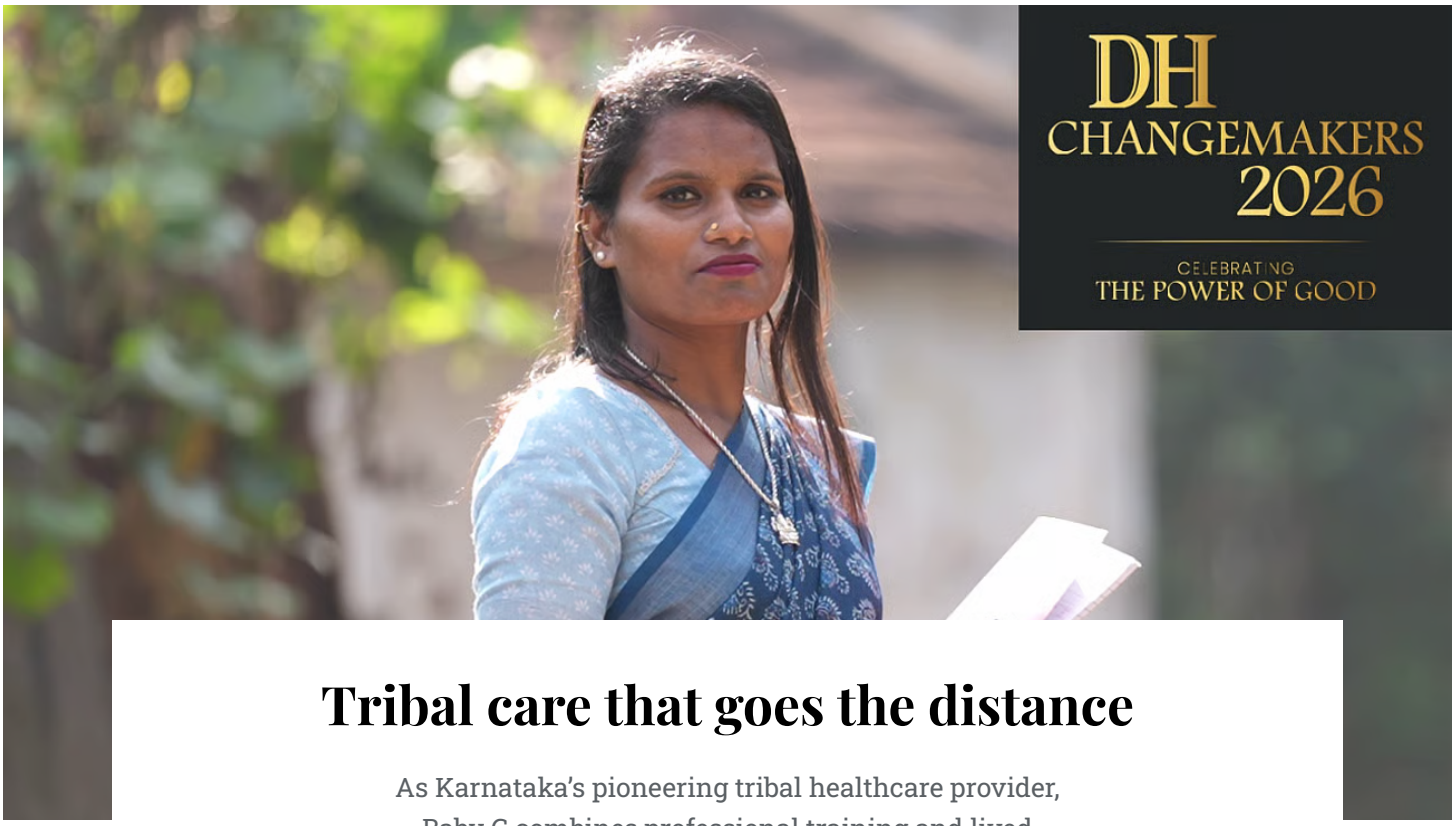

Tribal care that goes the distance

As Karnataka's pioneering tribal healthcare provider, Baby G combines professional training and lived experience to ensure Adivasi communities access life-saving care

Varsha Gowda Last Updated : 01 January 2026, 00:48 IST

On a cold December morning, as the district hospital in Chamarajanagar whirred with a new roster of hurried admissions and anxious relatives, an 18-year-old woman from a remote Adivasi hamlet was wheeled into the labour ward. It was her first pregnancy, and it had already been fraught with complications. Her baby was born weak, weighing just 1.22 kg, and was admitted to intensive care to battle infections and gain strength.

But the family, anxious to return to the safety of home and unsure of the hospital's rhythms, kept preparing to leave. Doctors insisted the infant needed time, warning that leaving early could be fatal.

Each time, it was Baby G, the district tribal health coordinator, who stepped in, sitting with the family, listening first, then carefully explaining what a few extra days could mean for a critically ill newborn. When the infant was finally taken home at 1.4 kg, against medical advice, doctors say the family would have left much sooner without her guidance. The baby is now slowly recovering at home.

For many Adivasi patients, public hospitals remain intimidating and alien. Access to healthcare is usually curtailed by distance, language barriers and systemic discrimination. The result is delay, even in emergencies, with diagnostics and life-saving interventions failing to reach indigenous people when they are most needed.

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Baby was appointed Karnataka's first district tribal health coordinator by the Department of Tribal Welfare at a time when access to traditional medicinal plants was declining among forest-dependent populations and modern healthcare remained out of reach.

The role was envisaged to improve hospital access for Adivasi populations. In addition to helping patients receive free treatment, these health navigators assist with Aadhaar enrolment, Ayushman Bharat benefits and community outreach.

The scheme is currently operational in district and taluk hospitals across six Karnataka districts. In Chamarajanagar, for instance, there is one district hospital and four taluk hospitals with tribal health navigators.

Since her appointment, Baby has helped around 2,000 indigenous people access care. Her role provides rare but vital representation for Adivasi communities within the public health system.

“Despite investments in tribal health and education, Adivasi communities remain underrepresented in professional fields. Her work also aims to inspire young indigenous women to join healthcare delivery systems and extend care to their communities,” says Dr Prashant N S, director, Institute of Public Health, the technical partner of the Tribal Health Navigator model under which Baby was recruited.

A familiar face

The absence of crucial care at the primary level means that preventable or treatable conditions often worsen before patients reach higher centres, explains Madegowda C, a PhD scholar and a leader in the Adivasi community. “Though Asha workers and doctors in primary healthcare centres are important for disease identification, many of these roles in the hundreds of hamlets remain unfilled,” he says. This means that cases build in severity.

When the ache in her knees became persistent, Lakshmi, a 50-year-old Soliga woman from B R Hills, was referred to the Chamarajanagar Institute of Medical Sciences (CIMS) for tests. “When I got to the hospital, it felt like I was in a sea of people. I did not know where to go,” she says. The corridors, usually thick with urgency, felt overwhelming, even hostile. “Doctors do not speak to us well. They turn us away and barely explain anything,” she says. “Sometimes they shout at us and treat us as if we do not understand at all.”

She hurried back home, and her condition went undiagnosed for several years after. This year, as her condition worsened and even basic movement became more difficult, Lakshmi knew she could no longer stave off a hospital visit. “It had become difficult to even stand and move. Managing my plot of land, a primary source of income, was becoming impossible,” she says.

This time, her anxieties about returning to the hospital eased when she learnt that Baby would be at the hospital to help her navigate the process.

With her support and direction, Lakshmi travelled to district hospitals in Chamarajanagar and Mysuru, navigating admissions, diagnostics and consultations that had once felt impenetrable. With timely attention and appropriate medication for chronic arthritis, her condition is now far more manageable.

Padregouda, a Soliga health worker who coordinated Lakshmi’s referral, explains how Baby’s presence altered the experience. “Knowing where to go, who to go to, has helped persuade people who fear modern medicine to receive medical intervention,” he says.

The presence of social networks often determines how hospital systems are navigated. “These networks do not yet exist for tribal populations at the level of secondary and tertiary hospitals,” says Dr Tanya Seshadri, a community health consultant and adjunct faculty at the Institute of Public Health.

Adept in medical settings, Baby navigates this delicate line of providing direction and rebuilding trust among communities long alienated from public healthcare while confronting the structural inequalities embedded within the system itself.

To do this, she works closely with doctors and staff at primary and community

health centres, ASHA workers, and district and taluk health officials to coordinate referrals and hospital visits.

Her dual role as a healthcare professional and a member of the Soliga community allows her to tackle one of the most persistent and overlooked barriers to care. “Treatment dropout rates are high among Adivasi communities. Many do not wish to stay beyond a day, as this adds costs for food and accommodation,” says Dr Tanya.

Navigating language barriers, Baby serves as a bridge between the community and medical staff, says Dr Manjunath, dean of Chamarajanagar Institute of Medical Sciences. “She has earned the trust of her community and can explain and persuade them to follow treatment when needed,” he adds.

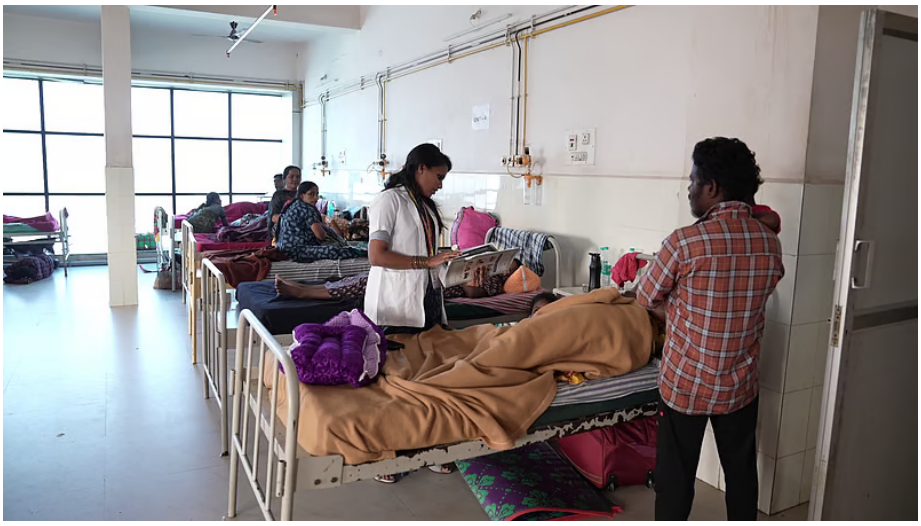
Beyond treatment, toward access

In the first few months after her appointment in 2023, Baby held several community orientations to familiarise people with her role, common health issues and barriers to care.

During this period, she found that many indigenous families lacked even basic identification documents, which often blocked access to welfare schemes meant to make healthcare free. “Many hospital costs are covered or waived, but a caste certificate is essential,” Baby explains. To help families avoid test and admission expenses, she coordinates with ASHA workers and local health staff.

Baby and other health navigators raised the issue during a meeting with Deputy Commissioner Shilpa Nag. “We collaborated to hold a camp-based registration drive. Officers reached people in remote areas, including those who were bedridden or physically disabled,” Nag says.

About 7,000 people obtained identification documents through the drive in 2023. Baby’s efforts in ensuring that maternal health goals, particularly institutional deliveries, are met have also been commendable, Nag adds.



“There are prenatal check-ups and tests that expectant mothers are required to attend. Baby has helped tackle reluctance to come in for these,” she explains. These interventions are vital for lowering maternal and infant mortality rates, which remain high among tribal populations in India.

Nearly 65% of indigenous women between 15 and 49 years are anaemic, and more than a quarter still deliver at home. Infant mortality stands at 74 per 1,000 live births, significantly above the national average.

Recognising the prevalence of genetic blood disorders among Adivasi communities, Baby coordinated with primary healthcare centres and hospitals to ensure testing for sickle cell disease and thalassemia.

Training, trust and lived experience

Her interventions have helped save many lives, says the Chamarajanagar District Health and Family Welfare officer S Chidambara reflecting on her work. “Beyond the confines of the job, it is her sincerity and commitment, whether the case is simple or

critical, that drives her involvement from admission to discharge," he says. On several occasions, Baby has personally accompanied patients referred to hospitals in Mysuru.

What strengthens her ability to do this, Baby says, is a combination of professional training and lived experience. "Medical language can be intimidating, and conditions need to be explained with patience and clarity," she says. This emotional intelligence, she adds, is integral to nursing.

It is also a skill she observed growing up. Her mother, also a trained nurse, would recount her workday after coming home, and the care and patience she showed her patients left a lasting impression.

As a Soliga woman working within the system, she is acutely aware of how institutional practices, often unintentionally, exclude Adivasi people. From a young age, her father emphasised the importance of giving back to the community.

This remains her motivation as she continues to navigate the space between hospital and community. "Since it is a pilot project, I have been actively involved in defining the role for myself and for those who come after me," Baby says. She hopes that her team can set an example that other districts with socially vulnerable populations can emulate.

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