Prem Jyoti – A pioneering medical work among Malto tribals

Prem Jyoti Hospital is a 30 bedded healthcare and community health facility situated in Chandragodda, in the Sahibganj district of Jharkhand. Dr. Isac and his wife Dr. Vijila Isac pioneered a medical mission work among the Malto tribals of this region, an extremely backward tribe, afflicted by poverty and disease and living in a land that was for all practical purposes cut off from the rest of civilization until recently. The hospital is part of a larger organization called Emmanuel Hospital Association (EHA) which has 20 hospitals and 35 projects all over India. The pioneering work among the Malto tribals by this humble doctor couple has brought about a remarkable and wholesome transformation in the lives of the villagers. In a candid interview, Dr. Isac David talks about how their work started and grew, the difficulties faced and the impact on the villagers.

Would you like to describe the Malto tribal people among whom you work- their land and culture?

The Malto tribe

We work in a place called Chandragodda in the Sahibganj district of Jharkhand. The district has a population of around one million, of which about 40% are tribal. Our journey began in 1996 when God gave us a burden to reach out to the health needs of a diminishing tribe called the Maltos.

The Maltos are of Dravidian origin. They live in the hills and are called “paharias” or hill people. Their population is about 1 lakh at present. They look very similar to South Indians and even their language has about 300 words that are similar to Tamil and other South Indian languages. Their grammar -cultural practices are also similar to those observed in South India. They are chiefly involved in agriculture but because the land is rocky, the yield is poor. Poverty is a major issue and unscrupulous money lenders take advantage of their situation by lending money at exorbitant rates and cheating them even when they repay their loans. Extreme poverty has in the past led many of the tribals to robbery and dacoity in the surrounding regions.

Malto society is matriarchal and the prospective bridegroom pays a bride-price for marriage (which may be a few sacks of grains, a pig and a few bottles of liquor). They have a tradition of welcoming visitors by washing and anointing their feet with oil and garlanding them with wild flowers. They are fond of a kind of black tea with salt and sugar which they serve when welcoming visitors.

What were some of the problems faced by the Malto tribals?

Illiteracy and lack of access to good health care were major problems. When we started in 1996, the literacy rate was only about 4%. Secondary health care facilities were severely limited and access to health care was even worse. There was only one hospital in the entire district where Caesarean sections were being done until our hospital was started. The immunization coverage was 7%, under-5 mortality rate was 380 per 1000 and infant mortality was around 250 per 1000, maternal mortality rate was 23 per 1000 deliveries (figures of 1997-99). Many children were orphaned due to the high maternal mortality rate, and these infants were often taken care of by their siblings who were themselves children.
**Illnesses:** Infectious diseases are the main cause of death. The area is hyperendemic for malaria which is a major killer. Kala azar is another very common vector borne disease. Sand flies which transmit the disease thrive in Malto communities because of the high humidity and the fact that animals live along with people in their homes or very close to the home (animals are not kept in separate sheds due to fear of robbers and dacoits). Sandflies grow very well in the cracks and crevices of these mud houses.

**Poor nutrition:** Though they cultivate maize, vegetables and cow pea-, nutrition is very poor because of recurrent infections. Moreover, because of unsafe drinking water, diarrhoeal diseases are very common. About 85% of children below 5 years are malnourished and one third of children do not even reach the age of 5 years. In the initial days, in the 90s, cholera was very common especially in the rainy season. Entire village populations were sometimes wiped out by cholera. Now, with better health facilities and awareness, cholera is rarely seen. Tuberculosis was also rampant among the tribals.

**Access to health care:** To reach a health facility the villagers would have to walk for about 2 hours downhill and then travel by the uncertain public transport for another hour to reach the town. When they would reach- the Primary Health Center (PHC), doctors were often absent or medications were unavailable. Private practitioners were not an option because of the unaffordable fees. So most tribal villagers did not approach a health care facility when ill. The first person they approached was usually a witch doctor who practiced magic and used some herbal remedies which were by and large ineffective. Only when a person was well advanced in the course of an illness and nearing death did they think of approaching a doctor. Most people walk for several hours to reach the hospital.

Access to health care for villagers is still difficult and primitive. Sick patients were brought in bullock carts, or on a bed suspended by ropes from a bamboo pole. It is difficult to do this because of the hilly terrain and the problems are worse during the monsoons.

Transport facilities are slightly better now with indigenously made tricycles called ‘Tela gaadis’ available. However the roads are so bad and travel takes so long that it is not uncommon for women to deliver on the way to hospital. I am happy to say that some roads have now been modernized and few four wheelers are also available for transport.

**How did your work among the Malto tribals start?**

The FMPB (Friends Missionary Prayer Band) were the first to start a work for the uplift of the Malto tribals. Seeing the huge health needs in the region, they approached EHA for a health care programme among the Maltos. With the help of EFICOR, funds were obtained from a Canadian Development agency. At the same time, both of us (my wife Vijila and I) had just completed our Family Medicine degrees and were looking for a place where there was a need for doctors. Thus in 1996, EHA in partnership with FMPB and EFICOR, started the health care programme and we were the first doctors.

We started as a team of five (2 doctors, a pharmacist, a lab technician and a nurse) in a single room clinic with a vision statement of ‘Reaching out with the light of God’s love, to make a difference.’ At first we were intimidated by the whole situation and wondered how five of us could make a difference to 80,000 people scattered in more than 700 villages. However, God gave us the wisdom to select and train local people as Community Health Volunteers to help in taking healthcare to the Malto people.

In 1999, we started with a 6 bedded health center and saw it grow to 15 beds in 2005 and presently we function as a 30 bedded hospital. Along the way a hostel for nurses, a chapel, dormitory and other buildings were built. Our team has grown from 5 to about 80 at present.

Our mission is to become a Christ-centered community that reaches out to the poor and the
marginalized, especially the Maltos, through quality health care, empowerment of communities, catalyzing transformation, developing local leadership and expertise and to serve as a model that will challenge others to do the same.

**Could you describe the healthcare model that you follow?**

We have a two-tier system: 1) At the primary level, the community health care programme is run through the help of community health volunteers (CHV) and mobile clinics who bring women needing antenatal checkups and children needing immunization to the hospital. 2) The second tier is the hospital which serves as a secondary care center for those who need inpatient care or diagnostic facilities.

**Community health volunteers:** Our community health volunteers (CHV) are the backbone of our primary health care system. They are members of the community who are selected and trained to deliver health care. There is a high level of acceptance of these volunteers as they are from the community itself. The role of CHVs is to examine villagers, identify pregnancies and illnesses and bring them to the mobile clinics. They also conduct surveys and report to us every month. As they are mostly illiterate, we developed illustrated reporting formats. Using pictures, they are able to report on vital statistics, births, deaths, pregnancies etc. at our monthly reporting meetings.

**Mobile clinics**

Since access to healthcare is very difficult, we try to help by reaching out to the villagers by travelling to the community using mobile clinics.

Though we travel by jeep for one to two hours, to access the villages, the villagers still have to walk 45 minutes to one hour to reach the mobile clinic. In these clinics we have integrated health care where we do antenatal checkups, immunization and patients who need hospital care are either brought directly or referred to the hospital. The mobile clinics are held wherever place is available, sometimes in a school, the verandah of a building or even under the shade of a tree.

**Outpatient clinic**

We have an outpatient clinic in the hospital that sees patients who come to us or are referred by our volunteers. Our outpatient clinic was initially manned by two doctors (Dr. Vijila and I) and nurses. From the beginning trained nurse practitioners have been managing the outpatient clinic. They screen patients with infectious diseases and provide antenatal check-ups and health education. Lately, we have had some young doctors who have joined us to help with the work in the hospital and OPD.

**In-patient care**

Infectious diseases make up a large number of our inpatients – malaria and kala-azar are very common. Other illnesses we encounter are tuberculosis in various forms (pulmonary, meningitis, pleural effusion), snake bites, septic arthritis, dental problems, pregnancy related problems like eclampsia etc. Tetanus cases are still seen, as immunization coverage is still poor. We are not able to have ventilators for want of regular electrical supply. I remember one young boy who was manually ventilated for 72 hours following a neurotoxic snake bite – fortunately he survived and did well.

In the initial days, we had 5 deliveries a year. The number has risen to 800 a year in the hospital. Our caesarean rate was around 19-20% but has risen in the last six months to 30% because some PHCs have started functioning in the vicinity and have started referring complicated cases to us. Uterine rupture is often seen (one case every other month) and eclampsia is common.

**Community based organizations:**

Recently we have started organizing community based initiatives because we realized that health alone will not bring transformation within a community. We are aiming towards holistic transformation in terms of health, economy and spirituality. Towards this goal, some self-help groups have been formed especially among women in the community to improve agricultural practices and means of livelihood. We try to address social issues like sexual promiscuity, alcoholism, migration to cities for livelihood and child trafficking. We also work along with the Government system to build capacity (through training programmes) and motivate the health staff working there.

**Training the next generation of Maltos**

We were able to send some of the Malto children who had finished school to nursing schools. Some of the Malto tribal girls themselves have become nurses and serve their community now.
Human interest stories - Prem Jyoti

How were you able to communicate with villagers who were illiterate and who do not even have a script for their language?

It was difficult and so we had to innovate and do things differently.

**Medicine through songs:** As many of the Maltos are illiterate, we give them health education through songs. The Maltos are an oral community and songs are the traditional medium of learning. So we composed songs in their local language - to convey health education messages. We found that many of them had difficulty in following the prescribed dosage and duration of medicines. So we formulated a way in which the medicine dosage, frequency and other details were offered to them as songs. So when a patient is diagnosed with an illness and prescribed medicine, our health care volunteers sing out the stanzas of the prescription song to enable them to take their medicine correctly. The health education songs pertaining to the illness (Eg. use of mosquito nets for malaria) are also added on so the patient gets the complete package – prescription plus health education in one brief singing session.

The Maltos possess a very good sense of humour and are a very innovative community. If given a theme, they are ready with a skit with props within 10 minutes. In the fields, it is easy to gather a group of 30 to 40 people, if we use skits to get the health message across.

We also designed flash cards to help explain disease prevention measures to the community. We had to design them ourselves because the flash cards that were available were ineffective in conveying the message. So we took photographs of villagers and their surroundings and printed flash cards with those images. These cards were a big hit among the villagers and they came in large crowds to see them as they were seeing photographs of their own community for the first time.

**How did you decide to work in this remote region among tribals?**

I am a native of Madurai and I did my MBBS in Madurai Medical College in the year 1984. When I was in medical college, I had a desire to work among the poor. I was invited to go to Oddanchatram, so joined Christian Fellowship Hospital and did a non-formal course with Dr. Rajkumar. The course was later recognized for DNB Family Medicine. My wife Vijila had committed to serve the poor when she was 11 years old. After graduating from MBBS, she too joined the same 2 year Family Medicine programme in Oddanchatram. By the second year, we realized that we both shared the same vision and values and decided to get married.

After our marriage, we decided on a survey trip to five mission stations. We felt God’s leading to go to the Malto tribals. We got a promise from Isaiah chapter 35:8 – *There is a king’s highway and those who travel on it, though they are fools, will not lose direction.*

The place where the Malto lived was very backward with no infrastructure, transport or facilities and with high levels of poverty and illiteracy but since we felt strongly led by God, we decided to go there. The language and people were strange, the terrain was hilly and the need was vast – we wondered what we could do in this situation? The FMPB was looking for doctors to start a medical work and we were looking at work among the Malto – so things worked out and we decided to start a medical mission among the Malto.

**How was this passion to work among the poor born?**

I have had this passion since childhood and it developed during my stay in Oddanchatram. We used to go to the hills of Pachalur to conduct medical camps. We walked 7 kms one way in hilly terrain to reach our destination. It was physically tiring but we met the people, listened to their problems and needs and attended to their illnesses; there was a tremendous sense of fulfillment. This is how it became clear to me that I would work among the most backward and poor people who are in need of health care. I also came to know about the health needs of people in North India through the stories of missionaries who worked in those areas. Vijila had visited and stayed at a mission health centre with Dr. Sam David in a tribal area in Andhra Pradesh, during her MBBS days, and that helped her decide to work among the poor.

**What were the initial struggles and how are things now?**

Initially when we started our work among the Malto in Chandragoddha, there were no places to stay. So during the first one and half years, we stayed in a rented house in a nearby town called Barharwa. We started mobile clinics to the village and then started staying for four days in a week among the tribals. An outpatient clinic was held in the town two days of the week and in the tribal village for 4 days in a week. The work among the tribals was started by selecting volunteers from the tribal community and health training was started.

**So you actually stayed in the huts of the tribals?**

Yes, we stayed in the huts of the tribals and ate whatever they ate. I would say that was the golden period of our work. It enabled us to understand how the tribals lived, their beliefs and cultural practices.
and also learnt their language. It did not take us much
time to build a rapport with them and start medical
work, thanks to the ground work done by missionaries
earlier. The tribal people were in fact eager to teach us
the language because they had been longing for
doctors to work among them.

The hospital was constructed on 6 and ½ acres of land
donated by the tribal community. Tribal land cannot
be sold but may be donated for a common good. We
started the hospital in 1999, three years after starting
our work among the tribals.

The Hospital in 1996

The Hospital in 2007

What were the practical difficulties you faced?
There were difficulties all along the way. For
the first fifteen years, we did not have a steady source
of electricity. A generator was used during the
outpatient clinic and in case there were any
emergency surgeries. We did not have the luxury of
electricity where we stayed in the initial days.

Isolation was a major difficulty. We were
isolated from the rest of the world due to lack of
communication facilities. It was difficult to contact
our family or friends when we had trouble or if we
simply wanted to talk to someone familiar. There
were no landlines for telephone. To make
one phone call, I had to travel 16 kms on
a motorcycle (which would take one
hour) to the nearest railway town. There I
would catch a train to the next town
(another one-hour journey) to make a
phone call. For the last 3 years thankfully,
a mobile tower has come up nearby and
we are able to make mobile calls. At
present, we also have very limited internet
facilities – just enough to send and receive emails.

Sickness was another practical difficulty. I
had around 26 attacks of malaria and constant
tiredness was a problem. By now, I think I am
probably immune to the parasite and do not suffer as
much. Education of children was another issue in the
remote region. Initially we home schooled both our
daughters. Thankfully there are many good residential
schools in Tamil Nadu which were especially started
to look after children of missionaries and my children
have been having a good education. My daughters, on
their part are very understanding and they have shown
admirable maturity in their studies and attitude
towards life. The decision to send our elder daughter
was not easy but they themselves decided to move
into a residential school.

Were there any disappointments or difficulties that
ever made you question your commitment?

Being a small team, there were difficulties
between us occasionally. There were also occasional
difficulties with our partner agencies regarding
support to our cause. However God has been a rock of
strength and we have been encouraged through many
friends through their lives and prayers. The Life
Revisions seminars held by Dr. K.O. John were very
helpful. We also took periodic retreats and breaks to
renew our vision and so we did not get burnt out.

What changes have you seen in the Malto villagers
through the health care programme over the
years?

Through the community outreach
programmes and health education, the health-seeking
behavior has definitely improved. This is chiefly due
to the efforts of our community health volunteers.
Infant mortality rate has reduced in the target villages
from around 250 to 68 per thousand. This is a
noticeable impact that we have seen. Maternal
mortality rate (MMR) has decreased from 46 per
thousand to 8 per thousand. We are able to see more
women come to us for antenatal check-ups and
bringing their children for immunization. The number
of hospital deliveries has gone up significantly and
this has a significant bearing on the MMR. We have
seen an improvement in the economic
status of the villagers through our self
help groups and through school
education. Some of the Malto girls were
sent for training in nursing and they
have come back as nurses in our
hospital. Mariam Malto was our first
GNM nurse from the Malto community.
She also had RCH training and now
helps us as a nurse practitioner in the
outpatient clinic and in the mobile
clinic.
Human interest stories - Prem Jyoti

Our dream
Though we started as a small community health programme, it has grown to the extent that we now serve 5 blocks in the Sahibganj district. Our dream is that no woman should die in childbirth, that malaria and kala-azar be controlled, that we can start a nursing school that provides ANM training, that we will continue to be a voice for the voiceless, a shelter for the needy, a place of hope and healing and that God’s love and light may flow from Prem Jyoti to the entire district. We dream that we will be able to train Maltos to become doctors and nurses so that they can take over the administration of the hospital and serve their own community.

The story of Anita Malto
Anita Malto was a lady who was diagnosed to have severe anemia and kala-azar and had a child who was severely malnourished (weighing only 1.5 Kgs). She was brought by one of our community health volunteers (CHV) named Mariam. If it was not for Mariam, this lady would have died along with the baby. Mariam herself is from the Malto tribe who was trained to be a CHV. This is how the mother and child looked when the child was 6 months of age.

From left to right
Anita Malto and her sick child,
The family after a few months,
Mariam Malto, Community Health Volunteer (in pink sari) with the mother and child.

Although we started off as just two health care professionals, we are able to see young people who have made a long term commitment come and join the team. God is raising up the second generation of doctors and nurses and that is exciting. We dream of Malto villages becoming like “Heaven on earth” with holistic transformation in their spiritual, physical, social and economic lives. Men and women living with a sense of fulfillment, unity, hope and love, free from exploitation, empowered to claim their entitlements and to pave the way for a brighter future for their children.