct diagnosis and treatment. Good (1994) highlights the objectification and commoditisation of health and human suffering in modern medicine and argues that within the life world of medicine, the body is newly constituted as a medical body, which is distinct from the bodies with which we interact in everyday life. He says that the anatomy lab is a site where the emergence of the body as a site of medical knowledge happens. Lawrence (1995) points out that the trend of objectification in medicine began with the development of science at the end of the eighteenth century and then progressively in the nineteenth century when disease was separated from the experience of the sufferer and relocated it in a system of thought about the human body based on the findings of pathological anatomy. Knowledge that was once embedded within everyday life experiences and their local setting is thus separated and subjected to the specialist’s development in modern system of medicine (Bury 1998). The development of the hospital was important in this process of objectification and as part of modernity, bedside medicine gave way to hospital medicine. Thus, treatment became mechanical and prescriptions were based on diagnosis at first glance as Badami (2011) points out. Nimma (30) from Kunnal colony went with her child for eye checkup when the doctor came to the village clinic. She reported,

After looking into the eyes of the child with a torch, the doctor scribbled something on the paper without a proper checkup. I did not give the medicine the doctor gave my child. I threw it when I came back home.

Nimma’s narration indicates her anger towards the doctor and the doctor’s indifference; he neither showed any personal attention nor took any effort to convince her about the child’s defect and the capacity of that medicine to heal. However, in the case of an illiterate Paniya, the written slip of paper to list the complaints, diagnosis and treatment further marginalises them as Badami (2011) points out. And giving a slip without proper explanation of the illness and treatment worsens the situation.

In contrast, Veena (18), a Paniya woman from Kunnal colony reported,

If I get a headache, my grandmother will do the healing for me. When grandmother touches me with her hand itself, I find relief. Unless I am very seriously ill, I do not like to go to the hospital.
Veena’s description shows how much she was emotionally attuned to the healer and the healing process in their cultural context. However, the doctor’s lack of attention and indifference is a very common complaint among Adivasis and they approach doctor’s private clinics and private hospitals expecting better treatment and at least minimum personal care. It appears that Adivasis did not believe in the magical capacity of the object called medicine and often complained that doctors do not take time for checkup especially in government hospitals and village clinics which offer free treatment for Adivasis. More than free treatment, they aspire for quality treatment from Government health institutions with proper care, attention and explanation about the details of the sickness. As Good (1994:71) points out, the world of medicine gets built up as a distinctive world of experience - a world filled with objects that simply are not part of our everyday world, and however, in this objectification process the subjective experiences and feelings are not given importance. The situation of Adivasis is worsened by the class and ethnic differences between them and the medical practitioners. Issues arising out of medical ideology on the one hand and the stratification systems on the other are at best perceived as arising out of lack of sensitivity or as attitudinal problems on the part of service providers.

One of the Assistant DMOs reported,

There is so much difficulty to give personalised attention to the Adivasis in government hospitals. Also there is lack of link between the PHC, CHC and District Hospitals. In the district hospital if there is a personalised link up system for the Adivasi patients they will not become strangers in the system. If their local doctor refers and informs the District hospital early, they will get special care and they will be happy. Otherwise, they are thrown here and there like a shuttle in the game of badminton. Also doctors are assigned to multiple programmes like immunisation camp, sterilisation camp, non-communicable disease camps, eye screening camps etc. Every month there will be 40 to 50 programs and the task is heavy. To create an Adivasi friendly atmosphere is not easy in an overloaded system like ours. Special management training has to be given to the staff to make changes in their attitude.

An NRHM officer in the district said,

If there is a personalised link up system through ASHA, PHC, doctors and specialists, the situation may improve. Now there is no warm relationship among them and Adivasi people may suffer due to unfamiliarity with the modern system. They do not know where to go and get things done in the hospital as well as accessing help from different institutions meant for them.

The objectivisation is perceived more acutely in reproductive health practices. The Adivasis who saw delivery as a part of lifecycle phenomena now started perceiving it as
an area that needs medical intervention due to complications which are unfamiliar to them to deal with and through the modern discourses on the importance of hospital delivery. Vellan vaidyan from Kurichia community reported,

Today caesarean operations are very common in delivery cases. During pregnancy, nutritious food and vitamin tablets are given in excess and the child’s head grows big and natural delivery become impossible. In our culture, we will not give meat or extra nourishment to pregnant ladies but they eat plenty of leafy vegetables as it is common in Adivasi culture. In the past, Adivasi women’s work included removing the husk of paddy grains by pounding with a wooden log (nellukuthal) and this help to make the hip area soft and flexible and help them for natural delivery. This also helps blood circulation and safe delivery. Modern medicine advises to take rest during pregnancy and there is a chance for complications and an increased number of operations have been reported in recent years. Before, there were not many complications reported among the Kurichias during delivery and that was due to our lifestyle and diet practises.

The Assistant DMO, admitted that prenatal, antenatal checkups and delivery have became high tech and there were incidents of gynaecologists behaving rudely with the patients and ASHA workers if they go to an ordinary doctor for an initial checkup instead of consulting specialists from the beginning. Devaki from Valli colony narrated an incident that had witnessed while she was admitted for delivery in the district hospital. ASHA workers brought three Paniya pregnant ladies from the village and they were waiting to see the gynaecologist. There were three gynaecologists on duty that day and they called all their regular patients for checkup. These Paniya ladies were standing in one corner and the doctors came and told them that they were not their patients and left without examining them. Even cases were reported by ASHA workers that they were scolded for bringing patients who were not registered for antenatal care.

Members of Paniya and Kurichia community reported that there were safe home deliveries till recent times (2000 to 2010 period) in their settlements. In a group discussion, Paniya women reported that they prefer home delivery but now majority of them fear chances of complication due to various health issues and they were forced to opt for a hospital delivery. From 2005 onwards there were no home deliveries among the Kurichia women in the study area and they said they preferred hospital delivery, as the risk during delivery has increased today and they attributed it mainly to the contaminated and poisonous food they use and lifestyle changes. They expressed there was less complication in the past during deliveries and many middle aged and old ladies among Kurichias and Paniyas stated that they came back from their work place and gave birth to
babies and that after delivery they returned to normal life within one month. For them delivery was an ordinary event and complications like anaemia, bleeding, low or high blood pressure were reported as common among Paniya and Kurichia women.

In recent times, obstetrics has became one of the most important areas for medical intervention and the medical system as a whole objectifies the phenomenon of delivery. The ASHA workers were instructed that there should not be any home delivery and that every delivery should take place in the hospital. The responsibility is placed on ASHA workers and instead of aiming at safe delivery, the health policies were trying to institutionalise delivery care fully through the services of the ASHA worker. Instead of promoting health with a holistic plan from the beginning of pregnancy, the healthcare program is confined to save the life of mother and child and reduce the infant mortality rate (IMR) and maternal mortality rate (MMR). Continuous weakness and ill health of the pregnant and breastfeeding mothers among the Paniyas were neglected in effect. Referring to such tendencies, Oakley (1980) argues that modern medicine increasingly ‘sequestrates’ childbirth from the everyday world of women and of lay practises and practitioners. She points out that the consequence is that the doctor-patient relationship dominates the women’s attitude and experience in pregnancy and the entire focus becomes the medical management of delivery.

Urha from the Paniya community stated,

After delivery, Paniya women are becoming very weak. After my delivery, I was hospitalised due to lack of blood and they could not do sterilisation due to weakness.

Urha asked her husband to undergo vasectomy but he was not ready for it fearing a health risk. However, the gender differences make the female body more vulnerable to modern medicine and obstetrics. In birth control methods, a clear gender division can be noticed among the Paniyas and the Kurichias. Even though the women were weak after delivery, men were not ready to undergo vasectomy. The hospital staff also advised the women to approach them after improving their health and ignore counselling their male partners to undergo vasectomy. In the case of Urha, before she could become healthy enough for the operation, she conceived the next child. During my last visit, she had given birth to her ninth child. This indicates the patriarchal values existing in the community as well as in
the medical field. These women who were medically unfit for tubectomy are found to be bearing several children.

Eva, another Paniya woman from Valli colony reported that her husband was ready to undergo vasectomy when he came to know that there was no health risk involved and that he could go for wage labour as usual. This indicates that awareness building and change in the patriarchal notions of medical institutions may lessen the gender disparity in sterilisation. However, perceiving the threat of Adivasi extinction, the government policy insists that the sterilisation operation can be done among Adivasis only after they had three children and after the second child was of age three. Generally, the Paniyas and Kurichias were found to be very pragmatic towards sterilisation. Pachan, a Paniyan from Richur settlement said,

Today we are not against sterilisation operation as we have no money to bring up more children. Three to four decades ago, we could fetch food items from forests and common lands and the children had only minimum needs and there was the possibility of bringing up ten to eleven children.

It was reported by the PHC staff and ASHA workers that prenatal and antenatal checkups were not done at regular intervals by Paniya women, but the Kurichia women were very regular. The Centre of Excellence (2006) study reports that prenatal medical checkups are not practised by about half of the respondents in their survey (213 out of 436) but they visit PHCs or government hospitals in case of sickness. Their study also reported that half of the cases of delivery among the Adivasis are not with the assistance of a doctor. In their survey, out of 404 delivery cases, 46 were assisted by the traditional midwife, 146 by relatives or friends, 194 by the doctor and 18 by nurse midwife. However, the appointment of ASHA workers was reported as a small relief but even they showed reluctance to follow up with Paniya pregnant ladies as they did not remember the correct dates of checkup and their due dates of delivery. If they failed to reach pregnant women to the hospital on time for delivery even after having taken them for the minimum three checkups and injections during the initial stage of pregnancy, they may even lose the small remuneration of Rs. 200 (at the beginning phase it was Rs. 600). One ASHA worker reported that to follow up a Paniya woman from the beginning of pregnancy till the end and reach her to the hospital for delivery was a very tedious job. In the case of Kurichias and non-Adivasis, they themselves take responsibility to go to the hospital on
time and there was no ‘risk’ for the ASHA worker. On the contrary, even the literate Paniyas find it difficult to remember the dates of the Last Menstrual Period (LMP) and due date of delivery. For them it was difficult to think chronologically as they follow nature’s cycle to remember the events rather than use a calendar.\(^{34}\) If a date is given to them for follow up meetings or awareness programmes, they seldom remember it. Again, the tendency of the system was to blame Paniya women, as extra efforts were needed to include them.

Even after the appointment of ASHA workers, there were Paniya women who did not receive essential and emergency obstetric care from skilled health workers. There were incidents of chronic weakness of mothers and infant deaths in the study area due to lack of timely assistance. For instance, in Knnil Paniya colony, Neena’s blood pressure suddenly increased when she was seven months pregnant and she was seriously ill when they reached her to the hospital. From the District hospital, she was referred to the Medical College at Calicut and she delivered two still births. Meena also became very weak and she took almost six months to recover. At times Paniya women meet with complications like sudden delivery at home or on the way to the hospital. Even during 2009, they reported incidents of still births as well as death of the child after delivery. In Knnil Paniya colony, one mother lost five of her children and for the sixth delivery when she reached the hospital, the doctor sent her back as there was time left for delivery. When she reached home she delivered and the child died.

Delivery was previously attended by traditional birth attendants from the Paniya and Kurichia communities. The Paniyas called them *eettukarathy* and the Kurichias called them *vetti*. *Eettukarathys* and *vettis* are becoming extinct today as hospitalisation is projected as a must by the state and allopathic medical institutions. However, Paniya women from the study area reported that if there is any complication, they find it difficult

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\(^{34}\) Even now calendars are rare in their houses. The Paniyas were not seen rushing to save time and money and I experienced it with other Adivasi groups also. While staying with an Adivasi family in Attappady, I saw that one child was seriously ill and I rushed to the hospital with the child and mother. We did not have enough money for the expense and eagerly waited for the child’s family to come. Somehow we managed the money in the hospital by giving the name of the organisation that we were in contact with. When the child’s family reached it was late evening and when we enquired they explained that on the way they found a rabbit, caught it and cooked it and came to the hospital. Neither the past nor the future holds any concern, but the timeless dimension, the present, is more alive in the Adivasi mind and it is against the capitalist culture of speed and progress.
to reach them to the hospital because taxi drivers were not ready to go with them as they have no guarantee about the payment of taxi charge immediately. Further, there were no trained midwives among them to attend to complicated cases and the babies were born without enough protection and care.

The two higher officials in the health field who were interviewed were aware that causes of illness among Adivasis were not well addressed in the health field. One official (The assistant DMO) reported that there was resistance from the Government to address the root causes of ill health and there was lack of political will to intervene in their health issues holistically. However, the Public Health Centers (PHCs), did not stress enough their lack of land, lack of clean water facility, lack of food availability, lack of space for proper sanitation and drainage system and lack of employment as major reasons for their ill health even though the concept of public health envisage intervention in all these areas. The PHC programmes remained at the superficial level and included the immunisation programme, family planning, distribution of iron and folic acid, other curative measures and awareness programmes. The Assistant DMO, Wayanad district criticised the depoliticisation of health and stressed the need for redistribution of resources and said,

Without an integrated approach to look into the multiple causes of their illness starting from nutritional deficiency, they could not improve their health status. Their land issue also has to be addressed for improving their health status and Kurichia people’s better health is due to their access to land and to the organic food items they produce. To improve the health status of the Adivasis, their general status has to be improved and for that a multipronged approach is needed. Those who are in power are not sensitive to look into this issue holistically and their preference is curative care than preventing illness among Adivasi communities.

There are health officials who agree that the material condition of the Paniyas and Kurichias has to be improved first for improvement in health. However, their perceptions still fall in the developmentalist perspective and they do not envision a pluralistic approach to health which promotes the modern as well as traditional systems according to the specific context. The health professionals still believe that modern medicine is superior and that the healing culture of the ‘other’ is backward and treat them as objects rather than subjects having a distinct language, culture, experiences and feelings. The experience of discrimination and violence faced by the Paniyas and Kurichias is another consequence of the processes of objectification.
Discrimination and Violence

There were incidents that even in the private clinics Paniyas were neglected and humiliated. An ASHA worker from Thavinjal panchayat reported that a Paniya family wanted to consult the gynaecologist at her private clinic expecting better care and they were scolded and sent back to the out patient department (OPD) in the government hospital. The pregnant Paniya woman wore a *chudidar* when she went for checkup and doctor mockingly said to her, “....you are fashionable enough to wear chudidar, but do not know to give answer to the questions I ask. Now it is time to remove the *chudidar*”. When the ASHA worker asked why she was not treated in the private clinic, the doctor said that they did not know the LMP and that it was risky to treat such patients in the private clinic. The ASHA worker also reported that the Paniyas generally did not remember the LMP and they were always scolded by the doctors for that. Even ASHA workers who were committed to their work, find it difficult, as they do not remember the date but they remember events according to the environmental calendar. For instance, even now they say “when paddy was plucked, while sowing the seed, when coffee seeds were plucked, during the last rain etc.” to denote the month of beginning of pregnancy and for a non-Adivasi ASHA worker it is difficult to calculate the date accordingly. The Kurichias, being more educated and market oriented than the Paniyas did not face it difficult to remember dates and going to the hospital on time. However, there were incidents of neglect and discrimination faced by the Kurichias too. Swathy, a Kurichiya woman from Champa settlement maintained,

I took my mother, a paralysed patient to the district hospital when puss formed due to catheterisation and the resultant restlessness. Since the doctor we consulted previously was on *Sabarimala* duty she waited for a long to get some assistance and care. The doctors did not checkup and according to some nurse’s advise, I went to the pay ward and gave fifty rupees to an assistant in a blue sari and brought her to remove the catheter and fix a new catheter. She was so angry when I called her and warned me, “Do not bring her again to this hospital”. I did not say anything to her thinking that I may have to go to the hospital again. I did not report this to my relatives who were waiting outside the room fearing the consequences. The catheter fell off after two days and I did not take her again to the hospital and preferred to clean the bed rather than listen to their insults.”

Krishna from Tulsi *tharavad* recounted his friend’s wife’s experience in the District Hospital. Since his friend had some ‘influence’ in the hospital he could get a pay ward for his wife. When she was admitted in a private room for delivery, a female Muslim doctor shouted at her for occupying a private room... “Why do you occupy this room? For
Adivasis there are general wards, why don’t you get admitted there? Oh you are Brahmins among Adivasis no?” When the Kurichia woman asked for water after delivery, she was scolded and was told, “chicken biriyani would be served for you instead of water”. Even though they felt deeply hurt, they were reluctant to fight with the doctors fearing their vulnerability at times of illness and delivery and future repercussions. However, the class and medical power that the medical system and the doctors hold is difficult to break through. Even the Kurichias being a comparatively powerful group among the Adivasis, they could not challenge the system or the doctor who misbehaved with them. The medical power, class, and ethnic background of the doctors are clearly reflected in their inhuman behaviour towards the Adivasis.

The discrimination is not only limited to the patients but also to the Adivasi employees in the health system. For instance Tribal Promoters are appointed in the government hospitals to help out the Adivasis. Though the work load is more for the Adivasi promoters working in the hospital they were paid only Rs. 2500 (recently increased to Rs.4000) like any other Adivasi promoter in the Tribal Development Department. And the other hospital staff, working in the same room doing almost similar duties got a better salary and other allowances. Despite this, they were used by the other non-Adivasi hospital staff for doing their duties such as writing slips for admission and giving passes for collecting patient’s free share of food. Further, officials of NRHM said that non-Adivasis were not ready to accept the Adivasi ASHA workers and sidelined them saying that they were not efficient. NRHM officials reported that to avoid this discrimination they have planned to call the Adivasi ASHA workers first to give them initial training before beginning the training officially. A non-Adivasi NRHM coordinator of the area said that Adivasi ASHA workers were not efficient. About Paniyas, the construction was worse and he said that if we appoint Paniya ASHA workers, they will not achieve the target. This stigma was reflected in the selection process. Out of 785 ASHA workers in Wayanad district, there were only 79 Adivasi ASHA workers constituting 14 Kurichia and 11 Paniya ASHA workers, and the remaining were from other Adivasi groups.35 Even though the Paniya community is the group that needed the most support to approach modern medical institutions, the number of ASHA workers was

35 Information obtained through RTI Act from the district NRHM office at Mananthavady.
fewer among them. In the four Paniya and four Kurichia settlements selected for study, there was one Kurichia ASHA worker and none from the Paniyas. However, we cannot deny the fact that the Government is providing free medicines, free mobile clinics and assistance in terms of money and the following section delineates the experience of the Adivasis regarding government aid and free services.

**Health Related Government Programmes**

Apart from hospital facilities there are different ways in which the state extends its healthcare support to Adivasis. For instance, there are health benefits in terms of grants from MLA fund, panchayat and tribal development offices for treating tribal patients in emergency cases. There are other health protection schemes like Janani Suraksha Yojana (JSY) which benefits Adivasi women. In government hospitals, there is free provision of medicine and food and an amount of Rs. 50 for attendants to Adivasi patients. As a recent development, mobile clinics are arranged for free checkup. The following section will look into their experiences in availing the support from the Government.

Kanni, a Paniya women from Kunnil colony reported,

> In our colony only two families received help from the MLA fund for health needs and they were party supporters. One among them is educated and she knows to read and write but she did not inform others early and therefore, we could not get the necessary certificate from the village office and reach on time when the minister came and distributed the money.

There was concern about Adivasi unity being destroyed by the divisible politics of the development programmes and its discrimination of benefits. The Paniyas and Kurichias complained that party leaders recommend only a few people among them who were party supporters for health benefits. However, meagre amounts like reimbursement of money for medicine and diagnostic tests are availed by the Paniyas and Kurichias occasionally if they get support for filling the application and approaching the respective offices.

Tulsi Kurichia *tharavad* in the study area reported that they had a say in deciding the beneficiaries for health or other welfare programmes as they have more than 100 voters who are connected to their *tharavadu* property and affiliated to the same political party and because they have representation in the panchayat. However, in general, the Kurichia community also reported that their socio-political institutions and the power of their traditional leadership were diminished due to the intervention of local panchayats and
most of the time they were not included in decisions regarding their health needs. Naran from Chathavari tharavad suggested that instead of party leaders and administrators deciding the beneficiaries for government grants, they should be entrusted to their own community leaders which will help maintain unity and a healthy relationship in the tharavad.

There were Paniya and Kurichia women in the study area who reported that they got Rs.1000 (it is reduced to Rs.700 in 2010) for delivery through Janani Suraksha Yojana (JSY) programme with the help of doctors and ASHA workers. At the same time, the Kurichias and Paniyas said in no uncertain terms that if they needed better care during a delivery, they had to meet the doctor privately and give money in advance. Krishna from Kurichia tharavad said,

For a delivery case we get better care and treatment if we give Rs. 2000 by meeting the doctor privately. We need care at that time. So we become ready to do that.

This indicates that the benefit they get from government is again reaching the well paid doctor through private practise. However, while visiting the district hospital to meet a Paniya patient from the study area, Chandhan, another Paniya patient’s relative reported... “Since my wife did not go to see the doctors privately for prenatal checkup the doctor hesitated even to recommend her for the JSY amount Rs. 1000 meant for Adivasis for delivery expense”. He told the doctor that he would lodge a complaint and thus forced the doctor to recommend and sign the application form.

They have different health benefit schemes from the panchayat even though they are the last ones to know about these benefits. But, the Paniyas and Kurichias who have experienced repeated rejection or inhuman behaviour from local panchayat institutions, were reluctant to seek help from local government and health institutions. Even though a clerk in the village office reported the possibility of support available for health needs from the village office, Chaman a Paniyan from Valli colony, whose legs were almost paralysed, hesitated to avail of medical help. Chaman reported his experience of continuous rejection,

The agent who sells lottery tickets in our colony informed me about the help from the Block office for few diseases like paralysis, cancer, etc. He recommended me to one congress block member for help by seeing me in this condition and the member asked me to approach the Block panchayat office. After trying a few times, my wife stopped going for help to the
block office as we have no money to go repeatedly. My wife studied up to Standard VIII and even then she found it difficult to access available help from the offices. Our people are wandering in the offices for help.

Chaman’s wife Birdha went with the application thrice, but she could not meet the member who promised help and dropped the idea of going again. Since Chaman was suffering from weakness and paralysis and was desperately seeking some treatment, I encouraged Birdha to come with me to the Block office once again. We met the member and enquired about the help promised by him and submitted the application and asked him to check for missing details. The ‘trip sheets’ for travel expense were not signed and he promised to do it for her and submit it later. He said that we could go and collect Rs.5000 within a week. Birdha went to the office after a week and she could not get any clear answer from the office and she returned. Again on enquiry, the Block member informed us that we could go and collect the money within a week. But when we reached, the member was not there and from the G.O section in the Block office we found out that the application was not selected on grounds that there was no BPL certificate and the ‘trip sheet’ was not signed even though the member promised to collect the missing documents and submit the application when we met him first. We insisted that we would not leave the office without getting it done and both of us sat on a bench in front of the Block president’s office. When a Kurichia panchayat member came, I asked him why the Adivasis met with difficulty when Adivasi leaders were there to support them. He communicated it to the president who was also a Kurichian. The president called me and enquired about the problem and promised that he would ask the member to do it immediately. We proceeded to the panchayat to get the BPL certificate and we had to find out the BPL number to fill the form to get the certificate. On enquiring, one panchayat member said that the ward wise BPL numbers were written on the registers kept on the table outside. When we checked, there were few papers of Ward IX list and the required number was not in those papers. Again, on inquiry, we came to know that by contacting the panchayat member of that Ward we will get the number and we had to wait for a long time to get it from him. After resubmitting the application and contacting the president and member, she could get the money after two more weeks.

Having been with Birdha to get this benefit, it was easy to understand why they hesitate to go to offices to seek help. She was a Standard VIII dropout and she knew how to read
and write. Despite this she did not know the procedure to get the BPL certificate. This became difficult for me as well since the records were not kept properly. This revealed the time, effort and support needed for Adivasis to access different schemes. It was noticed that nobody was there to give the complete information about this health support scheme to the Adivasis. Even though Chaman’s family support the CPI (M) party and the block member of that area was from the same party, he did not help him. It was possible that the Congress block member was reluctant to follow it up knowing that he was a CPI (M) supporter. It was observed that Chaman’s father-in-law was very cautious in negotiating party allegiance by trying to hide the financial help they received while talking with some left party people, so as not to lose the chance of meagre support from them in future.

During the interviews, it was also revealed that they were the last one’s to know about the programmes and policies which were supportive to them due to their alienation to the whole health system and the local panchayats. At the same time, it was surprising to hear raging comments from non-Adivasi friends about the extra benefits for Adivasis, especially the Paniyas, which supposedly makes them lazy, irresponsible and non-responsive to their demand for wage labour. However, suppressing information from the Adivasis is also an important exercise of power over them and they are deprived of even the health benefits especially meant for them. The appointment of two Adivasi promoters in 2008, one from the Paniya and another from the Kurichia community to help Adivasi people was an instant relief to the people approaching the district hospital at Mananthavady to know about the health benefits and the procedures to access them. They reported that it was difficult for them to reach out to all Adivasis as the needs were plenty and that they needed special attention as their culture was different, and as they were ignorant about the hospital system of medicine. However, they expressed that in a general hospital it becomes difficult to give them special care.

One illiterate Kurichian from Champa colony reported,

The Adivasis are wandering for help in Adivasi offices and Panchayat offices. They are treating us like insects and not concerned about our plight. It is a dehumanising experience to go for financial help.
Even though illiterate Kurichias reported difficulty in accessing help from tribal development and panchayat offices it was observed that Kurichias were far better in accessing help from the offices than Paniyas. During one visit to the Tribal Development Office, Mananthavady it was noticed that a Kurichian was helping out a Paniyan for accessing help for healthcare support.

Naran, a Kurichia elder from Chaampa colony reported that introducing mobile clinics and grants for treatment would not address their health problems holistically. He maintained,

> Even after continuously meeting the same doctor for a long time, sometimes we are not getting healed and in mobile clinics new doctors come and how can they diagnose and prescribe medicine within a second? It takes a long time for a doctor to find out the exact illness. More than conducting mobile clinics in our villages, we seek better care in government hospitals and PHCs. Doctors have to take time to understand the problem thoroughly instead of hurrying from one clinic to the other.

The treating of doctor as god and the symbolic power attributed to modern medicine is challenged by them. Badami (2011) also observes the practise of doctors hurrying from one clinic to the other as they have target to finish the assigned areas within one day. However, the Paniyas and Kurichias health culture of giving personal care to the patient without calculating the time and money was neglected by modern health institutions. Hurrying from one clinic to the other will defeat the purpose of arranging mobile clinics in the Adivasis own cultural set up, but if it is to understand the economic, socio-cultural and environmental factors that affect their health in deciding the treatment in consultation with the people and if it is to give them enough personal attention, it can be an alternate model.

Other than these benefits, the state runs many social protection schemes like old age pension, widow pension and agriculture workers pension. However, there were sick Paniya women in the study area who were eligible and yet not able to access those benefits during emergency. These schemes were not of much help to them as they did not know the procedures and when they accessed it through someone’s help, it became very late. They reported that even the Adivasi promoters were not giving them enough help to access these benefits and half of the eligible people were not accessing the benefit in the study area.
National and state policies have to play a major role in the alleviation of malnutrition and related health risks. The free provisions, social security measures and the distribution of food through the Integrated Child Development Scheme (ICDS) give them a small relief. However, these free provisions are not the remedy for addressing Adivasi’s marginalisation in health status. In *anganwadis*, there is food distribution of nutritional cereals, green gram and oil but it is limited to children, pregnant ladies and adolescents and this is the main programme to prevent nutrition deficiency. The health condition of the Paniyas described earlier shows that this is not enough to maintain a balanced diet. For the Kurichias, these provisions were reported as helpful to maintain their health as they have land, a minimum prerequisite for an Adivasi to maintain health and well-being even though they too lack access to forest and natural resources. However, broader policies affecting food prices, employment opportunities, resource depletion are more important than promotion of healthcare through institutions. As food patterns and health practises were very much connected with the culture and ecology, location specific and culture specific plans and programmes have to be formulated to meet the nutritional needs of different Adivasi communities like the Paniyas and Kurichias.

However, the only hospital for Adivasis in Wayanad which was established in 1994 was converted into a general hospital in 2007 as the Adivasi department was not able to run it properly due to lack of doctors and funds. Hence it was transferred to the health department, and NRHM provided more staff and the in-patient section started functioning. When it was under the tribal department, the in-patient section furnished in 1994 was unutilised and wild plants and birds occupied the ward when I visited it in 2006. However, the hospital staff was happy that it was converted into a general hospital. They reported that when it was under the tribal department, they were not able to provide enough doctors, nursing staff, medicine and other facilities. The staff working there were temporary and when the health department took it they were given permanent posting. However, the health department did not take initiative to maintain it as an Adivasi hospital and provide more facilities for Adivasis. There were five posts for doctors. Even after handing over to the health department, they had only one permanent doctor and one temporary doctor appointed by NRHM. There was no laboratory facility, a dire need for the Adivasis as there were many TB and sickle cell anaemia patients among them. The
staff reported that the in-patient section was again dysfunctional by the middle of 2011.\textsuperscript{36} However, taking away the only hospital which was specially allotted for Adivasis was discriminating instead of giving needed support from the health department to renovate the hospital with more preventive and promotive interventions in healthcare. This indicates the reluctance in using general health funds for the Adivasi cause giving all the responsibility to the Tribal Development Department which is not equipped with necessary personnel and infrastructure to run a hospital.

According to Rao and Sexton (2010), the neo-liberal approaches in health reduce the state’s commitment to health and neglect the structural factors that govern and shape health or the ecology of disease. According to them, the interventions are constrained by cost benefit considerations and thus the focus is on the delivery of single healthcare interventions that are not integrated with other health activities and thus incoherent and fragmented. They point out that the emphasis on medicine rather than food, depending on ORS to treat diarrhoea rather than emphasising on water supply and sanitation, focus on anaemia during pregnancy rather than anaemia in general are examples. Vertical health programmes like immunisation, control against tuberculosis and family planning were still found to be the main thrust of community health programmes. Even PHCs and government hospitals are found alien to them with their vertical health interventions without political interventions such as initiating redistribution of resources. The voices of Paniyas and Kurichias affirm that health cannot be equated only with healthcare facilities and free provisions. According to Zurbrigg (1984), the very concept of health came to be equated with ‘health care’ and is thus commoditised. However, it is a ‘reductionist view’ equating health with healthcare (Zurbrigg 1984) neglecting the structural issues, the specific cultures and voices of the people. It emerges that there is lack of initiative from the health personnel to incorporate the local health skills and traditional health practises and cultural specificities of Paniyas and Kurichias in healthcare. However, in spite of the lack of recognition of Adivasi healthcare practises by the dominant medical systems and the State, Adivasis continue practising their traditional medicine, which is delineated below.

\textsuperscript{36} There were also promises to make this Adivasi hospital into a research centre for cancer and sickle cell anaemia.
Paniyas and Kurichias and their Traditional Healing

Adivasis healthcare practises are far more complex as they have retained the Adivasi healing traditions while attempting to use the biomedical services both public and private. Health seeking is therefore deeply influenced by pragmatic considerations as well as the Adivasi cosmology of health constituted by physical, social, environmental and ancestral influences. Hence any member of the community cannot take up the practise of Adivasi vaidyam; they have to be chosen or approved by the ancestral ‘gods’. However, the traditional healing practices of the Adivasis are marginalised because they are constructed as ‘primitive’ and ‘superstitious’ and get minimum support from the Government unlike other systems of medicine. Aethayil (2008) reports that the traditional Adivasi medicine and treatment are fast disappearing in Wayanad except for curing minor illnesses and majority opt for allopathic treatment. However, in spite of lack of space to evolve, the Adivasi agency is visible in challenging the values of dominant systems of medicine utilising their limited chances of practicing traditional medicine and by documenting it.

According to Nair (2002), lifelong association is needed for learning the techniques of diagnosing illness, therapeutic recipes and its administration. He notes that only persons with good character and sound mind were instructed the recipes as they believe that giving medicine require personal character. A Kurichia vaidyan, Vellan from Thirunelly panchayat reported,

I learned vaidyam from my father and I did not get it in dream. According to our tradition, only those who can continue it with faith in god and who follow our traditions and values to keep it a sacred mission will be initiated into this traditional medicine. Among the four children in my family, I had a special interest to learn vaidyam. I had love and respect for the plants more than the other children had and my father sensed it. Even though I learnt and memorised the medicines, I started practising it only after my father’s death in accordance with our tradition.

However, these strict observances were lessened in rigour and Kurichia vaidyars reported that they give more importance to protect their knowledge by passing it on to their next generation. A Vellan vaidyan reported,

Now out of fear of losing our knowledge we started teaching more youngsters. The knowledge for this is passing on through oral tradition from one generation to another. We often take our children to the places where the herbs are available, make them collect it and learn the names and then use it for the relevant illness. They have to learn the colour, smell, thickness of the leaves etc. when they collect it as there is possibility of mistakes due to
similarity in appearance and difference in the quality and healing power of these herbs which can affect the patients very seriously. Also youngsters assist in the preparation as well as distribution of medicine. They learn through observation, prolonged assistance as well as through the oral communication during treatment by the *vaidyan*.

Marginal government support was reported by Kurichias for training and practising their *vaidyam*. Kurichia *vaidyans* attributed the credit to Viswanathan Nair, one of the previous directors of KIRTADS, for the support they received and after his retirement they experienced lack of further initiative. According to Nair (2002), the establishment of a certificate course in Adivasi medicine after the launching of the Centre for Tribal Medicine (CTM) in Valad, Wayanad helped the revival of Adivasi medicine in Kerala. State level healers workshops conducted from 1994 to 2002 also helped to revitalise Adivasi medicine. The training has stopped and Adivasi *vaidyars* hope that it continues and there will be new initiatives from the Government to support them.

Vellan *vaidyan* reported,

> Even though I got a certificate from the Government for practising Adivasi medicine I could not receive any other help from government to develop my centre. I rented a small room for treatment in Thirunelli as my house is not accessible to the patients especially during the rainy season. The room is very small and there is not enough facility and there are almost 100 patients daily visiting my healing centre. Some patients need a long stay and as there are no rooms available in Thirunelli, I managed to get few rooms on rent in Kattikulam, 16 km away from here. I do not take any fees for my service and patients keep their small contributions in a small basket. The Government used to give me a yearly grant of Rs. 7,500 from 1995 to 2002, and they have stopped even that meagre support.

Rajan *vaidyan* from Kurichia community reported that he has benefited from the CTM and the Certificate Course in Tribal Medicine (CCTM) initiated by KIRTADS in 1993. The Government recognised the centre in 1993 and today it has developed into a government sponsored registered society called Indian Indigenous People Service Society (IIPSS). Kurichiya *vaidyars* reported that even though state support was less for the promotion of tribal medicine, it survives and flourishes through popular support in the local context and the voluntary efforts of the people who experienced healing from such centres.

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37 Dr. Rajan from the Kurichia community is the secretary and Achappan Vaidyar, another Kurichian, is the President of IIPSS during the study period. Around 150 indigenous medicinal practitioners of Kerala are members. In the directory of Adivasi healers, there are 37 Kurichia healers and only 9 Paniya healers in Wayanad (Nair 2002).
The IIPSS received funds from state government to run a three year certificate course in Adivasi vaidyam from 2003 to 2006. Twenty students were selected for the course, five each from Palakkad, Idukki, Wayanad and Thiruvananthapuram districts. They selected students from Kurichia and Kuruma community in Wayanad, Kani from Thiruvananthapuram, Chola Naikkar from Attappady and Naikkar from Idukki. Paniyas were not included in this course even though there were practitioners among them and they form the majority population among the Adivasis in Wayanad. However, according to Rajan vaidyan, there were 37 popular healers among the Kurichias whereas there were only nine Paniya healers in Wayanad (see also Nair 2002). There were no further initiatives or support from the Government or other agencies to develop Adivasi medicine after the initiative taken by KIRTADS. However, all of the respondents from Kurichia and Paniya communities in the study area were of the opinion that their traditional healing practices should be accepted and promoted by the Government.

Referring to organisations that showcase Adivasi knowledge and art, Rajan Vaidyan challenged,

Why all are asking for our knowledge? Adivasikku Mannum pennum poyi (Adivasis lost their soil and their women). At least we want to protect our knowledge on traditional medicines and we started documenting it. What we expect from the Government and other organisations is their support to develop our knowledge and market it by ourselves so that it can be a source of income for our community and our unemployed youth.

For its efficiency and value of science, Rajan vaidyan suggested Adivasi medicine as an alternate model which can effectively challenge the commoditisation and profit motive in other systems of medicine. Rajan vaidyan stressed the need for documentation of their knowledge pointing out the possibility of other agencies acquiring Intellectual Property Right for tribal knowledge.

Rajan vaidyan however, appreciated the openness of Tropical Botanical Garden and Research Institute (TBGRI) in Kerala to share 50 percent of commercial return for the drug Jeevani with the Kani tribe as they produced it using the traditional knowledge and resource base of Kani Adivasis.\textsuperscript{38} He saw it as a recognition for Adivasi knowledge. Anuradha (1998) reports that the idea of profit sharing is a step forward, but highlighted

\textsuperscript{38} Jeevani is an anti stress drug produced by tropical botanical garden and research institute from a local plant using the indigenous knowledge of the Kani Adivasi group in Kerala (Anuradha 1998).
the objections raised by KIRTADS that Kanis have got an unfair deal and TBGRI did not involve Kani’s in the decision to give licence to the Arya Vaidya Pharmacy Coimbatore for a period of seven years fixing a licence fee of Rs. 10 lakh. According to KIRTADS, TBGRI should consider ways and means to impart technical knowhow to the Kanis to manufacture the drug and thereby involve them further in the process instead of agreeing for 2 per cent royalty from the laboratory and sharing 50 per cent of it with the Kanis. According to KIRTADS the only way Adivasi medicine can survive is by preserving its original form and premises, otherwise it can be appropriated as a convenient resource base for other systems of medicine (ibid).

Even without government support, Vellan vaidyan can continue his practise without commodifying it. Paniyas, Kurichias as well as non-Adivasis were happy with Thirunelli Vellan vaidyan’s treatment and appreciated him for holding on to the traditional value of not demanding money for treatment in the midst of commoditisation of health services. Vellan vaidyan reported that he accepts only free contributions by the patients according to their financial situation. One Paniya woman from Arayal colony recollected with gratitude that sensing her poor economic condition, the vaidyan offered her bus fare to them for going back to their village. Another Kurichia patient, Jayanthi (49) from Thirunelli panchayat mentioned that her cancer was completely cured by Vellan vaidyan when she had lost all hope in allopathic treatment. Her daughter Pasha said,

We were advised by allopathic doctors to go to the Medical College at Calicut twice a month for radiation and injections. During difficult times, we collected money from our neighbours and relatives to go to the medical college for treatment. We tried Ayurveda medicines also for a while to get some relief. At last when Vellan vaidyan agreed to heal my mother after checking the nadi (pulse) it was a great relief. He did not even take the full expense for the treatment sensing our difficulty but only received the small donations we gave. At present, doctors certify that my mother is completely cured.

There were Kurichias, Paniyas and non-Adivasis who resorted to Adivasi medicine when Allopathy and Ayurveda could not cure their sickness. They narrated stories of curing different kinds of allergies, paralysis, lumps on the body, kidney stone, tuberculosis, kidney stone, jaundice, ulcer, diabetes and piles. People in Thirunelli said that around 100 people from different areas approach the Vellan vaidyan every day even though he is practising vaidyam in a small rented room in Thirunelli town. People from other states also approach him for healing and he reported curing patients of cancer from Bangalore.
While Vellan vaidyan practised with minimum facilities, Rajan vaidyan could develop his centre more systematically with government support. Rajan vaidyan, the first rank holder of the three year course in CTM conducted by KIRTADS, could make use of the government support to develop his healing centre. In his centre, Adivasi medicines and different types of Ayurvedic massages were practised for curing patients from Adivasi community as well as non-Adivasi community. He was proud that 34 Adivasi families from Kurichia, Kuruma and Paniya community are working in his centre in various sections beginning from collecting herbs to making medicines and assisting him in healing and earning their livelihood. He has his own building for practising vaidyam and so could give training to his assistants. However, a health system based on Adivasi principles, customs and values can be developed as an alternate to the dominant models in the medical fields. The Adivasi vaidyam developed in Thirunelly by Vellan vaidyan, in Eachom by Rajan vaidyan in Valad by Achappan vaidyan, in Kaniyampetta by another Rajan vaidyan are examples of successful initiatives of Kurichiya community managing the entire process of patient care and medication. The minimum resource base of the Kurichias due to their landedness and their better relationship with the forest department helped them to preserve some of their knowledge and skill and to practise their traditional healing using herbs. While, Kurichias use more herbal medicines, the Paniyas give thrust to their traditional spiritual healing with minimum herbal medicines as their sources of collecting herbs are completely alienated today.

Nair (2002) divides the Adivasi illness causation beliefs into two categories, naturalistic and supernaturalistic. Naturalistic causes include food, social and environmental related and supernatural include mainly the spirit related causes. They do *daivam kanal* (literally mean seeing god) and other traditional ritual practices to please the god and to be relieved from illness. A healer can be a religious functionary but not the other way. The Paniyas call their healer *daivakkarar* (spirit medium communicating with god) and the Kurichias call them *komarakkarar* or *marunnukaran pooppan*. Panam

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39 One Kurichia tharavad in the study area reported that earlier they had good relationship with the forest officials and guards and they used to prepare wild meat for them when they go for hunting. As Kurichiyans were hunters the forest guards and officials made friendship with them to enjoy the delicacy of wild meat. Thirunelli Panchayat president’s father, a Kurichia karanaavar told in olden times forest guards used to go to their houses asking for *chutterachi* (meet fried in fire) and they used to treat them with wild meat and black coffee. This reveals that Kurichiyans have experienced more friendly relationship with the foresters. This historical background helps them even today to negotiate with forest guards.
nokkal (tossing coin) is a method used in the Paniya as well as in the Kurichia communities to check whether the ancestral deities are pleased for curing an illness. Cleansing of the body using different mediums such as different herbs, water, silver coin and ash are practised by the Adivasis. However, one Kurichian elder negated the possibility of healing diabetes, heart disease, blood pressure and environmentally induced diseases through their spiritual healing practices and said that these are related to the lifestyle and food habits, and that without changing these habits, healing becomes impossible.

Agaisnt the backdrop of their slave history, Paniyas developed more spiritual healing practices. *Nadugadhika*, the ritual healing practice of the Adiya community is written in a dramatic form by K.J Baby (1993), that depict exorcising the evil spirits which they daily confront through that ritual. However, today to confront the evils of ‘modern development’ they may have to search for more creative ways of spiritual healing practices as they initiated the ancestral worship and ‘daivamkanal’ in Muthanga by proclaiming ‘we are here to heal the environment which is spoilt by a paper company ......”. Similarly, Lawrence (2001:180) introduces the Amman cult of oracles to heal the injury, trauma and violence of military attacks in Sree Lanka. She observes that “the agency of the oracle centres upon dissolution of a previous sense of self and identification of the body self with the Amman”. Rajan vaidyan from Kurichia community expressed “the negative energy which is accumulated due to various reasons is removed through Adivasi spiritual healing practices”. However, their spiritual healing is not limited to physical and mental problems but social evils are also dealt with.

The Kurichias have the custom of *Koottam parchil* (asking pardon to each other) for removing their ill feelings among themselves and to reunite each member with the community before beginning their agricultural work, life cycle rituals and festivals. They reported that these were occasions for renewal and healing in their life and for good yield there should be unity with fellow beings, nature, the animals and tools they use for farming. In the case of Paniyas during their life cycle ritual ceremonies like puberty, marriage and death and other festivals like Vishu there is an important custom where the entire community come together for *thettu theerkkal* (getting rid of all their mistakes) ritual to negotiate with god and community to receive blessings from their ancestral gods.
Kurichia elders and youth are also seen in trance in their festivals conducted in the *tharavad* temples and believe that they are guided by supernatural powers possessing them to remove all the ills of the community and larger society. They perform martial arts which infuse deep faith in the community members.

Paniyas combine their spiritual healing with herbal healing and massages. Lavan Mooppan from Kunnil colony who treat ailments like headache, fever, toothache, allergy, sprain, body pain, family conflicts, conflict with neighbours and so on. He narrated one experience of healing a non-Adivasi patient,

A non-Adivasi woman was fearful to walk due to pain on her back and legs. Allopathy medicine was not effective. I healed her mainly using our traditional spiritual healing and by massaging with oil and applying herbal medicine. Even though they were grateful and gave me money for healing, they advised me to not reveal their identity as it may tarnish the patient’s social status and religion.

However, in the selected settlements there were no Paniya healers who practise *vaidyam* with a government certificate. They conveyed that lack of herbal medicine in their surroundings is a block to continue their healing effectively. It was observed that in the Paniya tradition there were healers who practise ‘energy healing’ and other rituals to heal people from their own community. Touching and pressing on pressure points, application of oil on affected parts, massaging, cleansing using silver coin, use of ash and water as cleaning agents, possessing the evil spirit in the sick body in a trance and giving positive energy by reciting *mantras* (chants) with rhythmic to and fro movements were observed as ways of healing practised by the Paniyas for ailments such as fever, headache etc. As Badami (2011:117) points out, the *pena pattu* (song of the spirit sung during death ritual) and the entire ritual after death is an agency which infuse healing to the Paniya community as it reinforces their culture and ‘breathes life into a community that is believed to be slowly dying’. However, Paniyas and Kurichias continue ancestor worship and healing practices through ancestor spirits through the mediation of spiritual functionaries among them even after a long period of cultural interaction with other groups and which affirms their cultural diversity.

Thosha from Valli colony was undergoing medication for a serious illness in the district hospital. Simultaneously they treated him using their traditional spiritual healing, herbs and also taken him to a non-Adivasi astrologer for prediction. Then they took him
to a private hospital and they suggested doing scanning and there they diagnosed liver cancer. They used all the available treatment, spiritual and medical to heal their illness according to the context. When it became very serious again they depended on spiritual healing by their own daivakkaran. It appears that Adivasi medical practices are plural and they try to understand the health problem holistically. Badami (2011) observes parallels between the rituals of Paniya spiritual healer and the medical encounter. When the Paniya healer gives prasadam or blessed food to facilitate the internalisation of the healing process the doctor prescribe medicine after the consultation ‘ritual’. He points out that these parallels facilitate the movement between ‘traditional’ and ‘modern’ forms of healing but the power relationship they encounter between the healer and patient in these systems are different. As Eder and Garcia pu (2003) observes the tradition and modern are not opposite poles and there is a tendency to consider these poles as historical reality rather than methodological constructions. It emerges that Adivasi culture is against universal models or universal cause effect relations like the western medical model which is centered around the antagonistic biological perception neglecting their culture and environment.

**Cultural Alienation and Exclusions**

Medical institutions are alienating people from their cultures and it is much more in the case of marginalised groups like Adivasis. In a study on indigenous Maya medicine in Guatemala, Eder and Garcia pu (2003) point out that in western medical practice, the patient is isolated from the family, normal environment, psychic and cosmic perception and place them in specialised institutions like hospitals or health centres. On the contrary, the indigenous Maya medicine places the patients in the cultural context and resolves their health problems in accordance to their cultural identity.

The organisation of hospital and other health facilities like PHCs and CHCs and the daily routines of healthcare did not suit the Adivasi culture, especially the Paniya culture. The CHCs, PHCs and rural dispensaries are envisioned to ensure increased accessibility to health services for the rural population and their participation and self reliance. PHCs are considered core institutions of the rural health service infrastructure but it was reported that Paniyas still experience alienation from such institutions and show indifference to services of PHC unless there was an emergency. One day while visiting
Arayal PHC one Paniya men was struggling with a stomach ache and the nurse gave an injection and asked him to rest for a while. But, immediately after the injection he was trying to get up from the bed and go back home.

Alienation of the health professionals from the Adivasis is cultural more than economic. Their complaints about Paniyas as ‘unhygienic’ and ‘illiterate’ reveal their distaste to treat the Paniyas. The field staff reported that community participation was less among Paniyas compared to Kurichias in PHC activities. However, Nayak and Babu (2003) point out that community participation is advocated as a main tool for attaining the WHO’s health for all goal by 2000 AD. They criticise the centralised, bureaucratic, over professionalised and the top down approach of the existing system which neglects the health problems of vulnerable sections like Adivasis.

Routine programmes such as immunisation and DOT treatment happen in the colony. It is also reported that there is no regular follow up of the field staff or ASHA worker from the PHCs that could have avoided many deaths related to pregnancy and ill health, such as the death of Yarah’s child one and half months after delivery, that was discussed earlier.

It is observed that there are long queues in front of the OPD in the government hospitals and doctors rush to finish the consultation within time. It is reported by people in the study area that majority of the doctors run private clinics after their duty in the hospital. The Paniyas and Kurichias expressed that after this long waiting doctors prescribe medicine without a proper checkup in the general OPD in government hospital. So most of them prefer to work for the day and by evening go to doctors private clinics with the money they earned expecting minimum care and patience from the doctors.

The Paniyas reported that in government hospitals even serious patients from their community were not attended to and sent for scanning to diagnose their sickness. Most of the cancer cases among Paniya communities were detected in the last stage due to lack of needed attention from government hospitals.

Bemi from Valli colony was suffering from chest pain, stomach pain, burning sensation in the stomach and lack of appetite. She was having severe stomach ache and vomiting when she ate food. She was consulting regularly and taking medicine from the district government hospital for six months from the OPD section. As there was no relief they went to a private
doctor for a checkup. Doctor advised scanning and a lump was found in the stomach and as she was very weak she was sent to the medical college for operation. In the medical college, they diagnosed cancer and since her liver was seriously affected they could not do the operation and she died within three months.

However, such incidents force Paniyas to go to doctor’s private clinics instead of going to the general OPD in the district hospital.

In the official narratives, there was emphasis on the low health seeking behaviour of the Paniyas. Lack of education, lack of information about health problems and superstition are pointed out as the reasons for neglecting modern medicine and its services. Anganwadi teachers and ASHA workers also reported that the Paniyas were reluctant to reveal their sickness unless they were very seriously ill and even pregnancy cases were not reported on time to the ASHA worker. PHCs reported that Paniyas were reluctant to do follow up but Kurichias were very prompt in follow up and taking medicine till they get completely cured. In awareness programmes too, the participation of the Paniyas was very low compared to that of the Kurichias. According to Mohindra et al (2006) the Paniyas show resignation to their situation and report better health in spite of their vulnerable health condition, which he attributes to their extreme deprivation and exclusion.

Even for very serious cases, the Paniyas did not rush to the casualty, but waited outside to be called and attended to by the hospital staff. Even in the case of life threatening diseases, they were not seen to panic and so to capture the seriousness of their condition and to save their lives, the doctors had to develop more sensitivity towards the Paniya culture. As the assistant District Medical Officer reported,

Paniyas and Kurichias approach the hospital when they are very serious and are not like the other non- Adivasi patients who approach the hospital even for a cold and cough. But in the OPD special care cannot be given to the Adivasis as there will be a lot of patients.

With many years of experience in the district hospital, the assistant DMO acknowledges that Adivasis internalise their illness as their tolerance level is higher than non-Adivasis. In general, it was observed that Adivasis were not reactive to their illness and they had enough tolerance at the face of illness and death. But this cultural specificity of Adivasis is not given importance by majority of the doctors and in the hospital wards also they were given least consideration as they do not pester them for care, or scream or make noise like the non-Adivasis if not attended to. Being an experienced person, the assistant
DMO recognised the Adivasi culture of seeking hospital facility only during emergency and the need to provide special care. However, Adivasi voices revealed that generally doctors are insensitive to their culture and thus their tolerance leads to further neglect and reproduction of inequality.

Majority of the hospital staff are reported to be insensitive to this cultural speciality of Adivasis. They usually complain about their etiquette and social relationship. Beginning from the security guard, the Hospital staffs’ sharing, revealed the cultural alienation, the Adivasis especially the Paniya community experience in the district government hospital. Security Guard reported,

For them it is difficult to approach us face to face. Paniya’s language and culture is different and they will not understand what we say. They mingle only with their own people. They have no cleanliness. Murukku (chewing betel leaves, tobacco leaves, pieces of arecanuts and lime) and spitting is their habit and the hospital premises become dirty. They will not keep the timing and there will be clash between us if we do not allow them to go inside during doctors ward visit. If we scold them for that some of them will shout at us and give complaint in the police station.

Paniya culture and mainly their language became a barrier in utilising the hospital facilities. Doctors, nurses and hospital watchmen at the gate often complain that the Paniyas did not understand and could not stick to their prescriptions and treatment, but the Kurichias responded more positively. What was observed was that the Paniyas find it difficult to explain their illness due to lack of fluency in Malayalam which is the medium of communication in hospitals in Kerala and that was an important cultural barrier especially for the Paniya elders. Naturally to diagnose their illness, it demanded more time and understanding from the doctor but generally they experienced negligence. The Kurichias are fluent in Malayalam except for the very old members and they were seen free and less fearful in the hospital atmosphere. However, to avail minimum facilities and benefits in biomedical services and to understand each other’s meaning, the Paniyas need minimum skills, which they lack.

The security’s narration revealed the extent of cultural alienation experienced by the Paniya community even in a government hospital which was meant for poor people. The lack of cultural space experienced by common people in the modern medical institutions was much more in the case of Adivasis, and especially in the Paniyas. Their habits, language and dress were not accepted by the common people and hospital staff and they
were generally described by hospital staff as unclean, illiterate and ignorant. It was observed that Paniyas were very often lost, both in the practical and metaphorical terms; they wandered in the modern medical institutions to find out x-ray, laboratory, scanning facility etc. since they could not read and were seen perplexed by the technology and the bureaucratic procedures. According to Barucha (2001) any illness involves an alienation from one’s normal self producing and uncomfortable sense of being entrapped in someone else’s body. One has to work through this alien body in order to reconnect to one’s own. According to him, this condition become scary when one falls ill in a foreign country where without knowing the language, gestures, or cultural codes, one could be doubly alienated from one’s own body, and from the environment itself. In the hospital situation, Adivasis especially Paniyas were observed in such a doubly alienated situation as they were not accustomed to the cultural codes and language of the non-Adivasis.

The voices of the Adivasis expose the insensitive approach of the health system towards their specific cultures, language and ways of survival. When the Paniyas are asked to follow the rules, they get annoyed and there were incidents of the Paniyas registering cases against the hospital guard for misbehaving with them. In another case, early morning a Paniya woman admitted in the district hospital disappeared without anybody’s notice. The Kurichias behaviour was reported as decent by the hospital guard, but even he admitted that the dominant culture attributes a lower status to Kurichias too as they fall in the category of Adivasis.

In Valli colony, Chaman was first admitted in the hospital for retention of urine, sudden onset of lower backache and weakness. First it was diagnosed as spinal meningitis and the treatment was started. Again with the recurrence of symptoms and weakness and numbness on both legs he was admitted and the diagnosis was recurrent myelitis and evolving neuro myelitis optica. Even though he had gone to the hospital when the symptoms started appearing, he could not be saved from the disability. Now he is having severe pain in the abdomen, sleeplessness, numbness on the legs, difficulty to urinate and his legs were partially paralysed and it was difficult to walk even with support. He needed medicine and his wife Birdha was hesitating to go to the hospital. She said,
I am afraid to go to the hospital. The Doctor will scold if I am not able to respond to him immediately. Even if we have to die, we do not feel like going to the hospital.

With continuous compulsion and accompaniment only she became ready to approach the doctor. Doctor was found impatient to listen even though there was only two patients left in the queue for consultation.

Prabhath, a Paniya Adivasi activist said that they need separate doctors and nurses in the government hospital to respond to their needs as they were neglected in the hospital. However, from the above descriptions, it was evident that the cultural alienation and neglect experienced by the Adivasis cannot be addressed by appointing a separate doctor for them but the Adivasi culture has to be absorbed into the entire medical system. Doctors have to acquire knowledge about what Adivasis believe and do about health and illness in their culture and treat them as subjects rather than objects. However, when the entire health system is seeing Adivasi culture as backward and their language and habits as low standard the inclination will be to force them to accept the dominant culture which is labelled as superior by the non-Adivasi health personnel.

Although for the Paniyas in Arayal, the PHC was next to their colony (100 meters away), they approach the PHC only in critical stages. Their relationship with doctors and nurses were not cordial and they did not approach them for minor ailments like other non-Adivasis and Kurichias. The Paniyas expressed that the whole compound was like a forest and they used its resources freely and when the PHC staff started staying in the compound, the Paniyas lost access to this land and its resources like jack fruit, mangoes, firewood etc. A pharmacist who worked for ten years in Arayal reported that the Paniyas used to pluck jackfruit and fetch other fruits and vegetables from PHC compound even after the hospital staff started staying in the compound. On the advice of the non-Adivasi land owner, the PHC staff tied a red ribbon on the tree and spread the news that it was dangerous to approach the tree as the old lab technician had hung himself eight years ago on that tree, and naturally Paniyas stayed away as they were frightened of evil forces. The Paniyas used this plot of land which was next to their colony as their own until the hospital staff occupied the land and took on its resources with the establishment of the PHC there. This indicates that the history of alienation is complex and is affected by present disparities and discrimination on the one hand, and varies according to each
specific context. In this case, the government servants who were appointed for the well-being of the Adivasis became a reason for lack of access to resources.

Also they reported that with the establishment of formal structures of governance like *Oorukootams* and local panchayats, and modern systems of medicine and law by the state, the Mooppan lost authority over the people on decisions regarding material, political and health problems. Bama Mooppathi from the Paniya community reported that even their *daivams* are depicted as lifeless and their belief system as superstition by dominant religions, especially by Pentecostal Churches and the converted Adivasis who were seen preaching the gospel. The complete negation of their systems and world views play a role in making Paniyas alcoholics and drug addicts and affect the community’s unity and social health.

It was observed that Kurichia Karanavars hold more power than the Paniya Mooppan in political decision making and conflict resolution as they have hold on the *tharavad* property, its membership and the local panchayats. However, there were educated youth among the Kurichias too, who disown their Karanavan and their eco spirituality and healing practices as it is depicted as primitive by dominant groups. For instance, Rameshan from a Kurichia nuclear family commented, “As a researcher it is interesting for you to study about our culture and it is easy for you to say that your customs are excellent. But we are the ones becoming museum pieces in front of others”. Thus, the social constructions of the dominant groups and their reproduction through various agencies further perpetuate their alienation. Adivasis challenge or at times perpetuate these constructions of primitivism forced upon their culture and healing practices.

In Wayanad, the folk medicine practised by Kurichias, especially Paniyas was being challenged due to diminishing sources of herbs as well as lack of support from the government. However, traditional treatment still exists among the Kurichias and their knowledge as traditional healers gained popularity in the study area, especially when they cured diseases which modern medicine fail to cure. The Paniyas also follow their traditional healing but have lost their vast knowledge due to lack of access to herbs when they lost their access to common lands and forests. The training given through IIPSS, the minimum remuneration given for a period of seven years by the government through KIRTADS and the better availability of herbs in their land helped the Kurichias to
continue their healing tradition. However, in the larger society, the Kurichia doctor is also considered an Adivasi medicinal practitioner who is deemed as less knowledgeable than his allopathic or Ayurvedic counterparts. Rajan vaidyan was well aware that the symbolic power they achieved through their traditional wisdom is limited to the local context and to their patients. Here it is relevant to refer to Good (1994) who points out that biomedicine is often given the credit of universal scientific account of the human body and illness and non-western and folk medical systems are regarded as systems of belief and discounted. However, this scientific rationality adversely affects the Adivasi folk medicine in Wayanad. While the dominant constructions of modern medicine alienate them from their culture and healing practices, the commercial trends destroy their wealth of herbs, clean and natural environment.

Vellan vaidyan commented on how commercial trends destroy their wealth of herbs and alienates them,

When the wage labourers collect herbs for Ayurveda companies they are not bothered about their regeneration. For instance, they collect kurumthotty (sida acuta) in the month of Kanni (Malayalam month falls in September mid October), the time of its flowering. When Adivasis collect kurumthotty they collect it in the month of Thulam (October mid to November), when the seeds start falling down and assure its regeneration. We love and respect the plants and with their permission we pluck it. We will not collect the plants after 6’o clock in the evening when the plants are asleep.

The indigenous cultures continuously offer a critique of the commercial culture of the modern institutions of healthcare. Vellan vaidyan also pointed out the local threat they face in practising indigenous medicine,

The tourism development in the area further increases the chances of destruction of herbs. The tourism project grabs all our lands by lavishly spending Rs. 1 lakh for one cent and there is no possibility of accessing a piece of land for the Adivasis or accessing a room for rent to practise indigenous medicine in this area. My patients are staying in a faraway place for completing the treatment as there is no facility in this area. The rent for a room is Rs. 3000 per day in the resorts and their consumeristic lifestyle erodes our culture of living with minimum comforts and protecting the natural resources for our livelihood.

Adivasi people sense the threat to their survival when they see a huge number of land brokers even in their interior small towns selling land at a high price just for resorts and real estate business, destroying the forests and agricultural lands around them. Vellan vaidyan said that still they have herbs in plenty on the hills and in the forest near his
house, but the future is unpredictable with the ever increasing number of resorts in that area.

Adivasis own critique is endorsed by various studies. Nair (1995) argues that the health of the Adivasis was affected by the loss of their habitat and incursion of other cultures. He points out that the communities whose natural habitat is less affected are healthier and they have space to continue their use of herbal medicine for healing. Nayak and Babu (2003) point out that the present day model of healthcare services in India has evolved over the last two centuries following the British model which ignored the indigenous belief systems, lifestyle and healthcare institutions and practices which worked as an organic unity. According to them, instead of integrating modern science and technology into the healing traditions and cultures that existed in India, a total shift has been made to a western system of medicine.

However, the agency of Adivasis recognised the need for incorporation of their values, culture and belief system and healing practices into the health system. As Daykin (1999) points out the concept of healthcare underlines the power and authority of the expert and professionals at the expense of recipients. According to Daykin, practises of control establish the authority of the knower by disciplining the subjectivities of the cared for. He suggests resisting this trend and introducing alternate approaches that celebrate difference and choice. While Adivasis gave importance to the whole person and his/her experience, bio medical constructs overemphasise professionalism and the health policies legitimise and institutionalise bio medical practises. However, the Adivasis became the worst victims of power and control in the medical field as their tolerance level is more and they keep silent at the face of suffering and control, fearing the practical consequences. Thus, modern medicine displaces the traditional medicine and is an integral part of state’s development agenda, it also marginalises the Adivasis from its healthcare services. However, the Adivasi world views and healing practices offer a critique to this western paradigm and its hegemonic interventions in the world of medicine through their epistemologies of pluriformity and context specificity. As Eder and Gracia pu (2003) observe, the Western paradigm rule the world of medicine through its hegemonic capitalist relations and it is transferred and reproduced through government norms which support this paradigm.
Development and Adivasi Health

State’s interventions in Adivasi health reveals that they have a biomedical and developmentalist perspective towards health and state initiated programmes mainly revolve around these perspectives in solving Adivasi health issues. Health is considered as an integral part of ‘development’ of a community in the modern development discourse. Better health is accepted as a very important determinant of development. Nandy and Viswanathan (1990) critically comment that today, development is not only a treatment of economic ills of society but ‘development of healing as a science’ has become an important component in the ideology of development. They criticise the modern discourse which projects the idea that development is no longer development unless it takes the benefit of modern medicine to the traditional underdeveloped parts of the society. However, Adivasis have a pluralistic and holistic approach to health and they critically analyze the state’s approaches which neglect the broader aspects of health and illness.

Fertilisers and Pesticides, a Threat to Health

Health is determined not only by the biological and physical fitness of the body but also by the surrounding external environment. Clean air, water and uncontaminated food ensure good health. The increased use of chemical fertilisers and pesticides in agriculture for increased production destroys the health of the people through contaminated food and poisonous air. A Kurichian elder from Tulsi tharavad was of the opinion that Herbs are not acting on our bodies anymore as we are consuming contaminated poisonous food. As we use anti venom for snake bite, poison only can act against poison and we go for modern medicine even though it is harmful as having side effects.

The Kurichias and Paniyas in the study area pointed out the ill effects of using chemical fertilisers and pesticides and they try to avoid the use of it. They reported that non tribal people use it in big quantities and it contaminates the air, water sources and leafy vegetables which the Kurichias and Paniyas also use and it affects their health. Jacob (2006) highlights the extensive spread of banana cultivation in the paddy fields of Wayanad and the increased use of chemicals and pesticides. In banana cultivation the seed itself is soaked in chemicals and at every stage in the growth of the sapling, heavy doses of pesticides are applied. He notes that when the flower emerges, the tip is cut and
chemical is directly applied to the cut to make the fruit heavier and larger. Tea plantations and other plantations on the hill sides also use huge quantities of chemicals.

A non-Adivasi school headmaster who earlier worked in Valad, Thavinjal panchayat reported that the number of cancer patients were increasing in that area due to extensive use of pesticides for banana cultivation and according to his study Valad area was the most affected place in the Thavinjal panchayat. However, the Kurichias in Valad area continue their paddy cultivation extensively except for small patches of banana cultivation and they avoid chemical fertilisers and pesticides as much as possible. Manjan from Tulsi tharavad in Thavinjal panchayat said, “We believe firmly that we are not supposed to do anything that hurts the earth”. He criticises harshly the use of ‘Timit’, DDT (Dichlorodiphenyl-Trichloroethane) etc. for cultivation as it is hazardous to health. He perceives that it can cause cancer and that it is very harmful to the digestive system. He attributed the less number of cancer cases among the Kurichias to their practise of self cultivation without using pesticides and chemicals and the use of homemade food items instead of market items. The Adivasi understanding is only articulated in scientific language in many studies. Bhatt (2000) affirms that the use of chemicals and pesticides can be harmful to health and the biohazardous compounds can act as endocrine disrupters that can cause infertility, menstrual irregularities, spontaneous abortions, birth defects, endometriosis and breast cancer. Further, he notes that women are at a greater risk than men, especially with the rise in environmental estrogens.

Naran from Chathavary tharavad mentioned that the government has not done anything to promote or develop the natural manures and pesticides that they have been using for centuries. He expressed the urgent need to move back to their traditional farming practises which was the secret of their health. He felt that the programmes of Krishi bhavan (Government Agricultural Department) were encouraging the use of chemical fertilisers and pesticides by supplying them at subsidised rates. Subsidies were given for buying fast growing hybrid seeds which required chemical fertilisers, pesticides and water in large quantities. However, the Kurichia’s traditional seed varieties which were resistant to pest attacks were partially replaced with hybrid varieties but they were conscious to use minimum chemical fertilisers and pesticides. The Paniyas were forced to
forage and procure food materials from non-Adivasis fields, and they became more vulnerable to the effects of chemical fertilisers and pesticides.

All of the Kurichia elders interviewed mentioned that an important cause of illness was the use of chemicals and pesticides and if the government controlled their use, part of the health problems would be solved. They suggested that government make strict laws to stop the malpractise of using pesticides. However, it is the state development policies which impose capitalist agriculture on marginalised communities with extensive use of chemicals and fertilisers which destroys their health as well as moral and spiritual relationship with nature and human beings and thus destroys the balance and well-being.

Ippi from Knnil colony reminded,

Be careful, when you collect leaves from paddy fields. In our neighbouring village called Tharuvana, Palliyal colony due to food poisoning the death of a four year old girl Manjitha happened after eating rice, and ponnamkanni leaves (a leaf variety extensively used by Paniya community) collected from paddy fields. Now we cannot eat even the leaves, which sustained our lives through generations. Kaumuti newspaper reported this incident ...two hours after consuming food the child started vomiting and had dysentery. They gave the child some medicines for vomiting and dysentery from a nearby medical shop, but the child died the same night. Next day, when their neighbours came to know about this they reported it in the nearby police station in Vellamunda. The police came and admitted three others who had eaten the food and were seriously affected in the district hospital in Mananthavady (see also Kaumuti newspaper February, 20, 2007, page 10, Calicut).

Further, they reported that many of the leaf varieties were destroyed with the new cultivation practices using chemicals and pesticides and they were afraid to collect them from the fields as they were contaminated with chemicals and pesticides.

In Chathavary tharavad, Naran from the Kurichia community said,

While working in the paddy field, I saw some ripe bananas in the neighbour’s garden and I ate it with tea. After some time, I experienced stomach ache that usually I do not feel while working. I told my neighbour that I ate the ripened bananas from his field and got a stomach ache. Then he revealed that he had applied hormones the previous day. With the application of hormones mixed with brandy to the banana bunch, they become big and shining and they fetch a better price. But it will cause harm to our stomach. Besides, the farmers use furadan to the banana flower which is harmful. We buy bananas from the market, how can we trust and give them to the children to eat?

Naran reported that there are Kurichias who use chemical fertilisers and pesticides but in lesser quantities compared to the non-Adivasi people. He reported that as he did not use
chemicals and pesticides for growing paddy, people from different areas come to buy paddy from his house. He reflected and said that when they had plenty of cattle they could produce and collect food items in plenty which were not contaminated by chemical fertilisers and pesticides and they were healthier. He criticised the profit motive of the non-Adivasi population who saved money for many generations by spoiling the earth and its resources and the health of the people which is the main asset of poor people.

Loss of Commons, Issues of Food Availability and Food Diversity

The introduction and promotion of cash crops through government policies reduced the extent of common lands and fallow lands that the Paniyas and Kurichias used for food crop cultivation as well as gathering purposes. This shift in crop pattern affected the Paniyas drastically as the employment opportunities became less in the cash crop sector. It also affected the poor among the Kurichias who go for wage labour as well as the subsistent farmers among them holding small plots of cash crop gardens. Also the spread of monoculture cash crops with the encouragement of government policies captured the commons used by the Paniyas and the Kurichias.

According to Fernandes (2006), the Common Property Resources (CPRs) were one of the main sources of nutrition and the basis of Adivasi economy and culture. Paniya and Kurichia leaders reported that their access to commons (not named as CPRs on an institutional basis) till the 1970s supported them for their survival, contributed to their socio-economic, cultural and spiritual well-being and enabled the healthy upbringing of their children. According to Shiva (1993), the dominant political formations structure how the knowledge about the commons is produced and circulated. Along with the power structures which control knowledge, Dietrich (1992) points out that the ecological and cultural crisis caused by a development model which is neo-colonial, capitalist, patriarchal and violently attacking the base for material and spiritual survival is destructive of both nature and culture. It appears that to improve the health and well-being of Adivasis, they have to reacquire their lost habitats, with their lost commons.

Further, as Fernandes (2006) points out, the women’s work outside the home was socially recognised as they were the main food gatherers and collectors of firewood. With the loss of CPRs from the British period onwards, the status of Adivasi women also
slowly eroded as they were unable to make an economic contribution to the family and that affected the health needs of the family as well (ibid). In Wayanad, women’s relatively high status in the Adivasi community depended on the resources they could access easily and the labour opportunities they had in the paddy fields. Several Paniya and Kurichia women said that now they would have to depend on men for their personal and family expenses and their freedom was diminishing with this economic dependence.

The destruction of nature not only destroyed their sources for survival but their vast knowledge about these resources has been systematically marginalised under the impact of modern science and development (Shiva 1988). Rasa, a Paniya woman said that her grandparents knew more than 80 varieties of leafy vegetables. Her mother used to mix different varieties of leafy vegetables they accessed from the surroundings and prepared *puzhukku* with pumpkin and *thoran* by mixing different leafy vegetables to make the food more wholesome till three to four decades ago. Rasa said that her mother used to add medicinal leaves also in the *upperi* to protect her children’s health. Rasa being a tribal promoter working in the district hospital added that their food practices in the past provided the minerals and vitamins needed for the body. With the loss of CPRs and access to forest resources and the conversion of large extents of paddy fields, the Adivasis have lost their knowledge base and are deprived of these sources to meet their family’s health needs as subsistent workers and gatherers.

In a group discussion, Paniya women said that their work load has doubled due to depletion of natural resources and even with a day’s toil they find it difficult to fetch firewood for the family and food materials for daily requirement as the land and forest around them was privatised. In the lean periods in the past, when they experienced scarcity, they could depend entirely on wild tubers, leafy vegetables and other resources from forest and common lands. Paniya women stated that today they solely depend on men for food materials during lean seasons of employment. Women and men spent only a meagre amount towards family expenses after spending the wage on alcohol and their entertainment. As a result, the nutritional status of the family and specially that of women and girls deteriorates as they are the last ones to eat after feeding the entire family. Antony (1995), in his study on Paniyas and Kurichias points out that the burden of poverty is most often borne by Adivasi women.
While going in a group to bathe in a stream, Urha a Paniya woman reported that the purampokku lands (commons) like the banks of the thodus (streams) and streams they used for fetching food items are now encroached by non-Adivasis and the space available to them is restricted to one or two kadavu (entrance to river/stream) for washing and taking a bath, which creates in them a feeling of total dispossession of nature’s gift which they had enjoyed freely. The Paniyas reported that earlier in the thodus near their colonies fish and leafy vegetables were plentiful and they freely made use of these resources. They even cultivated vegetables like brinjal and bitter gourd on the sides of the thodu. Now these patches are in private properties and not accessible. However, the thodus were relatively more accessible to Kurichia tharavads as their land and paddy fields are on the shore of these thudios, not only providing them direct access to fish and leafy vegetables but also a feeling of stewardship of nature’s resources. Kurichia nuclear families in the study area were also living as a cluster and they have paddy fields and ponds of their own and better accessibility to these resources than the Paniyas. Undernutrition due to alienation of resources makes the Paniyas unfit for work, which further worsens their means of livelihood. However, the common property resources of Adivasis has become private property now and the Adivasis, seen as trespassers, will be thrown out if they enter these private enclaves, no matter if it is for firewood, water or leafy vegetables. The feeling of alienation to their own surroundings as they were threatened while accessing the natural resources they had enjoyed earlier has affected their health and daily living than previous decades as all commons vanished with private occupations and forest conservation programmes; Paniyas become thieves if they entered the areas where they had moved freely. As Baviskar (2008) in her study on commons argues the material and symbolic values and meanings are inseperable in accessing and safeguarding the commons. The Adivasis in Wayanad not only have lost their resources for material existence but also their symbolic and cultural capital with the loss of access to commons and the bountiful nature around them.

In the study report on increasing suicides in Wayanad, Kurup (2007) points out that the large scale plantations and capitalist mode of production and production of cash crops for international market has made Wayanad a region of heavy economic activity and a significant foreign exchange earner for the country. However, the transnational movement of raw materials and capital affect the Adivasis most as they are subsistent workers and
still depend on natural resources for their survival. Further, agricultural policies aligned to
the market ignore the food needs of the Adivasi people and alienate them from their
livelihoods as they primarily cater to capitalist needs. According to Baviskar (2008), the
importance of managing plant species to assure a cost effective orderly supply of raw
material for industrial production led to the creation of new knowledge in managing the
commons and the decisions are inseparable from power regimes.

PDS System and the Adivasis

The government PDS system meant to ensure basic nutritional requirements of the poor
covers neither the Adivasi group nor their basic food requirements. Rice is the staple diet
of the Adivasis and the open market price is not affordable to the low income groups.
Savan from Paniya community reported,

The rise in the market price of rice affected us drastically and that is one reason for our
increased misery in recent years. The ration system is not helpful always. When we have
money, there is no stock of rice in the ration shop. In the colony, many of us have APL cards
even now. They say that it will be changed soon but till now (2010) they have not changed it.
Also in some families there were eight to nine members and what we will do with the weekly
ration of 8 kg of rice? Even though the government promises rice for Rs. 2, only BPL card
holders get it for Rs. 2. Even if we get the rice for Rs. 2 we have to spend a minimum of
Rs. 20 to Rs. 40 for preparing some curry to eat with. Many times we have eaten rice with
salt and during the lean season of employment, we eat only once a day.

In the Paniya settlements, it is noticed that the ration they buy only suffices for three or
four days as they have no other supplementary food items like tapioca, yam, colacasia and
vegetables and for the rest of the days they have to buy rice at the market price, which is
not affordable to them.

An Adivasi promoter reported that in Arayal Paniya colony, out of 42 families only
31 families had ration cards and among these nine families had Above the Poverty Line
(APL) cards and 22 families had Below the Poverty Line (BPL) cards (data collected in
2009) and all families were living in a pathetic situation of poverty and ill health. It meant
that nearly 50 per cent of them were excluded from this benefit. The nine families with
APL cards are very poor depending only on wage labour which is seasonal. When I

40 Paniyas reported that they are getting ration for 2 rupees/kg for BPLs and for APL card if they provide
a letter from their panchayat member in the year 2011; in 2012 they get ration rice for 1 rupee/kg. But still
Paniya’s and Kurichia’s APL cards were not changed to BPL cards and for APL cards they distribute only
5kg rice in a month for 1 rupee.
enquired at the PDS supply office about including them in the APL list, they explained that for each ward there was a stipulated number of BPL cards and if those were filled, they could not supply more BPL cards. The revision of the BPL list and the promise to include all the Adivasis in the BPL list has not materialised till 2011. The Adivasis expected that they would be included in the BPL list during the renewal of ration cards, but there was no change when they received the new cards. If they were included in the APL, there was no way for them to change it. This shows the failure of the state to address the needs of the Adivasis. The Kurichias are in a better position in accessing the BPL cards compared to the Paniyas but there were cases of APL card holders among them too. It was reported in *Malayala Manorama* (accessed on Monday, July 23, 2007) that in the 296 ration shops in Wayanad district, there were 12,000 [11,343 - according to the data from district supply office collected through RTI in 2008 by Neethivedi, an NGO at Kalpetta] Adivasi families with APL cards. They also reported that in Mulanchira and Ullilam Paniya colonies there were more than 30 APL cards, but they are not government job holders or landowners. This indicates the narrow targeting introduced as part of liberalisation and the need for policy reforms in this area of development.

Ramakrishnan (2008) reported that there were Adivasis with BPL cards buying rice from the ration shop for Rs. 9 instead of Rs. 3 due to their ignorance and the ration shop owner made a profit by cheating the Adivasis. The Paniyas in the study area reported incidents where the ration shop owner told them that the stock was over, thereby depriving them of their share of ration and forcing them to buy rice from the open market at Rs. 25 per kg. Awareness programmes conducted by *Neethivedi*, helped the Paniyas in a few colonies to understand the government provisions and corruption by ration dealers. This corruption is not limited to Wayanad as is well-known. For instance, it is reported that in the last three years, Rs. 31,585.98 crore worth of wheat and rice meant for the poorest was siphoned off from the public distribution system into the market illegally (*Times of India*, September 17, 2007, page 1, Mumbai).

However, till now the government has not fulfilled the promise of including all the Adivasis in the BPL list as it demands supply of more foodgrains. The Paniyas reported that among those who are staying in one house, one has APL and the other has BPL cards and they laughed at the inconsistency in the APL/BPL division. According to Jacob
(2006), it is difficult to find a single person in good health in the Adivasi colonies and the occasional free and price controlled food rations are not the solution to meet their basic needs. According to him, what is needed is not medicine but good living conditions and resource distribution for a better living. Antony (1995) points out that before the drastic changes in the economy of Wayanad, Paniyas food habits were closely tied up with the rhythm of the seasons and farming operations, but now they are tied up with irregular and seasonal employment opportunities and market fluctuations. However, the landless Paniyas met with the double threat of increase in prices of essential commodities and decrease in employment opportunities due to the change from rice cultivation to plantation culture.

Changing Cultivation and Availability of Water

In Thirunelli panchayat, many Adivasi hamlets reported that they were suffering from water scarcity. Local people and Kurichia elders reported that due to eucalyptus and teak plantations, the flow of water in natural sources like streams, wells and ponds in that area decreased and became dry during the summer. Shiva (1983) points out that eucalyptus cultivation is water intensive and reduces water availability for other species, reduces soil moisture, preventing the recharge of ground water and reduces local water tables. She argues that the introduction of such species will destroy the hydrological balance of such areas and contribute to increasing aridity, soil erosion and desertification.

The Kurichia and Paniya people in the study area criticise the claim of forest officials about their scientific knowledge in social forestry and forest management, which according to them has destroyed their environment and water sources. They said there was continuous low intensity rainfall for six months in Wayanad before the heavy rain fall. Now instead, low intensity rain for longer periods, and pouring rain and wind for a short period from June to August is a common phenomena and the streams, which had plenty of water earlier are now drying. However, the eucalyptus plantations which account for less than 1 per cent of the total plantation in 1960 in Kerala rapidly increased to 25 per cent by 1982 (Savur 2003). Savur points out that this rapid increase is due to the National Commission of Agriculture, set up by the government which recommended strengthening forest based industries with forestry. Overexploitation of nature and its resources in the name of development made water scarcity real in the study area. Lack of
water has deteriorated their health conditions with recurring infections and overcrowded living conditions leading to a cycle of infections, which become handy in reinforcing the non Adivasi perceptions of their being “unhygienic” and primitive in their habits. Thus, the Adivasis who depended on common sources of water, paid the cost of development. Besides, water scarcity is constructed by private agencies and the government to get sanctions for big projects like Jalanidhi and Giridhara.41

**Jalanidhi and Giridhara**

When I visited Thirunelli panchayat office at Kattikkulam, in 2007, the area was celebrating the victory of the Jalanidhi project funded by Oiska international for reaching water to the interior areas of Thirunelli panchayat. After four years, while visiting the villages for field work, people complained that the Jalanidhi water tanks were drying up and that there was no water supply after spending huge amounts of money. Duni from Champa Kurichia community reported that through the Jalanidhi project, they received water only for one and half years and after that there were complaints such as, “the pipe is broken”, “the motor is spoiled” or “the operator has not been paid” and so on. Nippan, from the Kurichia community showed an empty tank near his property, which promised water for 139 families in his locality (photo 25) by pumping water from the main tank at Thirunelli. He criticised the idea of making a huge tank for the entire area in an interior place without having the infrastructure to repair the damages of the huge machines used for pumping water to the entire area and preferred small local initiatives.

The Giridhara project was exclusively meant for Adivasis but the planning and implementation was totally top down and one Paniya as well as one Kurichia family reported that they were compelled to build the tanks even though they had other sources for water, and they were threatened, “If you reject this fund you will not get other funds”. However, forcing development on them without respecting their need or cultural specificities is seen as a total failure. The Paniya family said , “The tank has taken the major portion of our small yard and it is a nuisance to us. When we have well water, why

41 Jalanidhi is a rural water supply and sanitation project by Kearala government which is partly funded by World Bank. Giridhara is a Water project in Kerala for supply of drinking water to the Adivasi areas.
will we use rainwater stored in tanks?” However, in the same colony, another cluster of families experienced real water scarcity and their tank was not completed and was dysfunctional (photo 26). One Adivasi who was involved in the Giridhara project told me secretly, “It was not successful as envisioned and in many colonies mosquitos are laying eggs in the tanks and if Adivasis go to the court, the court may order its demolition”.

In all the Paniya settlements selected for in-depth study, they reported water scarcity especially in the summer. When the health personal attributed the ill health of the Paniyas to their lack of cleanliness, they did not mention the lack of potable water facilities in these settlements. However, according to the target oriented biomedical approach, this responsibility did not fall under the responsibility of the PHC or other state health departments. As the Adivasi leader Janu rightly complains, without giving drinking water and a place to stand up straight, the image of an unclean people was being created about the Adivasis (Bhaskaran 2004). In a group discussion, a Paniya from Kunnil colony reported,

We were depending on our neighbours for a long period for drinking water. In 2009, after continuous complaints, the panchayat sanctioned a tube well for drinking water facility. We were drawing water from the tube well using a bucket and it was taxing for our women and children. When the elders go for work, our children draw water from the tube well using a bucket and they get chest pain. The bucket fell into the tube well three times and now it is not possible to draw water from it and again we depend on our neighbours for water. Our neighbours are not happy to give water from their private wells and we experience scarcity. The Government built a water tank almost 15 years ago, but do not allow us to pump water on grounds that we did not pay the electricity charge. For rainwater harvesting, the Giridhara project built tanks and in this colony two tanks are not completed and not usable. Children throw waste into it and mosquitoes breed.

It was surprising to observe that the Adivasis had to draw water from the tube well with a bucket (photo 27) and it was a very difficult task when I tried to do so. Women sought the help of men when they became tired. Paniya elders reported that there were enough water sources like ponds, streams and kenis (small traditional wells made using panamkutty – Palmira stems) for their use till three to four decades ago. All those traditional sources have vanished with the new development planning. The Paniyas said that taking water from a non-Adivasi well or pond was not restricted till two decades ago. However, with increasing development interventions, the social relations have changed and sharing of well water has become a favour and a liability. Also the latrines in their colonies are unclean and not usable as there are insufficient water facilities. Here, we see that the
government policies are not in tune with their cultural milieu. Their traditional and clean water sources were destroyed in the development process and the new sources are not providing them enough water for a healthy and clean life.

A few Kurichia youth in Thrissilery, Thirunelli panchayat maintained that as a result of three rounds of eucalyptus plantation, their water resources had dried up. In spite of the protest of the people in Thrissilery, the forest department has decided to continue with the eucalyptus plantation after its third cutting (last rotation) in the Thrissilery section of north Wayanad forest division. They reported that the water flowing from that particular area of forest was meeting the drinking water needs of 1600 families and watershed for cultivating 800 acres of paddy fields near the forest earlier. However, they reported that forest department officials were moving forward with the idea of planting eucalyptus again as it was a government decision. The Paniya and Kurichia communities in Thirunelly reported that their natural water sources dried up in many areas and the alternative sources were not effectively addressing the water scarcity. In Janu’s words, “We who dug the earth and found water at will are now reduced to agitating for drinking water supplied through pipes” (Bhaskaran 2004: 47).

Further, with the conversion of paddy fields, the common ponds used by the Adivasis have been destroyed. In the remaining paddy fields, paddy cultivation has been converted into banana cultivation which dried up the water sources. Mehta (2008) points out that water scarcity is not natural, but created through anthropogenic interventions, resulting from bad water management and land use practices. As she argues, scarcity is both real and constructed, sometimes constructed through political and policy processes. According to her, scarcity was earlier accepted as a fact of life that affected everybody more or less equally, but with modern development interventions, it affects the poor and marginalised and creates social differentiation.

**Marginality, Resistance and Sustained Critique**

The voices and experience of people suggests that the improvement in the health condition in the Adivasi areas can be achieved only through a comprehensive approach which includes their understanding health and illness and the culture of healthcare and healing. Thus, issues related to health cannot be managed by the health system alone but
through political intervention of distribution of land and access to natural resources which was the essential basis of the Adivasi community, and which has to be addressed as the first prerequisite for their health. Jacob (2006) stresses the importance of land and points out that the destruction of the environment and its resultant ill effects are more crucial to those who do not have means of subsistence and thus explains the better health status of the Kurichias compared to that of the Paniyas. However, a radical transformation in the state policies is necessary to address the issues in the agrarian sector and the resultant deterioration of nature and unemployment of Paniyas and the lack of profit for agriculture in the case of farmers like the Kurichias. The study by the Centre of Excellence (2006) has pointed out the decline of paddy cultivation, crash in prices of cash crops and the resultant unemployment of the Paniya community. As Kurup (2007) points out, the governmental policy of agricultural pricing adversely affected the paddy cultivators and resulted in large scale conversion of wetlands to garden lands. Paddy fields, common lands and forest lands, which were store houses of Adivasi food items were destroyed and today they cannot rely on them for their employment and sustenance and this has marginalised the Adivasis and affected their health drastically. The subsistence economies and the ecological balance of the region were affected through capitalist agriculture and the aid policies for development, which further destroyed their local resources for a healthy life.

A sustained critique against the State and its policies is emerging in the voices of the Paniyas and the Kurichias as there is a wide gap between Adivasi world views and state perceptions. Ellan Mooppan from Arayal colony said,

Those eucalyptus and teak trees planted by the foresters dried our water sources and now the government is asking us to pay for water. I will not pay for water. We have never paid for water in our lifetime. I told the *jalanidhi* officers that if I have to pay for water, there is no need to fit the pipe in my yard. But they have installed it. Since I did not pay the money I have no water in that tap.

The Paniyas like to have tap water in their houses, but it is observed that they resist paying user fees or even electricity charges for supplying water, which they had accessed freely for centuries from common sources. During field work, it was observed that the Paniyas and Kurichias still prefer to have water from natural sources for cooking, and they mainly use pipe water for washing and other purposes. Ellan Mooppan was not able to accept the reality of commoditising water by paying user fees. However, this is
another example of a top down development model, which neglects the voice of the people and their governance in local issues.

The leafy vegetables, wild fruits, tubers, honey, fish and crabs that were available in the commons, forest lands and paddy fields were the sources of their energy and health during slavery and the early independent period. The extension of plantations, the land assigned in the forests during ‘grow more food campaign’ encouraging cultivation, large scale migration and encroachment of the common lands by private parties, reservation of forest etc. affected this source of supplementary diet of the Adivasis in most areas of Wayanad. The loss of food materials, herbal medicines and the destruction of natural resources alienated them from nature-their abode of deities and life sustaining resources and affected their health. Loss of their forests, paddy fields and commons and extensive use of pesticides and fertilisers in the private lands around them not only destroyed their material basis for a healthy life, but they lost their close bond with these entities and the resultant alienation and dependency affected their social, mental and spiritual health.

While they are losing life sustaining resources that they had freely accessed on the one hand, they are discriminated in healthcare and neglected in preventive and promotive healthcare services on the other. According to Zurbrigg (1984:127), ill health is an institutionalised form of violence in society and suggests a more just distribution of resources to address the issues of health. As Badami (2011) points out, the biomedicine treats the symptoms of marginality and not the root causes of illnesses and marginality of the Paniyas. According to him, most of their illness is associated with poverty and marginality. He points out that without trying to reconfigure the social, political and economic conditions, treating the generally observable physical symptoms are favoured by the health professionals in the PHCs. Further, reaching healthcare to the poor and poverty alleviation alone cannot reduce the inequalities in health as this approach ignores the political, social, ecological and cultural contexts of the Adivasis.

There were incidents of resistance when Adivasis were not cared for in emergencies. The pharmacist in Arayal PHC reported that in 2006, the Adivasis mobilised themselves and demanded a regular doctor when an Adivasi girl died in the area without getting timely treatment. On another occasion, when the doctors in the PHC refused to attend to one of their emergency cases, the Adivasi people jointly protested. Two Adivasi children
fell into a pond and Adivasis reached them to the Arayal PHC and the doctor who was on duty that day did not turn up. Even though the hospital staff maintained that there were no doctors that day, the Adivasis found one doctor watching TV in his quarters. The children died before reaching the district hospital. Even though the children were not from their colony, the Adivasi people living in the neighbourhood of the PHC turned violent and broke the doors and glass windows of the hospital and protested against this negligence. When the police came to arrest the protesters, all the Adivasis in the locality, especially the Paniya women blocked the arrest saying that they would all go to the police station if they arrested the protestors and the police could not arrest them. However, in most of the cases, they had to bear the discrimination and negligence as they were dependent on these health facilities in vulnerable situations. Even though they show indifference at times, in emergency situations they put up a joint front to protest against the PHC for better care.

Krishna, from the Kurichia community, a Zilla Panchayat SC/ST working group member during 2001-2002, reported that he along with another panchayat member from the Kurichia community, forced the Block panchayat to allot funds to build a maternity ward for the Adivasis in the district hospital as they heard about incidents of Adivasi women giving birth to babies in vehicles, hospital verandas and on the roadside. He reported that non-Adivasi panchayat members tried their best to use that amount for building a community hall, road and bridge and removed the Adivasi application before it came to the district development seminar for decision making. Since the Kurichia panchayat member argued strongly, the panchayat sanctioned the funds. Even though the ward was built in the name of the Adivasis, preference is given to non-Adivasi patients. The non-Adivasi patients go for regular checkups to the doctor's private clinics and with her/his support, they arrange the room or ward facility in advance in the district hospital. The Adivasis, especially the Paniyas reaching the hospital in the last stage of delivery were found to be adjusting on the floor and verandas of the hospital till they got one bed to share with another. What needs to be changed here is not the number of facilities, but the attitude that Adivasis deserve only minimum care and the demeaning constructions about their culture. The power relations existing in society and the health system has a detrimental effect on Adivasi health and well-being.
In another case, Jaya, a panchayat member from the Kurichia community approached the duty doctor, to know about the condition and the details of illness, when a patient from her panchayat was referred to the Medical College. Since the duty doctor hesitated to give details, Jaya complained to the Hospital administration and the duty doctor had to apologise. Being a panchayat member, Jaya could use her power. The position as a panchayat member in Kerala bestowed her with the symbolic power to challenge the authorities. Having experienced humiliation and corruption, when Jaya became Minister, one of her priorities was monitoring the Adivasi offices and Adivasi institutions to check corruption and discrimination. Another panchayat member from the Adivasi community reported... “Our party is organising a strike for an Adivasi ward in the district hospital… if our demand is heard and the ward is built then we have to go on strike again for neglecting the Adivasi ward by the hospital administrators and staff.”

Escobar’s (1995) analysis of the transformation of the poor into the assisted and the deep consequences of it is relevant to mention here as free medicine and health benefits are considered a panacea for all Adivasi health issues in Wayanad, without addressing the issues contextually. He points out that poverty and ill health appeared as social problems requiring new ways of interventions in society and new mechanisms of control. The new apparatuses of knowledge and power emerged to optimise life by producing it under modern scientific conditions. Bury (1998) argues that the general tendency of modernity itself is towards objectification and separation of embedded experience from everyday life. It is reported that there was no initiative from NRHM for introducing other systems of medicine, as doctors in Kerala were against cross practise even though NRHM seeks to revitalise local health traditions and mainstream AYUSH infrastructure. Abraham (2008) points out that the state policies have worked in a manner that supports the hegemony of allopathy in public healthcare. However, the inequality and lack of care is passively and actively resisted by the Adivasis as illustrated in the above sections.

42 AYUSH is the name of the government department which advocates Ayurveda, Yoga, Unani, Siddha and Homeopathy.
Conclusion

It is evident that the Paniyas and Kurichias recognise their marginal position in the modern health system, demand for better care and at the same time put forward a critique of the biomedical developmentalist approach in dealing health issues. In the Adivasi world view, land, environment, rituals, community and spirituality, everything is connected and the disconnection and imbalance is very much related to their illness and the regaining of balance is related to their well-being. Badami (2011) points out that immediately observable physical symptoms were treated by health professionals at the PHCs and that it was impossible to understand the serious health problems in short consultation without adequate follow up. He observes that the effects of inadequate social, political and economic conditions are also interpreted in medical terms and the sole responsibility of illness falls on the patient. The construction of body and sickness in the dominant biomedical terms marginalises the Adivasis as they are not socialised into the biomedical system and its mechanistic and compartmentalised approach. So they experience the double burden of marginalisation as the biomedical approach is alien to their world view and also due to discrimination inscribed in the health system.

Generally without serious complaints, the Paniyas do not go to the hospital and this feature deserves special attention. The term, ‘Adivasi’ creates a perception in the non-Adivasi mind that they deserve only minimum care and comfort in the state initiated health programs and especially for the Paniyas who have had a slave caste identity in the past. The unequal power relations reflect drastically in the health field. Unequal power relations are not only limited to the realm of discourse but extend to the realm of practise as Escobar (1995) points out. The approach of seeing the doctor as the ultimate knower of the truth about illness through the language of disease and the patient as a passive agent is prevalent in modern medicine as Bury (1998) points out. In Foucault’s language, it is a ‘docile body’ caught in the web of medical knowledge and medical power (ibid). Foucault unravels the multilayered forms of power and its mechanisms, and shows that power plays in manifold ways, reaches the individual, touches their bodies, affects their actions and attitudes, discourses and learning practises in everyday life (Gordon 1980). In the case of Adivasis, especially the Paniyas, these unequal power relations are not only experienced in relation to the state and its machinery but by the entire society around
them with a caste ridden, patriarchal, hierarchic mentality affecting their body, mind and spirit and disturbing their balance and well-being.

The Kurichias and Paniyas experience a lack of cultural space to integrate themselves with the modern system of medicine, but the Paniyas are more alienated and lack the skill to access even the meagre benefits and resources allocated to them. The Kurichias are comparatively resilient to the discrimination. It emerges that their specific cultures and subjective experiences have no place in the discourse of modern medicine and their traditional health practises need to be promoted as it offers a model in the highly commercialised profit oriented health sector in Kerala. In Adivasi culture, it is highly unethical to work for profit when people suffer from life threatening or other health problems. Their health culture centered on their world views are found holistic and place a challenge before the commodification of health and illness. Further, the political economy of health and redistribution of resources become more important than mere healthcare services in determining their well-being.

The conversion of health to the mere provision of medical facilities and care that are technology intensive, expensive and accessible only to a select few still marginalises the Adivasi population. According to Roy Burman (1983), in an Adivasi society the moral order predominates the technological order. He points out that in the technological order, men are bound by things or are themselves things. He suggests that when the nation state is geared to the anti-monopoly pro-peace mobilisation on a global scale, the Adivasi communities have the potential to show the way forward. Through the voices of Paniyas and Kurichias, we have seen that the culture of commoditisation of health services and people are entirely opposed to the Adivasi culture which treasures healing as a divine mission to their fellow beings. Thus, integration of Adivasi culture into the health system can reduce fragmentation in health practices and the alienation of people in the modern health system. However, tribal world views are considered lack of knowledge and superstition, instead of looking at it as another approach to health and illness. It emerges that there is need for recognising Adivasi’s pluriform expressions of healing and they seek space for evolution of their healing practices through a sustained critique of state programmes. The Paniyas as well as the Kurichias assert that their unique tradition as
well as environment is central to their well-being but the developmentalist state neglects these two areas and institutionalises healthcare.