People's Health Assembly

People's Charter For Health

PEOPLE'S CHARTER FOR HEALTH

INTRODUCTION

In 1978, at the Alma-Ata Conference, ministers from 134 members countries in association with WHO and UNICEF declared "Health for All by the Year 2000" selecting Primary Health Care as the best tool to achieve it.

Unfortunately, that dream never came true. The health status of Third World populations has not improved. In many cases it has deteriorated further. Currently we are facing a global health crisis, characterised by growing inequalities within and between countries. New threats to health are continually emerging. This is compounded by negative forces of globalisation which prevent the equitable distribution of resources with regard to the health of people and especially that of the poor.

Within the health sector, failure to implement the principles of primary health care, as originally conceived in Alma-Ata, has significantly aggravated the global health crisis. Governments and the international bodies are fully responsible for this failure.

It has now become essential to build up a concerted international effort to put the goals of Health for All to its rightful place on the development agenda. Genuine, people-centred initiatives must therefore be strengthened in order to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.

Several international organisations and civil society movements, NGOs and women's groups decided to work together towards this objective. This group together with others committed to the principles of primary health care and people's perspectives organised the "People's Health Assembly" which took place from 4-8 December 2000 in Bangladesh, at Savar, on the campus of the Gonoshasthaya Kendra or GK (People's Health Centre).

1,453 participants from 92 countries came to the Assembly which was the culmination of eighteen months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

The Plenary Sessions at the Assembly covered five main themes: Health, Life and Well-Being; Inequality, Poverty and Health; Health Care and Health Services; Environment and Survival; and The Ways Forward. People from all over the world presented testimonies of deprivation and service failure as well as those of successful people's initiatives and organisations. Over a hundred concurrent sessions made it possible for participants to share and discuss in greater detail different aspects of the major themes and give voice to their specific experiences and concerns. The five days event gave participants the space to express themselves in their own idiom. They put forward the failures of their respective governments and international organisations and decided to fight together so that health and equitable development become top priorities in the policy makers' agendas at the local, national and international levels.

Having reviewed their problems and difficulties and shared their experiences, they have formulated and finally endorsed the People's Charter for Health. The Charter from now on will be the common tool of a worldwide citizen's movement committed to make the Alma-Ata dream a reality. We encourage and invite everyone who shares our concerns and aims to join us by endorsing the Charter.

PEOPLE'S CHARTER FOR HEALTH

PREAMBLE

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed.

This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations.

VISION

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world — a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives.

There are more than enough resources to achieve this vision.

THE HEALTH CRISIS

"Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us."

(A voice from Central America)

In recent decades, economic changes world-wide have profoundly affected people's health and their access to health care and other social services.

Despite unprecedented levels of wealth in the world, poverty and hunger are increasing. The gap between rich and poor nations has widened, as have inequalities within countries, between social classes, between men and women and between young and old.

A large proportion of the world's population still lacks access to food, education, safe drinking water, sanitation, shelter, land and its resources, employment and health care services. Discrimination continues to prevail. It affects both the occurrence of disease and access to health care.

The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximise their private profit. Neoliberal political and economic policies are made by a small group of powerful governments, and by international institutions such as the World Bank, the International Monetary Fund and the World Trade Organisation. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people both in the North and the South.

Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

PRINCIPLES OF THE PEOPLE'S CHARTER FOR HEALTH

– The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.

– The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma-Ata Declaration, should be the basis for formulating policies related to health. Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed.

– Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.

– The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.

– Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

A CALL FOR ACTION

To combat the global health crisis, we need to take action at all levels – individual, community, national, regional and global – and in all sectors. The demands presented below provide a basis for action.

HEALTH AS A HUMAN RIGHT

Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

– Support all attempts to implement the right to health.

– Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.

– Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.

– Fight the exploitation of people's health needs for purposes of profit.

TACKLING THE BROADER DETERMINANTS OF HEALTH

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.

Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations.

Many countries of the world and especially the most powerful ones are using their resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

– Demand radical transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.

– Demand the cancellation of Third World debt.

– Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.

– Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.

– Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.

– Demand that national governments act to protect public health rights in intellectual property laws.

– Demand the control and taxation of speculative international capital flows.

– Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.

– Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social and political challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

– Demand and support the development and implementation of comprehensive social policies with full participation of people.

– Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.

– Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.

– Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.

– Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.

– Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.

– Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.

– Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

– Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.

– Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).

– Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.

– Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.

– Reduce over-consumption and non-sustainable lifestyles — both in the North and the South. Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.

– Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.

– Demand measures to prevent accidents and injuries in the workplace, the community and in homes.

– Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.

– Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

War, violence, conflict and natural disasters

War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

– Support campaigns and movements for peace and disarmament.

– Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.

– Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.

– Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.

– Demand the end of occupation as one of the most destructive tools to human dignity.

– Oppose the militarisation of humanitarian relief interventions.

– Demand the radical transformation of the UN Security Council so that it functions democratically.

– Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.

– Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.

– Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.

– Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.

A PEOPLE-CENTERED HEALTH SECTOR

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

– Oppose international and national policies that privatise health care and turn it into a commodity.

– Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.

– Pressure governments to adopt, implement and enforce national health and drug policies.

– Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.

– Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.

– Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.

– Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.

– Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.

– Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.

– Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.

– Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

PEOPLE'S PARTICIPATION FOR A HEALTHY WORLD

Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's

civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:

– Build and strengthen people's organisations to create a basis for analysis and action.

– Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.

– Demand that people's organisations be represented in local, national and international fora that are relevant to health.

– Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.

The People's Health Assembly and the Charter

The idea of a People's Health Assembly (PHA) has been discussed for more than a decade. In 1998 a number of organisations launched the PHA process and started to plan a large international Assembly meeting, held in Bangladesh at the end of 2000. A range of pre- and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a *People's Charter for Health*.

The present Charter builds upon the views of citizens and people's organisations from around the world, and was first approved and opened for endorsement at the Assembly meeting in Savar, Bangladesh, in December 2000.

The Charter is an expression of our common concerns, our vision of a better and healthier world, and of our calls for radical action. It is a tool for advocacy and a rallying point around which a global health movement can gather and other networks and coalitions can be formed.

Join Us - Endorse the Charter

We call upon all individuals and organisations to join this global movement and invite you to endorse and help implement the *People's Charter for Health*.

PHA Secretariat, e-mail: [redacted]

Website: [redacted]

Mailing address: [redacted]

Amendment

After the endorsement of the PCH on December 8, 2000 it was called to the attention of the drafting group that action points number 1 and 2 under Economic challenges could be interpreted as supporting the social clause proposed by WTO, which actually serves to strengthen the WTO and its neoliberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading system, the two paragraphs were merged and amended.

The section on War, Violence, and Conflict has been ammended to include natural disasters. A new action point, number 5 in this version, was added to demand the end of occupation. Furthermore, action point number 7, now number 8, was ammended to read to end all kinds of sanctions. An additional action point number 11 was added concerning natural disasters.

People's Charter For Health

I approve the text of the Charter
I wish to Support the Movement
I wish to actively participate in the Movement

(You can tick all the three)

Name: _____

Organisation: _____

Address: _____

_____

Tel: _____ Fax: _____

E-mail: _____

Date: _____

Signature: _____

Please return to:

Dr. Ravi Narayan
Coordinator
PHM Secretariat
CHC Bangalore
367 "Srinivasa Nilaya", 1 Block Jakkasandra,
1 Block, Koramangala, Bangalore-560034, India
email: **secretariat@phmovement.org**
website: www.phmovement.org

Dr. Ravi Narayan
Coordinator
PHM Secretariat
CHC Bangalore
367 "Srinivasa Nilaya", 1 Block Jakkasandra,
1 Block, Koramangala, Bangalore-560034, India
email: **secretariat@phmovement.org**
website: www.phmovement.org

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People's Health Movement

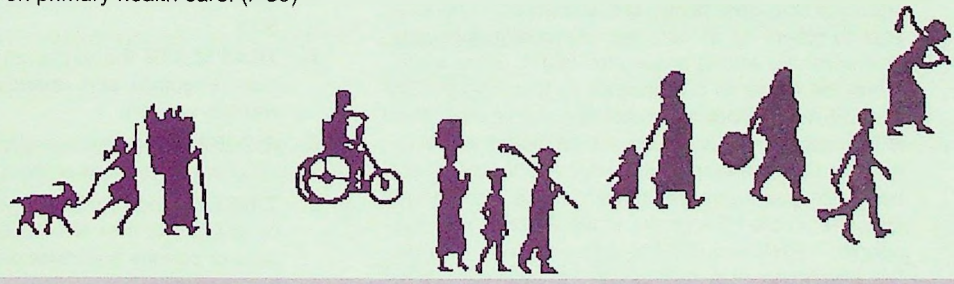
Alma Ata Anniversary

September 1978 was a defining moment in the struggle of the people, especially the poor, of the world for health. The health decision makers from 131 countries endorsed the Alma Ata Declaration, a document so much ahead of its time and so radical that the participants expected resistance to its implementation. Resistance to and subversion of the primary principles of Alma Ata was so widespread that in September 2003 as we look back on the last twenty-five years, the gains have been limited and the health status of the poor around the world continues to be abysmal. In between, another moment, Health for All 2000 came and went without causing any ripple. There are several reasons why this happened, some of them being: the reduction of the scope of Primary Health Care through the concept of selective PHC, neo-liberal economic policies, the debt crisis, trade imbalances and such on the one hand and the prescription of the IMF and the World Bank in the form of Structural Adjustment Programs, on the other. Conspicuous in its absence has been political will, either of the implementers or people themselves around the world. The results are plain to see: vital indicators such as infant mortality rate, maternal mortality rate, malnutrition levels have deteriorated around the globe, diseases thought to have been contained or eradicated such as Leishmaniasis, Leptospirosis, Plague have reappeared. Malaria and Tuberculosis have returned in virtually untreatable forms, TB killing 500,000 people per year in India alone, HIV-AIDS, Ebola virus and a host of other newer diseases have appeared on the scene. Just to reiterate the point, in Alma Ata itself, since rechristened as Almaty, IMR which was 12 per 1000 live births in 1978, is now 60/1000. A sad but apt commentary on the state of public health in the world.

The 25th Anniversary, therefore, does not call for any celebration but rather calls for a deep introspection on why things have come to such a pretty pass. It is also the moment when meaningful efforts to reaffirm the principles and practice of PHC that would make health a reality for those who need it most need to be started and nurtured. One lesson that has been recognized is that unless people take charge of their own health, no systems would work. People's participation was indeed one of the bedrocks of the Alma Ata Declaration. People's Health Movement of which all of us are a part, is one very hopeful step in that direction.

PHM and its constituents across the globe will mark this year as the Year of Alma Ata to raise the consciousness of people and decision makers to the founding principles of Alma Ata and to re-establish the primacy of PHC in our struggle for equity in health. One hopeful sign is already on the horizon – Dr. Lee, the new DG of WHO has already started a serious initiative on primary health care. (*PCJ*)

In this Issue



Editorial Committee :
Prem John (Editor), prem_john@vsnl.net
Qasem Chowdhury, gksavar@citechco.net; Hani Serag, hserag@yahoo.com
Assisted by Prasanna Saligram; Secretariat@phmovement.org

PHM Secretariat, CHC-Bangalore, # 367, "Srinivasa Nilaya", I Block, Jakkasandra I main I Block Koramangala, Bangalore-560034, India; tel: + 91-80-5128 0009
fax: +91-80-552 5372 email: secretariat@phmovement.org
website: www.phmovement.org

WHY ALMA ATA ANNIVERSARY?

1. The Alma Ata Declaration was finalized at the Alma Ata Conference in September 1978. So September 2003 is actually the 25th anniversary month. For purposes of our local regional and global reflections, we could focus on 2003 as the year of the anniversary reflection.

2. The coordinates in the post Alma Ata reflections should include not only what happened to the Primary Health Care Strategy at the Global and country levels but also reflect on special initiatives and programme like Essential Drugs strategy; the code for Marketing Breast Milk substitutes; the expanded programmes of immunization and a series of international initiatives all the way from the GOBI-FFF, safe motherhood to RBM, TFI, GAVI, MMV, Global fund for AIDS, TB, Malaria and others.

3. The Alma Ata Declaration and the Peoples Health Charter could be used as the framework of analysis. With the changing visions and roles of international health agencies like WHO and UNICEF who were co-sponsors of the Alma Ata meeting; and the growing development of World Bank as a key health player; and the effects of neo-liberal economic policies of liberalization, Globalization and privatization; and evolving international instruments of governance like WTO, IPR, GATT etc., The whole primary health care/community health/peoples health context has changed drastically and our analysis must be both historical and contextual. The role of other actors including NGOs and civil society can also be discussed.

4. The changing leadership of WHO and UNICEF over the years including the change in WHO in 2003 must be added to the analysis and the opportunity used to discuss not only international health concerns and international health programmes- initiatives and trends but perhaps also significantly the type of international health leadership we have and what we need.

5. With PHA and WSF and similar, visible, international, solidarity and collectivity, this is also an important year to reflect on all our own networking, lobbying and advocacy efforts around the world. Since while it may be easier in our analysis to focus on WHO/ UNICEF/World Bank and national governments – the NGO-civil/society and peoples networks will also have to take the responsibility for not becoming an adequate countervailing power to this neo-liberal distortion in the HFA goals. While we too failed the people, – PHA and PHM at different levels may be the beginning of a new phase, a new collective commitment and 2003 must include a critical self reflection of our own initiatives, campaigns and perspectives before 2000 AD. We need to build sustainable mechanisms of functioning so that the momentum continues and gets more deeply socially rooted

6. The biggest challenge for all of us in PHM is to ensure that the PH Charter does not go the same way as the Alma Ata declaration - forgotten, distorted, selectivised, verticalised, commercialized and ignored. PHM was meant to be a global challenge to this global amnesia. We need to evolve a different strategy this time and use 2003 as a launching pad for it. As we celebrate the Alma Ata Anniversary, let us also celebrate the evolution of the People's Charter for Health. Two documents that support the struggle for Health for All, Now.

The Alma Ata Anniversary Pack

The PHM Secretariat has prepared a pack of materials that would make it easy for our constituents to mark this event. This pack consists of several papers such as: Why Alma Ata Anniversary, Some suggestions for the celebration, The Declaration of Alma Ata- September 1978, The People's Charter for Health-December 200 The Million Signatures on the Internet to Demand "Health for All, Now".

Some background papers with excellent analysis of the problem based on available empirical data by well known thinkers and activists such as David Werner, Debabar Banerji David Sanders and Prem John are also there.

This compilation done by Unnikrishnan, the media coordinator of PHM, was released in PHM related events during October 2003 in the form of a booklet titled "Health for all Now! Revive Alma Ata!' first in Che and Espejo Forum in Ecuador followed by Italy, Canada, Philippines and India.

FOR MORE INFORMATION / MATERIAL PLEASE VISIT www.phmovement.org

A-Z of ideas for celebration of the Alma Ata

A. ***DISCUSS*** the Alma Ata Declaration and the People's Charter for Health

B. ***SIGN*** the million signature campaign for Health for All Now

C. ***TRANSLATE*** the signature campaign note into your own language and release a vernacular language website version

D. ***REVIEW*** the primary health care experience in your state or country and present it at this meeting

E. ***IDENTIFY*** case studies of primary health care projects by government or NGO/civil society initiative in your state or country and invite project leaders to share their experiences.

F. ***RELEASE*** a press statement or media brief for the occasion and release it through a press conference

G. ***CELEBRATE*** your Country's Health Policy if it has been Primary Health Care oriented or has tried to reach Health for All in your country context.

H. ***HONOUR*** Primary Health Care workers in your state or country.

I. ***ORGANIZE*** a small exhibition on Alma Ata Declaration principles and the action points of the People's Charter for Health.

J. ***ORGANIZE*** a convention of Primary Health Care workers and community level PHC volunteers. Listen to their experiences. Endorse their work.

K. ***WRITE*** articles in bulletins and journals on the Health for All / Primary Health Care and People's Health Movement Themes.

L. ***ORGANIZE*** a street event, a public march; a candle light vigil; a human chain; a children's rally; a cycle rally; a walkathon; a run for health; to express solidarity with the Health for All Now campaign.

M. ***ORGANIZE*** street theatre or folk culture events that express solidarity with the theme through skits and songs and other forms of cultural expressions [Themes : Explore the distortions done by the market economy to the Primary Health Care; celebrate how the people have resisted these distortions or how they have taken health in their own hands].

ORGANIZE talks in schools on the theme – People's Health in People's Hands. Thereby inspiring the next generation to the Health for All challenges.

O. ***ORGANIZE*** a Radio talk on the theme.

P. ***ORGANIZE*** a Television show – an interview or a panel discussion with Primary Health Care activists in your area.

Q. ***WRITE*** a letter from your PHM Circle to the Government of your country (Health Ministry and other related ministries, i.e., women, child, labour, rural development, environment, etc.,

R. ***TRANSLATE*** the Charter into your own language and release it at the anniversary celebration.

S. ***DISTRIBUTE*** the Charter or translated version actively on this occasion and or present it to key health officials.

T. ***ORGANIZE*** a rewriting of the Charter into a simpler local language version with examples, drawings and case sheet and release it / distribute it at the meeting to members of the community.

ORGANIZE a public signing of the Charter and the Million Signature Campaign in the town square or town hall or some central point in the bulletin.

V. ***ORGANISE*** Alma Ata Anniversary meetings in Schools of medicine, nursing schools, health worker schools and sensitise the next generation of health professionals to the Health for All Now campaign.

W. ***ORGANISE*** a musical evening or cultural programme. Have a few health and development songs to endorse the HFA campaign.

X. ***LAUNCH*** a PHM Circle in your institution / local area / state / country – do so as part of the celebration.

Y. ***INNOVATE*** other ideas that are more creative, more collective, more in solidarity with the theme.

Z. ***FINALLY, SEND*** us a report, copy of invitation, programme, poster, photographs, video clippings, press releases, background paper/s, educational materials or any other handouts about your event (whatever you do for the Alma Ata Anniversary) – so that we can put it on the PHM exchange or Website. (*RN*)

Coordinating Office

The Coordinates of the new office:
Mailing Address:
People's Health Movement Secretariat (Global)
CHC, # 367, Jakkasandra 1st Main,
1st Block, Koramangala, Bangalore – 560 034, India.

E-Mail contact IDs:
phmsec@touchtelindia.net
secretariat@phmovement.org

E-mail pertaining to communications/website should address:
Comm.phmsec@touchtelindia.net

Telephone numbers are:
+91-80-5128 0009 (Direct line)
+91-80-552 5372 which number is also the fax

Gonoshasthaya Kendra, Savar, Bangladesh will continue to be in charge of publications, the News Brief and also the Archives. Dr. Qasem Chowdhury, the outgoing Coordinator will handle this.

He is at: *gksavar@citechco.net*

Dr. Prem Chandran John helps edit the Newsbrief. He is at: *prem_john@vsnl.net*

***Enlarging the Network*: The validity and strength of any movement depend on how far and how wide we are able to spread (not to speak of how soon and how much in depth). Every new contact, every new network brings hope and joy. Here are a few new places where PHM's foot print has been implanted:**

1. **West Africa:**
   a) **A new country contact established in the Western African region E-mail: asdebtg@yahoo.fr**
   b) **Sierra Leone**
   c) **Cote D'Ivoire**
   d) **Ghana**
2. **Southern African region:** Mauritius .
3. **East and Central Africa :** Congo
4. **Europe:** Bulgaria
5. **South America:** Bolivia
6. **India:** The states of Jharkhand, Uttaranchal

The ***Million signature campaign*** launched to demand Health for All Now! in this Alma Ata Anniversary year is now available in 2 other international languages namely ***Italian*** and ***German***. Similar efforts can be undertaken by different countries to translate the website in their country languages. For further information and help on this please contact unni@phmovement.org

News from the Secretariat

1. The new PHM Global Secretariat in Bangalore, India inaugurated by Mr. Olle Nordberg and Dr. Qasem Chowdhury:

Mr. Olle Nordberg from Dag Hammerskjold Foundation, one of the founding networks of the PHM inaugurated the PHM Global secretariat in Bangalore, India on 19th February 2003. Dr. Qasem Chowdhury, the outgoing coordinator of the PHM Global secretariat was also present during the time. Besides Dr. Ravi Narayan, the Coordinator, the secretariat consists of Prasanna Saligram as the Communications Officer and Srindhi as Secretariat support staff. The PHM secretariat in Bangalore is hosted by the Community Health Cell. Besides electronic communication systems, the secretariat also houses a lot of resource materials from various parts of the world and in various languages

2. Jagdishwar Goburdhan, former Health Minister of Mauritius visited the Secretariat

Mr. Jagdishwar Goburdhan, former health minister of Mauritius who was responsible for setting up a people-responsive "**Community Health Fund"** in Mauritius, spent two days at the Secretariat starting July 4th sharing his experiences in the field of Primary Health Care. Since his visit a new initiative called "Mouvement Sante Communitaire" (People's Health Movement) has taken root there. They are also sending a delegation of 7 people to the International Health Forum, Mumbai, India preceding the World Social Forum in order to learn the process of Health Forum so that a similar meeting can be held in Africa.

3. Meeting in Bangalore of some of the Steering committee members to finalize the proposal for PHM

Some of the Steering group members: Zafrullah Chowdhury, Prem John, K. Balasubramaniam and Mira Shiva met on July 28th 2003 to finalize the proposal for PHM Global activities.

4. A meeting on the Traditional systems of medicine (TSM)

30 people - activists, academics and practitioners people involved in Traditional systems of medicine (TSM), met on 29th July 2003. The meeting focused on bio-piracy involving herbal plants as well as the increase in commercialization of the traditional systems of medicine. An urgent need to systematically document these systems of medicine was felt. Also discussed were WHO's initiatives in traditional systems, whether they promote pluralism or hamper it with a new set of regulations? A small PHM- TSM circle was formed. A TSM workshop at the World Social Forum highlighting people's voices in TSM is planned.

5. Funding group meets in London

Most of you may not be aware that PHM secretariat (Global) and most of the PHM activities have so far been running on the pitiful remnants of funds that were raised for PHA 2000. This is of great concern to all of us. Therefore the funding group consisting of Andy Rutherford, Prem John, Ravi Narayan, Olle Nordberg as well as Pamela Zinkin, Dave McCoy, Alifia Chakera, Mike Rowsen and Udayakumar met in London on 23rd and 24th of October 2003 to discuss the strategies for future funding and to finalise the Proposal.

6. Dialogue with WHO in Madrid:

From London Ravi Narayan went to Madrid to participate in the WHO meeting entitled "Future strategies for Primary Health Care". This was an opportunity used by PHM to present people's perspectives as expressed in the People's Charter for Health. This opportunity was also used to present the PHM's concerns on WHO's policies.

7. Planning Strategy

A three-year strategy planning exercise has been initiated by the Secretariat through a series of communications to all members of the Steering Group and the Secretariat support group. The process is ongoing and will be completed in October 2003.

8. A communication strategy

A communication strategy is being evolved so that all the methods presently being used including website; PHM exchange; news brief; press releases; publications and email communications are better focused and directed towards specific objectives to support the growth of the movement. The strategy evaluation was stimulated by a thought provoking paper by Andrew Chetley entitled 'PHM Communication Matters'. (chetley.a@healthlink.org.uk & webmaster@phmovement.org).

9. PHM – Global Website

The baton of the Global web site has been transferred to Prasanna (PHM Communications Officer) from Nand Wadhwani (PHM - Cost Rica), who was the website consultant and manager till recently. We hope all of you will actively participate in telling us of your activities to help us update / upload the website actively. As a PHM policy, we are now suggesting some standardized methods of communication regarding events and initiatives (A separate communication follows).

10. The Global Health Equity Watch project

The PHM / GEGA / WEMOS joint initiative for a Global Health Equity Watch report has progressed well with a detailed framework evolved by Dave McCoy, Mike Rowson and an informal advisory group through e-group discussion. This has now been circulated for wider comments. ((David.McCoy@lshtm.ac.uk & mikerowson@medact.org).

WHO and PHM

After the close interaction at the World Health Assembly in Geneva, May 2003 when we introduced PHM to the incoming DG, Dr. Lee Jong-wook, PHM received a letter from him expressing his desire to work closely with PHM in the coming years. This is good news indeed!

News from the Regions

1. *SOUTH AFRICA REGION*

*A South African Alma Ata Anniversary meeting entitled **'Twenty Five years after Alma Ata'** was held end of August 2003 supported by David Sanders and the PHM Circle <lmartin@uwc.ac.za*

2. *EAST AND CENTRAL AFRICA REGION*

Kenya

PHM Kenya Circle was launched on 23rd August 2003 at Mombasa. Participants from Tanzania, Kenya, Uganda, and Netherlands participated in solidarity.

A post launch seminar was held, attended by 20 participants from Kenya, Uganda and Tanzania, which chartered the way forward for PHM Kenya and its collaborators and partners in health (phmkenya@yahoo.com)

Tanzania

Mwajuma has continued to establish contact with other networks and the Alma Ata Anniversary pack was mailed to 150 addresses in Africa (masaigana@africaonline.co.tz)

Uganda

***'Uganda Coalition for Access to Essential Medicine'** was formed to be a stronger voice for advocate and campaign for fair legislation and access to essential medicine. (heps@utlonline.co.ug)*

3. *MIDDLE EAST / NORTH AFRICA REGION*

Palestine

A regional meeting of PHM contacts was held on October 17th in Cyprus. (jihad@shabaka.net)

Egypt

AHED conducted a one day seminar on 25th year Alma Ata Declaration in Egypt at the end of August 2003. The PH Charter was distributed / promoted during this meeting (hserag@yahoo.com).

Cyprus :

A PHM Regional meeting was organized in Aya Napi, Cyprus, on 17-18th of October 2003 to make a year plan for the region. 13 countries were represented. Documents in Arabic and English are being prepared <jihad@shabatic.net>

Portugal :

The World Consumer Congress, facilitated by Consumer International, was held between 17th to 19th October 2003, at Lisbon, Portugal. bala@haiap.org and <carmelita@ciroap.org>

4. *INDIA REGION:*

*The National Working Group of the Jana Swasthya Abhiyan (PHM India) met in Bangalore on 26-27th July 2003 to plan for PHM activities and the Alma Ata Anniversary in India. The discussions included themes such as **The Right to Health Care campaign** to be launched by PHM India on 6th September 2003 at Mumbai as part of the Anniversary campaign; planning the initial framework of the International Health Forum in Mumbai on 14-15th January 2004. cehatpun@vsnl.com*

*In August 2003, PHM India held a workshop on **'Hunger Watch'** in Bhopal.*

*On 5th September 2003, a Workshop for activists from 18 states on the **"Right to Health Care"** campaign was organized by PHM India, at Mumbai, as part of the Alma Ata Anniversary celebration and over 250 people attended the meeting. On 6th September 2003, a National Public Consultation of PHM India with the National Human Rights Commission was also held. **Testimonies** from many states on the **'Denial of the Right to Health Care'** were recorded. PHM meetings and workshops have taken place in several states – Karnataka, Andhra Pradesh, Tamil Nadu, Maharashtra, Rajasthan.*

5. *SOUTH ASIA REGION:*

Bangladesh

PHM Bangladesh Circle management committee met on 5th June 2003 to review the experience of Bangladesh participants at PHM Geneva, May 2003 (dorpco@bangla.net, afmimam@dhaka.net & phmbc@dhaka.net).

A National Health Convention on 25 years of Alma Ata Anniversary was held on 6th September 2003 at Dhaka (dorpco@bangla.net, afmimam@dhaka.net & phmbc@dhaka.net).

Sri Lanka

Prem John of ACHAN/PHM visited Colombo on 29th August to 1st September 2003 to meet PHM contacts and increase their involvement in PHM. (hariprem@eth.net & prem_john@vsnl.net).

6. *SOUTH EAST ASIA REGION:*

Philippines

Health Action Information Network and Health Link Exchange Worldwide, UK, organized a 6-day Communication for Advocacy Training workshop in Manila from July 22-26, 2003 <hain_sj@kalusugan.org>

A forum on 25 years of Primary Health Care was held in Manila on 12th September 2003 (bdelapaz@uplink.com.ph)

Philippines :

An International Conference on 'Challenges in Health work in a Globalized and Terrorized world: Continuing our Resistance' was organized in Manila, from 2nd – 10th November 2003 by the International League of People's Struggles – Adhoc Health Commission, PHM Philippines and IPHC – Philippines (bdelapaz@uplink.com.ph).

7. NORTH AMERICAN REGION:

USA

As a follow up of PHM -USA 8- city tour in March 2003 of Zafrullah, Ravi and Thelma (PHM South Asian leaders) the coordination of PHM-USA activities is evolving. Four circles have been launched - War and Health Circle; Health and Trade Circle; Environmental Justice Circle; and US Health Care Access Circle (sarahs@hesperian.org).

A coordinating group has been set up to address different needs including listserve relations / monitor; website; conference coordination; publications; finances and PHM International relations (sarahs@hesperian.org)

Alma Ata celebrations were organized at the Doctors for Global Health Annual Meeting at Berkeley - end of July 2003 dghinfo@dghonline.org

Canada :

The Canadian Conference on International Health on the themes : The Right to Health influencing the Global Agenda and How Research, Advocacy and Action can shape the future was held in Ottawa, 26-29th October 2003. ***'A Right to Health Care Now Campaign'*** *from the perspective of PHM and IPHC was organized by Maria Zunega <maria@iphcglobal.org>. A workshop on* ***'Public Private Partnerships'*** *was organized by Jose Utrera with WEMOS and IPHC participation <jose.utrera@wemos.nl>. Another Workshop on* ***"Liberation Medicine and PHM"*** *was organized by Lanny Smith <vze2x6qm@verizon.net>. Abhay Shukla from PHM India presented a paper on* ***"Right to Health Care"*** *campaign cehatpun@vsnl.com*

8. CENTRAL AMERICA, MEXICO & CARIBBEAN REGION

Guatemala

A meeting of PHM activists took place to share experiences and to plan action strategies from the region.

Mexico

A workshop on 'WTO – Food and Nutritional security : A Global Concern' was organized by WEMOS for delegates on 12th September during the 5th WTO Ministerial conference at Cancun, 10-14th September 2003 <trade@wemos.nl>. Many PHM members including Mira Shiva and Carmelita Canila attended the Cancun meeting.

Nicaragua

The E-mail list serve called REDLATINOAMERICANASALUD has been very active. This list serve is moderated by the IPHC office in Nicaragua and is open to all Spanish language persons who attended PHA 2000, as well as others who have subscribed to the first serve.

Apart from the above, this region has a network called "The Regional Committee for the Promotion of Community Health" founded in 1975, which is vital to PHM Mexico, Central America and the Spanish speaking Caribbean and is fully involved in PHM and its activities. Efforts are on in most countries for the Million-Signature campaign. Regular activities are being carried out in the framework of the 25th Anniversary of Alma Ata. Activists are also preparing a response to the PAHO PHC document.

Ecuador

An International Primary Health Care Forum in Quito was held, 20-24th October 2003. It was be preceded by the Che and Espejo Forum in Cuenca in the week 13-17th October 2003 (aquizhpe@yahoo.com).

9. SOUTH AMERICAN REGION

Brazil

Sr. Ani, PHM Brazil, informs us of the PHM campaign ***Hearing the Voices of the Unheard*** *is going on well, of special significance in a country affected by the domination of Banks and Multinationals and where the vast majority of people do not have computers. PHM is promoting pamphlets explaining the campaign, adding a slip for signatures and enclosing a copy of the declaration of Alma Ata. All these are presented in assemblies – local and regional meetings as well as individually among poor communities. Hundreds and thousands of grass roots folk are signing up.*

[Can other countries adopt (adapt) this simple low cost method to their own cultures and situation? Write to Sr. Ani for further details *<Acwlepalis@aol.com>].*

Bolivia

MAP International, Bolivia, has informed that they are endorsing and promoting the spirit of the People's Charter for Health in their educational activities as well as in the different projects.
<mapbol@supernet.com.bo>

10. EUROPEAN REGION

UK

Reaching the 40th Translation of Charter

A recent list from Pam Zinkin who is coordinating / tracking translations of the Charter, brings great news.

Finalised and on the website *– Arabic, Bangla, Chinese, Danish, English, Farsi, Finnish, Flemish, French, German, Greek, Hindi, Indonesian, Italian, Japanese, Kannada, Malayalam, Ndebele, Nepalese, Philippines, Portuguese, Russian, Shona, Sinhalese, Spanish, Swahili, Swedish, Tamil, Urdu, Ukrainian.* ***Promised*** *Cambodian, Tonga, Lithuanian, Norwegian, Welsh, Thai, Dari, Pastun, Creole, Vietnamese, Welsh and Bulgarian.*

Also available Audio in English and in English with Braille titles

[If you have done translation into your own language not in the above list, please let us know immediately to add to the list. Can we reach the 50th Mark by the PHA anniversary on 8th December 2003? (pamzinkin@gn.apc.org and gksavar@citecho.net)]

Russia

A Conference was held in the Medical Academy of Postgraduate study in St. Petersburg on Alma Ata - Health for All is necessary and possible. 300 participants attended including over 32 social and medical NGOs. The Charter was published in the Medical Academy Newspaper and a special Russian edition of Charter distributed to all participants. This was reported widely in the popular press (simb@comset.net).

The materials of the conference were also used during the Hearing on the Medical compulsory insurance reformation at St. Petersburg legislative assembly (simb@comset.net).

Netherlands

The Women's Access to Health Care campaign was launched by WGNRR in collaboration with a large network of organizations including PHM on 27 May 2003. In many parts of the world, there have been local and national launch and related events <wahc@wgnrr.nl>.

Germany

PHM was invited for a meeting on Genetics Research in Germany to discus the profound challenges of the new human genetic technologies and the need for social controls. The conference was held,October 12-15, in Berlin. It was organized by the Heinrich Boell Foundation and the Institut Mensch, Ethik und Wissenschaft (in Berlin), and the Center for Genetics and Society in California (Dr. Sigrid Graumann - graumann@imew.de). PHM was represented by Gilles de Wildt<gillesdewildt@yahoo.com>.

A Seminar on 'Public, Private Partnerships – Hand in Hand with Industry? was organized by BUKO, in Bad Boll, in Germany, 3st October – 2nd November 2003. Panelists will included Zafar Mirza (Pakistan), Thelma Narayan (India), Jose Utrera (The Netherlands), Judith Richter, Christiane Fischer and Andreas Wulf (Germany). This was followed by a series of smaller meetings in different towns of Germany, with Zafar Mirza of Pakistan and Thelma Narayan of India as resource persons.

Switzerland

Dr. Bala and David Woodward represented HAI and PHM respectively in the Millennium Development Strategy Task Force on Access to Medicine Workshop at Geneva in June 2003. David presented a paper on 'Medicine and Pharmaceutical Technology as Public Goods' (bala@haiap.org and woodwarddavid@hotmail.com).

Bulgaria

An IBFAN linked Bulgarian NGO called NM – Women and Mothers against Violence which has more than 1600 members and volunteers has offered to translate the Charter into Bulgarian and spread PHM in their country. They work on protection of mothers and children's health, support of breast feeding, infant feeding and trade issues <ibfanbg@rtsonline.net>.

Italy

A PHM Italy meeting was held in Bologna, Italy in July 2003 facilitated by AIFO. Dr. Thelma Narayan, PHM India was a special invitee and resource person in Health. A discussion with Medical faculty and students of the University of Bologna was also facilitated by her and Sunil Deepak of AIFO (sunil.Deepak@aifo.it).

The AIFO biennial conference was held in Rome on 25th and 26th October 2003. A three member PHM team (Ravi, Maria and Mwajuma) received a Human Rights Award on behalf of PHM.

REJOICE WITH US!

The President of Amici di Raoul Follereau foundation (AIFO) of Italy, Dr. Enzo Venza, presented the award to PHM for safeguarding Human Rights at their Biennial meeting on 25th of October 2003. It was received by Ravi Narayan from Asia, Maria Hamlin Zuniga from Latin America and Mwajuma Masaiganah from Africa. The meaningfully done Citation reads:

"To the Multitude of excluded people for whom the People's Health Movement speaks. To their desire for life and future. To their intelligence and abilities. To the new world sprouting from the actions of grass-roots movements, a world where the supremacy of people over profit can be re-established".

Spain

*A WHO Global Meeting on '**Future Strategic Directions for Primary Health Care'**. was organized in Madrid, Spain, 27-29th October 2003. PHM was represented by Ravi Naraya, the Global Coordinator.*
secretariat@phmovement.org

Switzerland

Forum 7 of the Global Forum for Health Research, will be held in Geneva from 3rd to 7th December 2003. PHM participation in many sessions is evolving. lmartin@uwc.ac.za

11. AUSTRALIA, NEW ZEALAND AND PACIFIC REGION

Australia

The Government of South Australia launched a Revitalised Primary Health Care policy on 12th September 2003. Fran Baum and other PHM colleagues were involved. PHM has sent a congratulatory message. Fran had also requested PHM friends to send short messages of how they could support struggles for health in other countries <fran.baum@flinders.edu.au>

Macmillan Education, Australia, publisher of secondary school textbooks in Melbourne had requested permission from the PHM Secretariat to reproduce a screen shot of the PHM Website in their forthcoming book – Achieving Health and Human Development. A print run of 10,000 copies to be distributed in Australia and New Zealand in November 2003 is planned. School children will be invited to visit the PHM website and answer a set of questions about what they find there (Karen Forsythe - <kforsythe@copperleife.com>).

12. CHINA REGION

Our efforts to re-start the process in China have not yet been very successful. Unnikrishnan will be visiting China shortly for an Action Aid workshop and will try and make some contacts with PHA-I participants.

[Suggestions and volunteers to follow up in this region are welcome]

FORTHCOMING EVENTS

Australia :

An International Health Education and Health Promotion Conference will take place in Melbourne, Australia, in April 2004. PHM Australian colleagues are exploring how to organize a PHM event in the Conference. Please contact the Conference authorities after visiting the web page < 2004.com.au> and request for nomination for a scholarship if you are keen to attend. You will need to send your name, address, email, age, area of interest and whether you would present a paper. Send this information also, urgently, to Fran Baum at fran.baum@flinders.edu.au

ONWARD TO MUMBAI

India :

The International Health Forum in defense of the Health of the People is being organized by PHM on 14-15th January 2004 at Mumbai, India. This Forum will precede the World Social Forum, which will be held from 16-21st January 2004 at Mumbai. (For further information see Section B) <ctddsf@vsnl.com> and <secretariat@phmovement.org>

If undelivered, please return to:
PHM Secretariat
CHC-Bangalore
367 "Srinivasa Nilaya"
Jakkasandra, 1st Main, I Block, Koramangala
Bangalore-560034, India

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[Opinion Survey]

COMMUNITY HEALTH INTERNSHIP CUM FELLOWSHIP SCHEME

Dear Fellows / Mentors,

Kindly fill up the knowledge / skill / attitudes that

(i) **as fellows**, you have picked up during your linkage with CHC or

(ii) **as mentors,** you feel you could inculcate in the fellows during their field posting with your organization / project.

This is an opinion survey which will be collated to produce an update on an earlier check list prepared at the start of the scheme.

An opinion survey on Attitudes, Skills & Knowledge to be developed during the Scheme.

Attitudes:

Skills :

Knowledge:

During the internship / fellowship linkage with CHC, we encourage interns / fellows to do as much reading as possible. As fellows or mentors, please recommend any book, booklet, journal, document as a **'must read'** during the period of linkage:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Place :

Date

Name & Signature

(Use additional sheets if required)

20 Thursday February 1997

20 feb 97

बांधो न मुझे, मैं बंधने तोड़ दूंगा
सैलाब में दरिया हूं, मैं रास्ता ढूंढ लूंगा॥

ख्याल बुलंद हूं, तालीम न दो मुझे
फकत उन्वान दो मुझे, मैं फलसफा ढूंढ लूंगा॥

मानिन्द ए ताईर हूं, पिंजरा न मेरे लिए
खुला छोड़ दो, फलक रास्ता ढूंढ लूंगा।

औरत हूं, इंसां हूं, केवल नहीं हूं मैं
दे तलाक दे, मैं रास्ता ढूंढ लूंगा।

साहिल नहीं, किश्ती तो तूफां की है आशिक
फकत उतार दो, मैं बादबां ढूंढ लूंगा

न सहरा न कारवां ही बसेरा सकेंगे मुझे
निकल पड़ा जो, रस्ते आप ढूंढ लूंगा।

Appointments

8

अकेले ही आया था, जाना भी है तन्हा
वक्त आने पे, मैं कारवां ढूंढ लूंगा

9

10

इश्क कैसा है मर्ज की मानिन्द मुझमें
11
तू जाम दे हाथ मैं, मैं मयखाना ढूंढ लूंगा

12

1

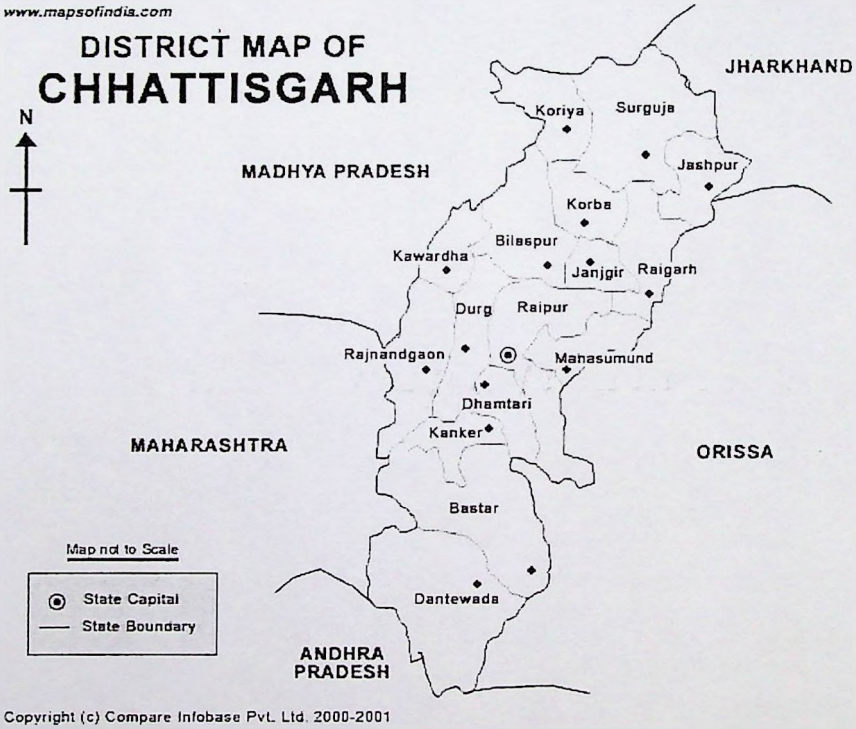
ख्वाब देख मेरे यार तो खुदा हासिल होगा
मांग उठेगी दिल से तो फरिश्ता ढूंढ लूंगा।

The Mitanin Programme- the context, rationale and policy perspective.

Dr Alok Shukla,
Secretary,Government of Chhattsigarh,
Department of health and family welfare

The context:

Chhattisgarh is a new State carved out of Madhya Pradesh on 1st November 2000. It is the 9th largest State in the country. It has a population of a little over 2 crores. Chhattisgarh has 16 districts, 96 tehsils, 146 blocks, and approximately 9,129 village Panchayats. It has about 19,720 villages, and 54,000 habitations. The State has 9 Municipal Corporations, and 66 other Municipal bodies.



Chhattisgarh has relatively poor health infrastructure. It has only 9 District Hospitals. Only 114 Blocks out of 146 have Community Health Centers. It has 786 Sectors and 3878 Sections. Large number of posts of doctors, and paramedical personnel are vacant. Many PHCs in the remote tribal areas do not have doctors.

Chhattisgarh has approximately 34% Scheduled Tribe population, 12% Scheduled Caste population. and more than 50% Other Backward Classes. People are relatively poor. The State is rich in natural resources. It has large reserves of coal, and iron ore. It also has a lot of lime stone and Bauxite. Recently Diamond has been found in Chhattisgarh. Chhattisgarh has approximately 40% forest cover. The Literacy levels of Chhattisgarh are quite high. Health Statistics are on the other hand, still poor. Some important figures from the 2001 Census are given below: -

Indicator	India	Chhattisgarh
Population	102.70	2.07
Decadal Growth Rate	21.34	18.06
Sex Ratio	933	990
Literacy Rate	65.38	65.18
Female Literacy Rate	54.16	52.40

Some other important Health Indicators are given below: -

INDICATOR	INDIA	CHHATTISGARH
Population	98.13	2.06
HDI	45	39
Sex Ratio (1991)	927	985
Crude Birth Rate (SRS 2003)	25.4	26.3
Crude Death Rate (SRS 2003)	8.4	8.8
Total Fertility Rate (1997)	3.3	3.6
IMR (SRS 2003)	66	76
Couple Protection Rate by Sterilization %)	30.2	29.5
Adult Literacy Rate (age 15-34)		
Total	56.86	46.62
Male	69.56	64.13
Female	43.48	29.14
Scheduled Caste Population (%) 1991	16.73	12.2
Scheduled Tribe Population (%) 1991	7.95	32.46
Urban Population (%)1991	25.7	17.4
Percentage of Married Women in 15-19 age group (1991)	35.3	41.89
Proportion of Women in Work Force (1991)	22.3	40.99
Proportion of Farm Labor in work force (1991)	26.1	23.06
Houses with Electrification (%) 1991	42.4	31.67
Houses with Safe Drinking Water (%) 1991	62.3	51.1
Villages connected with mettle roads (%) 1991	36.96	20.84

Though we have progressed a lot in the field of health, yet we still have a long way to go. Diseases like diarrhoea, malaria, leprosy, and tuberculosis still present a major health problem in the State. Measles still causes death of children in the State. Our Infant Mortality Rate is 76, which is very high in comparison to the developed States of the country. Many women still die during pregnancy, and labor for want or proper care. Anaemia, and malnutrition are present in the State on a large scale.

The system of Public Health, which has developed in the last few decades, has been constrained by an increasing distance between the people, and the health services. Underlying this is the increasing complexity of the health system itself. The result of this is that people are not able to benefit fully from these public health services. On the other hand after being educated in the ultra-modern, mechanized, and urban environment, doctors are not interested in working in rural areas. As a result of this today there is a great shortage of trained doctors, and health workers in rural areas. On the other hand incompletely educated quacks are taking advantage of the public in these areas. On the one hand the Health Department feels that people do not take advantage of the services offered by the Government and on the other hand people feel that Government is not able to provide even basic health care services to them. The reality lies somewhere in between, and there is gap both on the supply side as well as on the demand side. Present policies have instead of empowering people, increased their dependence on the Government machinery. Our present system is wholly hospital based. In this system, treatment of diseases has got precedence over prevention of diseases, and programmes of improvement of Public Health. We must remember that all our policies should be made keeping communities in focus, as empowerment of people is out ultimate goal.

Health infrastructure is very limited in Chhattisgarh. 10 of our 16 districts do not still have a functioning district hospital though government sanctions for converting them to a district hospital have now been accorded to all of them. There are 146 blocks in the State, yet there are only 114 Community Health Centers. Most hospitals do not have modern equipments. There are only two medical colleges in the State. Even the hospitals of these medical colleges do not have adequate modern equipment. Health department gets a very limited amount of money for medicines. Because our programmes are not focused on the community, the poor do not get the desired benefit of even these limited resources. Though programmes are made to benefit the people living below the poverty line, in reality it is only the middle classes who are able to take advantage of them. The real poor often times are not able to access government health facilities, and lose both money and health at the hands of quacks.

Being a new State we have no infrastructure in many fields. There is no drug-testing laboratory in Chhattisgarh. Medicines can therefore not be tested in the State. Similarly there is no facility to test food adulteration in the State. There is no institute to train health workers in the State. A good system to collect health statistics also does not exist in the State. A good Information, Education, and Communication machinery is need to ensure community participation in health. It is simply lacking in the State.

Needs of Primary Health

At present Health Services are focused on cure of diseases. Enough attention is not paid to promotion of health, and prevention of diseases. Though a big system of Primary Health, having Sub Health Centers, Primary Health Centers, and Community Health Centers, has been created, during the last few years, yet this system is not able to work according to expectations. It is necessary to improve this system. The following needs to be done for this: -

1. Make a system of Public Health based on the community, in which people should be able to solve their day-to-day health problems themselves with the help of local doctors. The help of many Non-government organizations existing in the state and the Private Sector should be taken for this.
2. In order to empower communities for Public Health it is necessary to develop an understanding of Public Health among the social workers, and communities, and develop capacity to solve ordinary health problems at local level. Training of voluntary workers, and people working in social sectors will have to be organized for this. This will have to be done on a large scale, and the efforts of voluntary workers will have to be integrated with governmental efforts.
3. A good referral system will have to be developed for such decentralization of Health services, so that people know clearly where they have to go for solution of problems, which they cannot solve at local levels.
4. Full assistance of Local Government institutions should be taken for the decentralization of Health Services. There is a very developed and capable system of Panchayati Raj institutions and Urban Local Bodies in Chhattisgarh. These institutions have been given full responsibility for Public Health by law. It is necessary that these institutions are trained to make their full use in the health sector, and adequate powers are delegated to them.
5. While planning for expansion of health services it is necessary to keep in mind the rights of the disadvantages classes. Many studies have shown that the poor are not able to take advantage of the schemes, which the government has made for the poor. Therefore we must ensure during the planning process itself that the benefits of the scheme go to the target group. New strategies, making use of the private sector will have to be examined for this.
6. Our programmes should help innovations, and provide full opportunities to new ideas.
7. Training of people working in the government system will also be necessary, so that they are able to work in partnership with Local Government institutions, Non-government organizations, and Private sector for empowerment of people to benefit the disadvantaged classes.
8. There is a big challenge to bring the doctors of Indian Systems of Medicine, and other systems of Medicine in the mainstream of Public Health. People in villages often times have great faith on these systems of Medicine. These systems of

Medicine have sufficient human resources too. It is necessary to plan for their maximum development, and maximum use in Public Health.

"Mitanin": The Community Health Worker Scheme

It is a generally accepted fact that improvements in Primary Health can be made only through the involvement of communities in the delivery of health services. However different people mean different things when they talk of community participation. Some of these different meanings are described below: -

1. To some persons the meaning of community participation is wholehearted acceptance of Government schemes by the people. They feel Government knows what is best for the people, and therefore makes the policies and programmes, which are best suited for their good. If people do not benefit from such programmes it is their own fault, as they do not participate fully in Government schemes.
2. Some people feel that community participation means demand generation for the services provided by the Government. If this view is accepted it will mean that though all services are readily available to the people, they do not make use of these services, as they do not know what is good for them. Government should therefore launch Information, Education, and Communication (IEC) programmes, so that people understand the importance of using the services. According to this view also the blame rests squarely at the people for not using services.
3. Still other people feel that the community can participate in Government programmes in service delivery as well. These people acknowledge that the service delivery mechanism of the Government may not be foolproof, and therefore people may not have access to services. They thus feel that Community can help the Government in service delivery. The concept of depot holders of simple medicines, and contraceptives is such a concept. Most planners in Government now realize that the outreach of Government staff is limited. They also accept that increase in the numbers of Government employees to increase the outreach to all the habitations is not cost effective. The decision of the Planning Commission of India to freeze the number of Sub-Health-Centers at the 1991 population level is the result of such realization and a very real resource crunch. Still these people do not really accept the ability of communities to plan and work for their own good. They do not believe in the "Empowerment Approach"
4. There is a very small group of people who has faith in the ability and the power o the communities to shape their own destiny. This group of people feels that community participation should mean empowering the community to plan and work for their development. They feel that Government should help the community in making their own village health plan, and implement it. This should however not become an excuse for withdrawal of the Government, but should the lead to a more meaningful partnership between the Government and the Community. "Right to Health" is an inalienable right of the people, and it is the duty of the Government not only to make all the services available to the people, but also empower the communities so that they can demand, and get what is due to them.

We are a firm believer in the Empowerment concept of people's participation and are committed to ensure this the field of Public Health. Government of Chhattisgarh has launched the ***"Mitanin"*** scheme for this purpose. Mitan in Chhattisgarhi means a close friend. Mitanin is a female friend.. In this scheme it is proposed that one woman will be identified in each habitation in villages, and in each lane in cities, to work as the main link person between the Government and the community. This person will be a friend of the community, and will therefore be known as the ***"Mitanin"***.

This scheme involves some guarantees to the community from the Government, and some responsibilities, to be taken by the Community, and Panchayati Raj Institutions. These responsibilities are described below.

1. **Responsibilities of the Community and Panchayat:**

1.1. Publicity of the scheme in the communities.

1.2. Mobilizing the communities for Health.

1.3. Helping the communities to identify one *"Mitanin"* for each habitation.

The *Mitanin* can be any woman living in the habitation acceptable to the community. It is not necessary that she should have formal education, but it will be helpful if she knows how to read and write. She should be willing to devote her time to activities relating to the health of the community.

1.4. Helping the community in deciding a compensation package for the *Mitanin*. The *Mitanin* will be a volunteer, who will not get any honorarium or salary from the Government. However she will need to be compensated for her time and efforts by the community. No uniform compensation package is being suggested in the scheme. The compensation package should be agreed between the community and the *Mitanin*.

Some suggestions for the compensation package are: -

The community may pay the *Mitanin* directly a fixed amount, either in cash or in kind (in the form of grain). This can be monthly or yearly. Payment to be made in kind every year at harvest time.

The Panchayat may decide to pay the *Mitanin* something from their funds.

The community may decide to pay the *MItanin* a certain amount either in cash or kind for services rendered as user fee.

The Panchayat may decide to allocate five acres of land along with a source of irrigation as *"Mitanin land"*. This land will not be transferred in the name of the *Mitanin*, but she or her family will be allowed to cultivate this land and take the usufruct till she is working as the *Mitanin* of the habitation. This is similar in concept to the *"Kotwari land"*

Cash contribution by each family to be paid to the "Mitanin" every week/month/year or cash fee at predetermined rates for services to the individual families.

Any other method of compensation, which the community and the "Mitanin" agree upon.

One should attempt to get the agreement reached between the "Mitanin" and the community of the habitation to be in writing. The scheme recognizes that this is a difficult process and may be possible to initiate only after at least one year of the programme has passed and its utility is visible to the community. If she regularly gets the drug supply and the slides she sends get reported in time and her referrals gets honored, then the community would be much easier to convince for supporting her.

1.5. Provide space in each habitation for health related activities, including immunization, labor, storing of medicines, etc.

2. **Guarantees by the Government:**

If the Community and the Panchayat fulfill their responsibilities, they can make an application to the collector of the district for the Government to fulfill its guarantees, and the Government will then guarantee the following: -

2.1. Government will train the *Mitanin* identified by the community and the Panchayat.

2.2. Government will give refresher training to the *Mitanin* as often as is necessary, and till such time as the *Mitanin* is fully competent to do her job well.

2.3. Government will integrate the *Mitanin* in the Government Health delivery system.

2.4. Government will provide all the free medicines, other materials, and services to the community through the *Mitanin.*

2.5. Government will provide an essential equipment and medicine kit to the *Mitanin* for Maternal and Child Health, Reproductive Health, Family Planning, safe drinking water, sanitation and epidemic control.

There are 54,000 habitations in approximately 20,000 villages, and 10,000 village Panchayats of Chhattisgarh. Ideally, when the scheme is fully implemented, we hope to have a trained *Mitanin* in each of these 54,000 habitations, and also in every lane of the slum areas of the cities. Thus we are aiming at training approximately 60,000 *Mitanins.* It is hoped that these trained *Mitanins* will be the cutting edge of actual delivery of all Primary Health related services to the community. They will work in close coordination with and under the supervision of the ANM. They will be compensated for their services not by the Government but by the community.

In order to implement the scheme the following steps were taken: -

1. Action Aid India was identified as a strategic partner NGO for the scheme, and the State Government entered into an agreement with Action Aid India for this purpose.
2. A dedicated core team of professionals was developed at the State level for the implementation of this scheme. This team is called the State Health Resource Center (SHRC). The personnel for this core team have been drawn from NGOs working in the field of Health from all over the country.
3. Training modules for the *Mitanin* were developed. The modules are in many parts. There is an inception training, which is given to every newly recruited *Mitanin*, and then other training capsules, which are administered at the Primary health center or

training institutions at regular intervals, as the *Mitanin* starts her work. The training module is in Hindi, and has been made keeping in mind that the trainee is a neo-literate. The module has lots of practical exercises, and field work. Difficult concepts should are explained with examples from the local environment. The training has a provision of being run at the pace of the learner, and takes into consideration different learning styles, and different learning capacity of different people. The training module has detailed and clear cut instructions for the trainers. Good quality and appropriate teaching-learning material is being developed.

4. Development of a training package of training of trainers (TOT).
5. Training of trainers.
6. Publicity of the scheme, and training of Panchayati Raj representatives.
7. Community Mobilization.
8. Identification of *Mitanins*. More than 20000 *Mitanins* have already been identified, and have undergone the first phase of training.
9. The continuing training of the *Mitanin* and her integration with the Health Delivery System is an ongoing activity in all the *Mitanin* blocks.
10. Certain activities which are important for the programme include Training of PHC doctors and training of MPW (M) and ANM. These activities should be started soon.

Role of "Mitanin"

"Mitanin" in Chhattisgarhi means a friend. In fact She is much more than a friend. It is an age old tradition in the villages of Chhattisgarh, that people make other people their "Mitan" or "Mitanin". It is customary in the villages of Chhattisgarh for girls to become Mitanin of their close girl friends. This is done ceremoniously. Once the two girls have become Mitanins, they are closer to each other than real sisters. This relationship continues for the rest of their life, even after they are married, and becomes a bond between families The "Mitan" or the "Mitanin" is a friend not only in this life, but even in heaven. The friendship continues even after marriage, and becomes a bond between families. The "Mitans" and "Mitanins" are ready to sacrifice everything for each other. It is this tradition that the scheme seeks to revive. The "Mitanin" therefore is not just a voluntary worker, but will be a friend, philosopher and guide for the community of the habitation. The community of the habitation should have full faith and confidence in the "Mitanin" and they should have a rewarding, friendly relationship, which may also have a sentimental element. In this sense the "Mitanin" will be a true guide to the community of the habitation in all their endeavors. In the field of Public Health the "Mitanin" will have the following functions: -

1. She will give health education to the community of the habitation.
2. She will take on the leadership role in all Public Health activities of the village, and will encourage community service for public health specially in -
    a. Cleanliness of the village.
    b. Ensuring safety of drinking water.
    c. Making a parapet wall on all wells and covering all wells.
    d. Making soak pits and proper drainage system in villages.
    e. Teaching proper drinking water storage practices to the people.

f. Encouraging people to make and use sanitary latrines.
g. Taking care of the health of women and children specially promoting good health practices by -
    i. Teaching good nutrition practices.
    ii. Teaching good breast feeding and weaning practices.
    iii. Taking care of iron and iodine deficiency by propagating the use of iron folic acid pills, and iodized salt.
    iv. Propagating the use of iron and Vitamin A rich foods, and giving supplementary Vitamin A to children.
    v. Ensure regular weighing of children to monitor growth and development.
    vi. Ensure at least 3 Ante natal checkups for all pregnant women.
    vii. Ensure that all deliveries are institutional deliveries.
    viii. Ensure 100% registration of births, death, marriages, and pregnancies.
    ix. Provide consultation on MTP services.
    x. Provide consultation on Family Planning services, and ensure regular supplies of contraceptives.
    xi. Help women in reproductive health.
    xii. Provide counseling to youth on matter related to adolescence, puberty and sexuality, with special reference to STD, and HIV AIDS.
    xiii. Important health education inputs on diseases like Malaria, Leprosy, Tuberculosis, Diarrhoea and Dysentery.
    xiv. Be a link between the Government Health system, and the community for all National Health Programmes.
    xv. Provide Health Education for other important things.

3. She will provide first aid, and over the counter (OTC) drugs for minor ailments.
4. She will be trained in taking care of common illnesses in the village, and will gradually take on the responsibility for treating these diseases in the village. This will be done gradually during the refresher training organized every fortnight in the sector hospitals. The emphasis in these trainings will be on skill development. The "Mitanin" will be allowed to treat diseases only when she has attained the required proficiency levels in both knowledge and skills. She will be examined periodically, and given certificates of proficiency. The important thing in deciding whether she should be allowed to treat a disease is the confidence, which she has in her own ability, and the confidence, which the sector health team has in her ability. A detailed system of examination, and certification will be worked out.
5. She will be given the knowledge to refer all cases beyond her competence to the proper place where they can receive proper health care.
6. **Relationship with the ANM and other Health Staff:** - The ANM and other health staff will look at her as the most important asset in the habitation through which they can reach out to the community. The "Mitanin" will look at the ANM as her chief source of knowledge and strength. The two will not be competitors but will complement each other. Essentially the interrelationship of the "Mitanin"

and the ANM or other sector health staff will be positive fulfilling, rewarding, friendly and supportive.

a. **The ANM will do the following for the "Mitanin" -**
   i. Train the "Mitanin" in the fortnightly refresher training courses.
   ii. Teach skills to her by making her do things under supervision.
   iii. Conduct examinations at frequent intervals for certification.
   iv. Be the main link between the "Mitanin" and the health system.
   v. Provide support to her in all difficult situations.
   vi. Build confidence of the "Mitanin" in taking care of the village community.
   vii. Be the chief spokesperson of all the "Mitanins" in her area to the government system.
   viii. Ensure supplies of health education material, essential drugs, record keeping material, contraceptives, etc.
   ix. Counsel the "Mitanin" in her work specially in unforeseen situations.
   x. Provide legitimacy to the health related work of the "Mitanin" in the community.
   xi. Help the "Mitanin" in all referrals.

b. **The "Mitanin" will do the following for the ANM -**
   i. Provide support to her in the community of the habitation for all Public Health work.
   ii. Provide her basic data about the community of the habitation.
   iii. Help her in the registration of marriages, pregnancies, births and deaths.
   iv. Determine the contraceptive preferences of the community and help the ANM in the CNAA strategy of family planning.
   v. Be the main source of information about the community of the habitation.
   vi. Create an environment in favor of positive health in the community.
   vii. Help the ANM in staying in the village, and organizing camps and other health related activities.
   viii. Provide legitimacy to the Public Health work of the ANM in the community.
   ix. Help the ANM in surveillance of important diseases.
   x. Help the ANM in organizing relief, and in the prevention of epidemics.
   xi. Help the ANM in all health related campaigns.

7. **Relationship with PRIs** - "Mitanins" will work in close association with PRIs. The selection of "Mitanins", and the agreement between the "Mitannin" and the community of the habitation will be approved by the Gram Sabha". Public Health is an important function of PRIs under the 73rd Constitution amendment. At present the PRIs do not have any mechanism of performing this important function. With the introduction of the "Mitanin" scheme the PRIs will be able to discharge their duties easily. Civil society, and a free press are important pillars of

a democracy. These two do not really exist in a village. The "Mitanin" can perform the functions of both "organized civil society", and a "free press" in a village to provide succor to and sustain democracy at the Village Panchayat level. She will be in constant dialogue with the people of the village on all important issues, and therefore she is competent to be the voice of the civil society. Similarly she will the main source of transmitting information about development schemes, and work of the Panchayat, and government to the people. In this manner she is similar to the free press.

a. **Panchayats will do the following for the "Mitanin" -**
    i. Gram Sabha will approve the selection of "Mitanin", and also the agreement between the "Mitanin" and the community of the habitation.
    ii. Panchayats will ensure that the community of the habitation honour their side of the agreement.
    iii. Panchayats may decide to pay the "Mitanin" something for the services they render.
    iv. Panchayats will help in the irrigation of the "Mitanin land" if provided by the community of the habitation or the collector.
    v. Panchayats will monitor the work of the "Mitanin", and if they find that the "Mitanin" has not performed her duties well, the Panchayat may remove her, and ask the community of the habitation to select a new "Mitanin".
    vi. Panchayats will ensure that the "Mitanins" get good training, and get regular supplies of publicity material, contraceptives, essential drugs, and other things.
    vii. Panchayats may use the "Mitanin" in the implementation and monitoring of other welfare, and community empowerment schemes.

b. **"Mitanin" will do the following for PRIs -**
    i. She will send regular reports to the Panchayat about the health status of the community.
    ii. She will attend meetings of the Panchayat whenever she is asked to do so by the Panchayat, and will give all information about the health status of the habitation, which is necessary for the Panchayat to make informed decisions about the programmes, and schemes being run in the habitation.
    iii. She will help the Panchayat to implement, and monitor such other welfare schemes, and community empowerment schemes, as the Panchayat may require her to.
    iv. She will follow all lawful instructions of the Panchayats.

8. The "Mitanin" will gradually take on such other responsibilities, and perform such other functions as the Panchayats and the district administration may decide. She will be trained for performing these duties, and duly compensated for them by the concerned departments.

The "Mitanin" will be the main link between the government and the people in a habitation. It must be stated here that in order to derive full benefit of the scheme it will be necessary that health department delegates full powers of programme planning, and implementation to PRIs. Capacity building of PRIs will also be necessary.

Selection of "Mitanins"

"Mitanins" are to be selected by the community of the habitation. The selection has to be formally approved by the "Gram Sabha". However, just a formal approval of the Gram Sabha without involving the community will defeat the very purpose for which the "Mitanin" scheme has been conceived. The selection process described below is to ensure that the community actually decided who the "Mitanin" will be, and the process of community does not remain on paper. It is therefore important that the process is followed in letter and spirit.

The selection process follows the following steps: -

1. A series of workshops and sensitization meetings were held at the state level and district level to orient the representatives of PRIs and key officials and convince them about the scheme. PRI representatives not only understood the full import of the scheme, but are also committed to its success.
2. A team of facilitators was then selected and trained to sensitize the community in each habitation, and help the community in the selection of the "Mitanin". One team of facilitators was trained for each block. It was ensured that facilitators know the local language well, understand the local culture, have positive social attitudes, and faith in the inherent strength of communities, are good communicators, know how to work with groups and are willing to live in villages with the villagers, and make night halts in villages. Some examples of persons selected as facilitators are: -
    i. CDPO or Supervisor of ICDS.
    ii. ANM or LHV.
    iii. Village level workers of various government departments.
    iv. Panches.
    v. Members of Didi Banks (Credit and thrift groups of women)
    vi. Members of Zila Saksharta Samitis.
    vii. Members of Watershed committees or JFM comittees.
    viii. NGO workers.
3. The facilitator then visited the selected habitation as many times as necessary. Often they made night halts in the habitation. They spent time with the community, so that the community feels that they have become one with them, and freely share their joys and concerns. This is a rather prolonged process, and should not be hastened.
4. Once the facilitator has the confidence of the village community, the subject of the "Mitanin" scheme is discussed with them. The concept is explained in detail. The facilitator then discusses the possible choices, and the pros and cons of choosing various prospective women as "Mitanins" These discussions are held in

an informal environment. The facilitator tries to develop consensus amongst the members of the community on the choice of the "Mitanin". The facilitator also discusses with the prospective "Mitanins" the things, which the job entails, and the responsibilities, which they will have to undertake.

5. Once the facilitator is convinced that a consensus is emerging on the choice of "Mitanin", the facilitator calls a meeting of the community of the habitation to make a formal choice. In this meeting the voluntary nature of this work and the possible different ways of the community compensating the "Mitanin" for her services are also discussed freely.
6. A number of village level activities, which are mobilisational in nature, are carried out. Of this the use of the kalajatha for spreading the spirit of the programme and enthusing the people to participate in this programme is one major step. There can be other major publicity and mobilisational activities like wall writings, posters, meetings, cultural events etc to build interest in the programme.
7. Once this stage has been reached, a formal meeting of the Gram Sabha may be called, and the agreement approved by the "Gram Sabha". The sarpanch of the Panchayat will then endorse the agreement, and then send a request to the Block programme team to train the "Mitanin"

Training of "Mitanins"

After a "Mitanin" is selected, and a formal agreement is signed between the "Mitanin" and the community of the habitation, and approved by the Gram Sabha, the Village Panchayat endorses the selection and in effect sends a request to the Block Medical Officer to train the "Mitanin". All the expenditure on the training is borne by the Government. "Mitanins" are provided training in many stages. First stage of the training, itself made of six rounds is institutional. The second stage of the training will be a series of refresher trainings organized at regular intervals at the panchayat or cluster level or PHC through suitable training institutions and training arragnements.

First Stage : Institutional Training: - This training will include the following: -

1. Attitudes: - The training is designed to bring in positive attitudes in the "Mitanin" about the power of people, empowerment of women, the strength of community work etc.
2. Knowledge: - She is given knowledge about basic concepts in Public Health, various Government schemes, and programmes, National Health Programmes, Signs and Symptoms of common diseases, etc.
3. Skills: - Skills relating to communication, management, group behavior etc. will be developed during the course of the training. Skills relating to disease treatment are also developed.

The "Mitanins" are trained through a participative process of group work, field visits and studies, visiting areas where community health volunteer scheme has been successful,

practical demonstrations, and field exercises. After each round of training they are deployed and supported in a set of activities at the village level. The first two rounds are on health rights and knowledge of available public health services and on child health. The third round is on women's health. The fourth round is on control of communicable disease and the fifth and sixth rounds are on first contact curative care. At the end of an year they would also have a training on village level health planning.

Second Stage : Refresher Training" : - Refresher training are organized monthly at the sector PHC/ cluster level. This training will concentrate on reinforcing what was learnt in the first stage plus further practical aspects of diagnosis and treatment of common illnesses and a lot of troubleshooting and on the job training. It will aim at skill development and practice so that the "Mitanin" gradually develops confidence and is able to take care of the health needs of the community. This training will need to go on indefinitely- it is a continuous process.

The specific skills she would be trained in include: -

1. Making of peripheral blood smears.
2. Detection of anemia.
3. Antenatal care.
4. Weighing of children.
5. Recognizing malnutrition and being able to counsel the family on integrated management of childhood illness with a focus on malnutrition.
6. Recognizing Acute Respiratory Infections, and giving specific drug from her kit when required.
7. Recognizing fever, and giving choloroquine presumptively.
8. Recognizing when a patient should be referred to a hospital.
9. Recognizing signs of dehydration, and administration of ORT.
10. Conducting local level health education meetings for specific groups.

The Sector/cluster training team will make an assessment of the knowledge and skills of the "Mitanin" from time to time, through an assessment system,on the basis of which she will be provided refresher training and allowed to take on more of the responsibility of health care of the community gradually.

In conclusion:

This chapter only outlines the basic concept of the ***"Indira Swasthya MItanin"*** Scheme, and the broad contours and outlines of its implementation. The remaining chapters of this book will describe the processes in far greater detail. It needs to be stated that the scheme is in its infancy yet, and therefore it is premature to assess the impact of the scheme on Public Health. It must however also be mentioned that the scheme has evoked great enthusiasm in all the villages, and peoples' participation is very visible for all to see.

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HEALTH SECURITY FOR THE POOR : HEALTH INSURANCE THROUGH HEALTH CARE COOPERATIVE

Dr P.R.Panchamukhi*

Nayantara Nayak**

Fears are sometimes expressed particularly in the context of developing countries that economic reforms consisting of liberalization, privatization and globalization, primarily focus on economic objectives of efficiency of resource allocation and the social objectives of distributive equity and social development are likely to receive a back seat in the course of pursuit of economic objectives. Much is documented in the literature on the compression of the government budget in general and the overall budget of the social sector in particular, especially in developing countries during reform. This compression is more likely to affect primarily the poor and the less privileged in the society. Obviously, it is not enough if the problem is diagnosed. What is necessary is to introduce immediately the counter measures to tackle these likely developments. It should be noted that such counter measures to safeguard the interests of the poor are required under all occasions, whether there are economic reforms or no economic reforms, for, the problems of equity (inequity) lie very much in the nature of the components of social sector itself, particularly in the context of a stratified society like India. This will be brought out from Section I of the present paper. Economic reforms however are likely to aggravate the problem.

Demand for health and education, the main components of social sector, is generally highly income elastic. Similarly, access to health care and educational opportunities is also found to be highly income elastic. In a regional perspective, demand for and access to health and education seem to be elastic with respect to the level and rate of economic development of the region. It is also worth noting that health and

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* Director CMDR Dharwad Karnataka

** Associate Fellow CMDR Dharwad

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education confer both private and social benefits. Opportunity costs of education and health are generally fairly high particularly for low-income households. Costs of maintaining health, costs of getting education and avoidance costs of ill health and non-education are too high to be overlooked. From all these points of view, **education and health are considered in public finance literature as** ***merit goods***, implying that they are so meritorious from the point of view of social welfare that issues of their provision cannot be left to the decision making of the individual or private sector alone but they need to be considered by the collectivity or public sector also. In the present paper an attempt is made to focus on issues relating to the provision of health care facilities particularly for the poor keeping in mind the characteristic features of health calling for involvement of the collectivity or public sector in its supply or making provision for it. The paper suggests a mechanism of involvement of the collectivity – community and the government, which would help better access and utilization of health care services by the poor. *The focus of the paper is on health insurance facilitated by the health care cooperative of providers of and beneficiaries from health care services.*

The paper is divided into four sections.

In *Section I*, unique characteristic features of health relevant in the present context are briefly outlined.

Section II examines some of the resource allocation plans to the health care sector suggested in the literature, keeping in mind the requirements of the poor in general and the poor among the socially less privileged sections of population in particular. Its main focus is on the basic issues that need to be considered while implementing the plan.

Section III presents a brief review of the experiments of health care cooperatives and health insurance as in practice in selected countries with a special focus on the experiments and proposals in India.

- There is no universally acceptable yard-stick for measuring health level of individuals. Also, there is no acceptable definition of health. As a result, there is a greater probability of episodes of general ill health (which might, at times, lead to major ill health episodes) being overlooked or treatment of which is likely to be postponed. This happens particularly in the case of poor households and in the case of those who have low social status even in the case of a well to do family. On the other hand, rich households and only socially better off members of even a better off family (such as earning members or male members or members who are accepted as heads of households, even though they are not earning members, or those who are ritually superior, such as mother in law rather than daughter in law, etc) are likely to receive more attention regarding even small health problems also, since they can afford the high costs of such medical attention and treatment or resources are made available for them rather than for others for this purpose in view of their ritual status. Thus, the *probability of medical care attention* is *a positive function of socio-economic and ritual status of the individual / household in question. In other words, in the Indian context, availability of medical care attention is not just in accordance with the demand and need for it but it is most often in accordance with factors other than these.*

- In view of the low economic status of the members of poor households, who depend upon their physical capabilities and skills for meeting their daily subsistence needs, it would be imperative for them to maintain their physical and mental well-being at a fairly high level, which enables them to put in work and earn daily livelihood. Illness causes immiserization of the poor and hence it is necessary for the people to avoid illness or debilitating morbidity causing further impoverishment and immiserization.[1] This is particularly seen in the case of those members who work in the unorganized sector and who work on a daily wage basis. Thus, what one may call, the '***subsistence need for medical care attention***'

[1] Hsio and Sen reported that 40 percent of the entrants to poverty in a particular year in India attributed poverty to illness episodes in the family. Hsio, William and Priti Dave Sen (1995) 'Cooperative Financing of Health Care in Rural India' Quoted in TN Krishnan : *Economic and Political Weekly* April 13 1996

Section IV, which is the concluding section, outlines major elements of a health security plan for the poor incorporating the insurance strategy first in general terms and then particularly for one of the villages in Karnataka, for which field data were collected for the purpose. This example attempts to indicate the order of resource requirements if such a plan needs to be implemented on a wider scale. It also examines whether there would be resource savings if such a plan with community involvement and contribution is implemented in place of the present practice of government itself taking the entire responsibility towards health security for the poor.

I. HEALTH AND HEALTH CARE SERVICES AS AN ECONOMIC GOOD IN THE INDIAN CONTEXT

Health is an economic good, the peculiarities of which need to be explicitly recognized in any health security plan. We briefly outline below some of these peculiar features particularly in the typical Indian context, with her own unique value system, traditions and socio economic conditions. In the Indian context health services would also have their own peculiarities in respect of their supply and demand, which deserve a special attention while developing a health security plan for the poor. It can be seen that inequality in access and utilization are inherent in the very nature of health and health care services as an economic good, particularly when it is left to market forces.

Is Inequality in Access and Utilization Intrinsic to Health and Health Care ?

From the following characteristic features of health and health care it would be clear that conscious efforts have to be made to safeguard the interests of the poor so far as the needs of the poor are concerned. Social and economic backwardness would further aggravate these inequities.

is a negative function of economic status of the individual member in question. This should not be taken to mean that better off people give less importance to health and health care. On the other hand, they pay more attention to even a small disturbance in their health, as stated earlier. What is implied here is that *for the purpose of subsistence earning, meeting the need for health care is more mandatory for the poor than for the rich.*

- *Some of the health care facilities are, by and large, in the nature of indivisible goods, while services from these facilities are characterized by a fair degree of divisibility and rival-ness in consumption. These may be termed as lumpiness in supply but a fair degree of divisibility in utilization.* In view of this lumpiness, large investments are needed to supply these facilities. There is a tendency of *cost recovery charges from the purchasers of services being over estimated* in such a situation. In view of speedy technological changes in the field of medical science and public health and hence expectation of foreign initiatives in the background of globalization, uncertainties associated with the occurrence of morbidity episodes requiring the use of a particular facility, uncertainties associated with the use of the created facilities by the affected persons, etc. there seems to be *an undue haste in cost recovery by the investors making the charges for the users unduly high.* Added to it, the instinct of greed and a desire for more and more and more also contributes to this tendency for over -charging.

- Another factor also contributes to this tendency, which is the result of some of the **recent developments under economic reform regime.** In view of the declining interest rates on borrowings and trends of privatization, such facilities are likely to be created with the help of borrowed funds[2] by few private initiatives that can provide the necessary collateral required for loans from financial institutions. This would also give rise to a situation of *few sellers* **operating in the health care**

[2] CMDR proposes to study the changes in financing of activities of medical care providers before and during the period of economic reforms. For such a study micro level field data need to be collected from private sector providers. We have not come across any such longitudinal micro level study in the literature.

commodities markets. *Such sellers can control price of services and also indirectly the clientele utilizing these services.* This characteristic feature would have significant implications for access of the poor to health care services.

- *Health care services consisting of both material and manpower services – are likely to get concentrated in urban areas* in view of their characteristic features outlined above. Since large percent of agricultural labourers are located in rural areas, they are more likely to be deprived of the necessary benefits from health care facilities, which are not adequately available in rural areas. *Health facility mapping* for rural and urban areas in different states of the country would reveal how the facilities get clustered disproportionately to the population in urban areas.[3] It is useful to work out *regional inequality indices of health care facilities in rural and urban areas* of different states. District-wise facility mapping would more clearly bring out the deprivation of rural areas. Field studies show that the rural folk have to walk down / travel in bullock carts or tractors for miles together in search of medical assistance in the case of illness episodes. It is also worth noting that most of the health care centres located in many villages are mostly non-functional, ill equipped and inadequately manned. This also suggests that the *health facility mapping needs to be done keeping in mind the functional existence of the facilities rather than merely their physical existence.* Intra regional facility distances are most often found to be an inverse function of the level of economic development of the region, suggesting that *the poor in the less developed regions are likely to be more adversely affected than the poor in the more developed regions.*

- Considering gender dimensions of commodity of health and health care would bring out many important aspects worth noting while developing a health security plan for the poor. Generally, women are considered as health care providers in the family. However, health of the health care providers in the family is generally

[3] One such attempt is in progress at CMDR in the case of Karnataka state. In view of information gaps only public medical care facilities are being mapped.

overlooked, not only by other members of the family, but also by women themselves. Traditionally, low social status of girls and women in Indian family contributes to this. As a result, female members, right from baby girls to elderly women in the family are likely to be more deprived of health care services than male members, starting from baby boys to elderly men in the family. This discrimination is more severe in poorer families, rural areas and poorer states. Health condition of female members in poorer environment- regions and households is likely to be much worse than that in more developed regions. *Access to, utilization of and benefit from health care services are thus a function of gender with adverse effects in the case of female members.*

- *If health and health care are under-priced in the present period even though the price payable for them by the beneficiaries in the long-run works out to be much higher, then* generally, there is a likelihood of the normal law of demand to operate vigorously in the short run keeping in mind the price in the present period only. Thus, in the case of demand for health care services defective telescopic faculty seems to operate. Price elasticity of demand is generally very high for the people of all economic levels and at all price levels. But, at high income levels and at high price levels price-elasticity is likely to be higher, other things remaining the same.

- *There is an asymmetric information flow for medical care providers and patients, with some information available more with providers and some other crucial information available more with patients.* For example, scientific, medical information about diseases-causes and cure in general, is available with medical care persons-doctors, nurses, etc. But, information about how they feel while suffering from disease, while receiving treatment and after treatment, etc lies essentially with the patients. Information about preventive care and promotive care is available with medical and public health personnel whereas information about the effects of these measures of care is available with only the clientele-beneficiaries.

- Considering the aspects under the above two paragraphs, it follows that **there is a risk of overuse of certain types of care by the people, particularly at higher income levels,** since they can afford larger expenditures on drugs. Excessive use of drugs and medical services is termed in the health insurance literature as 'moral hazard' implying probably that people consume more of medical care than what they really require and that such over use is likely to be hazardous also. People's expenditures might be guided by what one may call, ***presumptive prescriptions by medical experts***, who in turn might act under wrong information or self-interest considerations. Provider-induced-over-use of drugs and medical services or even self-induced over use might ultimately exaggerate demand for drugs and services and distort long term planning in the case of the health care sector.

- *Price and income elasticities of demand for health and medical care are likely to be high at high income and price levels than at low income and price levels.* In view of this, generally, special attention seems to be paid by providers to those drugs and services, which cater to the needs of high-income groups of population. This leaves the needs of the poor unconsidered in normal circumstances, unless special initiatives are made for the purpose. This is evident from the location of medical care services in urban areas, where, generally richer sections of population live, the rate of growth of tertiary care investment is higher than that in primary care in rural areas and similar indicators. Analysis of drug prices meant for the common care and for tertiary care should also be revealing from this point of view.[4]

- Preventive health care services are characterized by special features, which deserve attention of analysts, while designing health security plan for the poor. Demand for preventive care is much less clearly articulated than demand for curative care. Also, effort for meeting this demand is also much less in this case as compared to curative care. Articulation of the need for preventive care is

[4] CMDR has commissioned a study of drug prices, the results of which would throw a light on these issues.

obviously a function of level of awareness among the people about its importance. *Since the effect of absence of such care is felt much later after a long time lag immediate appreciation of the importance of preventive care is generally not seen both by the individual beneficiary or the collectivity as a whole.* This is one of the reasons why the decision makers do not undertake the projects for preventive care so enthusiastically. Even at the individual level much attention is not given to measures for preventive and promotional care as in the case of curative care.

- As indicated above, preventive care can be of two types, viz. individual-specific preventive care and collectivity specific preventive care. **Demand for both types of preventive care is a positive function of level of income of the individual and the collectivity apart from the level of awareness about the importance of such care in the functional capabilities of the individuals.** Hence, preventive care becomes a predominant merit good, being so meritorious from the point of social welfare that it calls for collective intervention for provision over and above private initiative for its provision. *Since the poor in particular, are likely to be more vulnerable if such care is not available it becomes necessary to devise ways and means for its provision to help them.*

From the above conceptual background relating to health and health care services as economic goods, it is clear that generally the poor cannot safeguard their own health care interests and that such interests can be safeguarded only if suitable mechanisms are evolved. Such mechanisms should be developed incorporating the involvement of the people, invoking the spirit of altruism and mutual sympathy among those who have higher ability to pay and better capacity to organize services with a longer out-reach both with respect to time and number of people. It is felt that the spirit of cooperation, which already prevails among the people in India, particularly in villages, needs to be aroused for invoking this spirit of altruism and mutual sympathy. Sympathy and mutual sympathy have been considered as one of the six springs of human conduct by Adam Smith. In his *Theory of Moral Sentiments* Adam Smith devotes one full chapter to

eulogize the ' Benefits from Mutual Sympathy'. Mutual Sympathy has received the highest importance in the codes of conduct sanctioned by many religions of the world also. Therefore it would be useful if this spirit of mutual sympathy is utilized for helping the poor in their health care needs. Since the poor cannot bear the high costs of health and medical care it would be necessary to *devise a mechanism invoking the spirit of mutual sympathy and cooperation, through which it is possible to provide health care services at reasonably low current costs spreading the rest of costs in suitable installments in the future.* The mechanism should explicitly note the seasonality (as in the case of agricultural labourers, for example, who get earning opportunities mainly during the agricultural seasons) and at times irregularity of the income flows to the poor households and adjust the payments towards health care costs to such income flows. This mechanism should also recognize the fact that occurrence of illness and its duration are uncertain. *Any organizational mechanism that can pool the risks of illness of the poor households and that can provide for convenient cost payment arrangements should greatly help the poor.* Health insurance is considered as such a mechanism, which can greatly help the poor. Health insurance is also a mechanism for gaining access to health care that would otherwise be unaffordable.[5] If cooperative elements were integrated with health insurance then it would have an added advantage for the poor.

II MAIN ISSUES REGARDING HEALTH INSURANCE AND HEALTH-CARE COOPERATIVES

Health insurance and health care cooperatives can be considered as the methods for pooling of risks of different types of ill health across individuals and over the period of time. A number of issues in this connection have received the attention of researchers. Some of the important ones are briefly outlined below.

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[5] John A.Nyman : 'The Value of Health Insurance : The Access Motive' *Journal of Health Economics* 18 (1999) This study shows that even in the U.S. access motive is facilitated by insurance and that the poorer of the Americans are enabled to have access to costly medical care, which they could not have afforded before

- When health sector budgets are getting compressed during the period of economic reforms can health insurance mechanism maintain the overall budgets for health care sector at high levels ? In other words, can insurance be considered as a dependable source of financing of health ?

- Government provision of health care services is believed to safeguard the health care needs of the poor. In this background, to what extent can health insurance mechanism be considered as responsive to the needs of the poor ?

- Does health insurance mechanism lead to what is termed in the literature as *moral hazard*, implying more than an optimal use of medical care services ? Choice of the best health insurance plan involves a trade off between the gains from risk reduction in connection with the disease/s covered under insurance and the loss of moral hazard.[6] How far are people in a country like India in a position to make such a best choice ?

- Does this excessive consumption of medical care have its own implications for health of the users ? Studies have tried to show that having insurance is associated with having better health.[7] The hypothesis of effect of excessive consumption on health status, needs to be tested with micro level data.

- Does this excessive use of medical care services by the rich result in less availability of services for the needy, who may not be in a position to bear the cost of health insurance itself? Does this also result in inefficient allocation of scarce medical care and financial resources of the economy in the ultimate analysis ?

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[6] Willard G. Manning, M. Susan Marquis : 'Health Insurance : the trade off between risk pooling and moral hazard' *Journal of Health Economics* 15 (1996)

[7] Beth Hahn, Ann Barry Flood : 'No Insurance, Public Insurance and Private Insurance : Do these options contribute to differences in general Health ?' *Journal of Health Care for the Poor and Underserved* V1 6 1995.

- In view of its effect in terms of excessive demand for medical care services, **does health care insurance lead to further rise in price of such services and also in insurance premia in the long run, making health care more costly for the poor**, the very problem, which the insurance mechanism wanted to tackle itself ? These aspects would be very crucial in the context of developing countries where cost escalations would lead to further deprivations of the vast masses of the poor.

- **Making health insurance mandatory is likely to result in a welfare loss for those who had not purchased it earlier.** This issue needs to be examined in the specific context about which not much research seems to have been done.[8]

- **Does insurance mechanism sustain itself in the long run?** This question is relevant because the overhead costs and operating costs of such a mechanism are likely to be quite heavy and which might not be recovered from the clients through premia ?

- If the premia are hiked up significantly in order to recover the costs then in what way would this mechanism be different from the private market based supply of health care services ? **A rise in premium might discourage the less privileged people to go in for insurance cover.** One of the studies in US has estimated that a 1 percent rise in insurance cost would lead to a 1.8 percent reduction in the probability of persons seeking insurance cover.[9]

- **Should health insurance be provided by government itself or by the private sector initiatives or by both ?** If both private sector and government are operating at the same time, would there be a tendency of government being *crowded out* by the normally aggressive private sector initiatives ? In the context

[8] Michael Chernew *et al* : ' Worker Demand for Health Insurance in the Non Group Market: a note on the calculation of welfare loss' *Journal of Health Economics* 16 (1997)
[9] Gruber, Jonathan and James (1994), Tax Incentives and the Decision to purchase health insurance : Evidence from the self employed. *Journal of Health Economics* , 109(3).

of the U.S. however, employer delivered health benefits are reported to have been replaced by the government insurance mechanism.[10]

- Some studies have also shown that significant health status differentials among the insurers are observed in the case of public and private health insurance systems, with lower status in the case of the former.[11] Would this mean that provision of publicly managed insurance for the poor and privately managed insurance for the rich would lead to health status disparities among the poor and the rich in the society ? *What is the optimum public private mix in the case of health insurance ?*

- Does insurance mechanism in general ensure high **quality of health care services** ? Does government operated Health Insurance ensure better quality of services or private sector operated insurance would achieve that objective ?

- **Whose out reach is better- private sector's or government's,** so as to ensure availability of health care services to the poor, to the socially less privileged, to the people in remote areas, to children and to the elderly also (as, normally private health insurance operators are found to exclude people outside a certain age)?

- Does health insurance mechanism provide for **articulation of the health care needs by the people who are in need of such services** ? Or, does this mechanism strengthen the **dominance of the providers in the health care sector** ? Would this imply the relevance of Say's Law of Markets in health care market (Supply creates its own demand) with its concomitant implications for the clientele ?

- Can health insurance mechanism be so structured as to integrate the **equity considerations** ? Thus, can there be differentiated premium system, distribution of claims in cash or kind, coverage of all types of health care needs such as

[10] A number of studies are conducted to examine the relationship between public and private health insurance systems. For a list of some of such studies please see references at the end of this paper.

preventive, promotive and curative needs, etc. ? Can a Health Insurance mechanism cover the *risks also of common ailments of masses*, which at times become economically costly for those who lose their work days on account of such weakening common ailments and which reduce their work output ? Should premia alone be graded or service charges also be so graded or both, to ensure equity in access and utilization ?

- Are people in a country like India aware of the advantages from health insurance so that it would have a fairly good demand just enough to sustain it in the long run ? What measures need to be taken to raise the level of their awareness about the value of health insurance ? [12]

- Can health insurance be extended to rural areas, un organized sector, all types of occupations and all income levels, all age groups, etc. for, inclusion of these under the insurance cover is feared to increase the risk of losses of insurance providers who are traditionally considered as *loss leaders* in the economy ?

- If health insurance supply is opened up to the *private sector* and also to the *international operators* then there is allegedly a risk of foul practices in health care supply. In the case of foreign companies operating in the system there is also a risk of repatriation of profits and resources from India to the other countries. Under such circumstances, what countervailing checks and safeguards need to be introduced to regulate their activities ?

- How should clientele beneficiaries' involvement be ensured in the functioning of the health insurance system so that people themselves become a watch dog for its functioning ? Can co-payment, coinsurance, group insurance, etc serve this purpose ?

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[11] Beth Hahn and Ann Barry Flood : *Op cit.*

[12] Over 92 percent of the non insured households both in rural and urban areas are not aware of the existing health insurance schemes. This is the result of a NCAER –SEWA survey (1999) as reported by Anil Gumber : 'Health Care Burden on the households in the Informal Sector' *Indian Journal of Labour Economics* Vol 45 No. 2. 2000.

These and many other issues deserve the attention of policy makers and analysts having an objective of improving the access and utilization of health care services for the poor and provide a useful health security plan for them. We believe that health insurance can be a useful health security plan for the poor if it is managed neither by the public sector nor by the private sector but by the people's sector. By people's sector we mean a cooperative of the people, which is specially created for the purpose of fulfilling the health care needs of the poor. Health insurance through health care cooperative is thus considered as a mechanism worth trying in the Indian context. Such a mechanism has been tried in some form in India and in some other countries also It would be useful to learn from these experiments and design a ***mechanism based upon the principles of mutual sympathy and pooling of risks*** for the benefit of the poor particularly in the rural areas of the country.

III A BRIEF REVIEW OF EARLIER EXPERIMENTS:

We noted above that health care cooperative and health care insurance are the two organizational initiatives that can be suitably integrated to help the cause of the poor. In what follows we briefly review the experiences of selected countries for which information is available, about the experiments of health insurance through health care cooperative. This review would help us in designing a health security plan for the poor, which we propose to develop in one of the villages of Karnataka for which data were specially collected. CMDR proposes to adopt this village or a cluster of villages in the region to implement the plan in its action research programme.

The review is presented for thirteen countries, for which the information was readily available, starting from a developing country like India to the developed country like USA. Only the salient features are outlined without going into the details. For convenience the Indian experiences are outlined at the end.

1.

The replacement of collective agricultural production by the household responsibility system as a result of economic reforms is said to have led to the decline of collectively funded Co-operative Medical Scheme (CMS) in China. The study by Yu Hao and others[11] reports that during collective farming CMS assisted farmers to meet health care costs in more than 90% villages. Considering this the government of China is encouraging the establishment of such CMS, which are said to have been set up in rural China with the help of local government.

Cooperative Medical Scheme (CMS) in Wuzhaun Township:

The plan for CMS was drawn by researchers of Shanghai Medical University. Based on household survey, the design for CMSs with varying service coverage, premium and reimbursement ratio was developed.

Features:

- Membership in 5 villages is said to be voluntary and open to all rural households.
- Premium of ¥ 5 per member, with ¥ 4 (0.5% of annual per capita) from individuals and ¥ 1 from county government. Village collective or local government though agreed to pay premiums for extremely poor households, did not pay in actual practice. Few farmers paid in terms of produce (grains). ($ 1=¥ 8.3, ¥1=Rs. 5.5)
- Services: Free registration, reimbursement for treatment and injection fees at village level, free immunization for children(up to 7), pre and postnatal maternal care and delivery service.

[15] Yu Hao et al (2000), Financing Health Care in poor rural Counties in China:Experience from a Township- Based Cooperative Medical Scheme, IDS Working Paper 66

- Management: Committee established with members from township government. Salary of Manager was paid by local govt.
- *Drugs: Village doctor is allowed to buy drugs from township health center and sell them to patients at fixed prices.
- *Village doctor has to hand over prescriptions to CMS Committee for examination and reimbursement of drugs, treatment and injection fees. 1/3 rd of the difference between wholesale and retail price of drugs was paid to the Committee which redistributed the money to village doctors at the end of the year as a performance bonus.
- *In each of the five villages one village doctor was contracted to provide health care irrespective of membership. Maternal and preventive care were organized with the help of township health center.
- Health Bureau supplied equipments and published regulations, cards and forms.

54 per cent of the households were members (984 HHs with 3355 population). HHs. which had access to health care did not *become* members. There was an average of 2.2 visits per member per year. The level of reimbursement was ¥ 2.08 per member and it varied from ¥ 3.73 to ¥ 0.8. Full time doctors were more popular. Share of drugs in total fees reduced due to CMS, which was service oriented (from 90% in 1993 to 76% in 1997). Need for continued assistance from government, encouraging poor households to become members. Increasing maternal care, which is lacking and promotion of health education are suggested measures.

2. Philippines[14]

Voluntary Health Insurance for residents of poor rural communities: In Philippines National Health Insurance Law passed in 1995 aims at universal coverage for

[14] Ron Aviva and Kupferman Avi(1996), A Community Health Insurance Scheme in the Philippines: Extension of a community based integrated project. Technical Paper - No.19,WHO, Geneva.

a range of health care benefits. In the meantime government has encouraged community health projects to develop health insurance scheme.

ORT (Org. for Education Resources and Training) Mother and Child Care Community Based Integrated Project (MCC) is run by ORT which is an International Voluntary Organisation. This project was launched in La Province of Philippines. The project provides pre- school education and basic health services. ORT Health Plus Scheme was launched in 1994.

Population: Covered the families of children attending 13 ORT centers, members of ORT co-operative and the general population of the communities where day-care centers were located. Total coverage was expected to be 2500 HHs. But, only 300 families registered in the first year. Family was the membership unit.

Services: ambulatory and in-patient care, prescribed drugs and ancillary services provided by doctors and nurses in day care centers.

Finance: considering the income flow patterns in the population contributions were collected monthly, quarterly, bi-annual and annually. Differential level of contribution for members and non-members of medi-care and family size was followed.

Contributions: P 50-single person
P 100- standard family
P130-large family (25 pesos=1 $)

These accounted for less than half the amount that the families spent on basic health care, excluding in-patient care. For those with medicare the premium for out-patient care was P 70 per month.

For the initial period ORT project continued to pay the salaries of doctors and two nurses in day care center. Non insured persons had to pay P 50 per consultation and for

drugs at cost plus 50%. For insured the cost of drugs was cost plus 20% much below the market rates.

Management: CMS is administered by ORT Multi-Purpose Cooperative which is formed by parents and staff of day care center to increase household income and sustainability of day care centers.

3. Brazil

One of the largest provider(usually owned by doctors) owned Cooperatives is said to have been established in Brazil in 1967. By 1994 its member owners were said to be 60000, with independently practicing doctors(1/3 rd of national total). Under this Unimed system an individual or 30000 enterprises which provided health insurance to their employees could get agreed services from any member doctor anywhere in Brazil.

4. Tanzania[15]

Tanzania is reported to be among the first countries in Southern Africa to introduce prepayment scheme. Tanzania has implemented Community Health Fund (CHF) based on prepayment system in rural areas. Strong community organizations existing in the country are reported to be the facilitators of growth of community dispensaries. The CHF aims to provide primary health care, maternal and child health care (including deliveries) preventive and promotive health care. The risks and benefits are shared among large pools of households and each pool is reported to be consisting of 50000 individuals. Each household will be given a health card at a cost of S 2.57 per person per year and hospital charges add up to additional premium. There is political support, matching funds by donors and government to community fund and cooperation from health care providers(doctors). But, these CHFs are said to be facing operational problems, management and rising costs.

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[15] Beattie Allison et.al.ed.(1996). Sustainable Health Care Financing In Southern Africa-EDI Policy Seminar held in Johannesburg, South Africa. EDI-World Bank.

5. Spain

In Catalonia, a combination of user-owned and provider- owned cooperative known as Integral Health Care Cooperative system is developed by the Espriu Foundation.

Similar cooperatives operating at community level are said to exist in Italy. In Malaysia, it is reported that government and doctors are exploring the ways to set up a complementary system of provider – owned and user-owned cooperatives.

6. Ghana[16]

An evaluation study undertaken by the PHR reveals that **Nkoranza community health insurance scheme in Ghana** has proved to be successful in terms of sustainability and making quality care affordable to a high percentage of vulnerable households in the district. The study was undertaken after eight years of operation of the scheme and was funded by DIDA and WHO.

The scheme is said to be self-funded (premium income). It is said to be first of its kind in Ghana and has brought fame to the district by its mere survival. But, the PHR study pointed out that there is a lot of scope for improvement and expansion of coverage. Presently the scheme is reported to be covering only 30% of the total district population. The reasons for low coverage have been identified as inappropriate registration period, misconceptions in the community about the scheme, lack of marketing (educational) communication, lack of accounting and computing, lack of monitoring and evaluation, negative attitude of hospital staff and massive adverse selection i.e. tendency to register only the high risk groups (aged, children...). One of the encouraging factors noteworthy to be mentioned is that, though the district is reported to be having high level of poverty, poverty is not recorded as a major factor for poor coverage. There is said to be demand

[16] Atim Chris and Sock (2000). An external Evaluation of the Nkoranza Community Financing Health Insurance Scheme, Ghana. Technical Report, 50. PHR Project Publication.

for maternal and child health services including deliveries for which members were willing to pay extra amount. But, there is said to be resistance for co-payments or deductions on the existing hospitalization cover. The PHR research team has recommended incentives for registration of all members organizing Annual General meetings with the help of funding from district government, supervision from community volunteers, steps to improve relations between the hospital staff and the community and inclusion of maternity care to boost membership.

7. Italy:

In Italy, it is reported that local governments support community based health and social service cooperatives

8. Canada:

The report of the International Cooperative Alliance states that in Canada, as per the study undertaken by Federal and Provincial governments, community health centers were a cost-effective alternative to private practice as they are operated at lower cost per patient and offered more preventive and health promotion services and also accessible to disadvantaged persons.

9. USA

(i) In USA, user-controlled health cooperatives operate as HMOs. Group Health Cooperative of Puget Sound in Seattle is said to be the largest of these with 478000 members (1993). Medical care along with preventive care is provided for a fixed prepaid fee.

(ii) The United Seniors Health Cooperative provides the 9000 elderly owner – members high quality, affordable long term health care services.

(iii) User owned health cooperatives operating in partnership of government exist in USA. In 1994, there were 900 democratically governed and community owned. Community and Migrant Health Centres in rural areas and inner cities serving low-income communities. For 500 such centers funding was available from US Public Health Services.

10. Japan

(i) Members of the consumers movement have set up Health cooperatives supported by the Medical Cooperative Committee of the Consumer's Cooperative Union.

(ii) Members of multi-functional agricultural cooperatives have organized health services supported by the National Welfare Federation of Agricultural cooperatives.

11. Singapore

In Singapore Health Cooperatives have been established by The National Trade Union Congress in 1992 which represents 52 trade unions.

12. Sweden

In 1990s, the Medicop Model, a model for consumer owned cooperative medical care centers is reported to have been developed in Sweden on behalf of the housing and insurance cooperatives. It is reported to be providing cooperative partners for local government authorities interested in contracting health care services and facilities.

13. India

The following paragraphs present a somewhat detailed account of some of the important experiments[17] in India in this connection. We also briefly evaluate a plan of medical care provision for the poor through insurance as presented by TN Krishnan, one of the pioneer thinkers in this field.

1. SEWA: The Self Employed Women's Association (SEWA) provides health care to its members through two health –co-operatives viz. Mahila Sewa Lok Swasthya Co-operative and Krishna Dayan Co-operative. The services are particularly preventive health and immunization services. Rational drugs are supplied at low prices at 3 centres. Childcare is provided through 3 childcare centers and Crèches.

   Health Insurance coverage is reported to be not mandatory for SEWA households. Coverage is extended to members who make contributions. And, for members who have linked their fixed deposit savings with the insurance scheme, there is also the coverage for maternity benefit. SEWA bank runs Integrated Social Security Insurance Scheme with the help of LIC and United India Insurance Corporation. It covers events of death, accidental death, sickness, accidental widowhood and loss of household goods and work tools. On an average insured person in SEWA households is reported to be paying Rs. 70 to Rs.80 p.a. (Gumber A. and Kulkarni V., 2000). Gumber and Kulkarni's study in Gujarat brought that, SEWA beneficiaries are interested in extending coverage to additional household members and that there is strong preference for SEWA type of health insurance scheme by the people. People in rural areas preferred public sector hospital services with some contributions from community and managed by Panchayat. Their study revealed that out-of –pocket expenses of insured (ESIS) households were lower by 30% for acute and chronic diseases and

[17] **NIHFW (2000), Development of Health Insurance in India- Seminar Report.**
Other studies worth considering in this context, from which information is gathered for the analysis below, are listed in the References at the end of this paper.

by 60% for hospitalization cases as compared to SEWA and non-insured households.

2. **Sugar Producers' supply, processing and marketing cooperatives in Maharashtra State are reported to have set up a chain of hospitals and dispensaries for members** throughout the region of their operation. These function in the nature of cooperatives though they are not formed as health care cooperatives themselves.

3. According to a study by Dr. P.R.Sodani in Rajasthan, people preferred to pay an annual premium of Rs. 243 per capita under health insurance given a package of services and coverage of expenses excluding transport. For coverage of transport they preferred to pay Rs. 286 p.a. and Rs. 347 for coverage of transport and wage loss.

4. **A public school in Delhi has introduced Health Insurance coverage with the help of GICI**, to its students (a group) with a premium of Rs. 50 per child per year covering a risk unto Rs.100000 per year.

5. According to a study conducted by K.S.Nair in **Delhi's slums**, households in informal sector spent 8.87 % of their per capita income on health care as against 4.47% by households in formal sector. Households in formal sector were willing to pay Rs. 145 per capita per annum and households in informal sector were ready to pay Rs. 103 per capita p.a. They preferred a combination of hospitalized, non-hospitalized and chronic illness care benefit **under health insurance**.

6. VHS in Tamil Nadu has been providing health care services to rural poor for nearly 30 years. Based on the joint family income, membership fees are charged. The scheme provides members, free annual check-up and curative and diagnostic services at concessional rates. There is no waiting period between joining the scheme and the right to receive health care. Dr. N.S.Murali reported that most

members renewed or enrolled only at the time of acute illness. He has reported that *an NGO cannot sustain Health insurance scheme from the premia received from poor members. Support by government in terms of subsidy and levying minimal user charges to users are important for the sustainability of the insurance scheme.*

7. U.N.Jajoo[18] and Co-Professors from the Dept. of Medicine, **Mahatma Gandhi Institute, Wardha set up a co-operative health service unit** in a village, in a school building with an initial contribution of Rs. 4 per family. Later a health insurance scheme was mobilized by collecting agricultural produce @ of 2.5 kgs per acre for farmers and, at a flat rate of 5 kgs for agricultural labourers. **Village dispensary is linked to Sewagram hospital.** Village dispensary is run by VHW. VHW is supported by a medical kit and monthly service of a mobile medical team. Only acute and emergency cases are treated free of charge and for normal deliveries and chronic illnesses 25% of the hospital bill is charged.

8. **In Mallur village in Karnataka, a Health Cooperative attached to a Milk Cooperative was set up long back in 1973.** Encouraged by the success of the milk cooperative the members persuaded doctors of the St.John Medical College to start a health care center which would be self sustained, financed and managed by the community. The health cooperative provides services to nearby six villages. In the first two years, members contributed one-two paise per litre of milk. Later, 5% of the profits from milk sale were given to health center. Presently there is no funding from milk cooperative. Interest earnings from the initial fund created by milk cooperative and user charges are the source of finance for health center. State government has given land, ANM service, family planning service, vaccines and nutritional supplies. St.John Medical college contributes Rs 250 p.m towards health care costs of the poor. The Health center is managed by Gramabhivruddi Sangh and a Committee of 9 members including doctors from

[18] Jajoo U.N.et.al (1985), Rural Health Services : Towards a new strategy ? Health Care Who Pays? WHO Health Forum 6:WHO.

health cooperative and St.John Medical college. There is said to be frequent absence of doctors in health center as the cooperative cannot pay the service charges of doctors at market rate.[19]

9. **Insurance scheme for the Poor as proposed by TN Krishnan :**

T.N.Krishnan proposes[20] hospitalization insurance plan for persons below poverty line, which he suggests, can later be extended to other sections of the society. Health insurance for the poor is justified on the ground that illness episodes take away a major portion of the income of the poor. The present **Jana Arogya Scheme** seems to be similar to the insurance scheme proposed by Krishnan.

He argues that as the proportion of falling ill requiring hospitalization is small in a large population, risk pooling can be done at a small cost with an appropriate insurance scheme.

Total cost of hospitalization is based on the NSS data (1986-87) which is adjusted to 1995. The average cost of treatment is taken to be Rs.500/- for the poor. The NSS data showed that about 4% of the bottom 40% of the population were inpatients. Taking 50% increase for 10 years the proportion of inpatient for 1995 is taken to be 6%. With this rate the total cost would be Rs.900 crores (6% of 300 million poor i.e. 18 crores x Rs.500). This works out to be an average cost of (900 crores / 30 crore population) Rs.30 /- per poor person which would cover cost of medicines, room rent, tests and consultation charges upto a limit of Rs.5000/- per family per annum. He suggests that the Govt. should provide for the total cost under anti-poverty programme or by re-allocation of expenditure.

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[19] Dave Priti Sen(1997), Community Control Of Health Financing In India: A review of Local Experiences, Tech. Report No.8, PHR, Maryland.

[20] Krishnan T.N.(1996), Hospitalization Insurance : A Proposal, EPW, April 3, Vol.XVI

To manage the health insurance implementation he suggests that the subsidiaries of GIC be converted into separate Health Insurance Corporations which work as not for profit organizations.

Panchayats will be responsible for identifying the poor and the consolidated list at the block level should be sent to Finance Ministry. Health insurance corporations should canvass and cover other population groups to meet their administrative costs and it is felt that the expansion of coverage may help to cross subsidise the poor, which will ultimately reduce the burden on government. Hospitalisation is to be referred by the PHC doctor and Corporations are required to directly settle the bills with the provider hospital. The cost of treatment should be indicated on the card issued to families. It is also proposed to set up block level Hospital Monitoring Committees to check the quality and price structure in hospitals.

He suggests that, village panchayats should levy a health cess on landholdings and businesses for universalizing the health insurance coverage. As suggested by Hsiao & Sen, he opines that a portion of this can be retained for strengthening PHC. In urban area health insurance is proposed to be implemented through trade unions, business and factory establishments and through NGO's for the urban poor. Contributions to health insurance could be made compulsory for all persons who have regular employment. These experiments he suggests should be taken up initially in two districts in each state and later can be expanded to all the districts based on experience.

OBSERVATIONS ON HEALTH INSURANCE SCHEMES IN INDIA.

- People are ignorant about health insurance. Mediclaim and, the Jan Arogya Bima policies designed to help the poor are not known to people.

- Many diseases are excluded from risk coverage (treatment for cataracts, dental care, sinusitis, tonsillitis, hernia, congenital internal diseases, fistula in anus, piles etc.) in the first year of policy unless such diseases are totally excluded as pre-existing. Expenses incurred in respect of any treatment relating to pregnancy and childbirth is also excluded.

- Jan Arogya covers only patients who are hospitalized. It is not for out- patients.

- There is lack of marketing. Villagers and the poor have to come to district places to know about the scheme and to become members. Offices of the insurance companies have not made any efforts to popularize these schemes in rural areas and even among urban poor and also middle class people.

- Officers of the insurance companies say that it is waste of time and money to go to people and market **Jan Arogya Bima Policy**. They say that it is difficult to convey common man about the policies. They agree that they have not taken up comprehensive marketing for popularizing the scheme.

- Health insurance policies for the employees of the organized sector are highly subsidized by government. Employee's contribution accounts for a small portion of total coverage (ESI and CGHS).

- Health insurance policies are introduced mainly by public sector.

- Health insurance adopted so far (except for employees) is a reimbursement policy. Individual patient has to pay to hospitals first and then claim the reimbursement and there is a long delay in getting the claim.

MAIN LESSONS FROM COUNTRY EXPERIENCES

The above thirteen country experiences seem to suggest the following conclusions that would help designing a Health Security Plan for the poor in the selected regions of Karnataka.

- To formulate a health insurance scheme for a community or a region **reliable data on health care costs and expenditure, utilization patterns and morbidity in the target population** would be useful.

- The Indian and other countries' experience in community financing of health care through pre-payment suggests that **co-operatives linked to economic activities have been the base for creating health co-operatives.** Members have contributed a part of the sale or produce or the profits to meet the health care expenses of their families and themselves.

- China's experience with CMS reveals that **it is not possible to sustain them with voluntary contributions.** Contributions need to be mandatory and members should confine to rules and regulations set in for CMS.

- The study on CMS in China emphasizes that **in addition to community contributions there is need for specific and effective mechanism to support CMS in the long run.**

- In developing countries the issue of cross subsidization for the poor to meet health care needs through health insurance needs to be worked out. In the absence of mechanism to make rich compensate for the poor, the local, State or the Central government should subsidize the provision of health insurance.

- In rural areas people are unaware of health insurance. People are willing to provide land, building and labour for setting up health facilities. If there is

proper guidance and education, they are even willing to contribute in terms of cash for future health risk. The Indian studies by Dr. Sodani and K. S. Nair reveal this. The currently on going study of CMDR in Karnataka also brings out the willingness of the people to contribute to the development health care cooperative.

- People prefer health insurance schemes which are cheaper and with minimum administrative procedures for getting the claim.

- People prefer maternal health care, hospitalisation and outpatient curative care to be covered under health insurance.

- People do not prefer to join health care co-operative when there are health facilities near by.

- Co-ordination with government agencies and officials in implementation of certain health services like maternal health care is essential for a health cooperative.

- Though members of co-operative health centers make prepayment for health care in terms of membership fees, it is necessary to levy user charges for two reasons. Firstly, to avoid misuse or over use of health facilities (as reported in U.N.Jajoo's Study). Secondly, it is generally opined that people do not take free services seriously.

- To control 'moral hazard' or the excess use of medical care, we can also adopt an incentive mechanism in the insurance plan in the form of reduced membership fees for those who have not taken treatment for two or more years. As said above, in Sewagram hospital, to prevent excess use nominal charges were taken from hospitalized patients for treatment of certain cases.

- Contributions should be based on economic status of the families. But, there should be fixed minimum payment for the poor.

- Since community programme involves creation of awareness, erosion of interest, trial and error in the application of the project and adoption of the project by the community, it takes a long time (nearly 5 or more years) for any programme to be deep rooted in the community.

- Treatment by VHW at the village level indicates that a trained health worker can attend many of the diseases suffered by villagers and there is no need for expert doctor all the time.

- Hiring the services of a medical expert daily would be costly for the villagers. Existing health insurance structure, which relies on low and differential premium system cannot meet these expenses. Therefore, as done in some experiments, monthly or fortnightly or alternate day services of expert doctors can be provided in different villages by mobile medical unit.

- It is not possible to treat all the cases free of charge. A financial limit needs to be fixed based on the severity of illness, number of cases/times of treatment per patient, etc. Based on these considerations the extent of contributions by beneficiaries can be determined. All these aspects can be incorporated in the co-operative health scheme financed by health insurance, as is done in Sewagram health care services in Maharashtra.

IV HEALTH CARE OF THE POOR THROUGH HEALTH INSURANCE AND HEALTH CARE COOPERATIVE: A CMDR PROPOSAL

In the background of the above experiences about people's involvement in health care plan for the poor, we have attempted to develop such a plan for a small region of Karnataka. The main elements of the health care strategy for the poor should be the following:

i. **This plan should cover all the poor**, irrespective of their social status and ability to pay.

ii. It should **provide for curative care in the case of all ailments, starting from the common cough and cold to major diseases.**

iii. The plan should **assign an added weightage to the medical care requirements of the poor and female members of the family** for the reasons mentioned earlier.

iv. The plan should make efforts to provide for **cross subsidization of costs of care.** This implies that there should be a provision for community contribution according to ability to pay rather than benefit received. This **community contribution should be mandatory** and not optional.

v. The plan should cover not simply curative care but also **promotive and preventive care services.**

vi. Health care **needs should be articulated by the people themselves** and medical services set up should only aid this process of articulation.

vii. Services should be supplied in accordance with the articulated needs.

Considering the above norms, it appears that a mechanism with cooperation between providers and beneficiaries for the purpose of supply of health care services and

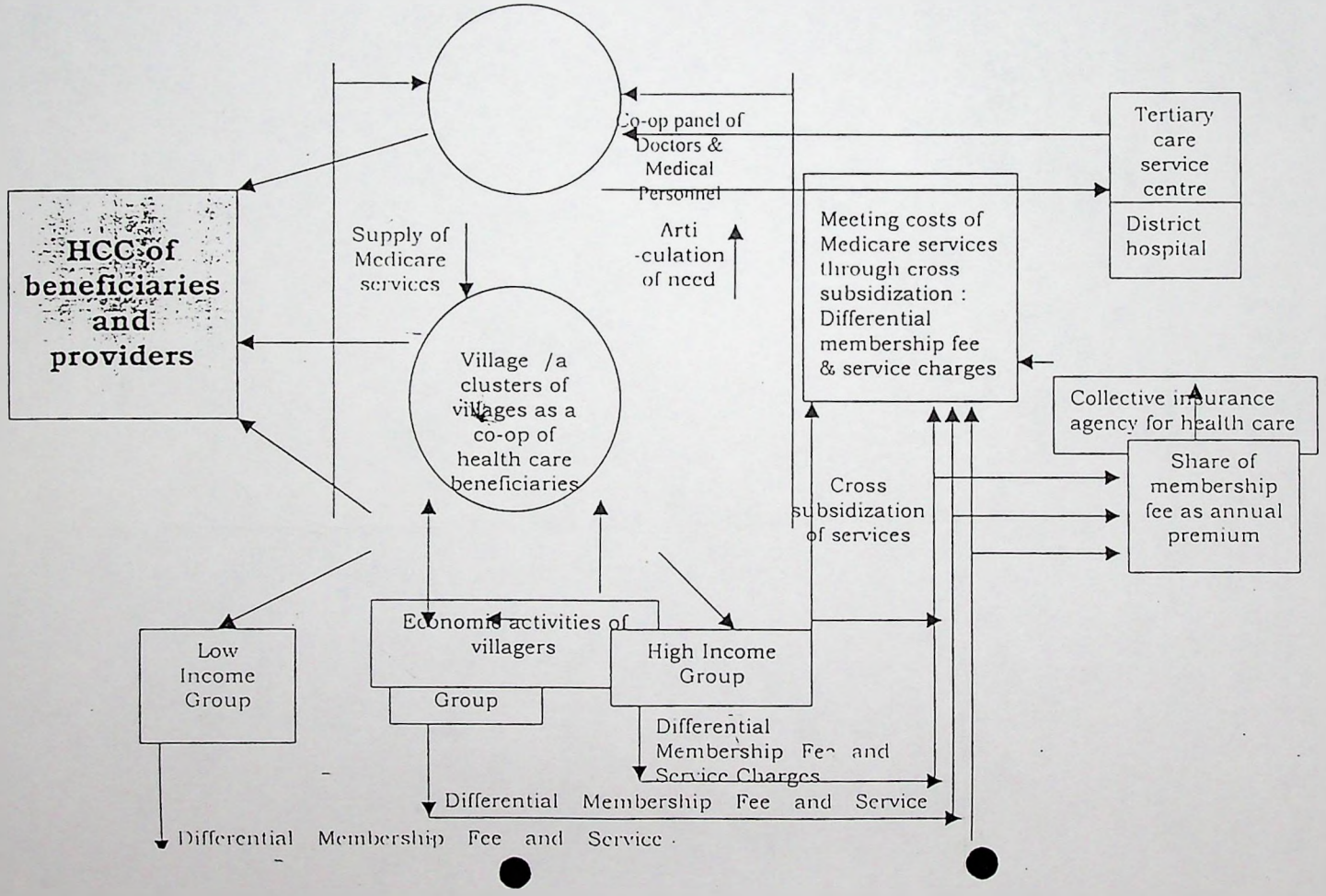
also for recovery of service costs would be helpful. As it is, in the Indian social set up, forces of mutual cooperation do exist in the institution of family, neighbourhood, village, etc.. Family is the most effective health care cooperative with elements of cross subsidization and support. Any health security plan for the poor should consider integrating the main elements of cooperative spirit witnessed in the case of family.

Health Security Plan should also recognize that costs of services are found to be rising in recent years so fast that individually they cannot be met, as incomes do not rise as fast as the costs. In such a situation cost sharing has to be visualized through a mechanism of a cooperative among beneficiaries and providers and through the principle of cross subsidization. The following flow chart brings out the important components of the suggested Health Security Plan for the Poor keeping in mind some of the norms laid down above.

Health Security Plan particularly for the Poor

through HCC and Health Care Insurance mechanism

CMDR as a facilitator of various links



OPERATIONAL ASPECTS OF METHODOLOGY OF HEALTH INSURANCE THROUGH HEALTH CARE COOPERATIVE:

The proposed health insurance through pre-payment and user charges is to be set up initially in one village (Chandanmatti or a manageable group of villages) and later extended to other villages each Panchayat being the unit of administration.

I. Membership: Each Household will be a membership unit. All the households in the Village will be covered under health insurance. A card will be issued to each household with details of No. of members, category of households and the details about the amount of user charges to be taken for treatment from household members. Each card should have provision to enter details of illness, treatment and cost of drugs for each member during one year.

II. Services: HCC will provide to its members curative out patient and in-patient care, child and maternal care (excluding deliveries), preventive and promotive health care services. Out patient care is provided at HCC clinic in the village. For in-patient care a link will be established between HCC and a private or district hospital which will provide referral service to members.

III. Management: The health insurance scheme will be managed by a Health Committee consisting of HCC doctor, PHC doctor, panchayat president, local doctor, mahila mandal / youth center member, school headmaster and five members from HCC.

IV. Membership fees: Considering that the burden of illness will be greater on poor households, a differential rate structure for membership may be visualized for households based on income level.

During the household survey in Chandanmatti village in Dharwad district of Karnataka, for example, respondents from the surveyed households expressed their willingness to pay an average of Rs.225 per household. Membership fee can be fixed keeping willingness to pay by the households. In view of different income levels willingness to pay by the households also would be different. Hence, differential membership fee can be determined accordingly. Membership is fixed for a family of two plus two.

Advantages from the Proposed Health Security Plan

From the proposed health security plan there are mainly four types of gains:

First, each individual becoming a member of the HCC and also linking his health care needs with insurance system through HCC, would find that he would get the health care facilities at his door step, without being required to meet various types of transaction costs. Transportation costs, cost of loss of wages for those attending upon the morbid person, additional food and other costs, etc can be avoided under this scheme. These health care services would be available at lower costs now than without HCC.

Second, provider of health care services like the providers' cooperative, would find costs of provision to be lower than before in view of the likely economies of large scale of operation. Even the insurance agency linked with providers' cooperative would find ready clientele for its insurance business ensuring better business.

Third, under the present scheme there is less chance of any resident member of HCC being deprived of health care facilities when needed, for, through the operation of the force of mutual sympathy, felt needs for health care services would be articulated, the needed services would be provided through the linkages of HCC and insurance schemes. As a result, finally, the likely direct and indirect costs of morbidity would be avoided. Cost avoidance is obviously the gain for the needy, particularly the needy poor.

Fourth, since the government had to bear the entire responsibility towards health care needs of the poor in a scenario without HCC the financial burden on the government would be higher than in the scenario with HCC, for, some of the costs of provision are now borne by the community itself through the system of cross subsidization. The spring of human conduct, viz. sympathy and mutual sympathy, which is a tremendous resource for social welfare, would be used and would stand promoted by the health security plan for the poor.

A concrete Health Security Plan for the Poor with data for one of the villages of Dharwad district of Karnataka is presented in the Appendix to this paper.

Appendix

A CONCRETE PLAN FOR HCC IN A VILLAGE IN DHARWAD DISTRICT

About the Village

Chandanmatti is a small agricultural village situated 8 Kms. from Dharwad. The village consists of 172 households with 1018 population. Fifty two percent of the population belongs to SC/ST, backward and minority communities. Fifty six percent of the population is literate. Twenty Seven percent of the households live below poverty line(<11000). But, nearly fifty eight percent of the household earn less than Rs. 20000 annually. Villagers do not have access to health facilities in the village. There is a primary school in the village. Bore well water is the main source of drinking water in the village. Villagers get this water through tap connections to individual houses.

Baseline Scenario

Analysis of out-patient situation

1. On the basis of reporting from the village during the survey, the estimated probability of incidence of sickness (outpatient type) =0.13
2. Therefore, annual prevalence of illness on average per resident person= 0.13*12=1.56
3. As per the reporting during the survey, the average cost incurred per morbid case per month =Rs.221
4. Therefore, the average annual expenditure on such sickness per resident of the village=Rs.344 (=221*1.56)

4. The HCC's cost on each out-patient per annum then works out to Rs. 115 (rs.68 on medicines +rs. 47 doctors' fees). With the prevalence of 1.56. the average cost to be borne by HCC per resident is Rs. 179 (1.56*115).

5. The patient himself spends Rs 86 (68+16+2) per illness. Therefore, with the prevalence of 1.56. the private cost to the average resident is Rs. 134 (68+16+2*1.56).

6. The average based on a three tier differential rates. a membership plus user charges of Rs. 87 to be collected per resident.

7. The balance sheet of financial and direct costs and benefits of HCC :

(in Rs.)

	For HCC	For resident	For promoting agency	Travel and special food	For the village economy
Cost	179	134+87=221	92	0	221+92+0=313
Income or benefit	87+92=179	179+134=313	0	31	313+0+31=344

Comments:

1. The individuals have to spend only Rs.221 on average, and get benefits worth Rs. 313.

2. For HCC, there is a break even.

3. The promoting agency will bear the initial burden at the rate of rs.92 per resident as additional system cost.

4. Saving in travel cost and food costs: since the patient and the attendent do not have to travel to places outside of the village, the saving on account of

5. As against this private cost directly incurred by the residents of the village, the average indirect costs likely to be incurred (based on the FGD and survey) are also estimated:

- According to the survey, the time lost by the morbid person is four days on average per incidence. With a prevalence of 1.56, the labour time lost per average resident is 6 person days. Value of this labour time is Rs. 300.
- On average two person-day of time is lost by another member of the morbid family to attend the patient. The implied opportunity wage cost is rs. 100. Therefore, for a prevalence of 1.56 on average per resident, the value of labour time lost is Rs. 156.
- With the treatment to be availed from outside of the village, as per the survey, the cost of travel plus incidenals such as food per morbidity is Rs 20. Therefore, the incidence of this cost per average resident is Rs 31(=1.56*20)
- The total indirect cost per resident
  = 156 + 300 +31=487

Scenario with HCC

Assumptions:

1. Only 50%of medicines will be provided free of cost, the rest will be borne by the patient.
2. Cost of pathological/radiological tests will be borne by patients.
3. A promoting agency will provide the subsidy for the initial years(covering costs of consultation and 50% of medicine cost. There is avoidance of travel and special food cost due to HCC.)

travel cost and food costs will be 31(18+2*1.56)per resident (as worked out under the baseline scenario).

5. The gains (indirectly) in the reduction of transactions costs are:

- On average the morbid patient loses only 3 days of his/her labour time (as against 4 days in the base scenario). This amounts to a labour time loss per average resident as 5 days (=1.56*3). The value of this time is Rs 250. Therefore the net gain because of HCC in labour time is Rs.50 (= 300-250)
- The loss of labour time of another member of the morbid family is also reduced. Assuming that only one day of labour time is lost, the value of the lost labour time is Rs. 78. The net gain in saving in labour time is Rs. 78 (as compared to the base line scenario, 156-78).
- The total indirect benefit therefore will be rs.50+78=128 per resident of the village.

Total savings

a. Residents =Rs.92+31+128 = 251

b. Village economy = Rs.31+Rs.128 –92 = 67

The case of in-patient treatments

- As per the survey, the average cost of an in-patient per year was Rs. 3084.
- The probabiliyt fo illness leading to hospitalisation, according to the survey data is 0.035
- Therefore, the hospitalisation cost per year per average resident is Rs. 109 (=3084*0.035)

In case, a health insurance scheme is worked out for all the residents with the jan arogya scheme of united insurance co (or any other). the insurance premium is Rs. 107 per year.

- Therefore, with proper promotional efforts and implementation, the HCC can bring in the insurance scheme to cover all the residents of the village, at no extra cost either to HCC or to the government.
- Needless to mention that the promotive and implementation efforts will be the basic catalists to be set in motion by the promoting agency.

How to manage the HCC in the long run????

1. In the long run, the HCC has to breakeven at the average cost of Rs. 179 per resident. There are several options that can be considered.
    - The memebrship fee and user charges can be gradually increased to go up to cover the cost at Rs. 179 per resident. This can be designed at a gradually increasing rate of 10% per year. Then, it will take a minimum of 7 years to be self-reliant. Till such time, the HCC will have to subsidised by one or the agency, be it the governemnt or a non-government.
    - Alternatively, since the HCC will reduce the pressure on the government outlets in health care (phc, chc and subcentres), the state governments can transfer some funds to manage the HCC under the zp or other direct allocations to the health sector.

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The Jawar Rural Health Insurance (Assurance) Scheme of the MGIMS Hospital, Sevagram : A micro experiment in the spririt of Sarvodaya ideology.

By Dr. Ulhas Jajoo, Dr. Anant Bhan

The idea for the scheme started from the Medico Friends Circle (an informal group that is concerned about issues of public health importance) students group that Dr. Jajoo initiated in MGIMS, Sevagram when he joined as faculty there in the Department of Medicine after completing his masters from the Medical College, Nagpur in 1976. The group would regularly meet and discuss the various issues of relevance in medicine. Fed up of their indoor discussions and ideological debates, the group decided to move out into the community and work with them. The students divided themselves into groups, which went to four different villages, one of which was to be chosen for the proposed fieldwork. The students finally zeroed in on Nagapur village, which was around 5 kms away from the Sevagram hospital because of practical considerations, and not the other village like Pujai though needy but was quite far away and transport facilities to which were abysmal. It was the first lesson that *roads and transport are related to health care*.

The group initially talked to the villagers about their health needs. In consultation, it was decided to run a dispensary in the local school on a weekly basis. They decided against using drug samples given by medical representatives because it was unethical. A small token amount was collected towards the drug bank from the villagers and the dispensary was started. The drug selection was based on effectivity, cost and toxicity. The generic drugs were used. In the process, the group could get insight of the *exploitative drug market*.

However, pretty soon the durgs ran out and on analysis, the group realized that the rich of the village were not paying up and it was actually the poor who had paid regularly. In the next village meeting, this was brought up and addressed. The rich felt hurt for being exposed publicly but then the flow of money became more regular.

Realizing that some kind of regular follow up was needed, it was decided to have a village health worker (VHW). Initially, they thought that the traditional 'Dai' could be given this responsibility but they realized soon that the community did not give her enough credibility. It bolied down to selecting a male health worker, from the community who was not necessarily poor. Also, he needed to be respected by the community to be able to provide a leadership role.

It was also decided that only those who could pay would be allowed to access the services at the dispensary. This led to a situation where the absolutely poor were not able to access the services. To cater to this target population, which needed support, the scheme was linked to the hospital which would help in sustenance of the scheme. Dr Sushila Nayyar, the Director and founder member of M.G.I.M.S. agreed to a policy that any person from the scheme would get free treatment from the hospital.

The next step was the establishment of a village fund. Dr. Jajoo had visited various health projects before initiating this scheme and these visits had shown him that the main reason for starting these projects was on compassionate grounds. The all-enveloping love often created dependency among beneficiaries. It breeds relationship of a doler and the begger. Moreover, these projects were so heavily financed that their replicability was not possible. (PRIA, 1986 study). Dr. Jajoo did not want donations from outside to finance the healthcare (based on the feeling of "Charity Corrupts People"). The purpose of the fund was not to raise financial support to the outreach programme, but to generate demand for qualitative service from the providers; in fact it was a tradition among villagers to collect voluntarily contribution graded according to capacity for religious village function, sport competition or for temple construction. The fund would finance the salary of the VHW and the drug requirements of the local dispensary, besides transportation cost of the mobile health team. Since Jawar (Sorghum) cultivation was quite common and it was easy to contribute in kind, it was decided to accept the contribution in the form of Jawar (Sorghum) – *the contribution would be according to capacity and the services according to need (the poor needed more support).*

The fund would act as a pre-payment scheme subscription, entitlements being free primary health care and subsidized referral care (Jajoo, 1993). A minimum amount was decided which would have to be paid by every family and also additional amount of Jawar would be charged depending on the kind of work that the family members were engaged in or on additional holdings. At present the health insurance contribution from the lowest income group (landless labourers) is 12 payali of Jawar per family per year (a payali is a measure equivalent to 1.25 kgs and a Payali of Jawar sells for around Rs. 4 at present market rates).

Since this ensured that uniform healthcare would be available to all those who paid for the village fund, some of the rich farmers felt that they were financing the healthcare of the poor and did not pay up. Thus, only 60% of the village was paying up for first year. This was brought up at the next village meet. To ensure payment, it was made clear that only those who contribute will get the benefits of the scheme. The persons from the village who had paid would get free treatment, but who did not contribute to the village fund would have to pay for the treatment. Those who had not

paid (after treatment) and absconded would be held accountable by the village and made to pay.

To prevent misutilization of services at the hospital, it was fixed that 25% of the costs of elective admissions like cataract, hernia, normal pregnancy would have to be paid by the patient, while the treatment for an emergency / unpredictable illness would be free at the hospital.

Gradually over subsequent years, as scheme gained credibility, the coverage of the scheme grew from 60% to 75% and finally 90-95%. The village fund would pay for the drugs in the local dispensary, the VHW's salary and the visit of the hospital vehicle once in three months.

The meetings in the village (Gram Sabhas) about the various aspects of the scheme would be held every year before Jawar collection and would occasionally be 'stormy' and heated discussions would ensue. This Gram Sabha would serve a dual purpose of evaluating the performance of the health structure and also enacting disciplinary action on irregularities committed by the villagers themselves. The Gram Sabha helped to facilitate communication between the health system and the beneficiary on one hand, while on the other it helped the villagers to command control on the VHW and the health team. On occasion, the Gram Sabha decided to change their VHW (Jajoo, 1993). The scheme helped the community have a right to demand good quality care from the system. It also ensured politeness and better behaviour in the hospital on the part of the providers.

On the basis of the lessions learnt from Nagapur, the team extended the health insurance scheme to other villages (presently there are 40 villages within a radius of 25 kms around the hospital, covered under the scheme).

Initially the VHW was paid a fixed amount in the form of Jawar, but later on it was decided that the honorarium would be decided in the village depending on the VHW's work performance, whether he had been helpful and accompanied the patients in the time of the need. This was to bring in accountability to his / her work.

As the scheme slowly started spreading to other villages, each village opened an account with a withdrawal by cheques facility. All the Jawar collected as premium would be sold and the money would be deposited in this account as the village fund. At the end of the year, the money remaining in the accounts would be transferred to the village fund for the next year – occasionally, a part of the fund would be transferred to the Kasturba Health Society to form a common pool of money for all the villages – a corpus, the interest of which could be used for procuring drugs (centralized distribution from the hospital). The money would also be used for organizing educative camps and

'Prabhodan Saptahs' (Educative lecture week series) where non health related topics including social / spiritual issues would be discussed.

Only 10% of the expenditure on the scheme as recovered form the contribution in the form of premium and 90% of the cost came from the hospital. Since the MGIMS hospital runs predominantly on Govt. financing, which is public money, it was felt that this would be a appropriate utilization of the same.

The structure of the scheme revolves around (Jajoo ; unpublished) :-

- Accessible hospital services of optimum quality.
- Accountability of Heath care system to the consumers.
- Affordability of the services to the poorest.

Dr. Jajoo and M.G.I.M.S. realize that the sustainability of the scheme (that it has to cater poor) without external support is not possible. It was and is their belief that the government needs to support these kind of schemes and subsidize them as a part of its social responsibilities.

Social financing has the following spin off benefits (Jajoo, unpublished) :-

- It increases the accessibility of the health services
- It promotes the operators concern of the health in the community
- It generates the concept of the right to demand a quality health care by the beneficiary population.
- It responds to priorities as judged by the community.
- It ensures that the services are acceptable.
- It keeps the service providers on their toes.
- It stimulates organizational self-confidence and paves the way for participatary culture at the community level.

At this stage, the pre-requisite for adopting the scheme was – at least 75% of village families should contribute for the village to be insured. The scheme found acceptability among villagers and once they insured, did not look back for the years to come.

It was at this time when the scheme extended focus from curative care to preventive and promotive health aspects. The strategy of cluster immunisation to achieve herd immunity was successfully implemented for vaccine preventable illnesses. The village sanitation was addressed by evolving an appropriate model of latrine. 'One house one latrine scheme' aimed at 100% coverage of village families. It was not a dole. The part contribution in cash came from beneficiary villager and the rest from Gram Panchayat and state funds. The model found acceptance of the state and central government for its replication.

Poverty being the greatest evil behind most of the health problems, as a logical corollary, the scheme extended its web to income generation programme, addressing village as a social unit for development. All familes in a village were offered membership of co-operative society for dairy development or lift irrigation scheme for agriculture where ever feasible. The later initiative could come through the bank funds. The constitution of co-operative society was framed in such a way that decisions could only occur with no less than 75% majority, thus making elections obsolete.

At this stage village health insurance scheme underwent first qualitative change. In addition to 75% participation, at least one of the following criteria was needed for elligibility.

- Participation in "one house – one latrine" scheme with near 100% coverage of village families.
- Organising lift irrigation scheme for all village families
- Organising milk co-operative for all village families
- Electing village panchayat by consensus

Organisation of people through income generation schemes became a focus issue, benefitting the whole community. The *eligibility criteria now heavily weighed in favour of community action*. The health insurance scheme had now reached a stage where it was helping and initiating action oriented culture of the village. The changed face of the insurance scheme gave impetus to 'one – house one latrine' scheme in many villages.

The various schemes available to the village are –

a) Jawar insurance scheme – under this 50% subsidy is given on outpatient care and 100% on all indoor care except for elective admissions (50% subsidy)

b) Subsidised family insurance scheme for rural area (Rs. 15 / person/year) when 75% of village families contribute. In this scheme outpatient and impatient services are provided with 50% subsidy. The village need not fulfill the above enlisted criteria for enrollment.

c) Indoor insurance scheme in which there is no insistence on 75% of village families to contribute. The contributions are at the rate of Rs. 15 / person / year. There is no outpatient subsidy offered, inpatient charges are subsidised by 50%.

d) The hospital runs a health insurance scheme for families living in semiurban pockets and in Wardha town, at the rate of Rs. 150/year for a family of five. The entitlement includes 50% subsidy in out patient and inpatient charges.

Income generation programme became quite successful and brought in visible economic upliftment, with it vices like alcohol, gambling, fierce party politics and competitiveness found inroads in the village. The police frequently found entry and visits to judicial court galloped. It was a lesson to be learnt – *cultural development must race ahead of economic upliftment for a effective change*. It was a turning point for the ethos of health insurance scheme.

If the *ultimate aim of the health insurance scheme is organising people at the lowest ebb of society*, we opted for women's self help group (SHGs), since the women in poor families are the '*prolitariat of the prolitariat*' (as quoted by Dada Dharmadhikari). The women are hard working among all classes and the ultimate sufferers. They are also culturally sane. The organisation of this culturally sane section of society found its initiative in the early 90s.

The organisation of women in to SHGs was need based, so that their dependence on money could be addressed by forming collectives that would be able to provide economic support when neded. It was noticed that the women would stand by each other and there would be transparency, leading to more accountability. The culture of decision making by consensus was thoughtfully inculcated in SHGs. As the money started coming (linkages with bank), women's status in family changed as she was now looked upon as a bread winner for the family too. The process helped empowerment of women.

By now it was realised that though *health care offers an ideal medium to get entry in village life (albeit costly), organising the entire community around it had not taken roots, simply because it was not and is not the priority need of the masses*. Illness as a calamity affects individuals and is rare to find epidemics sweeping the community around which a sustained mass action can be initiated.

The income generation programmes attract people as they serve their individual interest. Since the programmes addressing all village families were chosen (lift irrigation and milk co-operatives), every one hugged together to harvest the gains, creating a false impression of an organised community. In fact these programmes inculcated competitive life style and the greed that comes with it. The realisation dawned, that short of cultural ethos, mere economic upliftment treads the wrong path.

The health insurance scheme had now reached a stage where it was helping identify not only the action oriented culture of the village but also action oriented individuals with capacity to do good. All are not equal in a village, some are more reverable than others. The culture evolution needs active participation of these revered ones (Sajjan Samarth). With aim to organize them, the focus of health insurance scheme shifted to individuals and families than the earlier insistence on an entire village. Action

plans for individuals now emerged like – organic farming and Vastra Swavalamban (Cloth self sufficiency). These are acts in faith. For an intelligent direction of this kind, study circles (Prabodhan) became the need of the hour. It could not have been classroom learning. It had to be experiencial sharing.

The educational talks based on experiencial Wisdom were organised after the month of February, when the crop harvest was over. The usual site was temple, after "Arati" was over at 8 p.m. A discussion would be initiated on issues relating to their day to day life, linking them to social – cultural values. Organic farming was encouraged. The 'Role models' in various fields were put before the community. The educational trips to Role model's work place helped people imbibe goodness. Thus evolved programmes aiming Vastra Swavalamban and sustainable agriculture.

The focus of the scheme now shifted to organise and empower the revered ones. It aimed at breaking their *culture of silence* with a hope that reigns of power be vested in moral leadership. It is from this empowerment and leadership the anti-liquor movement has taken roots in the villages around Sevagram.

The Jawar insurance scheme underwent a major conceptual change, focusing on individuals and families than the entire village. The family had to fulfil at least one Criteria for eligibility of enroliment.

- Member of the SHG
- Experimenting organic farming
- Taken a vow for Vastra Swavalamban
- Active member of study circle in the village.

When the scheme began in 1979, the focus was on curative care; later on it became preventable care; it then reached the stage of promotive care through income generation schemes; the focus moved on to being social and now it is to encourage moral issues in society. Those that give priority to moral issues are insured under Jawar scheme, while the rest can choose any of the other schemes listed above.

The changing focus gave impetus to SHG movement. SHGs were linked to banks, enabling them to offer crop-loans to the members. It being a unregistered body, entirely runs on faith. It selects office bearers by consensus who by rule, do not stay in office for more than two years. All codes of conduct were evolved through group discussions. The culture of decision making by consensus and transparency in all transactions buttressed the faith women enjoyed among themselves. Since it enjoyed credibility of a dependable source of financial support, hence it did not see any defaulters of loan. The forum slowly took up educational role through experiencial sharing sessions, educative trips and by attending educational camps.

It was realized that common man/woman in particular, acts in faith and that is the driving force for him/her. This faith needs to be properly directed by the wise people.

Characteristics of the Oasis :

1. Affordable and accessible:

It is due to fact that families enrolling for Health Insurance contribute according to capacity but services are provided according to need

2. Acceptable :

The evidence - More that 95% enroll in the village. It speaks of its quality. All indoor hospitalization from adopted village occur in Kasturba Hospital, Sevagram. They do not go to the flourishing private sector in Wardha town.

3. Effective :

The Evidence – No maternal mortality in past 15 years.

- No death due to non-accessibility of medical care.
- No Tetanus, Polio, Whooping cough, Measles in last 15 years.
  Measles is the most sensitive indicator of herd immunity achieved.
- No misutilisation of resources.

4. Accountable :

The social finance has generated right to demand, which keeps the service providers of their toes.

5. Wholistic :

It is not an experiment planned from ivory towers with a tubular vision. The experiment has evolved with the involvement and feedback from the people and has transcended wholistically to the priority needs of the people.

6. Credible :

It is something that can not be quantitated but has be felt. It can be witnessed in –

- Late night village meetings where discussions turn in to educative sessions.
- Self-help groups not only as a transparent financing body but transforming in to a educative forum and Empowering women,

- Vastraswavalamban (Khadi for own use) and sustainable agricultural practices as a step towards freedom from exploitative market.

Self reliance in priority needs is a key to empowerment.

7. Trustworthy :

The gains of this experiment have been the relationship of a friend / partner, the free lines of communication with the beneficiary and the conversion to a big family. There is implicit trust involved and this enables the poor to share their pathos. They come to health care professional with the belief that they would do their best and leave the rest to destiny. A relationship of trust is thus established which brings people together and keep the scheme going on.

8. Replicability :

The credibility of scheme revolves around the will of the hospital management to support. Dr Jajoo is a pivot around which the scheme revolves. In his absence the need based health insurance scheme would continue, though the outreach activities and other dimensions of health would suffer.

Research :

The service to the people was main concern. Research was not really a focus because of lack of interested manpower. The focus was instead on operational research and on extending the scheme to community by emphasizing other dimensions related to health ethics. Over the years, the scheme has generated a lot of data but this needs to be analysed.

The operational aspects :

The hospital has now become much more accessible to the community and this has helped bring down the incidence of deaths like that due to pneumonia and diarrhoea. Vaccine preventable illnesses (tetanus, polio, whooping cough, measles) have disappeated once herd immunity was established and maintained by cluster approach to immunisation. From the year (1995) government adopted cluster approach to immunisation, vaccination is left to government ANM. The village worker performs a watch dog function to see that all eligible receive it.

The deliveries are free in the hospital for primiparous and for complicated pregnancy. The women can choose to have delivery either in the villages assisted by traditional birth attendant (TBA) or in the hospital. The services now being accessible, women choose to have hospital delivery. ANC (Antenatal care) up to 7th month are

handled by village health worker. While around 7th month, women report to Kasturba Hospital for assessment of pelvis, toxaemia and for receiving booster of tetanus toxoid. The area catered by health insurance scheme has not witnessed maternal mortality from last 15 years and the natal / prerinatal mortality has reduced significantly.

The monthly ANC visits in the villages have been given up. ANM visits villages once in three months, checking all records maintained by village workers (ANC registration, Vaccination, Birth, Death). With appropriate strategy for vaccination and ante-natal care, which utilises village based manpower to the maximum, the need of skilled manpower is reduced to the obligatory minimum. The ANM under the scheme acts at the second tier managing the administrative work of all the villages in addition to supervision of village based activities in 40 villages. She visits all hospitalised patients, assures expeditious services, entertains their complaints, keep records and informs tricky problems to Dr. Jajoo.

The process of selection of VHW has undergone a sea change. Initially TBA was preferred with a notion that she has natural access to pregnant women and new-borns. She belongs to lowest socio-economic class, is needy, hence would be most appropriate choice. The experiences was contrary. She was called only for conducting delivery and taking care of new born for next ten days since no body else would do it. She did not and does not enjoy enough credibility in the minds of people, that advice would be heeded. She had to take permission from her husband to accompany a patient in the night to the hospital, if emergency so demands.

The option shifted for a male member. With the evolving role of VHW, a person with leadership qualities, one who is respected in the community and has aptitude to serve, happened to be the choice. Since the village fund that could be raised from prepayments did not permit lucrative honorarium (it is hardly 1000 – 1500 Rs. Per year), only a person from middle class background with aptitude to serve could be selected. Since the selection was done in consultation with wise and elderly men and women of different caste groups in the village, often in front of the temple, the person acceptable to all had to be one beyond village party – politics.

With SHG movement taking shape, it was easy to locate women with leadership potentiality and serving aptitude. Most of the villages, at present have two village workers, one male and other female, assisting each other for the comprehensive development of village.

As the vision behind the scheme was ever evolving, Dr. Jajoo, ANM (Mrs Bagade) and village workers all underwent a problem based learning. Frequent meetings (Late night) with Gram Sabha, generated directions which way to go. At no time, need for a formal training was experienced. The team learned by doing and

experiential sharing. Every thing needed had to be learned by all. The learning transcended beyond scientific to socio-economic-political-spiritual dimensions of life.

According to Dr. Jajoo, the propagated glorified role of VHW as a liberator in late 80s and early 90s had to settle down to ground realities. For a peripheral health workers to perform successfully, an effective back-up referral system needs to be in place. The credibility, ultimately in the community is for curative care and not preventive care. The experience in Sevagram has shown that the acceptability of VHW depends greatly on how much support the medical team can give him / her as a link between the community and health delivery system (PRIA study 1986).

Community involvement in health care :

Community involvement is a glibly used slogan. It has different shades –

- *Community complacence* where community is a passive receiver.
- *Community co-operation* – where manpower support is offered by community.
- *Community partnership* – demands material support from the community in addition. In all these, there is a 'big brother' that dictates.
- *Community* participation is a politicised concept. The decision making lies with the people. There is a common feeling and hence spontaneity in action.

Health being a service sector, professional relationship is vertical. Health insurance scheme has horizontalised this relationship to the extent possible. It exemplifies health for the people. Sevagram could achieve community partnership while evolving models like 'one house one latrine scheme', milk co-operatives and lift irrigation co-operatives. The scheme did succeed in unifying village community through income generation programmes. But money brought with it liquor, gambling, party politics, police and judicial courts. *The fact brought home the painful realisation that pooling people together for material gain is not development.*

Village around Sevagram has witnessed community participation emerging during farmer's movement. It breathed its last because it aimed only for material gain.

The scheme experienced right kind of community participation emerging with Vastraswavalamban Yojana, sustainable agricultural practices and SHG movement of women in particular. It is an empowering experience, evidenced by the anti-liquor movement that is taking roots in village around Sevagram. *The right kind of community participation emerges when spiritual wisdom leads and lights.*

Experiencial Wisdom of last 20 years

For pro-people (poor) health services, self reliance is a myth. The Jawar scheme could raise around 10% of what is spent, by social finance. The private insurance which works on the principle of financial risk sharing on no loss basis, can never cater poor. Dr. Jajoo emphasizes that *pro-poor health care must be domain of state's welfare activity.*

It is possible to offer just primary health care to all within presently allotted government resources (250 Rs / Per capita year). The maldistribution of centrally pooled resources is what primarily ails our system. The percolation theory – that centrally allotted funds will reach to the periphery – fails. If the government decides to hand-over its percapita expenditure on health directly to Gram Sabha then there can be better control of the health services. Where they control health finances, they can negotiate services from the providers, it gives them a better pedestal. The community can then buy the services from the public or the Voluntary sector which is arguably propeople. Empowerment of people without ownership of resources is not possible. The bottleneck of Sevagram experiment was the fact that people did not own resources and were on receiving end and hence the programme remained vertical and complete participation was not possible.

It requires a radical political will to truly decentralise up to Panchayat Raj system and distributing resources to it on percapita basis. The structural adjustments of this kind can see replicability of Sevagram experiment.

Short of these structural adjustments where-ever 90% of the finances can be granted to the voluntary sector (as is the case of Kasturba Health Society), mechanisms and organisational part of the scheme would be replicable. The will has to exist, it can not be replicated.

Ethos :

We live in a society where "*all men are equal, but some are more equal than others*" ! It is not an egalitarian society, social relationships are exploitative.

The fact reminds of a story form Panchatantra --

"There was a forest. Out of all the animals, a wolf and a crane together were invited for the feast KHIR. (sweet rice-milk) was served to them in a plate and both were invited to enjoy the same. Guess who must have gulped it? The wolf had its day. The host was intelligent. He invited them again for a second round, but KHIR was now served in a MATAKA (earthen vessel). It was the crane's turn, whose beak could reach the depth of the vessel, while wolf's tongue could not."

Mere availability of public facility does not make it accessible to "Have-Nots". In a democratic society, "more equal" (Haves) have to be restrained, for public benefits to percolate down. It calls for appropriate structural adjustments.

Sevagram Village Health Insurance Scheme idolizes Health Care for the people.

Uniqueness of the Oasis :

- The Health Insurance Scheme reaches out to the unorganized sector, poorest of poor.
- It is the lone health care experiment, which considers village as a social unit and adopts villages.
- Thereby it attempts to empower the Gram Sabha in Panchayat Raj System
- We believe that blind charity corrupts people. It is not a dole. It raises social finance
- It evolves a relationship with the people by talking 'with them' and not talking 'at them'.
- The vision behind this experiment comes from our role model – Vinoba Bhave.

Our generation has heard about Gandhi and read of Gandhi. We have not seen Gandhi in action. We saw Vinoba in action. The line sketch of Vinoba that appeared on "First Day Cover" where his postal stamp was released, aptly depicts what Vinoba stood for.

- He has a lantern in his hand. The title reads – **Lead kindly light** or ***tamso ma Jyotirgamaya***. He leads the path.
- He has his vision on the horizon, which dreams the concept of an ideal society – a society based on principles of freedom and fraternity i.e. Gram Swarajya.
- Look at the compassion that embraces the poor. He empathizes with the poor and the downtrodden (Antyodaya) and leads them from darkness to light.

It is this specter that haunts us.

Lead kindly light

The ethos of the whole process of the scheme's evolution has to develop a democratic society, especially revolving round the village as a unit of society. The concept of village republic (Gram – Swarajya) of Gandhi- Vinoba – Jaiprakash Narayan, is the ultimate vision of the scheme. Vinoba gave a structural form to the vision in Gramdan. The power lies with the Gram Sabha which consists of one adult male and female member of each family in the village. It is the highest decision making body. The decisions are needed to be taken by near consensus. *Election is considered a foul mean and purity of end is decided by purity of means*. The leaders are selected and not elected. It is in sharp contrast to Panchayat Raj system which has in place narrowly elected (51% against 49%) group of representatives. The representative democratic structure is not pro-people in true sense and has been replaced by participatory democratic structure of Gram Sabha.

The concept is detailed under the Gramdan act of the Indian constitution that was engineered by Vinoba. Under this act, at least 75% of the population of the village should transfer the title of their land to Gram Sabha, then only such a village be called as Gramdan village. The villagers enjoy the right to plough, cultivate and consume the produce (Crop) from the land. However the land can not be sold to any body outside the village. They decide their own land records. Under this act, the ownership is collective, but the individuals continue to enjoy consumption right over fruits of their labour for generations to come. Thus it promotes a society which survives on 'bread labour' and does not permit 'intellectual labour' to exploit. The ideal society would be one that would revolve around concept of 'bread labour'. In such society there would not be much difference between the members and interdependence be obligatory. The decision making then would be a collective exercise which would decrease the possibility of unfair or wrong decisions.

The concept of '*labour currency*' which equals physical labour to intellectual labour is considered prerequisite for the equality in socialistic philosophy. By underpaying for physical labour, exploitative society pools the '*surplus value*' in control of '*more equals*', thus creating classes. By virtue of collective ownership of natural resources like land, water and forest, the Sarvodaya philosophy in Gramdan digs out roots of exploitative.structure in present society and paves the way to nurture values of *equality and freedom*.

Empowering Gram Sabha is the key to Gram – Swarajya. Empowerment occurs when resources are owned and freedom of decision making rests with Gram Sabha, when decision making is obligatorily by consensus or overwhelming majority, no wrong decisions can occur. The opinion of the silent majority now supervenes. The '*culture of*

silence' of revered-ones is now broken. As is a saying in eastern culture – "*God speaks through them.*"

It is not a wild dream. A tribal village – Mendha (Lekha) in Gadchiroli district of Maharashtra, having population of around 400, has implemented their slogan "Delhi-Bombay exemplifies '*Our*' government, '*We*' are the government in Mendha." The poor and illiterate people of Mendha exemplify empowering of people and the culture of Gram Swarajya.

How should health system be in the context of Gram Swarajya ? It has to be health by the people, for the people and of the people. Since the resources must be owned by Gram Sabha, the Sevagram experiment proposes distribution of centrally pooled resources by the State and Central government to be distributed back to village on per capita basis. ~~Since~~ The freedom-which services to buy – should also rest with Gram Sabha so that just decisions can evolve. Short of these structural adjustments (which requires strong political will), Kasturba Hospital Sevagram holds the government grants *in trust* and distributes public money appropriately by raising a model of *health for the people*.

Jawar health insurance scheme at Sevagram is an attempt to identify revered individuals (SAJJAN SHAKTI), empower by bringing them together, inculcate a culture of decision making by consensus and initiate acts of common faith.

Looking back at the experiment that this scheme has been, Dr Jajoo feels that a model has been developed, which is ideal and is replicable in an ideal kind of society envisaged. The lamp needs to keep burning until the fire catches on. This is a 'micro' experiment for a 'macro' ideal. Multiple experiments need to be done and time would only decide when they would be replicable. The need is to act locally, while thinking globally. *One step in the right direction is enough.*

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ASHWINI's Health Care System and the Composite Health Insurance Programme for Adivasis

January 2004

1.0 Introduction

Group Insurance is not a new thing to the Adivasis ! Even now in many adivasi villages, whenever somebody becomes seriously ill and needs to be taken to a hospital, there is a "collection" among all the houses in that village. With this money, they hire a vehicle and come to the hospital in a group. This kind of 'sharing the risk', which is fundamental to any group insurance scheme, had been practiced by the tribals for ages ! However, the modern economic systems and lifestyles made it necessary to fine-tune these traditional practices. This is the basis of the Composite Tribal Insurance Scheme of ASHWINI.

2.0 Genesis of ASHWINI

Though ASHWINI as an independent organisation was started only in 1990, its genesis dates back to 1986 when Stan Thekaekara and his wife, Marie started ACCORD, a Non-Governmental Organisation in Gudalur. Their main objective was to to fight the unjust alienation of the adivasi lands and other human rights violations by organising them as a strong group.

They facilitated the formation of village level sangams and these sangams enabled the adivasi families to prevent any of their land getting encroached by powerful non-tribals of that area or by the Government authorities. More than 200 such village sangams had been formed within two years. These sangams were federated at the taluk level into "Adivasi Munnetra Sangam" which till today remains the representative organisation of the adivasis, fighting for their just rights and striving for the socio-economic development of the adivasi community.

But, it was not only the problem of land. The village sangams again and again brought up the issue of health care. Women were dying during childbirth. Children were suffering from easily preventable diseases. Some intervention was urgently required. But, Stan and Marie were not doctors. They started looking out for some doctors through their contacts. Fortunately, they met two young doctors, Dr.Devadasan and his wife, Dr. Roopa, quite eager to take up the challenge.

3.0 Community Health Programme

Deva and Roopa joined ACCORD in 1987 just after their graduation from the Christian Medical College, Vellore and launched a community health programme in the adivasi villages. The main focus was to train village level Health Workers (HW) selected from the community itself, to identify and prevent illnesses like diarrhoea, to provide immunisation and nutrition to the pregnant women and young children, and generally to improve health awareness among the adivasi community. The team went from village to village, participated in the sangam meetings and regularly monitored the progress of the pregnant women and children.

Within a few years, the preventable deaths among the adivasis (like due to diarrhoea or during childbirth) were more-or-less eliminated. The HWs did a tremendous job in the programme, kept highlighting the health issues in the villages and closely followed-up the individual cases. The immunisation status of the children & pregnant mothers dramatically improved with the launch of

the community health programme. Issues like growth monitoring and nutrition were constantly brought to the notice of the parents by the health workers. Thus far, the health programme consisted entirely of these field activities. In spite of the successful community health programme, there were inevitable cases needing hospitalisation, there were high-risk pregnancies which required the women to deliver in a hospital, and acute cases of diarrhoea and fever among children too needed hospitalisation. Deva and Roopa used to refer such patients to the local Government hospital or to the private clinics.

But the experience with these hospitals was not very encouraging since the care and treatment given to these patients was not satisfactory, the doctors weren't there many times in the Government hospitals, the costs of treatment in private clinics were high (ACCORD subsidised these costs). Deva and Roopa were torn between following a few cases in these hospitals and visiting the villages all over the taluk.

Quite encouraged by the success of the community health programme and the role played by the adivasi health workers, the adivasi community felt that the next logical step would be to start a hospital of our own. There was a heavy demand from the village sangams to start a hospital. But the doctors were reluctant, saying that Hospital is a permanent institution which needs to be run 24 hours a day, all through the year - and for many years. The health team at that time was not equipped to handle such an institution. Moreover, the ACCORD team strongly felt that their intervention had to be time-bound and they will withdraw after a few years when the AMS can take over the initiative of protecting the rights of the adivasis. But, hospital is a permanent form of intervention which cannot be withdrawn. And, in any case, where are the nurses in the adivasi community (another basic philosophy of ACCORD was to identify youth from the community itself to deliver all the services to the people and to train them !) ? And, Doctors ??

4.0 Gudalur Adivasi Hospital

However, the community was strong in its demand and felt that the community health programme needed a hospital of its own to make it much more effective and acceptable to the people. So, they started a search for suitable people. Again as a curious coincidence, there landed up a doctor couple, Shyla and Nandakumar, willing to be part of the health programme. Having the ideal combination of skills as Gynaecologist and Surgeon, they were what the "doctor ordered" and the people were looking for ! Young adivasi girls were identified by the sangams and the new doctors started training them as nurses. Thus was born the "Gudalur Adivasi Hospital" [GAH]. In 1990.

With the establishment of the Hospital, we realised that this intervention is going to continue for a many years, and structurally it has to be different from that of ACCORD or AMS. So, the health programme, activities and the staff were hived off from ACCORD and a separate legal entity called ASHWINI was registered. From then onwards, Ashwini took care of the health issues concerning the adivasis and poor people of this area. While Deva and Roopa continued their focus on the community health programme, Shyla and Nandakumar started training tribal girls as Nurses. It was a major cultural change for the girls - from innocent village life to a three-shifts-a-day routine in the hospital. Training had to start from elementary Maths and English.

These adivasi nurses have come a long way in the next 10 years. They have become experts in conducting deliveries, in assisting the doctors in surgeries, in the general administration of the hospital, in ordering and managing the drug stocks, in designing systems to monitor the performance of the hospital (All the patient details have been computerised after 1996) and in analysing the financial aspects of the hospital management. They are constantly trained and their skills are upgraded to keep up with the growth of the programme.

Today, the Adivasi Hospital is one of the most sought after hospital in the Gudalur valley, not only by the tribals but also by the non-tribals of the local area. Patients are brought from distant villages by ambulance and good quality care is given. As all the staff are from the community and can talk the tribal languages, the tribal patients feel at home. Efforts were constantly made to keep the place culturally acceptable to them and the community gradually adjusted to the change. Today, there are cots in the hospital, they come forward for surgeries and many of them regularly show up for antenatal checkups etc. Some more young doctors came and worked in the hospital for brief periods - the health team getting enriched by the interaction with each of these doctors.

5.0 Sub-Centres

Till 1994, the health programme consisted of preventive care given by the HWs at the villages and curative care provided at the GAH. However, during many interactions with the sangam members, a need was felt to have another intermediate level comprising of a group of villages. The AMS had already divided the sangam villages into eight administrative zones called "Areas" and an Area Centre was coordinating the sangam activities of that particular Area. From 1995 onwards, a health Sub-Centre was started in each of these Area Centres.

These Sub-Centres coordinate the community health programme in the villages of that Area, provide first aid and primary level curative care by dispensing medicines, Screen patients regularly, refer those needing doctor's intervention to Gudalur Adivasi Hospital and follow-up the patients discharged from the Hospital. Initially the senior nurses and health staff took responsibility to manage these sub-centres. Later, a few more adivasi girls were trained specifically to run these sub-centres - They are called "Health Animators". As per the need, they keep shifting between the hospital and the sub-centres, so as to strike a balance between the curative and preventive programmes and to keep their skills sharpened and updated.

6.0 Management

Monitoring and review of the activities, both in the villages and in the hospital are done by the staff themselves in the monthly meetings. Besides, a Working Committee comprising of a few senior nurses and health animators has been constituted. This group looks ahead, takes care of the long term planning, budgeting and other policy issues.

ASHWINI is registered as a Charitable Society under the Tamilnadu State Societies Registration Act. The General Body of the Society is constituted from the senior AMS activists, the adivasi nurses / health animators and the doctors. All the members of the Executive Committee are adivasis. Thus, though ASHWINI is legally an independent identity, it continues to function under the umbrella of the AMS as an institution owned and managed by the adivasis themselves for their own development.

7.0 Breaking the Financial Barrier – The Insurance Scheme

The main objective of the insurance scheme is to break the financial barrier of the adivasi families at the time of illness. We have noticed that lack of liquid cash at the time of illness is one of the most serious barriers to the adivasis, preventing them from getting safe medical care and accessing hospitals. Our challenge was to encourage them to plan ahead and save something for the possible event of sickness in the future. For a community, eking out a day-to-day existence, this was a radical change. Saving for

the future itself was a new thing - leave alone for their health needs. But, we were convinced that this had to be done and hence, pursued our idea with the people relentlessly.

When Gudalur Adivasi Hospital was started in 1990, we discussed with the village sangams about the financial aspects. On the one hand, none of us wanted the hospital treatment to be totally free as this would not be sustainable in the long run. However, on the other hand, it would be difficult for the adivasi patients to pay the entire costs of hospitalisation. Combining this need for resources with the adivasi tradition of sharing, we arrived at the concept of group insurance. Though providing health care through insurance coverage is a very modern idea, we hit upon the same solution, but through a very different route and rationale.

We approached various agencies including some insurance companies. However, the insurance policies existing at that time were targeting primarily middle and high-income people living in the cities. The premiums were high as the claims ran into Lakhs to cover "costly" diseases like heart attacks and bypass surgeries. These policies would be totally inappropriate for the adivasi community where anaemia, malnutrition, safe delivery and care of young children were the major problems.

So, we needed a simple package covering these illnesses. Fortunately, following a long search, we met some enterprising officers of the New India Assurance Company who were willing to design a special package for the adivasis of Gudalur. After more than two years of discussions and negotiations, we were able to design a scheme, which would address the specific health needs of our people. We finally launched the composite tribal group insurance scheme in 1992.

According to this policy, for a premium of Rs. 15 per person per year, hospitalisation expenses up to Rs.1500 would be reimbursed by the insurance company. The Adivasi Munnetra Sangam decided to insure all its members. We started by insuring 5000 adivasis in 1992 and the number has risen to 13000 by 2002, as new villages and members join the AMS.

8.0 Policy Details

To avail of the Group Discount and Long Term Discount offered by the insurance company, ASHWINI insured all the members of the AMS for five years by paying the premium en bloc. In turn, the activists of AMS, including the Health Animators of ASHWINI collect the premium from the members every year. So, in essence, ASHWINI has taken a Policy with the Insurance Company for five years, whereas the AMS takes a policy for its members with ASHWINI every year.

This arrangement made sense, considering the many restrictions imposed by the insurance company on the diseases covered under the policy, the Rs.1500 ceiling and the delay in the reimbursements. To encourage the tribal patients to seek health care at the earliest and to make the health system more effective, our health care system has to be comprehensive and should provide for all the health needs of the community.

Policy Highlights (1992-2002)
Started : in 1992
Membership : About 12000
Agency : New India Assurance Company
Annual Premium : Rs.15
Claims : Up to Rs.1500 of hospitalisation expenses

For example, pregnancy related admissions were not covered under the policy during the first seven years. But, one of our major aims was to reduce the maternal mortality and to encourage the tribal women to choose safe confinement. So, even while the insurance company was not reimbursing the expenses of pregnancy related admissions, we continued to provide free treatment to the insured tribal

women who get admitted for pregnancy related causes. However, due to our persistent efforts and representations to various authorities including the Finance Minister of Government of India, the policy was subsequently modified in 1997 to include pregnancy related admissions for the 1st and 2nd deliveries ! The table below gives the differences between the policy offered by the company and the scheme offered by ASHWINI for the comprehensive health care of the AMS members.

Details of the Health Insurance Policy

Particulars	Insurance Company*	ASHWINI
Expenses covered under the policy	Only hospitalisation expenses	Apart from hospitalisation costs, includes OP treatment in the hospital and in Sub-Centres
Ceiling on the amount reimbursable	Rs. 1500 per year	No limit on expenses.
Diseases which are not covered	Chronic illnesses like diabetes, TB, etc.	All illnesses are treated free of cost.
Time taken to reimburse claims	From 3 to 9 months from the date of sending claims.	Patients do not pay any amount on discharge, and hence claims are instantaneous.

* Details of the policy with New India Insurance Company between 1992 and March 2002.

Summary of the Financial Details of the Insurance Programme from 1992-1997

Description	1992-1997	1997-2002
Total Premium paid to the insurance company	Rs.4,35,722.25	Rs.5,94,566.00
Amount reimbursed by the company	Rs.5,94,566.00	Rs.12,68,051.00

9.0 Premium Collection

Insurance collection is a major annual event ! The collection season commences with a meeting of the tribal staff of ASHWINI and the field activists of AMS to decide the premium to be collected from the members that year. Apart from the financial status of ASHWINI, issues like the income levels of Adivasi families and the general economic situation of the Society are considered while deciding the premium.

Year	Premium per person	No. of people who paid premium
1993	Rs. 4	3726
1994	Rs. 6	2744
1995	Rs. 8	3624
1996	Rs.10	4125
1997	Rs.12	3812
1998	Rs.12	4899
1999	Rs.15	4768
2000	Rs.17	4619
2001	Rs.17	4464
2002	Rs.20	4291
2003	Rs.22	4268

We started with Rs.2 per person per year in 1992, gradually increasing it every year. We are collecting Rs. 22 per person for the year 2003. The collection period commences on December 5th, a special day celebrated as Adivasi Day by the AMS and goes on till April 14th, another special festival, "Vishu" [New Year]. Depending on the situation each year, the collection period may get extended. In the earlier years, the sangam activists used to go from house to house, from village to village explaining the insurance scheme and collecting the premium. Now, as people are aware of the scheme, they come to the sub-centres to pay the premium.

The exercise of insurance collection is an important aspect of ASHWINI's health programme, as it keeps the focus continuously on the community. Instead of interacting only with the patients in the hospital, the insurance scheme gives an

opportunity for the field workers and sangam activists to interact with all the sangam members, to explain the health programme and to get a true feedback from them.

The percentage of AMS members who pay the premium to ASHWINI has been hovering between 35% and 50%. A survey done among the AMS members revealed that one of the main reasons for non-payment of premium was the lack of ready cash during the collection period. At present, we are trying to evolve different methods to improve the premium collection from the sangam members and to increase the awareness about the scheme in the villages.

10.0 Current Status

When the policy expired in March 2002, the New India Assurance Company informed us that they were considering a steep increase in the premium from Rs.15 to about Rs.40 per person per year. ASHWINI was not prepared for this precipitous hike, as it was using all its resources to meet the operational costs of the health programme. Subsequently ***Sir Ratan Tata Trust, Mumbai*** was approached for financial assistance to pay the insurance premium and we were extremely happy to get a positive response from them in July 2002.

With the help of Tata Trust and some experts, we had undertaken a comprehensive review of our 10 year experience with the insurance scheme. The conclusions of this study have given us some direction and guidelines to take forward our health care programme. Based on these findings, Tata Trust has extended funding towards paying the premium for about 12000 adivasi members and for some administrative costs in January 2003.

Based on the findings, we approached various insurance companies to restart our insurance scheme. Our negotiations with the Royal Sundaram Insurance Company Limited were successful and we designed a new insurance policy called 'Tribal Health Shield'. This scheme came into existence from May 19, 2003 and will be in operation for a period of one year. The major highlights of this policy are given in the table below :

Tribal Health Shield

- *About 12200 members of the Adivasi Munnetra Sangam are insured under this health insurance policy.*
- *Coverage of all illnesses including common illnesses.*
- *Coverage for Pregnancy related admissions for first 3 pregnancies.*
- *Maximum coverage limit is Rs.1000 per year (Rs.500 for pregnancy related admissions).*
- *Annual Premium is Rs.20 per person.*

We are also working to create an awareness about this model of providing health care to other NGOs and disadvantaged groups also by networking with them.

11.0 Future Plans

During the next five years, our efforts will not only be to consolidate our insurance programme in the sangam villages, but also to share our experience with other charitable organisations working with underprivileged people, so that a larger insurance scheme involving them could be created. Thus our successful experiment with group insurance could spread to other people who wish to address their own health needs effectively.

3

(14)

The Community Insurance - Which way to go.
(Wisdom out of experiential learning from SEVAGRAM)

Dr U N Jajoo
Professor in Medicine &
Incharge Health Insurance
Mahatma Gandhi Institute of Medical Sciences
Sevagram

The Concept

* Primary health care should be considered a fundamental right of the people (as it should be for primary education)

The Challenge

* The poor spend considerable amount on medical care to unregulated and exploitive private sector , primarily due to poor credibility of public hospitals .

* The privatization of public health services offers opportunity to misutilise state – health resources for private sector .

Thus , the private sector requires regulation .

The Disease

* Inspite of wide health care infrastructure in public sector , medical care has not reached the poor , rural people in particular , essentially due to i) paucity of funds and ii)lack of efficiency .

* The misdistribution of centrally pooled resources is what primarily ails our system . The distribution of central and state government funds is lop sided , favoring "haves " and neglecting "have-nots" , favoring "urban " and neglecting "rural "masses .

Thus , the optimal resources allocation (per capita basis) to primary health care hospitals is the first step to building credible services .

The Pre-requisite

*Primary health care services must provide free curative care for its acceptability to the poorest of the poor .

* The egalitarian health service can never be economically self reliant , if they have to preferentially serve the poor .

Thus , no private insurance will cater to the poor , and

The pro-people services must be shouldered by the state .

The Soul

* The credibility of the system revolves around

a) Accessible hospital services of an optimum quality

b) Accountability of the health care system to the consumers , and

c) Affordability of the services to the poorest .

The Fact

* It is possible to offer a non-biased primary care to all , within existing government resources , provided funds are locally available and locally governable in a efficiently managed decentralized setup.

The Direction

* The accountability of health care systems cannot be enforced vertically down . to incalculate responsiveness in public health care systems , a vigilant public audit system is required .

Thus , the empowerment of the people is the key towards accountability . The power emanates through the control of public funds and performance evaluation of public servants .

The public body empowered to undertake the above is a decentralized structure .

Thus , the gram sabha in the panchayat raj system be empowered with public funds (per capita basis , expenditure that central and state governments undertake).

The Participatory Nature

* Since charity corrupts people and does so absolutely , beneficiary should contribute towards health care services , albeit , according to their capacity and the priority need .

* The contribution according to capacity and services according to the needs . must be the guiding principle , for pro-poor services .

* Though the social finance so raised cannot meet the expenses of medical care . they can at least supplement them .Apart from offering an affordable post-payment mechanism to persons who need services but who are unable to pay (Risk sharing), Social financing has some spin of benefits –

i) It increase accessibility of health services ,

ii) It promotes operator's concern for health in the community ,

iii) It generates the concept of right to demand a quality health care among the beneficiary population .

iv) It responds to priorities as judged by the community ,

v) It ensures that services are acceptable ,

vi) It keeps service providers on their toes , and

vii) It simulates organizational self-confidence and paves a way for participatory culture at community level .

The Essence

* Primary Health Care is a fundamental right and the welfare state has an obligation to fulfill it .

* No private health insurance can cater to the poor .

* The pro-people health care services must be financially shouldered by the welfare state.

Thus , it should be obligatory for a welfare state to offer a health insurance scheme through its existing infrastructure .

* It is possible to offer just primary health care to all within allotted resources by central /state governments , provide it is distributed on capita basis in a decentralized panchayat raj setup.

* The credible emergency services should be for free , for them to be accessible by the poor .

* The social finance raised through consumer-contributions according to their capacity , raises the demand for quality care and incalculates community participation in medical care .

The Path to Tread

* As a part of constitutional obligation , let the state run community health care scheme. through its rural hospitals (village or Mohalla of a city as a unit of community).

* The health care scheme should raise the finances as prepayments from gram-sabha in panchayat–raj system .

* The health care budget of central and state government can be allotted on per-capita basis to panchayat raj system . The amount can be routed as pre-payment towards community health care scheme .

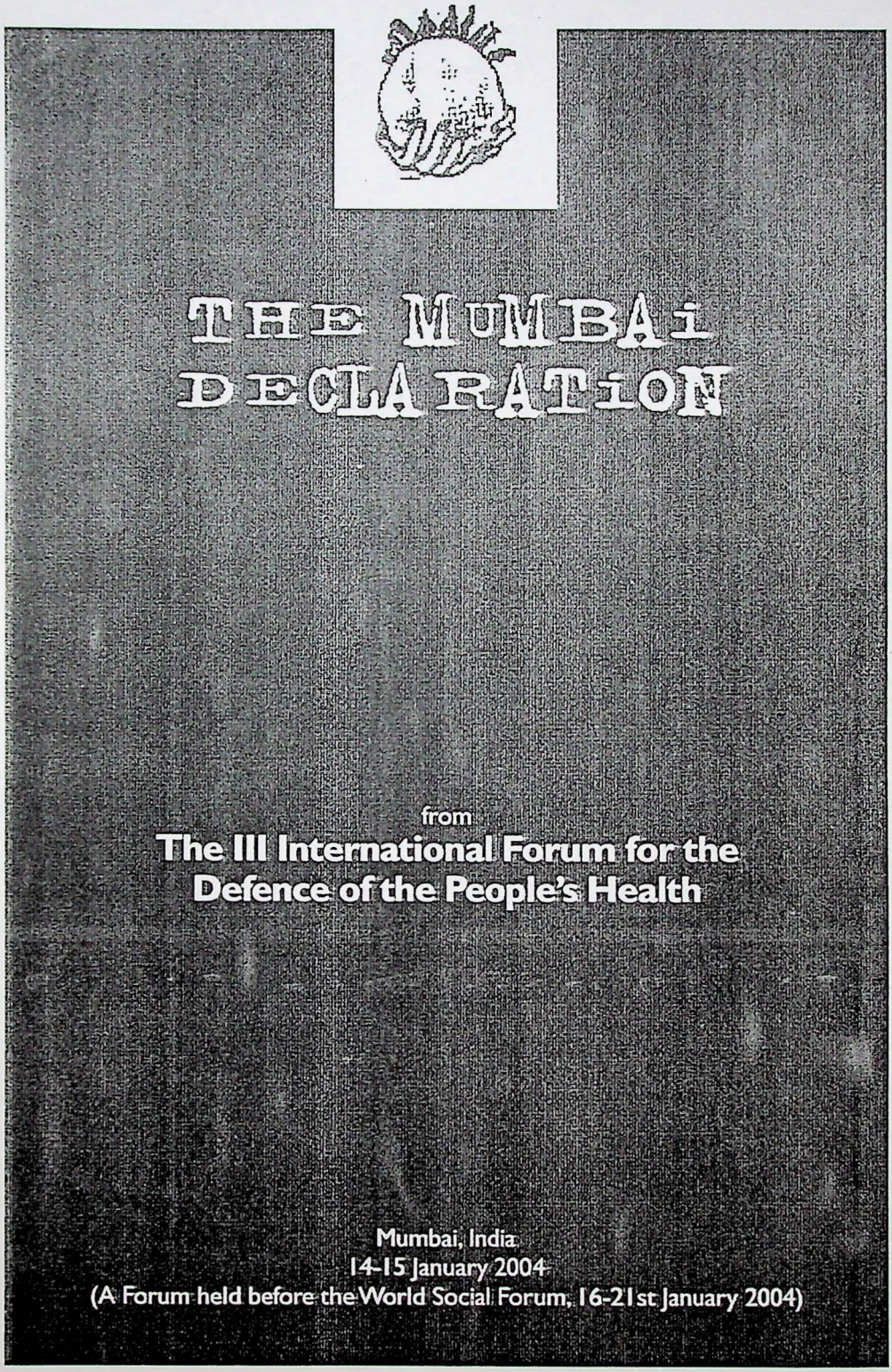
*Let private sector compete with the public sector by floating a community health care scheme of their own . The choice of selection rests with the gram sabha in panchayat raj system .

* Gram Sabha should raise social finance for unforeseen emergencies which rural hospitals fail to meet .

Kev Words

Structural Change - Decentralize
Empowering people - Just distribution of resources
Credible system - Affordable , accountable , egalitarian

Final document (13)



THE MUMBAI DECLARATION

from

The III International Forum for the Defence of the People's Health

Mumbai, India
14-15 January 2004
(A Forum held before the World Social Forum, 16-21st January 2004)

PREAMBLE

We, the 700 delegates from 44 countries[1], gathered at the III International Forum for the Defence of the People's Health at Mumbai on 14th and 15th of January 2004, reaffirm the validity and relevance of the People's Charter for Health, the foundational document of the People's Health Movement, which describes increasing and serious threats to health in the early 21st century.

Since the Charter's adoption in December 2000 at the first People's Health Assembly, at GK Savar, Bangladesh, the health of the world's poor has worsened and more threats to people's health have emerged.

Social, political, economic and environmental threats to health identified as the basic causes of ill health and the inequitable distribution of health within and between countries have increased.

Social, political, economic and environmental threats to health identified as the basic causes of ill health and the inequitable distribution of health within and between countries have increased

The III International Forum for the Defense of the People's Health provided opportunities to hear inspiring testimonies, from the world's poor and health activists:

- *Denouncing the denial of health to their communities and their efforts to overcome this injustice*
- *Threats to health from the unfair system of global trade and the imperialist policies of developed countries including unjust wars and efforts to counter them*
- *The Demands for acknowledgement of health as a universal human right and the implementation of Comprehensive Primary Health Care as a strategy to achieve Health for All*

The Forum recognized the particular discrimination suffered by many groups which makes achieving Health for All even more difficult. These included women, people with disabilities, sex workers, children living in difficult circumstances (including street children), migrant workers, people with mental disorders, Dalit people, Indigenous peoples in rich and poor countries, and all those affected by wars, disasters and conflicts.

The Forum demanded Health for All, Now! and reiterated that Another World in which health is a reality for All is necessary and possible.

The Forum brought together all the concerns and experiences shared into a *Declaration* for action, entitled *"The Mumbai Declaration"*. This Declaration is an update on the state of people's health across the globe at the beginning of 2004 and calls on People's Health Movement, Civil Society and Governments to evolve action in six key areas to achieve the goal of "Health for All Now!" dream.

- *End Corporate led Globalisation*
- *End war and occupation*
- *Implement Comprehensive and sustainable Primary Health Care*
- *Confront the HIV/AIDS epidemic with Primary Health Care and Health Systems approach*
- *Reverse Environmental damage caused by unsustainable development strategies*
- *End discrimination In the Right to Health*

End corporate-led globalization

Corporate-led globalization continues to be a major threat to health. Since the People's Charter for Health was adopted in 2000, the International Monetary Fund, the World Bank and the World Trade Organisation have continued to advance the economic health of corporations at the expense of global health.

The protection of intellectual property (through trade agreements such as the Trade Related aspects of Intellectual Property Rights, TRIPS) and unfair trading practices (through the General Agreement on Trade in Services, GATS) have caused enormous damage to people's health.

The tobacco industry offers a clear example: Tobacco kills, yet transnational companies continue to target youth and marginalized communities with their tobacco marketing strategies.

The epidemic of privatizations of water, electricity, education and health care, imposed by Structural Adjustment Packages (SAPs), has limited access to or removed the foundation upon which public health is built.

Public-private partnerships, as promoted by World Bank, Global Funds and International health agencies including WHO, have removed responsibility for health from the public sector, essentially privatizing health and treating it as a commodity rather than a human right. User fees have further decreased people's access to health care services.

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

- Pressure the World Bank and the International Monetary Fund to acknowledge their culpability in the current health care crisis, especially the damage caused by Structural Adjustment Programs;

1 Argentina, Australia, Bangladesh, Belgium, Brazil, Cambodia, Cameroon, Canada, Costa Rica, Cuba, Denmark, Ecuador, Egypt, France, Germany, Guatemala, Hong Kong, India, Iran, Italy, Kenya, Korea, Lebanon, Malaysia, Mauritius, Netherlands, Nicaragua, Nigeria, Norway, Pakistan, Palestine, Peru, Philippines, South Africa, Sri Lanka, Sweden, Switzerland, Tanzania, Thailand, USA, UK, Vietnam, Zambia, Zimbabwe

- Build the Campaign "No To Intellectual Property Rights" in our traditional systems of medicine and our seeds, to resist the efforts of the WTO and translational corporations to patent, own and trade in them;
- Demand the representation and active participation of people's organisations, health workers, and farmers in policy-making processes related to Access to Health
- Expose, shame and stop government officials, academic institutions, and civil society organisations from accepting money from the tobacco and other industries which undermine public interest initiatives internationally and nationally.

Calls for Action by Governments

- Regulate the entry and behaviour of the corporate sector in the social services such as health, education, transportation, etc., and ensure that public health concerns always take precedence over trade agreements and corporate profit;
- Resist "TRIPS-plus" through bilateral or regional trade agreements driven by the United States government and the institutions it controls;
- Ensure negotiations on "Free Trade" treaties and the like are transparent and democratic and not conducted behind closed doors;
- Resist pressure to privatise health essential industries (health care, electricity, water and education) and renationalise these industries;
- Sign, ratify and implement the Framework Convention on Tobacco Control (FCTC);

End War and Occupation

Since 2000, war, occupation and militarism have become ever more devastating threats to people's health. The violent imposition of imperial will has led to death, injury, and social and environmental destruction for untold numbers of people.

Actions in support of international law and pro-health and against the war in Iraq; the occupation of Iraq and Palestine; the construction of the Wall in Palestine are urgently needed

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

Strengthen the international anti-war movement through:

- Building the global campaign: "No to War, No to WTO, Fight for People's Health";
- Monitoring the impact of war, occupation, and militarization through a global "Occupation Watch";
- Targeting corporations which benefit from the war in Iraq, invasions and military occupations and those that enrich themselves (e.g. arms industry, pharmaceutical and food companies) by fostering ill-health through a "Boycott Bush" campaign;
- Establish peace initiatives at various levels based on justice and equality.

Calls for Action by Governments

- Refuse to take part in unjust and imperialist wars and occupations
- Work for world peace as a key determinant of health

Since 2000, war, occupation and militarism have become ever more devastating threats to people's health. The violent imposition of imperial will has led to death, injury, and social and environmental destruction for untold numbers of people.

Implement Comprehensive and Sustainable Primary Health Care

Since 2000, the Global Fund and other international health programmes of WHO, UNICEF and World Bank have continued to promote selective and vertical health programs which corrupt and weaken Comprehensive Primary Health Care as defined in the WHO Alma Ata Declaration.

Health professionals educated in the developing world and migrating to the developed world represent a transfer of billions of dollars from South to North. This unrequited training investment further burdens health systems already suffering from a precarious lack of human resources. The "brain drain" flows not only from developing to developed countries, but also from the public to the private sector.

Traditional and alternative systems of medicine are vibrant parts of Comprehensive Primary Health Care. Traditional Birth Attendants provide the first and often the only access to reproductive health in many areas of the world. These knowledge and traditions should be validated and their skills reinforced through continuing education, and support to the revitalization of local health traditions.

New areas, relevant to Primary Health Care, not adequately addressed in the Alma Ata Declaration need to be promoted in an integrated way. These include gender, environment, disability, mental health and traditional systems of health.

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

- Demand that universities and other training institutions incorporate Comprehensive Primary Health Care into the curriculum for all health professionals updated to address gender, environment, disability, mental health, traditional systems and other issues ;
- Lobby for widespread adoption of Community Health Workers and Traditional Birth Attendants as integral members of multi-disciplinary Primary Health Care teams.

Calls for Action by Governments

- Develop national policies on traditional and alternative medical systems and include them in national health programmes;
- Involve marginalised sectors in decision-making regarding policies that affect them;
- Strengthen health systems in the context of access, quality and equity;
- Establish Comprehensive Primary Health Care services based on the principles and strategies of Alma Ata outlined in this declaration and related to local needs and updated to address gender, environment, disability, mental health, traditional systems and other issues.

WHO has recently become stronger in its technical support to HIV/AIDS and has made an official commitment to pursue its 3 X 5 goal (3 million persons with AIDS receiving Anti-retroviral Treatment (ARV) treatment by 2005) through strengthened health systems.

PHM is concerned that the 3 X 5 initiative focuses on treatment alone, ignoring the complexity of the epidemic.

Calls for Action by WHO

To reaffirm the principles of Alma Ata and ensure that comprehensive approaches that focus on primary health care and strengthen health systems are the basis of all WHO global and regional strategies.

Confront the HIV/AIDS epidemic

The HIV/AIDS epidemic has continued to worsen since 2000, especially in Africa and increasingly in Asia and elsewhere. Spreading along migration routes related to globalization and to social and economic distress due to war, global trade and economic policies, HIV/AIDS is now associated with the resurgence of other communicable diseases of poverty, such as tuberculosis.

Access to ARV treatment has increased the life expectancy and quality of life of those who can afford it. The majority of AIDS patients being impoverished are denied access to treatment in violation of the principles of the international covenant on social, economic and cultural rights. Children orphaned by HIV/AIDS and women who are more vulnerable take a heavy toll.

WHO has recently become stronger in its technical support to HIV/AIDS and has made an official commitment to pursue its 3 X 5 goal (3 million persons with AIDS receiving Anti-retroviral Treatment (ARV) treatment by 2005) through strengthened health systems. Yet addressing the HIV/AIDS epidemic requires contextual solutions. We are however, particularly concerned that;

- The 3 x 5 initiative focuses on treatment alone, ignoring the complexity of the epidemic;
- High drug costs can lead to long-term dependency on donors;
- There is inadequate involvement of persons living with and affected by HIV/AIDS and civil society in planning, implementation and evaluation
- There is inadequate budgetary and related commitments on improving health systems, particularly Primary health Care to provide drugs and general health services and information in the long term.
- There is inadequate attention to life skill education, women's health empowerment and utilization of traditional systems of medicine.

While endorsing concern about the HIV/AIDS epidemic, the need for Primary Health Care oriented and Health Systems strengthening approaches to other communicable and non-communicable diseases in an integrated way is urgently required.

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

- Continue campaigns for the rights of people in poor countries to receive ARV treatment delivered through comprehensive PHC services.
- Facilitate Public Interest Litigations to oppose changes in Patent laws that is expected to escalate the ART prices.
- Make the links between the spread of HIV/AIDS and the underlying societal determinants such as poverty, war, displacement and participate in efforts to redress these injustices

Calls for Action by Governments

- Develop a comprehensive Primary Health Care oriented and health systems' strengthening approach to address the HIV/AIDS epidemic through interventions, including:
  - Peer education that includes sexual and reproductive health and rights information;
  - Oppose stigma and promote respect of and care for people living with HIV/AIDS;
  - Increased access to basic services by people living with HIV/AIDS;
  - Immediate availability of ARV drugs;
  - Support those affected by the epidemic through empowerment.

Calls to WHO

- To evolve a comprehensive approach emphasizing Primary Health care and health systems' strengthening approaches including preventive information and services and ARV treatment;
- Work towards reduction of high drug costs;
- Enhance involvement of people, affected communities and civil society in its planning and initiatives through proactive dialogue.

Reverse Environmental Destruction

The People's Charter for Health recognized that environment, livelihood, and people's health are interconnected and environmental degradation is a major threat to global health. Since 2000, continuing environmental destruction has had a highly negative impact on health.

Rivers around the world, like the Abra in the Philippines and the Narmada in India, are in danger of being destroyed, as are the lives and health of the people and communities who depend on these rivers.

Toxins in pesticides, fertilizers, defoliants (such as Agent Orange and those of the "War on Drugs" of Plan Colombia), waste from US Military Bases (such as those in the Philippines), dust from exploded depleted uranium ordinance (such as that used in Iraq, Puerto Rico), and medical and nuclear waste as well as from mining run-off and exploration for petroleum; are all poisoning our environment and represent a critical hazard to health.

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

- Monitor environmental damage caused by unsustainable development strategies with specific focus on pesticides, industrial and military toxic wastes, etc.;
- Link PHM with other organisations working for environmental justice at the grassroots,
- national and international levels. Join them in their struggles and invite them to join in our struggle for the People's Health.

Calls for Action by Governments

- Pass legislation to ensure governments can hold corporations accountable for environmental damages.

Women's right to health, including sexual and reproductive health, is violated not only by current socio-economic and political structures but also by religious and cultural fundamentalism. Trafficking of women and girls is a major public health problem, little addressed by governments where the trafficking is most rampant

End Discrimination in the Right to Health

The People's Health Charter asserted the right to health for all people. We reaffirm this by noting that the marginalized groups listed below suffer particular and on-going health problems requiring urgent attention:

- Around the world, many women lack access to basic health care, endangering them and their families. Women's right to health, including sexual and reproductive health, is violated not only by current socio-economic and political structures but also by religious and cultural fundamentalism. Population control policies violated human rights, including the use of disincentives and such reprehensible practices as forced sterilization of women. Newer contraceptives and reproductive technologies often ignore hazards to women's health and other ethical and moral issues;
- Trafficking of women and girls is a major public health problem, little addressed by governments where the trafficking is most rampant;
- Sex-selective abortion is a misuse of technology that discriminates against the girl child;
- The rights of sexual minorities and sex workers, including access to health care, must be respected;
- The health and human rights of persons with mental disorders are currently ignored or inadequately addressed throughout the world. There is an urgent need to provide effective community based programs for persons with mental illnesses.

- The unjust social systems like caste in India and ethnic discrimination in other parts of the world have created a health apartheid and human rights reality for the socially marginalised;
- Indigenous people in developed and developing countries suffer health problems at a higher rate than the general population of the country in which they reside. As they are forced to follow the hegemonic cultural and development paradigms, they are being deprived of traditional knowledge and traditional systems of medicine and access to basic resources;
- The health and other human rights of persons with disabilities are currently ignored or inadequately addressed throughout the world;
- Migrant workers living and working in the developed and developing world suffer poorer health than the general population surrounding them. Their basic human rights are denied through lack of access to health, education, housing, etc.;
- Children living in difficult circumstances, such as street children, AIDS orphans, children of war, etc. face increasing discrimination. Corporate-led globalization only increases the poverty in which they live and robs them of a dignified future.

This Declaration;

Calls for Action by People's health Movement and Civil Society

- Make concerted efforts to incorporate all the above marginalized populations, the "unheard and unseen", into their networks and facilitate their access to and influence in mainstream discourse.
- Ensure gender equity within the movement and within their own networks and communities

Calls for Action by Governments

- Make concerted efforts to incorporate the needs of marginalized populations, the "unheard and unseen", in health and development strategies and social policies in a Right's context.
- Ensure availability of disaggregated data on health status and access to health services for different groups (age, sex, region, ethnicity etc.,) in the community to make discrimination to the right to health more transparent and enable actions to be taken.

IN CONCLUSION

We, the members of the People's Health Movement and the participants of the III International Health Forum for the Defense of People's Health commit ourselves to promoting the People's Charter for Health 2000 and the concerns and calls for action of the Mumbai Declaration 2004.

- We believe that an Another World is Possible;
- A Healthy World is Possible;
- Health for All Now! is Possible;

Join us – Endorse the People's Charter for Health 2000 – Endorse the Mumbai Declaration 2004

- SIGN ON AND PROMOTE the People's Charter for Health (visit http://www.phmovement.org/charter/index.html)
- SUPPORT the Million Signature Campaign demanding Health for All, Now! (visit www.TheMillionSignatureCampaign.org)
- PROMOTE the Mumbai Declaration

People's Health Movement
Global Secretariat,
C/O CHC,
367, Jakkasandra 1st Main, 1st Block, Koramangala, Bangalore – 560 034.
Tel : +91-80-51280009 Fax : +91-80-25525372
Email : secretariat@phmovement.org Website : www.phmovement.org

Health for All: An Alternative Strategy

(Peoples' Role in their own Health Care)

Dr. N. H. Antia FRCS, FACS (Honorary)

Foundation for Research in Community Health
3 & 4, Trimiti-B Apartments, 85 Anand Park, Pune – 411 007.
Tel: +91-20-25887020 Fax: +91-20-5881308
E-mail: frchpune@giaspn01.vsnl.net.in

Health for All: An Alternative Strategy

(Peoples' Role in their own Health Care)

Dr. N. H. Antia FRCS, FACS (Honorary)

The Alma Ata strategy of 'Health for All', was an attempt to improve the health of the people of the 'need based' countries which had not improved but even deteriorated 25 years after their gaining Independence. It had certain basic flaws as enumerated below:

- It failed to address the basic underlying cause namely poverty and the reasons for its continuation and increase even after achieving Independence, under the guise of Representative democracy which was promoted by the departing colonizers.
- Unfortunately, in the attempt to impose a western techno-managerial solution, WHO had failed to consider the major factors responsible for the failure namely, the entirely different socio-economic, cultural and political conditions of these countries from that of the West.
- It attempted to provide a universal solution to a complex problem of health which varies from country to country, region to region and often even from village to village.
- It attempted to impose a western science based techno-managerial solution to what is essentially a socio-economic and political problem.
- The 'experts' who were recruited from the 'need based' countries to give an international image to WHO are also trained in the western medical mode in their own countries.
- WHO imposed a series of vertical programmes e.g. for population control under the guise of Family Planning with immunization, ANC, PNC and RCH as its accessories. Also for diseases like malaria, tuberculosis and HIV/AIDS these vertical programmes were to be implemented through a centralized and bureaucratic government Public Health Sector which was already alienated from the people. This also undermined the integrated concept of health and health care and diverted attention from basic curative services for the poor, leaving them to the mercy of a highly exploitative profit oriented private sector.
- The dominant role that the people and community can play in their own health and medical care viz. the PEOPLES sector has been almost entirely ignored with only lip service given to 'peoples participation'.
- The inroads of the World Bank and IMF by imposing the Structural Adjustment policy followed by Globalization, Liberalization and Privatization has not only adversely affected the health sector, as many others, but has also resulted in polarizing the countries, societies and their wealth. This has created increasing poverty among the masses, while promoting 5-star facilities and services for an affluent few.

Dr. N. H. Antia is the Director of The Foundation for Research in Community Health, Pune, India. Tel: +91-20-25887020, Fax: +91-20-25881308, E-mail: nhantia@vsnl.net

- Elected leaders who now control the political system of these countries have readily accepted the Representative form of Democracy based on the peoples vote; a form of governance devised by the West for its industrialization with disastrous consequences for their own poor. This has also resulted in co-option and corruption of the new leaders to help ensure a new form of economic re-colonization of these countries.
- Medical education and health infrastructure has been in keeping with these trends rather than for serving the majority.

These factors were failed to be addressed while devising the 'Health for All' strategy.

The government of India appointed a Joint Panel of the **Indian Councils of Social Science and Medical Science Research (ICSSR/ICMR)** in 1979 to study these social and technical components of health. Their report **'Health For All: An Alternative Strategy'** of 1981 provides a new approach based on a detailed study by some of the seniormost panel of social and medical scientists of our country.

The salient aspects of this report are as follows:

- That both health as well as medical care, as well as their implementation, primarily concerns the individual, family and local community.
- That the health of the people cannot be achieved unless there is simultaneous development of the economy and its even distribution, but also by factors such as education, nutrition, women's status, water, sanitation, housing and above all the political will and support for providing an egalitarian and decentralized form of governance viz. Panchayat Raj. Hence the dominance of several other factors in determining the health of the people.
- That even in the techno-managerial aspects of health and medical care, it is the people at the village and community level who have the ability to tackle almost 70% of all preventive, promotive and even curative medical care using the simple but highly cost-effective knowledge and technology available from all sources and systems of health and medical care.
- That this information and knowledge has to be conveyed to locally resident village women in a simple and effective manner, who with the intimate knowledge of their own village and their inherent social skills can also mobilize the community to solve the majority of their own problems.
- For the few problems requiring greater knowledge, skills and facilities a Community Health Center at the 1,00,000 or 30,000 population level with a hospital and training center should be made available as part of a graded referral service upto broad based medical and surgical specialty level.
- That the administrative and financial control of their services **must** be under the control of their own Panchayats upto the Panchayat Samiti level.

- That 95% of all health and medical care of the population upto the 1,00,000 to 30,000 level can be undertaken by such a PEOPLES' own **Community Health Care System** in a highly cost-effective manner.
- This would provide an accessible, acceptable, personalized, humane and cost-effective service, accountable to the people at every stage, in a face to face interaction.
- The report also stated, that this would have to await the advent of Panchayati Raj (people based decentralized form of governance) which has been subsequently implemented by the 73rd and 74th Constitutional Amendments of 1993 for both rural as well as urban areas.

The implementation of such a PEOPLES' Community Health Care System is even more relevant today with the failure of the Public System, burgeoning cost of the Private System, commercialization of health care by the Pharmaceutical and Medical Instrument industry, the spawning of 5-star hospitals operated as a commercial industry governed by CEOs, Medical Tourism and Health Insurance.

Such a Community Health Care System would ensure a far superior form of health and medical care under the control of the people, without recourse to legal measures to control the Private sector. It would also provide a humane, readily accessible and cost-effective Peoples own Health Sector. This would also eliminate the need for Health Insurance by providing health care well within the present 'out of pocket' expenditure of Rs.750 per capita per annum as enumerated by the NSS in 2000 A.D.

If such a system can undertake almost 95% of all health and medical care under the Panchayat within Panchayat Samiti level, there is no reason why three quarters of the current Public sector expenditure on health of Rs.250 per capita can also be handed over to the Panchayats at each of these levels.

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POLICY BRIEF

COMH'17.7-(11)

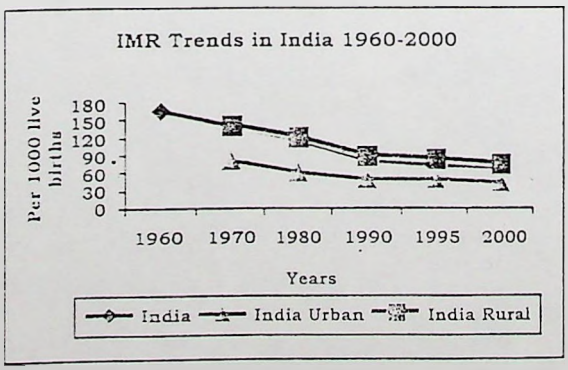
Save Public Health - Ensure Health for All NOW!
Make Health Care a Fundamental Right!

One of the best ways to judge the well being of the people of any nation is by examining the standards of health that ordinary people have attained. Healthy living conditions and access to good quality health care for all citizens are not only basic human rights, but also essential prerequisites for social and economic development. Hence it is high time that **people's health is given priority as a national political issue.** The current health policies need to be seriously examined so that new policies can be implemented in the framework of quality health care for all as a basic right. The following sections first take a look at the hard realities of people's health in India today, and examine some of the maladies of recent health policies. Next the availability of various resources, which could be utilised for an improved health care system is discussed, finally followed by certain recommendations to strengthen and reorient the health system to ensure quality health care for all. We hope these **recommendations will be incorporated by political parties in their election manifestos** for the upcoming general election as a demonstration of their commitment to public health. Jan Swasthya Abhiyan, a national platform working for people's health, looks forward to such a commitment from all political forces in the country.

How can India's health be shining, when ...

- **Infant and Child mortality snuffs out the life of 22 lakh children every year,** and there has been very little improvement in this situation in recent years.[1] We are yet to achieve the National Health Policy 1983 target to reduce Infant Mortality Rate to less than 60 per 1000 live births. More serious is the fact that the rate of decline in Infant Mortality, which was significant in the 1970s and [illegible]s, has slowed down in the 1990s. (See graph below)

- **130,000 mothers die during childbirth every year.** The NHP 1983 target for 2000 was to reduce Maternal Mortality Rate to less than 200 per 100,000 live births. However, 407 mothers die due to pregnancy related causes, for every 100,000 live births even today.[1] In fact, as per the NFHS surveys in the last decade Maternal Mortality Rate has increased from 424 maternal deaths per 100,000 live births to 540 maternal deaths per 100,000 live births.[1]



- **Three completely avoidable child deaths occur every minute.** If the entire country were to achieve a better level of child health, for example the child mortality levels of Kerala,[1] then **18 lakh deaths of under-five children could be avoided every year.** The four major killers (lower respiratory tract infection, diarrheal diseases, perinatal causes and vaccine preventable diseases) accounting for over 60% of deaths under five years of age are entirely preventable through better child health care and supplemental feeding programs.[2] The most recent estimate of complete immunization coverage indicates that only 54% of all children under age three were fully protected.[4]

- **About 5 lakh people die from tuberculosis every year**[3], and this number is almost unchanged since Independence![19] 20 lakh new cases are added each year, to the burgeoning number of TB patients presently estimated at around 1.40 crore[3] Indians !

- India is experiencing a **resurgence of various communicable diseases** including Malaria, Encephalitis, Kala azar, Dengue and Leptospirosis. The number of cases of **Malaria has remained at a high level of around 2 million cases annually** since the mid eighties. By the year 2001, the worrying fact has emerged that **nearly half of the cases are of Falciparum malaria,** which can cause the deadly cerebral malaria. The outbreak of Dengue in India in 1996-97, saw 16,517 cases

and claimed 545 lives[4]. Environmental and social dislocations combined with weakening public health systems have contributed to this resurgence.

- Diarrhea, dysentery, acute respiratory infections and asthma continue to take their toll because we are unable to improve environmental health conditions. **Around 6 lakh children die each year from an ordinary illness like diarrhoea.** While diarrhea itself could be largely prevented by universal provision of safe drinking water and sanitary conditions, these deaths can be prevented by timely administration of oral rehydration solution, which is presently administered in only 27% of cases[2].
- Cancer claims over 3 lakh lives per year and **tobacco related cancers** contribute to 50% of the overall cancer burden, which means that such deaths might be prevented by tobacco control measures[2].
- Estimates of mental health show about 10 million people suffering from serious mental illness, 20-30 million having neuroses and 0.5 to 1 percent of all children having mental retardation[2]. **One Indian commits suicide every 5 minutes[5]!**

As a nation, today there is a need to look closely at the deep problems in the health system, rather than making exaggerated claims. There is a need to recognize the growing health inequities, and urgently implement basic changes in the health system.

With political will and people's involvement, ensuring good quality health care for every Indian is possible!

The growing inequities in health and health care are unjust !

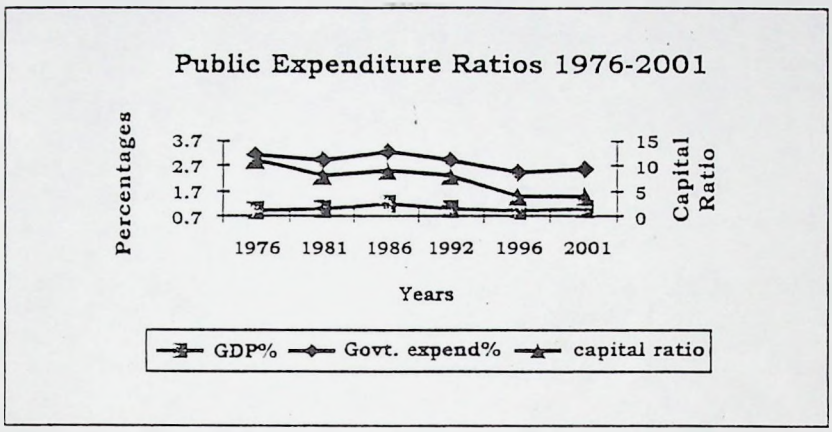
The Constitution of India guarantees the 'Right to Life' to all citizens. However, the disparities relating to survival and health, between the well off and the poor, the urban residents and rural people, the adivasis and dalits and others, and between men and women are extremely glaring.

- The Infant Mortality Rate in the poorest 20% of the population is **2.5 times higher** than that in the richest 20% of the population. In other words, an infant born in a poor family is two and half times more likely to die in infancy, than an infant in a better off family[3].
- A child in the 'Low standard of living' economic group is **almost four times** more likely to die in childhood than a child in the better off 'High standard of living' group. An Adivasi child is one and half times more likely to die before the fifth birthday than children of other groups[3].
- A girl is 1.5 times more likely to die before reaching her fifth birthday, compared to a boy! The **female to male ratios** for children are rapidly declining, from 945 girls per 1000 boys in 1991, to just 927 girls per 1000 boys in 2001[6]. This decline highlights an alarming trend of discrimination against girl children, which starts well before birth (in the form of sex selective abortions), and continues into childhood and adolescence (in the form of worse treatment to girls)[7].
- Dalit Women are one and a half times more likely to suffer the consequences of chronic malnutrition (stunted height) as compared to women from other castes. Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups.
- A person from the poorest quintile of the population, despite more health problems, is **six times less** likely to access hospitalization than a person from the richest quintile. This means that the poor are unable to afford and access hospitalization in a very large proportion of illness episodes, even when it is required.
- The delivery of a mother, from the poorest quintile of the population is **over six times** less likely to be attended by a medically trained person than the delivery of a well off mother from the richest quintile of the population. An adivasi mother is half as likely to be delivered by a medically trained person[3].
- The ratio of hospital beds to population in rural areas is **fifteen times** lower than that for urban areas[14].
- The ratio of doctors to population in rural areas is **almost six times lower** than the availability of doctors for the urban population[14].
- Per person, Government spending on public health is **seven times lower in rural areas**, compared to Government health spending for urban areas.

These **health and health care inequities are increasing**, and are deeply unjust -- a just health system would ensure that all citizens, irrespective of social background or gender, would get basic quality health care at times of need.

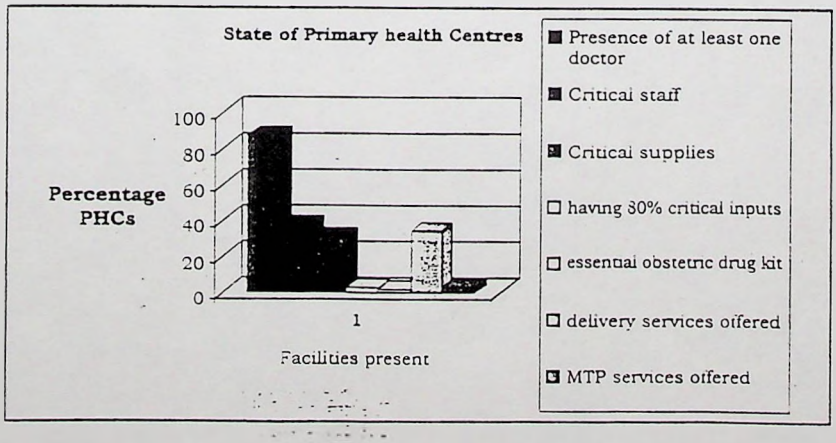
Public health being weakened, people's health being undermined

The NDA Government has recently claimed that one of its signal achievements has been the allocation of 6% of GDP to Health care. In reality, the government spends just 0.9 % of the GDP on Health care and the rest is spent by people from their own resources. Thus only 17% of all health expenditure in this country is borne by the government — this makes the Indian public health system grossly inadequate to meet healthcare demands of its people, and makes the health sector the **most privatised in the world.** Only five other countries in the world are worse off than India regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, Cambodia[6]). The W.H.O. standard for expenditure on public health is 5% of the GDP. The average spending today by Less Developed Countries is 2.8 % of GDP, but India presently spends only 0.9% of its GDP on public health, which is merely one-third of the less developed countries' average[6] !



The consequence of this dismally low allocation, which stands at the lowest levels in the last two decades, (in contrast to 1.3% of GDP achieved in 1985), is deteriorating quality of public health services. For example, Primary health centers (PHCs), meant to serve the needs of the poorest and most marginalized people have the following shocking statistics:

- Only 38% of all PHCs have all the critical staff
- Only 31% have all the critical supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs.
- In spite of the high maternal mortality ratio, 8 out of every 10 PHCs have no Essential Obstetric Care drug kit!
- Only 34% PHCs offer delivery services, while only 3% offer Medical Termination of Pregnancy!
- A person accessing a community health center would find no obstetrician in 7 out of 10 centers, and no pediatrician in 8 out of 10!



Source: 7

Private health care and essential drugs are increasingly unaffordable !

The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urban biased, tertiary level health services with profitability overriding equity, and rationality of care often taking a back seat.

- A growing proportion of Indians cannot afford health care when they fall ill. National surveys show that the number of people who could not seek medical care because of lack of money increased significantly between 1986 and 1995[3]. The proportion of such persons **unable to afford health care almost doubled**, increasing from 10 to 21 % in urban areas, and growing from 15 to 24% in rural areas in this decade[3].
- **Forty percent** of hospitalised people are forced to borrow money or sell assets to cover expenses[4].
- **Over 2 crores of Indians are pushed below the poverty line** every year because of the catastrophic effect of out of pocket spending on health care[4].
- Irrational medical procedures are on the rise. According to just one study in a community in Chennai, **45% of all deliveries were performed by Cesarean operations**, whereas the WHO has recommended that not more than 10-15% of deliveries would require Cesarean operations[5].
- Due to **irrational prescribing**, an average of 63 per cent of the money spent on prescriptions is a waste. This means that nearly two-thirds of the money that we spend on drugs may be for unnecessary or irrational drugs[4].
- The pharmaceutical industry is rapidly growing...yet only 20% of the population can access all essential drugs that they require. There is a proliferation of brand names with over 70,000 brands marketed in India, but the 2002 Drug policy recommends that only 25 drugs be kept under price control[13]. As a result many drugs are being sold at 200 to 500 percent profit margin, and essential drugs have become unaffordable for the majority of the Indian population.

Health policy developments since the 1990s have critically weakened the health system

The effectiveness of the public health system and access to quality health care, especially for the poor has worsened since the decade of the 1990s due to a variety of policy developments, at both national and state levels:

- Stagnant public health budgets and decreasing Government expenditure on capital investment for public health facilities.
- Introduction of user fees at various levels of public health facilities.
- Freezing of new recruitments and inadequate budgets for supplies and maintenance in the public health system.
- Contracting out health services or privatisation of health facilities.
- Encouragement of growth of private secondary and tertiary hospitals through tax waivers, reduced import duties, subsidized land etc. which have led to a further expansion of the unregulated private medical sector.
- Promotion of 'Health tourism' for foreign visitors, while basic health services remain inaccessible for a large proportion of the Indian population.
- Conducting occasional, expensive and largely ineffective 'Health melas' instead of upgrading the public health system as a sustainable solution.
- Deregulation of the pharmaceutical industry, lax price controls on drugs — the list of drugs under price control being proposed to be reduced to 25 drugs (compared to 343 drugs under price control in 1979).
- Many bulk drug manufacturing units have closed down due to liberalized import and dumping as a result of the implementation of the WTO agreement and autonomous economic liberalization policies. Due to reduction of customs duty and increase of excise duty, imported drugs will become cheaper while local drugs will become more expensive.

Is this inevitable ? Can only developed countries manage good health care for their people ?

Indians need not accept poor health as their inevitable fate! Many other developing countries, which have given a high priority to people's health, have achieved much better health outcomes compared to India. As a country, we spend a higher proportion of the GDP on health care compared to these countries – but an overwhelming percentage of this (83%) is private expenditure. As a result we have a weak public health system with poor health outcomes forcing families to spend a lot on private medical care, which is expensive, and not always appropriate, leaving us with **'poor health at high cost'**! Here is how some other Asian countries are doing in comparison with India...

Health Outcomes in Relation to Health Expenditures in some Asian countries[10]

	Total Health Expenditure as % of GDP	Public Health Expenditure as % of total	Under 5 Mortality	Life Expectancy	
				Male	Female
India	**5.2**	**17**	**95**	**59.6**	**61.2**
Sri Lanka	3.0	45.4	19	65.8	73.4
Malaysia	2.4	57.6	14	67.6	69.9

Does India have the resources to provide health care for all ?

As a country, Indians spend more on health care than most other developing countries, but this is mostly out-of-pocket spending. Health care facilities have grown substantially, but these are mostly in the private sector. The system is producing more and more healthcare professionals, but we lose them to the private sector, or to western countries. To give some idea of the available health care resources in India –

- Compared to 11,174 hospitals in 1991 (57% private), the number grew to 18,218 (75% private) in 2000[11]. In 2000, the country had 12.5 lakh doctors and 8 lakh nurses! At the national level, there is one allopathic doctor for every 1800 people, or one doctor from systems including ISM and homeopathy for 800 people. This means there are more doctors than the required estimate of one doctor for 1500 population[12].
- Approximately 15,000 new graduate doctors and 5,000 postgraduate doctors are produced every year and one-fifth of them leave the country for greener pastures[13].
- We have an annual pharmaceutical production of about 260 billion rupees[14], and we export a large proportion of these drugs - Sadly, while our exports grow, 80% of our people do not have access to all the drugs they require.

In short, we have substantial health care resources, but because of the privatised, unregulated and inequitable nature of the health care system, it is unable to ensure good quality health care for a majority of citizens. Rather than producing more doctors or setting up more private hospitals, what we need is a reorganisation of the health system, with substantial strengthening of public health, greatly enhanced public expenditure, regulation of the private medical sector and an overall planned approach to make health care resources available to all.

What can be done as immediate steps ?

The objective should be to **make Health care a Fundamental right and an operational entitlement**. This would require a National Public Health Act, which mandates right to basic healthcare services to all citizens through a system of universal access to healthcare. The Indian Constitution through its directive principles provides the basis for the Right to health care, and the Indian state has ratified the International Covenant of Economic, Social and Cultural Rights which makes it obligatory on its part to comply with Article 12 that mandates right to healthcare. Universal access to healthcare is well established in a number of countries including not only developed countries like Canada and United Kingdom, but also developing countries such as Cuba, Brazil, Costa Rica and Thailand. There is no reason why this cannot be made a reality in India. Hence we need to set in motion processes which will take us towards the goal of universal access to health care, in a Rights-based framework and with equity.

Some immediate steps related to the health care system that need to be taken include:

- Making healthcare a fundamental right by suitable constitutional amendment. The formulation of a National legislation mandating the Right to Health care, with a clearly defined comprehensive package of health care, along with authorization of the requisite budget, being made available universally within one year.
- Significant strengthening of the existing public health system, especially in rural areas, by assuring that all the required infrastructure, staff, equipment, medicines and other critical inputs are available, and result in delivery of all required services. These would be ensured based on clearly defined, publicly displayed and monitored norms.
- The declining trend of budgetary allocations for public health needs to be reversed, and budgets appropriately up-scaled to make optimal provision of health care in the public domain possible. At one level adopting a fiscal policy of block funding or a system of per capita allocation of resources to different levels of health care, with an emphasis on Primary Health Care will have an immediate impact in reducing rural-urban inequities by making larger resources available to rural health facilities like Primary health centers and Rural hospitals. Simultaneously, the budgetary allocation to the health sector must be increased substantially, targeting the 5% of GDP as public expenditure on health care as recommended by the WHO.
- If the public health system fails to deliver it should be treated as a legal offence, remedy for which can be sought in the courts of law. The public system must ensure all elements of care like drug prescriptions, diagnostic tests, child birth services, hospitalization care etc. One way to ensure this could be that in exceptional situations, where patients who do not receive these services from the public facility they may be referred to seek them from alternate facilities, which are registered with the state agency. Such registered and regulated facilities would honour such referrals, for which the state would reimburse them at a mutually agreed rate. This would maintain pressure on the public health system to provide all elements of care, and would ensure that the patient is not deprived of essential care at time of need.
- Various vulnerable and marginalised sections of the population have special health needs. There is a need for a range of policy measures to eliminate discrimination, and to provide special quality and sensitive services for women, children, elderly persons, unorganised sector workers, HIV-AIDS affected persons, disabled persons, persons with mental health problems and other vulnerable groups. Similarly, situations of conflict, displacement and migration need to be addressed with a comprehensive approach to ensure that the health rights of affected people are protected. The **People's Health Charter** deals with issues related to such special sections of the population, and can provide a basis for formulation of appropriate policy initiatives, in consultation with organisations representing these social segments.
- Putting in place a National legislation to regulate the private health sector, to adopt minimum standards, accreditation, standard treatment protocols, standardised pricing of services etc.
- Adopting a rational and essential medications-based drug policy. All States must have an essential drugs and consumables list and all the drugs and consumables on this list must be under price control. Further all state governments must adopt procurement and distribution

Indian People's Health Charter

We the people of India, stand united in our condemnation of an iniquitous global system that, under the garb of 'Globalisation' seeks to heap unprecedented misery and destitution on the overwhelming majority of the people on this globe. This system has systematically ravaged the economies of poor nations in order to extract profits that nurture a handful of powerful nations and corporations. The poor, across the globe, as well as the sections of poor in the rich nations, are being further marginalised as they are displaced from home and hearth and alienated from their sources of livelihood as a result of the forces unleashed by this system. Standing in firm opposition to such a system we reaffirm our inalienable right to and demand for comprehensive health care that includes food security, sustainable livelihood options including secure employment opportunities; access to housing, drinking water and sanitation; and appropriate medical care for all, in sum - the right to **Health For All, Now!**

The promises made to us by the international community in the Alma Ata declaration have been systematically repudiated by the World Bank, the IMF, the WTO and its predecessors, the World Health Organization, and by a government that functions under the dictates of International Finance Capital. The forces 'Globalisation' through measures such as the structural adjustment programme are targeting our resources - built up with our labour, sweat and lives over the last fifty years - and placing them in the service of the global "market" for extraction of super-profits. The benefits of the public sector health care institutions, the public distribution system and other infrastructure - such as they were - have been taken away from us. It is the ultimate irony that we are now blamed for our plight, with the argument that it is our numbers and our propensity to multiply that is responsible for our poverty and deprivation. We declare health as a justiciable right and demand the provision of comprehensive health care as a fundamental constitutional right of every one of us. We assert our right to take control of our health in our own hands and for this the right to:

- A truly decentralized system of local governance vested with adequate power and responsibilities, provided with adequate finances and responsibility for local level planning
- A sustainable system of agriculture based on the principle of land to the tiller – both men and women – equitable distribution of land and water, linked to a decentralized public distribution system that ensures that no one goes hungry
- Universal access to education, adequate and safe drinking water, and housing and sanitation facilities
- A dignified and sustainable livelihood
- A clean and sustainable environment
- A drug industry geared to producing epidemiological essential drugs at affordable cost
- A health care system which is gender sensitive and responsive to the people's needs and whose control is vested in people's hands and not based on market defined concept of health care.

Further, we declare our firm opposition to:

- Agricultural policies attuned to the needs of the 'market' that ignore disaggregated and equitable access to food
- Destruction of our means to livelihood and appropriation, for private profit, of our natural resource bases and appropriation of bio-diversity
- The conversion of Health to the mere provision of medical facilities and care that are technology intensive, expensive, and accessible to a select few
- The retreat, by the government, from the principle of providing free medical care, through reduction of public sector expenditure on medical care and introduction of user fees in public sector medical institutions, that place an unacceptable burden on the poor
- The corporatization and commercialization of medical care, state subsidies to the corporate sector in medical care, and corporate sector health insurance
- Coercive population control and promotion of hazardous contraceptive technology which are directed primarily at the poor and women
- The use of patent regimes to steal our traditional knowledge and to put medical technology and drugs beyond our reach
- Institutionalization of divisive and oppressive forces in society, such as communalism, caste, patriarchy, and the attendant violence, which have destroyed our peace and fragmented our solidarity.

In the light of the above we demand that:

1. The concept of comprehensive primary health care, as envisioned in the Alma Ata Declaration should form the fundamental basis for formulation of all policies related to health care. The trend towards fragmentation of health delivery programmes through conduct of a number of vertical programmes should be reversed. National health programmes be integrated within the Primary Health Care system with decentralized planning, decision-making and implementation with the active participation of the community. Focus be shifted from bio-medical and individual based measures to social, ecological and community based measures.

2. The primary health care institutions including trained village health workers, sub-centers, and the PHCs staffed by doctors and the entire range of community health functionaries including the ICDS workers, be placed under the direct administrative and financial control of the relevant level Panchayati Raj institutions. The overall infrastructure of the primary health care institutions be under the control of Panchayats and Gram Sabhas and provision of free and accessible secondary and tertiary level care be under the control of Zilla Parishads, to be accessed primarily through referrals from PHCs.

   The essential components of primary care should be:
   - Village level health care based on Village Health Workers selected by the community and supported by the Gram Sabha / Panchayat and the Government health services which are given regulatory powers and adequate resource support.

policies similar to what has been done by the Tamilnadu State Medical Services Corporation and hence ensure that essential drugs in the list are actually available in every facility.

- The state should introduce a new community-anchored health worker scheme, and implement it in a phased manner with involvement of people's organizations and panchayati raj institutions, in both rural and urban areas, through which first contact primary care and health education can be ensured.
- Integration of medical education of all systems to create a basic doctor ensuring a wider outreach and improvement of access to health care services in all areas.
- All state level coercive population control policies, disincentives and orders should be revoked. Disproportionate financial allocation for population control activity should not be allowed to skew funding from other important public health priorities.
- Integration of medical education of all systems to create a basic doctor ensuring a wider outreach and improvement of access to health care services in all areas. Effective regulation of the growth of capitation based medical colleges.

Conclusion

The persistence of unacceptably large numbers of avoidable deaths, resurgence of communicable diseases, declining quality of public health services and unaffordable, often inappropriate private medical care need not remain the lot of over a billion ordinary Indians. Recent policy changes of privatisation, declining public health budgets and pro-drug industry measures need to be replaced by strong public health initiatives, with the active involvement of communities and civil society organisations.

By and large, India today possesses the humanpower, infrastructure, national financial resources and appropriate health care know-how to ensure quality health care for all its citizens. What is needed is a major restructuring and strengthening of the health system. This involves two major ingredients: popular mobilisation for operationalising the Right to Health Care, and the political will to implement policy changes necessary to transform the health system. Jan Swasthya Abhiyan is today involved in the former task, by reaching out to people across the country, enabling them to mobilise for their just health rights. It calls upon political parties, which recognise people's right to healthy lives, to address the latter task, and to perform their historic duty by establishing and operationalising the Right to Health care as a Fundamental right.

This document focuses on the need for strengthening of the health care system, and certain immediate steps required for this. However, improvement of people's health requires equally importantly, provision of other necessary **facilities and conditions required for a healthy life**, such as safe drinking water, sanitation, food security, healthy housing, basic education and a safe environment. The **People's Health Charter** has dealt with these issues, and may be taken as a guideline to develop effective policies and improve people's living standard in order to achieve better health.

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- Primary Health Centers and sub-centers with adequate staff and supplies which provides quality curative services at the primary health center level itself with good support from referral linkages
- A comprehensive structure for Primary Health Care in urban areas based on urban PHCs, health posts and Community Health Workers under the control of local self government such as ward committees and municipalities.
- Enhanced content of Primary Health Care to include all measures which can be provided at the PHC level even for less common or non-communicable diseases (e.g. epilepsy, hypertension, arthritis, pre-eclampsia, skin diseases) and integrated relevant epidemiological and preventive measures
- Surveillance centers at block level to monitor the local epidemiological situation and tertiary care with all speciality services, available in every district.

3. A comprehensive medical care programme financed by the government to the extent of at least 5% of our GNP, of which at least half be disbursed to panchayati raj institutions to finance primary level care. This be accompanied by transfer of responsibilities to PRIs to run major parts of such a programme, along with measures to enhance capacities of PRIs to undertake the tasks involved.

4. The policy of gradual privatisation of government medical institutions, through mechanisms such as introduction of user fees even for the poor, allowing private practice by Government Doctors, giving out PHCs on contract, etc. be abandoned forthwith. Failure to provide appropriate medical care to a citizen by public health care institutions be made punishable by law.

5. A comprehensive need-based human-power plan for the health sector be formulated that addresses the requirement for creation of a much larger pool of paramedical functionaries and basic doctors, in place of the present trend towards over-production of personnel trained in super-specialities. Major portions of undergraduate medical education, nursing as well as other paramedical training be imparted in district level medical care institutions, as a necessary complement to training provided in medical/nursing colleges and other training institutions. No more new medical colleges to be opened in the private sector. No commodification of medical education. Steps to eliminate illegal private tuition by teachers in medical colleges. At least a year of compulsory rural posting for undergraduate (medical, nursing and paramedical) education be made mandatory, without which license to practice not be issued. Similarly, three years of rural posting after post graduation be made compulsory.

6. The unbridled and unchecked growth of the commercial private sector be brought to a halt. Strict observance of standard guidelines for medical and surgical intervention and use of diagnostics, standard fee structure, and periodic prescription audit to be made obligatory. Legal and social mechanisms be set up to ensure observance of minimum standards by all private hospitals, nursing/maternity homes and medical laboratories. Prevalent practice of offering commissions for referral to be made punishable by law. For this purpose a body with statutory powers be constituted, which has due representation from peoples organisations and professional organisations.

7. A rational drug policy be formulated that ensures development and growth of a self-reliant industry for production of all essential drugs at affordable prices and of proper quality. The policy should, on a priority basis:

   - Ban all irrational and hazardous drugs. Set up effective mechanisms to control the introduction of new drugs and formulations as well as periodic review of currently approved drugs.
   - Introduce production quotas & price ceiling for essential drugs
   - Promote compulsory use of generic names
   - Regulate advertisements, promotion and marketing of all medications based on ethical criteria
   - Formulate guidelines for use of old and new vaccines
   - Control the activities of the multinational sector and restrict their presence only to areas where they are willing to bring in new technology
   - Recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices
   - Promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas.

8. Medical Research priorities be based on morbidity and mortality profile of the country, and details regarding the direction, intent and focus of all research programmes be made entirely transparent. Adequate government funding be provided for such programmes. Ethical guidelines for research involving human subjects be drawn up and implemented after an open public debate. No further experimentation, involving human subjects, be allowed without a proper and legally tenable informed consent and appropriate legal protection. Failure to do so to be punishable by law. All unethical research, especially in the area of contraceptive research, be stopped forthwith. Women (and men) who, without their consent and knowledge, have been subjected to experimentation, especially with hazardous contraceptive technologies to be traced forthwith and appropriately compensated. Exemplary damages to be awarded against the institutions (public and private sector) involved in such anti-people, unethical and illegal practices in the past.

9. All coercive measures including incentives and disincentives for limiting family size be abolished. The right of families and women within families in determining the number of children they want should be recognized. Concurrently, access to safe and affordable contraceptive measures be ensured which provides people, especially women, the ability to make an informed choice. All long-term, invasive, systemic hazardous contraceptive technologies such as the injectables (NET-EN, Depo-Provera, etc.), sub-dermal implants (Norplant) and anti fertility vaccines should be banned from both the public and private sector. Urgent measure be initiated to shift the onus of contraception away from women and ensure at least equal emphasis on men's responsibility for contraception. Facilities for safe abortions be provided right from the primary health center level.

10. Support be provided to traditional healing systems, including local and home-based healing traditions, for systematic research and community based evaluation with a view to developing the knowledge base and use of these systems along with modern medicine as part of a holistic healing perspective.

11. Promotion of transparency and decentralization in the decision making process, related to health care, at all levels as well as adherence to the principle of right to information. Changes in health policies to be made only after mandatory wider scientific public debate.

12. Introduction of ecological and social measures to check resurgence of communicable diseases. Such measures should include:

    - Integration of health impact assessment into all development projects
    - Decentralized and effective surveillance and compulsory notification of prevalent diseases like malaria, TB by all health care providers, including private practitioners
    - Reorientation of measures to check STDs/AIDS through universal sex education, promoting responsible safe sex practices, questioning forced disruption and displacement and the culture of commodification of sex, generating public awareness to remove stigma and universal availability of preventive and curative services, and special attention to empowering women and availability of gender sensitive services in this regard.

13. Facilities for early detection and treatment of non-communicable diseases like diabetes, cancers, heart diseases, etc. to be available to all at appropriate levels of medical care.

14. Women-centered health initiatives that include:

    - Awareness generation for social change on issues of gender and health, triple work burden, gender discrimination in upbringing and life conditions within and outside the family; preventive and curative measures to deal with health consequences of women's work and violence against women
    - Complete maternity benefits and child care facilities to be provided in all occupations employing women, be they in the organized or unorganized sector
    - Special support structures that focus on single, deserted, widowed women and minority women which will include religious, ethnic and women with a different sexual orientation and commercial sex workers; gender sensitive services to deal with all the health problems of women including reproductive health, maternal health, abortion, and infertility
    - Vigorous public campaign accompanied by legal and administrative action against sex selective abortions including female feticide, infanticide and sex pre-selection.

15. Child centered health initiatives that include:

    - A comprehensive child rights code, adequate budgetary allocation for universalisation of child care services
    - An expanded & revitalized ICDS programme. Ensuring adequate support to working women to facilitate child care, especially breast feeding
    - Comprehensive measures to prevent child abuse, sexual abuse and child prostitution
    - Educational, economic and legal measures to eradicate child labour, accompanied by measures to ensure free and compulsory quality elementary education for all children.

16. Special measures relating to occupational and environmental health which focus on:

    - Banning of hazardous technologies in industry and agriculture
    - Worker centered monitoring of working conditions with the onus of ensuring a safe and secure workplace on the management
    - Reorienting medical services for early detection of occupational disease
    - Special measures to reduce the likelihood of accidents and injuries in different settings, such as traffic accidents, industrial accidents, agricultural injuries, etc.

17. The approach to mental health problems should take into account the social structure in India which makes certain sections like women more vulnerable to mental health problems. Mental Health Measures that promote a shift away from a bio-medical model towards a holistic model of mental health. Community support & community based management of mental health problems be promoted. Services for early detection & integrated management of mental health problems be integrated with Primary Health Care and the rights of the mentally ill and the mentally challenged persons to be safe guarded.

18. Measures to promote the health of the elderly by ensuring economic security, opportunities for appropriate employment, sensitive health care facilities and, when necessary, shelter for the elderly. Services that cater to the special needs of people in transit, the homeless, migratory workers and temporary settlement dwellers.

19. Measures to promote the health of physically and mentally disadvantaged by focussing on the abilities rather than deficiencies. Promotion of measures to integrate them in the community with special support rather than segregating them; ensuring equitable opportunities for education, employment and special health care including rehabilitative measures.

20. Effective restriction on industries that promote addictions and an unhealthy lifestyle, like tobacco, alcohol, pan masala etc., starting with an immediate ban on advertising, sponsorship and sale of their products to the young, and provision of services for de-addiction

Constituents of the JAN SWASTHYA ABHIYAN

The Jan Swasthya Abhiyan at the national level is the coalition of the networks of voluntary organizations and peoples movements involved in healthcare delivery and health policy, who made themselves a part of the Peoples Health Assembly campaign in India in the year 2000, and have continued to participate in this process. These national networks have numerous constituent organisations, which implies that a few hundred organizations are involved directly in the national process. Beyond these networks, several hundred other organizations have been involved at state, district and block level activities across the country. The networks that constitute the National Coordination Committee of Jan Swasthya Abhiyan are:

1. All India Peoples Science Network
2. All India Democratic Women's Association
3. All India Drug Action Network
4. Asian Community Health Action Network
5. Bharat Gyan Vigyan Samiti
6. Catholic Health Association of India (CHAI)
7. Christian Medical Association of India (CMAI)
8. Federation of Medical Representatives and Sales Associations of India (FMRAI)
9. Forum for Creche and Child Care Services (FORCES)
10. Joint Women's Programme
11. Medico Friends Circle (MFC)
12. National Alliance of People's Movements (NAPM)
13. National Alliance of Women's Organisations (NAWO)
14. National Federation of Indian Women (NFIW)
15. Ramakrishna Mission
16. Voluntary Health Association of India (VHAI)
17. Association for Indian Development, India (AID-India)
18. Breastfeeding Promotion Network of India (BFPNI) National Resource Groups:
19. Centre for Enquiry into Health and Allied Themes (CEHAT)
20. Centre for Social Medicine and Community Health, Jawaharlal Nehru University
21. Community Health Cell (CHC)

The representatives of all the above organisations constitute the National Coordination Committee of JSA, which is the national decision making body of the coalition. N.H. Antia is the Chairperson and D. Banerjee is the Vice-Chairperson of JSA. National organisers of JSA include B. Ekbal as Convenor, Abhay Shukla, Amit Sengupta, Amitava Guha, Thelma Narayan and T. Sundararaman as Joint convenors, with Vandana Prasad and N.B.Sarojini as National secretariat members.

Jan Swasthya Abhiyan presently has state units or contacts in the following states:
Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh, West Bengal.

Jan Swasthya Abhiyan contact addresses

B. Ekbal,
National Convenor, JSA
Ph: 0471-230663-4(O)
e-mail: ekbal@vsnl.com

Abhay Shukla
National Secretariat, JSA
Ph: 020-25451413 / 25452325
e-mail : cehatpun@vsnl.com

Amit Sen Gupta
Jt. Convenor, JSA
Ph: 011-26862716/ 26524324
e-mail: ctddsf@vsnl.com

Amitava Guha
Jt. Convenor, JSA
Ph: 033-24242862(O)
e-mail:
guhaamitava @hotmail.com

Thelma Narayan
Jt. Convenor, JSA
Ph: 080-5505924 / 5525372
e-mail: sochara@vsnl.com

T. Sundararaman
Jt. Convenor, JSA
Phone: 0771-2236104, 2236175
e-mail:
sundar2@123india.com

Sarojini
Member, National Secretariat
Ph: 011-26968972 / 26850074
e-mail: samasaro@vsnl.com

Vandana Prasad
Member, National Secretariat
Phone: 0120- 2536578
e-mail: chaukhat@yahoo.com

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COMH 17.5

CHW: Survivals

Dr Shyam Ashtekar

Abbreviations: CHW: (Community Health Workers), COPC: Community Oriented Primary Care, JSR: (Jana Swastiya Rakshak-the new CHW programme in Madhya Pradesh) FCC: (First Contact Care), FRU (First referral Unit- the rural 30-100 bedded hospital), PHC: Primary Health Care,

CHW DEBACLE IN INDIA

CHW scheme, an important 1978 option for reaching primary care/first contact care to villages of India was a dying scheme by mid-eighties; and now it is no more in 2002. The vacuum has been filled partially by somewhat similar variants from Govts, but in the main by the private doctors of various kinds in different states of India. As the already belated option of CHW failed to answer an important social need, markets have provided some options; for which the State and its policy makers and bureaucrats have to share the blame. Recent evidence suggests that there is very little that is learnt from this nationwide failure.

To set the record straight, Govt must publish the formal post mortem report of the CHW scheme, and if anything what was done to salvage the scheme through the two decades. It concerned five lakh CHWs and their villages. In absence of such an official statement on the issue, I am sharing my thoughts and concerns.

- First of all, the Indian health system planned under the Bhore committee report had little to offer on village level services, based as it was on a doctor-hospital centric state model of health care. The CHW appendix did not stick to the system. (In contrast China's effort was much better, but our policy community is unwilling to admit this fact. It is noteworthy that Mahatma Gandhi had started preparations for village level healers (See *home & village doctor* by Dr DasGupta) but the initiative was lost in oblivion after the Independence.
- Even though it was a belated effort to make amends, esp after the Alma Ata mandate, the scheme lacked steam in several departments—conceptualization, technical design, content, training, political management, finance, monitoring, linkages etc. Subsequent handing over to Family welfare dept put the last nail in the coffin. The Janata regime lasted only 30 months and the later Congress Govt was not impressed with the scheme. Medicines were withdrawn in eighties and then people forgot the CHW. Honoraria continued as litigations dragged and finally that too stopped.
- There was not much light at the other end of the tunnel either—the global experience on CHWs. A 1992 WHO review (WHO TRS) was seized of this and so were other experts

(Frankel). In a personal conversation in 2000, David Werner, the author of the famous WTND also could not find any large-scale country CHW programme worth mentioning. China was a solid exception and others countries who had the CHW scheme offered attenuated versions (Philippines for instance). Brazil has introduced a CHW programme as late as in 1995. Was there then something genetically wrong with the CHW programme? Was it unfit for any national system and only good for NGO islands?

- A hard look at various states in India shows that village-doctors that nobody made or dreamt of in Nirman Bhavan or Lodhi Road have been spreading in every state of India—east and west, south and north.

Although some states like MP and Chattisgarh are trying CHW variants in the states, at least the MP JSR scheme is headed the same way as the old CHW scheme (our own study in 2001-not published). This makes it imperative that we take a closer look at the issues and problems.

UNDERSTANDING THE JIG-SAW PUZZLE

The social engineering of CHW scheme is a complex matter and we see very different models in various countries and NGO areas. To make the issue more explicit, all the three words in the classical nomenclature **'Community Health Worker'** are rather vague concepts, esp in practice.

Community?	Health?	Worker?
Village?	'Development'?	Liberator, change agent?
Panchayat?	Health-esp. health primary prevention?	Worker (lackey)?
Government health dept?	National health programmes?	Guide? (Only IEC?)
NGO?	Narrow or vertical programmes?	Volunteer (little or no pay)?
SHG?	Primary medicare?	' A doctor' where there is no doctor?
Only left to individual?	Little of each above?	

ARE CHWS NECESSARY FOR PRIMARY CARE IN INDIA?

In the new century, primary care is surely still necessary and valid; but *is a CHW necessary for primary care*?

CHWs (or some of its variant) are surely necessary for primary care in villages (also parts of urban areas) in many states, if not all. Situation varies, as it may not be necessary like in Kerala. Conversely, in Bihar it may be frustrating to reintroduce the CHW as most villages have a home grown local medical practitioner[1]. Come to states like Maharashtra and Madhya Pradesh, there are large number of private medical practitioners in rural areas, but they are clustered in some rural centers. In One study in Maharashtra (ashtekar) we found that in 737 villages there were 555 doctors of all types, but they were all practicing in just 16% of the villages. On a roadside village in MP, we found over 30 clinics of doctors (in addition to the mini PHC) and obviously they depended upon surrounding villages for their clientele. In such situations, it is still possible to introduce CHWs in peripheral villages but they will have to prove themselves against the 'doctors'. I am aware that many experts may not like this connection but the reality is that even good CHWs find they lose out when an injection-doctor even starts visiting their village. First goes the curative and later go other health components. In short, a CHW may be theoretically necessary in all villages, but in the vicinity of 'doctors' the CHW option melts away. This is difficult to understand from a planner's and activist's end but very easy to grasp from the community's perspective. This leaves us with two tasks, an easy one and a difficult one—of choosing villages for CHW programme and of improving the content of the programme in several ways.

There are some fresh initiatives on CHWs in some states- MP, Chattisgarh, AP and in Maharashtra. The National Health Policy also makes some nuanced or wooly references about options. To make things clearer for new initiatives on the CHW I am making a matrix to underline the various issues and layers involved. Most of the early and current Indian CHW programme tried to steer clear the complexities and give an innocently simple 'minimal version' CHW programme and we know that they have faltered or failed.

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[1] This is an impression from JANA[illegible], an organization working in Bihar and adjoining states. Their understanding is that each village has more than 1 PMP.

Larger Matrix of factors related to Primary care by CHWs								
Place in Health System	**Who Owns it?**	**Technical content**	**Personnel policies**	**Supports**	**Stability and trends**	**Access factors**	**Political situation**	**Problems?**
Formal/ external/ mainstream	State	Task list- expected/actual	Entry/ selection	Political	Program life, attrition,	Distance factors	Democratic- centralized	Malpractice
Contribution to/ share of health services	Community	Training systems, books, software	Mobility/ Transfers	Financial	Expanding or shrinking ?	Cost factors	Democratic and decentralized	Survival
	Provider (private)	Orientation — preventive-curative	Promotion	Legal		Social factors: (caste and gender in India)	Oligarchic/ authoritarian	
		Use of different healing systems	Age/sex	Institutional			One party rule	

EXPANDING THE SEARCH FOR PRIMARY CARE 'MODEL'

Since the main objective is and must be *primary care* and CHW only a means to it, I have included village doctors as a pragmatic and existing option, and I am not alone on this since there are experts like John Rhode who wrote a book on rural doctors (Rohde). On this wider canvass of primary care by CHW schemes, NGO experiments and private village doctors, the complexities deepen. The approaches, inputs, processes, and outputs change according to the vehicle of primary care. My argument is that even if a classical State CHW model is not feasible in some states/districts, it is still feasible to make use of private PMPs and share the agenda with them on institutional basis. [2]

I am giving a schematic sketch (see figure 1) here of three perspectives on the CHW—the planners, the community and the candidates/care providers. Unless we combine the prime concerns of each perspective, there can not be a 'successful model'

At the end I am presenting a table (see table 3) depicting what is likely to happen to all the issues of concern when we deal with different models of primary care- Govt, private or combined.

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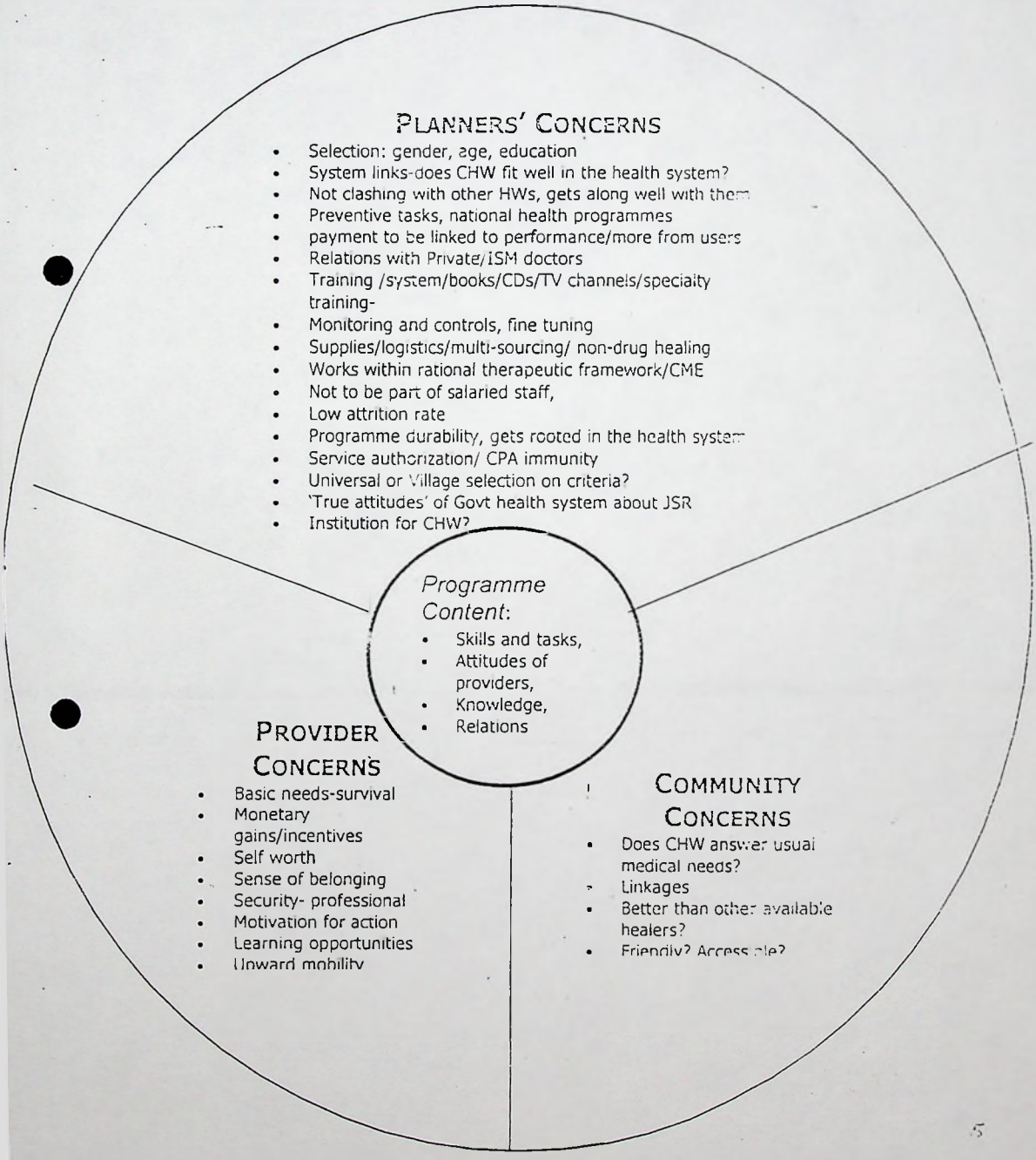
[2] I had a brief interview with Dr Gerald Bloom, an expert of the Bristol University, who has an intimate understanding of the China health scenario. As I was describing the ubiquitous PMP-quacks in India, he shrugged and said that it sounds much like China's rural doctors in the village health stations, many of whom have little training and are rarely monitored. I was taken aback by the comparison, can products of two entirely different systems be alike?

APPENDIX

FIG 1: FIRST CONTACT HEALTH CARE: PERSPECTIVE MAPPING



POSSIBILITIES WITH 'PRIMARY CARE' MODELS

(A) PLANNER'S CONCERNS

Major	Sub-issues	Usual Possibilities[3] with staff model	A combination model	Village doctor model
Selection	Gender: men or women	Men or women depending upon policy. Women tend to take even small pay jobs.	Mixed-alternate village/both man and women in each village/couple	Men mostly
	Age	late teens/early twenty candidates hunting for Govt. jobs	Post-twenty five yr. candidates, other health cadres	Generally post 25
	Education	Age strata will decide entries,	Negotiable	Need to be 10+ for respectable earning
	(caste)	Any	Any is possible..on criteria	Generally upper and middle.
Attitudes of candidates	Work motivation	Declines with tenure, upward mobility if any.	Depends upon candidates/returns/ work satisfaction	Monetary gains are the deciding factors for attitudes.
	Learning	Generally programme-related. Little motivation of their own.	Combining self-interest plus programme interests.	Self-learning, limited to skills that can sale.
	Communication	More with administration, less with people/users	Possible to ensure with both administration and users	Only client-oriented
Candidate locality		From anywhere, unless salaries limit choice to locality	Generally from locality	Usually from outside
Distribution		All, even hamlets, depending upon available funds and pattern	Not so evenly spread—small hamlets can be attached though. Sustainability is prime concern. May not survive in less than 2000 without contract payments.	Only big villages, cluster-centers. Can not survive on small population-below 2000. Overcrowding of PMPs can pose serious problems.
Training	Initial course	Can begin small, stepladder	Qualifying necessary, CME can be done	Initial crash course, little CME later
Monitoring	Social aspects	Poor control	Feasible-	Poor control
	Technical aspects	Theoretically possible	Possible- programme wise	Poor control
Medicine supply		Govt PHC/CHC	Govt for NHPs, from market for other needs.	Market, Medical Reps
Healing systems		Generally allopathic	Can increase choices with better training and public education	Generally allopathic
Preventives	Overall	Programme-specific	Programme-specific, but expandable	No interest (actually sickness-interest)
	NHPs	NHPs on priority	NHP on contract	Poor compliance for NHPs
Rational therapeutics		protocol-driven/ narrow	Possible with standard lists and rates.	Weak
Program durability		Yes and No	Can be stable	Generally stable, though with some flux. Increasing competition can destabilize PRMPs
Attrition		Negligible	Can be kept at moderate,	Negligible
System linkages		In built	Need to be designed and administered	Difficult & tenuous always abhorred.

[3] Assumes appointment of one primary care worker I each village.

Costs	To the Govt.	High	Medium	Low-nil
	To the consumers	Low or nil (except in case of bribes)	Medium to both	Highest
Payment modes		Salaries/honoraria/pensions	Combined: user paid at prescribed rates + contract payment for NHP/State programmes	User fees
Financial Sources		Taxation/grants to local bodies	User-fees or insurance plus programme grants	Fees or may be insurance at later stage.
Venue for work		Formal center necessary	Former center desired, but interim arrangements possible	Private room in bazaar lanes essential.
Legal status for providers		Easy-with Govt notification	Possible to work out	'Do not care", generally some cover is available.
'Couple'		Not possible	Possible, as payment is on contract for tasks/services	Unlikely, except when both husband and wife are practicing.
Examples		**ANM/MPW**	**Omnibus-GLY scheme in the 10th FYP of Maharashtra, Community nurse in AP**	**JANANI programme in Bihar**

(B) POVIDER (CANDIDATE) CONCERNS

Major	**Usual Possibilities[4] with staff model**	**Planners can manage[5] with a combined model**	**What happens with PMP model**
Basic needs	Mandatory-housing/ food/transport/security/	Some costs are less thanks to local residence.	High, ever increasing.
Incentives	Felt as 'always meager'	Always eager	
Income	Fixed-effort or no effort	Adjusted to services and tasks	Variable with services and opportunity
Seif worth/public image	Unduly low, tormented	Can live respectfully and socially useful career.	Unduly high
Learning	Limited to directives	Can be woven into the programme.	Limited to sales promotion
belonging (sense of)	To Govt. system	Both	To professional guild and user community
Professional security/stability	fair, because of unionization	In between, banks somewhat on Govt policy	Ever searching for better position
Supplies	generally fail to keep pace with needs		Self-procured, so usually ensured.
Upward Mobility	Limited, (a neglected issue in India)	Limited, but skills can be improved.	More equipment, facility upgrading.

[4] Assumes appointment of one primary care worker I each village.

[5] Assumes provision of facility on village showing some preparedness, proper candidates etc

(C)COMMUNITY CONCERNS

Major	Usual Possibilities[6] with staff model	Planners can manage[7] with a combined model	What happens with PMP model
Healing: (Medical needs)	Only limited, may not satisfy, may or may not heal.	Good healing + satisfaction mandatory for survival	satisfying it must be, (but may or may not heal)
Access	Time bound, programme-linked, not dependable	Ensuring good access is precondition	Time-elastic, but often distant. So access is limited
Economical?	May be free, if not doing private practice	Can save access costs and needless medication	High costs, and also hidden costs
Friendly?	Depends upon the person	Professional requirement	Professional requirement.
Lasting?	transfers, and visiting nature makes it look less like lasting	Can be	Generally
dependable	Not really-because of various factors		Generally dependable and accountable
User control	Poor, works through long politico-administrative links.	Can be fairly controlled.	Poor control on quality of care

OMNIBUS SCHEME ON GRAMIN LOKSWASTHYA YOJNA IN 10TH FYP IN MAHARASHTRA

Even as the CHW scheme vanishes in thin air and pada health workers scheme is equally evanescent, the primary care group of Maharashtra was arguing for a comprehensive and realistic alternative scheme for needy villages. Thanks to various circumstances and forces, five years of efforts resulted in inclusion of GLY in the 10th FYP of Maharashtra. I call it 'omnibus' for various strategic and conceptual reasons. The scheme will be tried on a pilot basis in 1000 villages first, with help of NGOs to start with. Later it will be expanded. We are trying to mainstream it with help of the Open University, legal status under MMC, panchayats & SHGs. The accompanying summary note may be helpful[8].

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[6] Assumes appointment of one primary care worker in each village.

[7] Assumes provision of facility on village showing some preparedness, proper candidates etc

[8] A larger note submitted the planning board is available for those who want it

GRAMIN LOKSWASTHYA YOJNA

(Submitted by Bharat Vaidyak Sanstha, Dindori, Nasik on behalf of PHC Group, Maharashtra

Even as we are nearing the end of year 2000, four out of five of our villages in Maharashtra do not have any resident health care facility. Even today many mothers die during delivery and health messages do not reach the poor and illiterate women. Vadi-Vasti Davakhana Scheme will solve this problem without the need for large investments by the Government. What's more is that the scheme is people-owned and sustainable, and will immensely improve the reach of National Health programmes. NCP, which is part of the present Govt, had promised in its election manifesto to implement **Gramin Lokswasthya Yojna**.

Vadi-Vasti Davakhana: Roles and Resources	
Place and Space for the 'Davakhana'	Given by village Panchayat /people
Cost of medicines for treatment[#]	*To be shared by the Govt. and the people*
Remuneration for the 'Vadi-Vasti Doctor'[*] /Health Practitioner	Basic honorarium from Public funds routed through Panchayat or other local body PLUS service fees fixed by village Panchayat.
Training of Vadi-Vasti Dr.[$]/Health Practitioner	Certificate course followed by continuing education.
Monitoring of Vadi-Vasti Dr. /Health Practitioner	Technical – PHC Group + Local NGO + PHC MO Social & Cost – Panchayat + local SHGs.

What would be the benefits of the scheme?

1. Resident Health Care Facility will be created in every village providing health care for all.
2. All National Health Programmes' coverage will increase substantially.
3. Reduction in Infant and Maternal Mortality rates.
4. Effective linkages with the Public Health infrastructure for appropriate referral and reduced burden on the government hospitals.

Who will implement the scheme?

The PHC Group[@] will help Maharashtra University of Health Sciences and/or Yashvanrao Chavan Maharashtra Open University to develop and conduct training course and continuing education. Technical monitoring will be by local NGOs and PHC MOs with inputs from the PHC Group. Social & Cost-monitoring will be done by the Village Panchayat and local self Help Groups

What is the State Government's role?

- Recognize the proposed certificate course under S/28 of Maharashtra Medical Council Act.
- Resolve to establish and facilitate linkages of the Vadi-Vasti Doctors'/Health Practitioner with the Primary Health Centers and the National Health Programmes.
- MUHS / YCMOU to be involved in the training.
- Involving Primary Health Centers in training and technical monitoring of Vadi-Vasti Doctors'/Health Practitioner's work and supply of NHP medications to them.
- Contribution to basic honorarium (routed through Panchayat or other local body) and towards cost of drugs

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[#] Modified WHO Primary Care list

[*] Village resident, selected and trained under the scheme

[$] Detailed curriculum, training methodology and retraining strategy proposed under the scheme

[@] **The PHC group**: Individuals and organizations working for decades on the issues of Primary Health Care like: Dr. Shashikant Ahankari, Dr. Anant Phadke, Dr. Abhay Shukla, Dr. Dhruv Mankad, Dr. Kranti Raimane, Dr. Pankaj Gandhi, Dr. Mira Sadgopal, Dr. Deepti Chirmulay, Dr Ashok Kale and Dr. Shyam Ashtekar (Coordinator)

Contact: Dr Shyam Ashtekar, Bharat Vaidyaka Sanstha, Contact: Sriramwadi, MG Road, Nasik, 422 001, Telefax 0253-580147, email: ashtekar@bom6.vsnl.net.in

In Search of Self-Sufficiency -- the Field Experience of a Department of Community Medicine

RAVI NARAYAN,
PARESH KUMAR

The Department of Community Medicine of St John's Medical College Bangalore, has been involved with the development of community health projects in many villages of Karnataka. The primary purpose of the department's involvement in health care delivery was the establishment of health centres for training intern doctors who have a compulsory three months rural posting during their rotating internship. This is a university and curriculum regulation.

From the very beginning it was decided that health projects would be planned and evolved in such a way that the community would be encouraged to participate in the planning and management of the centres. This decision arose from a pragmatic assessment of many other programmes that had been externally funded.

Whether the fund was governmental or voluntary, private or foreign, it was found that the process of external funding resulted in the super-imposition on the local community of a system planned, organised, budgeted and executed for the community through decisions taken outside the community. Such systems were often irrelevant, and consisted of structures that were too costly, too unwieldly and unrelated to local reality.

From 1973-1983, the department was involved with the development of three health care programmes in three different areas. While each project drew inspiration and caution from the previous experience, we tried NOT to get caught up/with the discovery of a 'model' approach. In each area we tried to build the best possible approach with the resources available following an informal process of analysing the local situation.

Case studies

Village M: The first venture was an attempt to tag on a health function to an existing successful milk cooperative. Village M had responded enthusiastically to the promotion of dairying by the government. Forty five per cent of the families owned milch animals and were members of a registered milk cooperative. The production of milk ranged from 2500-3000 litres per day. The milk cooperative committees agreed to a health cess of three paisa per litre of milk to be deducted at source when the payment to farmers was made. A sum of Rs 2500-2700 would thus be available every month for a basic health care system.

The health fund collected was used to employ a doctor and a nurse. Three villagers were selected for on the job training as dai, dispenser and records clerk. Apart from staff salaries the fund was also used for drugs, rentals, travelling allowance and other materials.

Resources like vaccines, vitamin and iron supplements, contraceptives, surveillance of communicable diseases and health education files and pamphlets were tapped from government health centres to avoid duplication. The college department provided supportive technical supervision and posted interns to assist the health team to various activities. It also supplied some equipment through courtesy of UNICEF.

The health cooperative was managed by a committee consisting of representatives of the milk cooperative, the department of community medicine and the government health department. This met every month to plan the activities of the centre.

Fifty five per cent of the families in the village were not members of the cooperative. These were families that were involved in sericulture (25 per cent) and landless labourers and harijans (30 per cent). In order to ensure an equitable and just availability of health services to the member and non-member sections of the village, the following policy was evolved.

Preventive and promotive services which included immunisation, vitamin and iron supplements, ante-natal and post-natal check up, chlorination of wells and so on was made available free to all members of the community. Curative services were free for members but non-members had to pay. A section of the village through this cooperative endeavour, were contributing the total costs of non-curative primary health care services available to all. This was an added and unusual benefit of the scheme.

The leaders of village M showed great foresight, entrepreneurship and ability to handle crisis. This was very much evident in some of

the decisions they took as the programme evolved.
Six months after starting the programme the village leadership boldly decided to sell milk to a private party rather than the government dairy because of the government's indecision to change procurement prices in spite of increasing costs. This was done in spite of the risk involved in the loss of certain subsidies promised by the government dairy. Even more remarkable was the decision to raise the health cess from three to five paise per litre in view of the 25 paise increase in returns per litre.
In later years there was a shift in the economy of village M from dairying to sericulture due to a massive World Bank supported programme in that district. Milk production decreased to 900 litres per day and the health cess had to be increased to 15 paise per litre to maintain committed costs. Sericulture boomed in that area but efforts to cooperatise it had failed.
The options available to the centre were to either close down or start charging for services irrespective of membership. Some money had been saved over the years for investment in a chilling plant. With decrease of milk production this had become unnecessary and the leaders with their usual foresight, unanimously decided to invest the money in a health endowment for the centre in fixed deposits in one of the local banks. The health cooperative thus became a health endowment.
Nine years later, the village leaders once again put aside some cooperative savings and tapped additional funds from a government scheme to invest in the construction of a permanent building for the health centre as well as a medical officer's quarter. Till then the centre had functioned in a a rented building. It is to the credit of the village committee that even ten years after involvement, the department of community medicine was not called upon to invest in a single brick in the village !
The relationship which evolved between the villagers and leaders of village M and the professional staff of the centre and department was one of respect and partnership. The professionals had to change their patronising and superior attitudes, often the result of 'professional education', and get used to discussing with the leaders and villagers as equals and co-workers. The health team's role changed from the traditional one of ordering, advising and prescribing to a new way of sharing and awareness building.
Since the community was paying for the whole scheme, another important learning experience which the team had was on the need for patience with representatives of the community. Every new investment, whether it was for polio vaccines, refrigerator or even health education materials, could be made only after the health committee was convinced of the need. This sometimes took weeks or months. In the years to come this patience resulted in a confident, active and sound local leadership which was neither subservient nor dependent.

Village S: At the request of a Women's League, the Department adopted village S to organise a health programme. Unlike village M, the economy of village S was very different. Most of the villagers were wage earners who had jobs in the city. They commuted to and fro through a government bus service. Very few families owned land and there was little dairy or sericulture. The church was an important feature of this village and had over the years responded to the needs of the people through sponsored charity and distribution programmes.
It was decided to start a health programme funded initially by grants from the Women's League and a foreign funding agency. A committee consisting of local leaders, the parish priest, the Medical Officer of the project and representatives of the Women's League and the Community Medicine Department was formed. This committee, in addition to managing the centre, was required to initiate development programmes in the village which would gradually contribute to the health fund and take over some of the costs of the programme.
Over the years the committee and more specially the medical officer and her husband, a social scientist (both resident in the village) initiated a poultry, a women's handicraft centre, a dairy and other programmes. They organised a youth club and a women's club to plan and run the development programmes. The health programme which was initiated concurrently concentrated on maternal and child health and two village girls were trained informally as health workers to assist the medical team.
However, all attempts at tapping local financial support for the health programme failed. It was neither possible to put a health cess on development activities nor convince the villagers to pay for the

Every new investment, whether it was for polio vaccines, refrigerator or even health education materials, could be made only after the health committee was convinced of the need. This sometimes took weeks or months. In the years to come this patience resulted in a confident, active and sound local leadership ...

services. Years of church sponsored welfare had created a stubborn dependence. In the past, appeals to the Bishop routed through proper channels had provided most of their needs -- food, jobs, education and medicines. They failed to be convinced of any need for self-support.

The village leaders participated in village committee meetings enthusiastically, offering advice , providing frank feedback and criticism, registering protest, offering support and encouragement when necessary, sharing perspectives and ensuring execution of decisions.

Villagers from neighbouring hamlets were ready to make contributions, including fee for services but in the absence of any participation from the two primary villages attempts at self-sufficiency were given up. To this day, the centre continues to be funded from external sources.

Villages of A-Block: In 1978, the State Government affiliated a government primary health (situated in Community Development Block A) to the community medicine department. This centre catered to a population of 72,000 spread over 101 villages. For two years the Department had a programme of supportive participation in all the activities of the health centre especially its maternal and child health and family welfare programmes. Then it was decided that the department team would try and establish health care programmes in the sub-centre villages of the block using a strategy evolved from the experience in villages M and S. These programmes would tap village resources and enlist community participation in their organisation. They would also complement/supplement the extension work of the government health centre auxiliaries.
Villages were identified, which were keen to establish local health centres. In each of them, village health committees were formed to manage and supervise the centre, operate local bank accounts, supervise funds. The assumption made was that payment for service even on a no-profit, no-loss basis would run up a deficit if no patient was to be refused treatment. Since there was a sizable proportion of the community who could not afford even the minimal costs, supplementary collections were vital to ensure the viability of the centres. A nationalised bank was tapped by the department for basic infrastructural costs for initiating such a programme. These included costs of a jeep, a social scientist's salary, internship stipends and seed grants per health programme for equipment and initiating a rolling drug bank of Rs. 3000 per centre.
In about a year's time villages B,G,Y and H were identified and four small programmes initiated. Village health committees were formed in all of them. These committees found accommodation for the doctors (interns from the medical college) and the clinic. The types of accommodation were a village cottage, a room of the village school, an unused parish priest's quarters and a village teacher's quarters. Rules for payment of services were drawn up and a committee member was put in charge of supervising collections and maintaining accounts. Follow up of defaulters was the responsibility of the committee.
Supplementary income was raised by each village committee in different ways. In one village donations were collected from the village families: others made collections during festival time, put a health cess on a milk cooperative collection, tapped, panchayat funds, got a water diviner to contribute his earnings during a season, or contributed the proceeds of a village drama to the fund, and so on.
In addition to financial resources, a host of other non-monetary resources were also contributed to the centres. These ranged from repair and maintenance of clinics and residences with materials obtained locally; hospitality for visiting staff and specialists during camps; assistance in the organisation of formal and informal health education programmes as well as village dramas and street theatre; prizes for baby shows; village volunteers for camps and clinics; participation of school teachers, dais and youth clubs and women's clubs in organising programmes and so on.
The village leaders participated in village committee meetings enthusiastically, offering advice providing frank feedback and criticism, registering protest, offering support and encouragement when necessary, sharing perspectives and ensuring execution of decisions. This active involvement in decision making and management of the centre turned out to be an important component of the dynamic totality of self-sufficiency. No doubt political wrangles, personality clashes and differences of opinion were part of the process but the overall experience was quite positive. Three village centres continue to function to date. Only one centre was closed down and this due to local politics which prevented the committee from functioning effectively.
These three case-studies (seven centres) represent a small attempt in the search for self-sufficiency of community health programmes. It is important to clarify that these

were evolving processes with phases of smooth functioning and points of crisis. More important than the micro-level study and analysis of these projects, is the derivation of broad conclusions based on the reality of these field experiences which pertain to the relevance and rhetoric aspects of this whole quest for self-sufficiency.

Self-sufficiency: Relevance and rhetoric

We are convinced that given an open, informal, decentralised approach, it is possible to initiate and sustain processes of self-sufficiency in health care programmes. Such processes can help take over a substantial part of the recurring costs of a programme.

Wider definition of self-sufficiency

Self-sufficiency as a goal should not be visualised in its narrow definition of local finances or monetary resources but must include a host of non-monetary material resources and human resources in the community. In its broadest sense, active participation by representatives of the local community in decision making in the programmes should be a crucial component of the goal of 'self-sufficiency'.

Funding 'process' not 'structures'

In the present socio-political reality, funding from external sources, be they government or private, industrial house or foreign funding agency will continue to remain a starting point for health care intervention programmes, even those in quest of self-sufficiency. However, if such external funds were used cautiously to fund process rather than constructions' or 'structures', then self-sufficiency would make some headway. Large buildings not only raise expectations in villagers but convince them of the vested interest that project personnel will have in the continuity of an externally funded programme. Both these put a stamp on future dependence and stimulate local initiative to extract advantage and exploit the project rather than contribute to its future support or development. In the Indian experience, buildings are quite often available for use in the village. In our experience, investment in brick and mortar is not only unnecessary but also counter productive to the quest of self-sufficiency.

Tapping government sources

Even when non-governmental organisations are involved with health care programmes that aim at self-sufficiency, our experience has shown us the importance of tapping all the available government resources as part of the strategy. Apart from preventing overlap or duplication of efforts, tapping government resources, especially if it is done through generating pressure groups or some degree of social activism in the community, is almost always a good policy. It ensures that the NGO realises its catalyst role and does not get carried away with institutional or project development nor the pursuit of an unrealistic parallel services.

Maintaining status quo

Our experience evaluated from the perspective of social justice for the under-privileged and poorer sections of the community raises serious concern about the pursuit of self-sufficiency as an end by itself. If financial self-sufficiency becomes a primary goal of the programme then this will ensure that the main contact of the programme will be with the existing leadership of the village which in the Indian situation consists of land owners and rich farmers.

Two experiences clearly taught us the subtle but definite way in which this aspect of village reality operates:

* When harijans and landless labourers began to invest in milch cattle, because jobs in sericulture provided alternative green fodder, the village leadership intervened by closing cooperative membership and forcing prospective members to sell milk to the cooperative rather than participate in it -- thus effectively keeping out the lower sections and affecting the availability of health services to them.
* Another case in point was that village leaders had agreed that Rs. 200 would be set aside every month from the cooperative fund for concessional or free treatment of poorer sections in village M. When there was an economic crisis due to shift in economy from dairy to sericulture this subsidy was slashed making health services once again inaccessible to the poorer sections.

Unethical Medical Practices

With the escalating cost of drugs, health teams committed to quests of self-sufficiency are often pressurised to balance the budget by resorting to practices such as administering of unnecessary injections and tonics, selling of physicians' samples, prescribing unnecessary drugs. These practices help to increase the returns. However even though these practices may be directed towards the affluent sections of the community, they are in principle unethical in both a professional and a social sense and not compatible with the principles of community health.

(Continued on page 44)

What next? A plan of action

At the end of four days, out of the floating, colliding, and exploding of issues, a plan of action somewhat miraculously emerged. It addressed the workshop's many recurring themes. First, a committee was formed to pursue the acquisition of management skills and the documentation of health financing experience.
Second, a commitment was made and a committee formed to increase the sector's advocacy role in policy making; particular priority was placed on regulation of the private health sector.
Finally, the importance of of continuing the debate over the sector's future directions was asserted.
To this end, a second annual health financing meeting was scheduled.

-- Madeline Hirschland has been a consultant with VHAI on health financing. Her background is in the financial management, administration and politics of voluntary organisations.

(This report is based on the workshop papers listed below, presentations, and give and take during animated and often fast-paced discussion. As the presenters alone are explicitly referred to in the text, we would like to acknowledge and thank all the workshop participants, many of whose ideas are included above, for their contributions to this evolving assessment of health finance in the voluntary sector.)

Berman, Peter, "Information Needs for Programme Financing"

Berman, Peter and Priti Dave, "Experiences in paying for Health Care -- India's Voluntary Sector"

Bhagat, A.K., "Management Information and Supervision"

Dave, Priti, "Community and Self-financing Health Programmes: Experiences from India's Voluntary Sector"

Duggal, Ravi, "State Health Financing and Health Care Services in India"

Ghosh, Sanjoy, "The Case of Urmul Rural Health and Development Trust"

Jajoo, UN, "Financing of Health Projects: Mahatma Gandhi Institute of Medical Sciences: The Sevagram Experience"

Mahapatra, Prasanta, "The Need for Developing a System of Sub-Allocation of Resources for Health Institutions in Developing Countries"

Menon, Raja, "Income Generating Projects for Health Financing"

Menon, Raja, "Health Financing - The CINI Experience"

Mukherjee, A.K., "Government Funding of Health Care"

Kumar, Paresh and Ravi Narayan, "In Search of Self-sufficiency: The Field Experience of a Department of Community Medicine"

Poddar, D.P., "Financing of Health Projects: WBVHA CDMU Experience"

Prabha, Sr., "Financing of Health Care - The Experience of RAHA

Rao, K. Venkateshwara, "Financing of Health Care - The Experience of Voluntary Health Services"

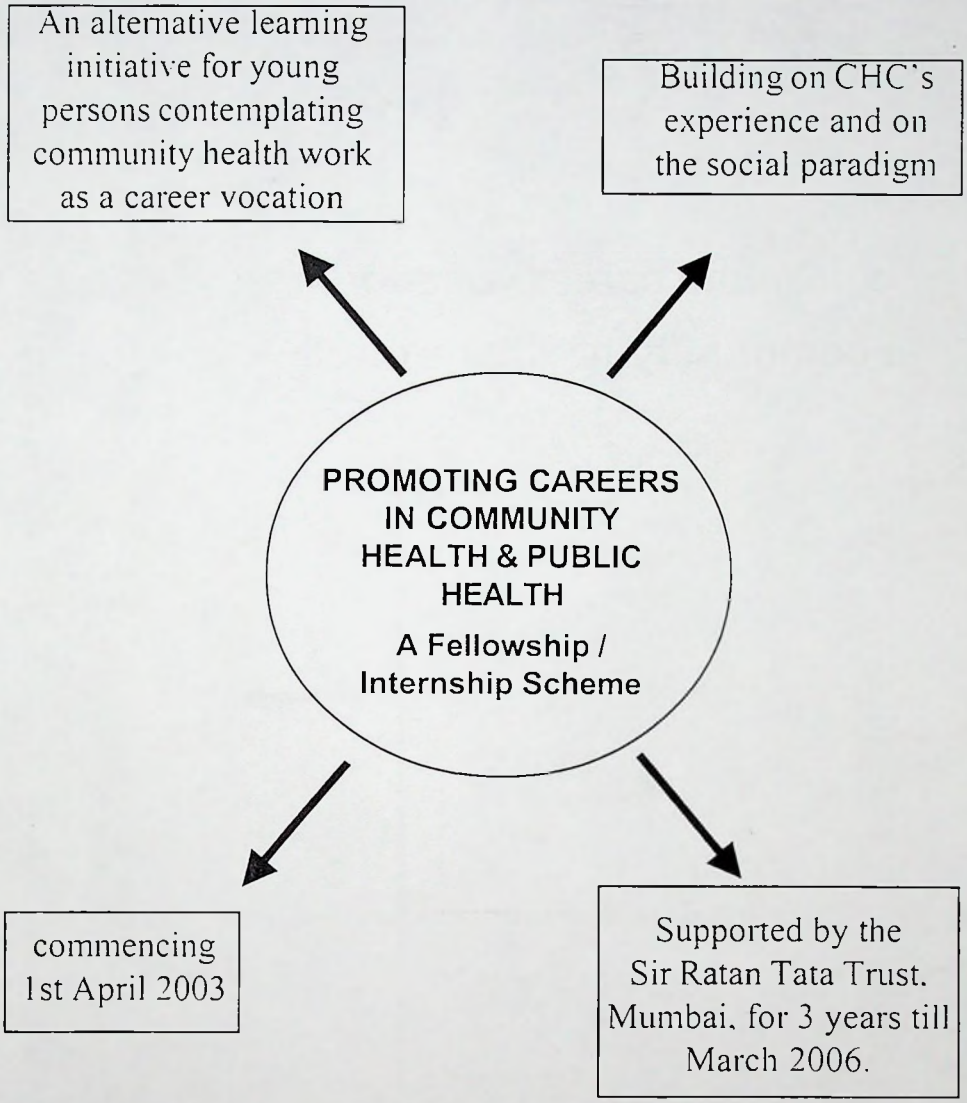
Sharma, S.C., "Government Funding of Healthcare Programmes"

Talwar, Prem P., "Strategies for Development of Technical Skills Among Voluntary Organisations: Some Experiences"

(Continued from page 35)

The goal of arriving at some sort of a model project in one village which can then be replicated in every other village has plagued the organisers of community health programmes all over the world. Our experience has clearly shown that this pursuit of model approaches is nonsense in reality. In the final analysis, self-sufficiency in terms of generating local community resources, be they monetary or material, should be an important but not exclusive objective of a community health programme. When it is exclusive it will ultimately keep out the poorer and under-privileged groups in society. For self-sufficiency to mean much to people and particularly the poor, the good should be reappraised and strengthened in its human sense of participation in planning and active decision making. Community health programmes would then strengthen the people's own ability to plan and organise programmes for maintaining their own health. These would mean an increasing commitment to demystifying medicine, health education, skill transfer, promoting autonomy and improving group relationships. Only such a process would make the pursuit of self-sufficiency 'relevant' rather than 'rhetoric.

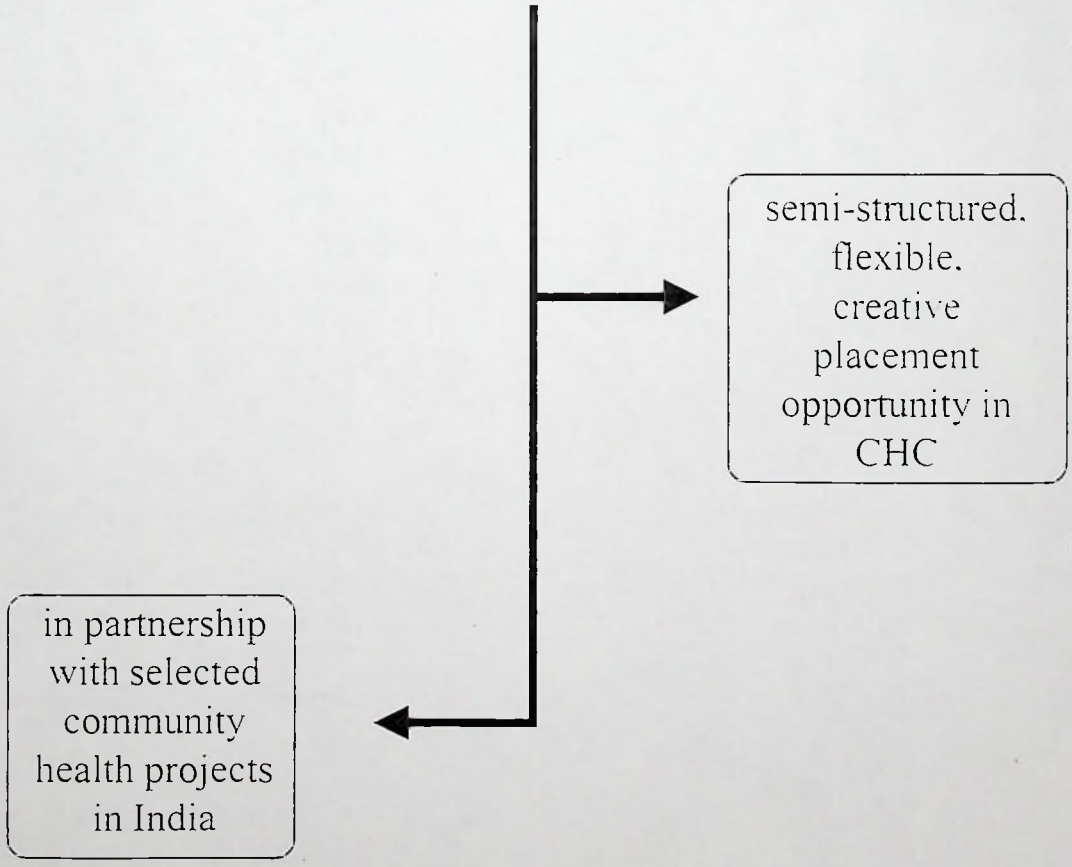
-- Ravi Narayan and Paresh Kumar are both at the Department of Community Medicine, St. John's Medical College, Bangalore.
(This paper was first presented at the ACHAN workshop on "Self-sufficiency in financing community health programmes -- rhetoric or reality" held at ECC, Whitefield, Bangalore, in January 1983.)



What should the scheme be called?

AIMS

To promote career vocations in community health through



OBJECTIVES

To foster a deeper understanding and praxis of community health by :

- building on individual needs and pace of participants
- strengthening motivation, interest and commitment to community health (personal affective domain)
- Sharpening analytical skills through study-reflection-self learning - guidance (cognitive domain)
- deepening understanding of social paradigm of community health and social context of work in India

DURATION & TYPE

a. Two short term internships of 6 months each :

- for young graduates of medicine, dentistry, nursing, social work, social sciences, pharmacy, other systems of medicine.
- annually 4 placements.

b. Two short term fellowships of 1 year :

- for PGs in community medicine / PSM public health / health management community health nursing / social sciences
- annually 2 placements

5. SELECTION METHODS / CRITERIA

a. Note by them on why and what they want to do, peer-reviewed

- interviews & discussion to assess social sensitivity and technical competence.
- previous social exposure, involvement and initiative
- creativity and openness
- conceptual and intellectual abilities
- broader knowledge base and interests
- Social skills, self awareness and reflection
- use a 3 member multi-disciplinary committee of SOCHARA members where necessary.

b. All India eligibility. Special focus on central, north and north-eastern India.

6. SEARCH METHODS

A. Announcements in health journals (NGO & professional)

B. Liaison with health professional institutions with quality UG / PG education

C. Liaison with training centres and resource centres

D. Lecture discussions with interns & PGs.

E. Alerting key persons during travels and meetings

7. PROGRAMME OUTLINE

Semi structured, flexible approach

✪

A set of core knowledge and skills will be identified for a curriculum that will evolve

✪

presentation, discussion, reading

✪

Participation with graded responsibilities in CHC activities

✪

Visit one community health project for 1-2 months to learn from action, training, research, using an integrated approach, writing a reflective report

✪

Write an article on a selected health topic for publication

✪

do an annotated bibliography

✪

undertake small research projects with community health / public health perspectives

A panel of CHC associates and SOCHARA members will be available for support

In NGOs selected for field placements, sp ecific mentors will be identified. An MoU will be established. There will be email contact a& field visits by CHC staff.

A senior CHC team member / peer will be designated as mentor for each candidate

8. MENTORING

9. PERSPECTIVE BUILDING

critical, creative thinking and understanding through :

- weekly journal clubs / presentation cum discussions, team meeetings
- writing
- CHC will organise an annual workshop on key community health issues with innovative community health practitioners
- peer-interaction between each other with networking, background papers, reflections

10. PLANNING

a) A meeting with previous participants from informal phase and some mentors to evolve programme

b) A meeting of organisational heads and mentors from NGOs to develop components, processes, MoUs, review mechanisms

c) Setting up an advisory group to steer and evolve the process

11. REVIEW AND EVALUATION

a. Annual internal reviews in CHC

b. Concurrent evaluation

- self-evaluation and reflection of candidate
- peer review at end of fellowship
- review by mentor / coordinator - quarterly / final

c. Ongoing informal feedback from participants and mentors

d. Follow up and tracking of fellows, and helping with placements in community health programmes.

e. Terminal external evaluation - in middle of third year - to plan for continuity, modification or metamorphosis, possible into a University linked course.

INTERNSHIP / FELLOWSHIPS IN COMMUNITY HEALTH (SRTT)
COMMUNITY HEALTH WORKSHOP – 1
14-16th April 2004

Questions for Panelists / facilitators

A. Globalisation and Right to Health Care

1. All "progressive" reports on health reforms and 'health for all' have spoken of "mass movements" or community involved initiatives (as opposed to community based / centered initiatives). However, mass movements in health are relatively unheard of. Over the years have we lost that vision or is it that, mass movements and initiatives involving communities are difficult / not possible in our current situation.
2. Defining the components of Right to Health Care and also the linkages with the Access to Essential Drugs, Right to Food / Water etc., and other campaigns.
3. How do we as civil society get together to work for ensuring the Right to Health Care! Ways forward.
4. In the context of the middle-class and the rich having access to reasonably good private health care in cities, towns and even large villages, is a mass-based campaign possible?
5. When talking of community health and primary health care, shouldn't the means of our campaign also follow the principles of these concepts?
6. In the context of globalization, are forums such as PHM being realistic and practical by taking principled stands against WTO, privatization, etc., and shouldn't it instead gear itself to find solutions in the existing scenario?
7. Isn't the 'Right to Health Care' campaign in India too legalistic (meaning – preferring the legal route over others).
8. Discussion around the changing patterns of investment by agencies like the World Bank (with investment in health decreasing from the state) and the funding agencies deciding the priorities of health care in funded areas!
9. Issues surrounding Brain Drain and how this phenomenon affects the health care delivery in developing countries!
10. Who decides about research priorities globally – why is most of the funding still going for first world diseases and those diseases which will provide more profits to multinationals? What is the role of WHO in this?
11. Positive outcomes of Globalization like the proliferation of the WWW through which we can reach out to the other parts of the world, know practices there and compare, know what is banned where; role of the information highway in facilitating transparency.

B. Community Health Workers

1. How can we learn from past experiences and design better CHW programs? Are they still relevant?
2. Successful CHW schemes as well as those which were failures.
3. What all should the CHW be doing? And what is out of bounds?
4. How does one prevent CHWs from becoming "quacks/injection doctors"?
5. Whether or not pay? Who should pay?
6. Who should the CHW report to?
7. What are the problems in upscaling the CHW scheme from a successful NGO experiment to a public program level?
8. Why is there a sudden pessimism about the CHW scheme?

9. How has gender played a role in CHW/CHV scheme – as far as I know, the JSR scheme in Madhya Pradesh had mostly or all males working while the Mitanin scheme has only women working in the system? Which one is beneficial?
10. Is it better to have a Community Health Volunteer (CHV) scheme where the CHV is not paid then the CHW scheme? (the Mitanin scheme being a CHV scheme)

C. Community Health Financing

1. Why community health financing is important?
2. What are the various models of community health financing tried nationally and internationally?
3. A few success stories in community health financing and a few failure stories
4. How did community health financing evolve? (a brief history)
    a) Who pays?
    b) How much do they pay?
    c) What do they pay?
    d) How much do they pay – they default on payment?
    e) What form of payment is there? (like the Jowar scheme of MGIMS)
5. In very poor communities is it possible to have community health financing? How?
    a) In a mixed community of poor, middle class and rich, how to work out community health financing?
    b) How to assess the capacity of people to contribute to community health financing?
6. Is Community Health Financing possible on a large-scale?
    a) How do we upscale?
7. What is the role of the government in these schemes?
8. What is the role of insurances schemes – public or private in community health financing schemes?
9. When we are calling it community health financing, how do we ensure that the community has control over the scheme?
10. To what level of care should the scheme cover costs? Should there be a limit on costs?
11. Should it be only for acute conditions or also for chronic conditions?
12. What is the difference between community health financing and profit oriented medical industry?
13. Can you keep offering scheme coverage to a family that has repeated pregnancies – say more than three or four – and thus spend precious community resources on a planned event? Would you not be denying the reproductive rights if you don't? Who decides?
14. How to deal with situations where poor people go into massive financial crisis due to profit oriented health care?
15. What are the other ethical issues associated with community health financing?

(Contributers : Anant, Mathew, Naveen)

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COMMUNITY HEALTH INTERNSHIP CUM FELLOWSHIP SCHEME

MENTORS REPORT FROM FIELD PLACEMENT

Points to be covered (check list)

1. Attendance
2. Punctuality
3. Regularity
4. Work Habit -
5. Tempo of work
6. Sense of responsibility
7. Student found to be a hard worker
8. Professional development
9. Sense of Commitment
10. Ability to take initiative and leadership
11. Level of interest in work
12. Level of self awareness
13. Sensitivity to the problems
14. Ability to respond objectively, promptly and appropriately
15. Ability to manage workload
16. Ability to use integrated practice skills consciously and appropriately
17. Any other comments and suggestions

Date :

Place

Name & Signature

747 research (5)

COMMUNITY HEALTH CELL
COMMUNITY HEALTH INTERNSHIP/FELLOWSHIP SCHEME
Note for Mentors*

1. Background, objectives and structure of the scheme

The Community Health Cell (CHC) has over the past two decades provided short term placements for young professionals who were in the process of considering / beginning or reflecting on their own personal commitments to community health. They spent 3-12 months at CHC. The learning process was individually oriented, with peer support, short assignments, self-study, presentations, writing of reports etc. Over 95% of persons continue to work in community health.

Through the internship/fellowship scheme, which commenced in April 2003, this learning / reflection opportunity will be made available to a larger number of persons. CHC is being supported by the Sir Ratan Tata Trust, Mumbai for the first 3 years of the scheme (April 2003 – March 2005). CHC will build on past experience, developing a semi – structured learning program through an ongoing participatory process, while retaining flexibility and individual orientation. Every year six persons from multi disciplinary backgrounds will be taken, two for a one year period and four for six months each. Selection criteria and a selection process have been evolved.

The learning process will include: a) inputs from CHC team members, associates and others, b) participation in field programmes of CHC c) field placements in NGOs running community health and development programmes in different parts of India d) participation in discussions, workshops, health related campaigns e) reading, self study, reflection, writing f) undertaking small research assignments.

A set of core knowledge, attitudes and skills are being developed as a guideline or checklist. A reading list is also being developed. Feedback from persons who have gone through the process is being obtained through meetings and correspondence in order to evolve the programme content, process and structure

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*Mentor-**n.** an experienced and trusted adviser; an experienced person in an institution who trains and counsels new employees or students. **v.** to be a mentor; **origin** from greek *mentor,* the name of the adviser of the young *Telemachus* in Homer's *Odyssey*.[Ref. Oxford English Dictionary]

Each person will be allocated a specific mentor in CHC for the training period. Mentors will be identified in the field NGOs where they will go on placement. Correspondence and meetings with field mentors will also be held. The role of the mentors is critical to the learning process.

2. The role of mentors

Each mentor will have one or two interns / fellows under their guidance. The allocation will be decided latest by the end of the first week of placement by the coordinator in consultation with all concerned. The choice will be based on the needs, background and interest of the student and the area of experience, expertise and interest of the mentor.

The mentor will be the person responsible for the overall guidance, nurture and development of the person placed with her / him. The relationship will be of partnership, with mutual respect and learning. Regular discussions will be held at a frequency decided mutually, but not less than once a week. Submission of written reports will also be discussed mutually. Previous experience has found that reflective reporting of events, monthly process reports and writing on health related issues helps in deepening ones understanding.

The mentor will help to plan the overall direction and structure of the placement within the overall framework of the scheme, in consultation with the student. While the senior CHC team as a group will develop the schedule of structured inputs the mentor will a) arrange the field placements in Bangalore / at CHC; b) identify topics for assignments / research, c) arrange the placement outside of CHC; identifying the NGO for field placement and negotiating the linkage within the framework of the scheme; d) she / he will keep in touch with the field mentor in the partner NGO and, e) will establish mechanisms of communication with the student during this period.

The mentor will refer the students to colleagues in CHC / SOCHARA members / CHC associates where specialized inputs are required outside one's own area of expertise. When students being mentored by colleagues come for discussion, mentors will share insights, experience and expertise, but will not interfere in the process of mentorship by the colleague. This is a caution to avoid confusion. Where necessary discussion between the

mentors will be held. It is necessary for mentors to have a clarity of one's roles and responsibilities and to recognize boundaries.

If there is a need for change of mentorship, this can be done through mutual discussions with the coordinator.

If the mentor is traveling for a long period, the students will be temporarily provided an alternative.

The mentor will write up a 3 monthly assessment or status report for discussion with the student and the coordinator.

3. Given below is the **"Expectation from a Mentor"** written by a young professional who has been on placement with CHC in the earlier phase.

"1. to discuss the history of community health and also the history of CHC giving reading assignments and fixing a time for meetings at least twice a week in

Beginning of week: stock of week and reading and plan for the week.
Towards end of week: evaluating the week and assigning weekend reading.

2. to coordinate interactive sessions with other team members on topics of interest and also possibly with partner organizations.

3. establishing a framework of expectations and responsibilities that is doable and flexible but is also time-bound so that work assigned gets finished by deadline.

4. help the candidate critically evaluate and consolidate on learning experiences from seminars, meetings, field trips.

5. identify the strengths of the candidate and also help the candidate to work on his / her deficiencies.

6. to network with other mentors to ensure uniform methodology in the overall context to avoid too much differences in the pace of learning of various candidates assigned to different mentors.

7. to not just give to the candidate but also imbibe from him / her.

8. encourage documentation of experiences so as to benefit others also.

9. to make the candidate comfortable by being a senior, more experienced colleague and friend and not just a drill master.

10. to ensure that at least the minimum goals and objectives of both the candidate and the fellowship are met at the end of 6 months / 1year."

4. The core elements

The core role of the mentor is to facilitate the search for a deeper meaning that young persons are seeking through community health. A supportive, encouraging environment, with some gentle direction will be provided by the mentor, keeping in mind an *"ashram"* ethos of reflective action. The technical component will be supplemented equally by a humane relationship to facilitate the growth of the young person in a unique way and direction that will be special to each one.

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INTERNSHIP / FELLOWSHIPS IN COMMUNITY HEALTH

COMMUNITY HEALTH WORKSHOP – I (2003)

&

COMMUNITY HEALTH FELLOWSHIP MENTORS MEETING

Date : 14-16th April 2004 (Wednesday to Friday)

Venue : Indian Social Institute, No. 24, Benson Road, Benson Town, Bangalore – 560 046. Phone: 23536960

OBJECTIVES

1. To facilitate a collective learning experience bringing together a select sample of community health innovators for a dialogue with future community health innovators.

2. To explore some current challenges in 2004 in a Primary Health Care / Community Health systems context with a particular focus on
   a. Community Health Workers
   b. Community Health Financing
   c. Globalization and the Right to Health paradigm.

METHODOLOGY

The overall method will be participatory, interactive with the team of fellows playing a more proactive role in facilitating the process of learning and documenting the key learning experiences from the workshop. This will include :

a) Teams of fellows – past and current to identify questions and issues in the 3 focus areas of the workshop i.e., community health workers, community health financing; globalisation and Right to Health Care through e group dialogue and literature review to be sent to resource persons in advance.

b) Four teams of fellows – past, current and new will facilitate the panel discussions; document or draw out learnings on charts during the panel process; rapporteuring the proceedings and integrating the learning experiences from all the sessions for presentations at subsequent sessions as reports or using other low cost creative communication techniques.

PARTICIPANTS

a) **Community Health Resource Persons**

1. Narendra Gupta (Prayas , NAPM/JSA, Rajasthan)
2. Sunil Kaul (ANT), Assam (SOCHARA)
3. Ulhas Jajoo (MGIMS), Wardha, Maharashtra
4. Fr. John Vattamattom, Sangamitra , SOCHARA, Andhra Pradesh
5. Sr. Dr. Aquinas CRHP, Hanur, Karnataka, SOCHARA
6. Dr. H. Sudarshan, VGKK KTFW, Karnataka (SOCHARA)
7. Dr. C.M. Francis (CHC)
8. Dr. V.Benjamin (CHC)
9. Dr. Thelma Narayan, (CHC)
10. Dr. Ravi Narayan, (CHC)
11. Dr. Paresh Kumar, (CHC)
12. Mr. S.J. Chander, (CHC), and
13. Mr. Prasanna Subrahmanya Saligram
14. Ms. Kumudini Kudalkar, SRTT
15. Ms. Rajani Ved, SRTT Representative

b) **Community Health Fellows – present and past**

1. Dr. Mathew Abraham – 2003:
2. Dr. Abraham Mathew – 2003:
3. Mr. Naveen Thomas – 2003:
4. Mr. Amen Xavier Kaushal – 2004:
5. Ms. Shalini – 2004:
6. Dr. Sandhya, Y.A. – 2004:
7. Dr. Deepak.
8. Dr. Rakhal Gaitonde
9. Dr. Anant Bhan
10. Dr. Gautam Hazarika
11. Dr. Sylvia Selvaraj
12. Ms. Sowbhagya
13. Mr. Ameer Khan
14. Dr. Asha Kiran

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COMMUNITY HEALTH CELL

COMMUNITY HEALTH INTERNSHIP CUM FELLOWSHIP SCHEME (INITIATED IN APRIL 2003)

1. Background

The Community Health Cell (CHC) has over the past two decades provided short term placements for young professionals who were in the process of considering or reflecting about their personal interest or commitment to community health. They spent 3 – 12 months in CHC. The learning process was person centered with peer support, short assignments, self-study, presentations, writing of reports etc. Over 95% continue to work in community health.

During the 1998 CHC Review certain directions emerged. One such important suggestion for a new initiative was :

"CHC should consider the evolution of a more structured training programme in community health, which explores and focuses on Indian experience and stimulates participants to the 'social / community' paradigm" (Proceedings of the CHC Review, April 1998).

The prophetic words of one of our senior peers were more specific:

"Fellowships of appropriate duration may be offered to interested young persons to expose and involve them, in a partially structured way, in activities of mutual interest. Hopefully, a small proportion of them may opt for longer association with CHC. Perhaps the more senior members of CHC should set apart more time for cultivating younger people". (Dr.P.Zachariah, ibid).

This idea was further developed in a note titled *"Towards a Centre for Community Health"*. Subsequent Executive Committee meetings and the Vision Mission meeting supported the need to strengthen and expand CHC's teaching role. CHC in 1999-2000 took responsibility for Training of Trainers through the Womens Health Empowerment Training programme; and continued providing teaching inputs on invitation to a number of academic institutions and to NGO groups.

2. Genesis of the Community Health Internship cum Fellowship Scheme

The idea and details of the scheme took concrete shape through discussions with the Sir Ratan Tata Trust, Mumbai in 2001 2. They had approached CHC indicating their interest in health. A recent review of the Trust had recommended

that they focus on human resource development in health. CHC was also looking for Indian sources of funds for its work. The time had come to actualize a community health teaching programme which would base on the values and ethos of CHC and build on its experience. As a preparation, in 2001 and 2002, CHC increased its intake of persons on placement. Most were postgraduate students in social work, and community health related disciplines.

3. The Scheme

The community health internship cum fellowship scheme commenced in April 2003, offering an opportunity for learning and reflection to a larger number of persons. CHC is being supported by the Sir Ratan Tata Trust, Mumbai, for the first 3 years (April 2003 – March 2005). The team competencies, infrastructure, work involvements and networks built over the years, supported by our other partners, Misereor and Cordaid, form the base.

The objective of the scheme is to " *promote life options in community health by offering a semi-structured, placement opportunity in CHC, in partnership with selected community health projects……*

a) Strengthening motivation, interest and commitment of persons for community health,
b) Sharpening analytical skills and
c) Deepening the understanding of the societal paradigm of community health (Ref – Project Proposal)".

A semi structured learning programme has been developed through a participatory process, retaining flexibility and individual orientation or person centeredness. Every year, six persons from multidisciplinary backgrounds will be taken, two for a one year period, and four for six months each.

Selection criteria and a selection process involving 4 senior CHC team members have been evolved and become operational. A search process has been set in motion. A list of core knowledge, attitude and skills, to be nurtured through the scheme, has been developed. A reading list is also ready. Feedback has been obtained from persons who have passed through the informal phase of the programme. An action plan for Year One has been developed. Two persons have commenced the one year internship and fellowship scheme respectively. One is a dentist; the other has an MD in Community Health. The Sir Ratan Tata Trust has appointed a consultant for process review and accompaniment of the scheme for the first year. She has spent a day in CHC interacting with senior team members and in a meeting with the whole team along with past and present fellows.

Each fellow / intern is placed with a specific mentor in CHC who is friend philosopher and guide. (A guiding note for mentors has been developed.) They participate in the various field programmes and involvements of CHC and interact with all CHC team members and some of our associates. They take graded

responsibilities in the field programmes and in organizing training programmes in community health. Making presentations, participating in group discussions, reading and written assignments, participating where possible in cultural forms of expression and popular education are undertaken as part of the learning process. They also have the opportunity to participate in workshops and meetings conducted by other organizations on themes relevant to their interests.

Placements with field NGOs involved in Community Health and Development in different parts of the country for a few months is part of the learning programme. Agreements are made between the partner NGO and CHC and a field mentor is identified. Building linkages and communication between the CHC and field mentors will be done. A meeting of partner organizations is planned. Increasing peer interactions through newsletters, and organizing an annual community health workshop on a current theme, is also planned.

The community health fellowship scheme is being seen as a twentieth year milestone project of the Community Health Cell. It will help CHC/SOCHARA become a higher level educational and research centre in Community Health. Into what has been termed the Community Health College (CHC).

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COMMUNITY HEALTH CELL
INTERNSHIP / FELLOWSHIPS IN COMMUNITY HEALTH
COMMUNITY HEALTH WORKSHOP - I

Supported by Sir Ratan Tata Trust

Venue : Indian Social Institute, No. 24, Benson Road, Benson Town, Bangalore - 560 046.
14 - 16th April, 2004

Sl No	Name	Name of Department / Organisation & Address	Signature	
1	Mathew Abraham	CHC, Kolamangalam		
2	Naveen	CHC		
3	Abraham Thomas	CHC, Bangalore (fellow) at 'Sanghamitra' Hyderabad.		
4	Rakhal gaitonde	CHC, Vellore		
5	Asha Kiran	Bangalore		
6	Narendra Gupta.	Prayas, Chi Horgarh Raj		MENTOR
7	DEEPAK. M.G	CMC. Vellore		
8	PRASANNA. S.S.	People's Health Movement		
9	Shalini	CHC Bangalore		
10	S.D. Ryinchen	CHC		

Sl No	Name	Name of Department / Organisation & Address	Signature	Remarks
11	Amen Xavier Kaushal	CHC		INTERN (2004)
12	Ameer Khan	CHL - B'lore		INTERN (2004)
13	Sandhya. H.A.	CHC, B'lore		INTERN (2004)
14	Ms Kumudini Kudalkar	SRTT Mumbai		SRTT
15	Sunil Kane	the end, Bongaigaon		Member
16	ULHAS [illegible]	[illegible]	[illegible]	Member
17	FR. JOHN VATTAMATTOM SVD	SANGHAMITRA, HYD		[illegible]
18	Thelma Narayan	CHC		Member
19	Ram Narayan	PHH/CHC		Member
20	Anant Bhan	AMCHSS, SCTIMST TRIVANDRUM		INTERN CHC

Sl No	Name	Name of Department / Organisation & Address	Signature
21	Soubhagya Somanadhan	Tata Institute of Social Sciences on placement	Soubhagya
22	P. J Chander	CHC	
23	PARESH. KUMAR	CHC	
24	Dupe Shailaja	CHC	
25	Sylvia Selvaraj	CHC	
26	C. James	CHC.	C. James
27	V N Nagarajarao	CHC	
28	C M. Francis	CHC	C M Francis
29	Eddie Poomalai	Vellore	Mentor
30	[illegible]	HCCR Hyd	[illegible] Member

Sl No	Name	Name of Department / Organisation & Address	Signature
31	E MANIKANDAN	ACCORD. NILGIRI DIST TAMIL NADU.	EManikanda
32	M ESWARAN	ACCORD NILGIRI DIST TAMIL NADU.	M. Eswaran
33	Dr. T. K. Deb.	Karuna Trust.	
34	SUNIL GEORGE	REDEMPTORIST SEMINARY BANGALORE	
35	Ignace Dungdung	REDEMPTORIST SEMINARY BANGALORE - 84	Ignace Dungdung
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PROGRAMME*

* Provisional

Date & Time	Programme Details
14th April 2004 Wednesday	
08.30 –09.30 a.m.	Fellowship (most participants reach venue on 13th night)
09.30 – 11.00 a.m.	Introductory session • Getting to know each other • Background of workshop • Finalising programme, process and methodology.
11.00 – 11.30 a.m.	**Tea**
11.30 – 1.00 p.m.	**Panel One : Globalisation and Right to Health**
Session I	*Panelists* 1. Dr. Narendra Gupta – PRAYAS, Rajasthan 2. Dr. Thelma Narayan : CHC JSA, Karnataka
1.00 – 2.00 p.m.	**Lunch**
02.00 – 3.00 p.m.	**Group Discussion** - Fellows in 2-3 group • Right to Health : A SWOT Analysis **Fellowship Mentors Meeting – I**
03.00 – 4.00 p.m.	• Reports from Group Discussion • Panelist responses • General discussions
04.00 – 04.30 p.m.	**Tea**
04.30 – 06.30 p.m.	Reports from current fellows (field experience in Karnataka, Jharkhand, Andhra Pradesh, IHF – WSF)
06.00 – 08.00 p.m.	Informal interactions and own time
08.00 – 08.30 p.m.	**Dinner**
08.30 – 09.30 p.m.	Videos Slides (panelists to bring slides of their work, initiatives or campaigns).

15th April 2004	Thursday	
08.30 – 09.30 a.m.	Informal interactions after breakfast	
09.30 – 11.00 a.m.	**Panel Two : The CHW Revisited**	
Session III	*Panelists* 1. Dr. Sunil Kaul – CHWs of Urmul & ANT (Rajasthan & Assam) 2. Dr. Ravi Narayan – A CHW overview & JSR Review (Madhya Pradesh)	
11.00 – 11.30 a.m.	Tea	
11.00 – 12.00 Noon	Group Discussion (Fellows) in 2-3 groups • CHWs – A SWOT Analysis	Fellowship Mentors Meeting – II
12.00 – 01.00 p.m.	• Reports from Group Discussions • Panelists responses • General discussion.	
01.00 – 02.00 p.m.	Lunch	
02.00 – 02.30 p.m.	War, Disaster & Health An update by Dr. Unnikrishnan, Convenor, PHM Circle	
02.30 – 04.00 p.m.	• Panel Three : Community Health Financing *Panelists* 1. Dr. Ulhas Jajoo : MGIMS, Wardha (Maharashtra) 2. Dr. H. Sudarshan (VGKK/KTFH/LOKAYUKTA) - Health Insurance Schemes (Karnataka) – / Dr. T.K. DEB. 3. Representatives* ACCORD, Gudalur (Tamil Nadu).	
04.00 – 04.15 p.m.	Tea	
04.15 – 05.15 p.m.	• Group discussion – Fellows 2-3 groups Community Health Financing : A SWOT Analysis	Fellowship Mentors Meeting – III

* C. KANNAN:
M. ESWARAN.

05.15 – 06.15 p.m.	• Report of group discussion • Panelists response • General discussion
07.00 – 08.00 p.m.	ANT – An Overview – Dr. Sunil and Jennifer Kaul. ANT – Assam
08.00 – 08.30 p.m.	**Dinner**
08.30 – 09.30 p.m.	Videos Slides (panelists to bring slides of their work, initiatives, campaigns)*
16th April 2004 Friday	
08.30 – 09.30 a.m.	Informal interactions after breakfast
9.30 – 11.00 am.	Creative presentations and reflections by Fellows on learning experiences of 14th and 15th
11.00 – 11.30 a.m.	Tea
11.30 a.m. – 01.00 p.m.	Looking ahead – (panelists and fellows)
01.00 – 02.00 p.m.	**Lunch**

* provisional

NOTE :

Some of the resource persons panelists who are 'mentors' of the Fellowship Scheme will meet with core CHC team members during the group discussions time to explore and further evolve the field training component of the Fellowship scheme.