ASHWINI

COMMUNITY OWNERSHIP AND MANAGEMENT OF A COMPREHENSIVE HEALTH PROGRAMME

Plans for the next phase of health intervention (2009-2011)

1.0 INTRODUCTION

Association for Health Welfare in the Nilgiris (ASHWINI) is a charitable society working with the adivasis of the Gudalur valley in the Nilgiris district of Tamilnadu. We have established a unique health care system during the last two decades, addressing the health needs of more than 15000 adivasis spread over 200 hamlets. Though started in a small scale with an effort to create health awareness at the village level, today the programme has grown into a robust health system, accessed by the adivasis at different levels. The most important aspect of this health intervention is the strong emphasis on involving the adivasi community and in training adivasi youth to deliver the services.

From 2002, we are associated with Sir Ratan Tata Trust in implementing some of the key programs of ASHWINI and this partnership has been quite crucial in our quest to establish a holistic health care programme. The two decades of work saw a tremendous improvement in the health status of the adivasi community, which was at a precarious state when we started the work in 1987. Having established a well-functioning health programme, we are now focusing our attention on ensuring sustainability of this process by decentralising the planning and monitoring of our programmes to village level and by encouraging the community to take up an active role in the management of the program. We are entering a new phase.

This proposal outlines the objectives, strategies and major activities planned for the first stage of this important phase.

2.0 BACKGROUND

2.1 Development Ideology and the Vision of ASHWINI

The primary objective of ASHWINI is to establish a health system that is **accessible, acceptable, effective and sustainable.** It should be **owned and managed by the people themselves**; and it should be a system capable of responding to the growing health needs of the adivasis, and their changing social conditions.

We believe that **communities can be empowered by a participatory development process of capacity building and decentralization that culminates in community owned and managed programs and institutions.** Ownership of institutions that cater to the mainstream population is a powerful tool in bringing about a change in social equations.

The focus in ASHWINI has always been on good health and preventive care, not just curative medicine. It is health in the context of a community and all its needs. In seeking optimum health, therefore, we are addressing issues of poverty and its causes; we are taking on the fight for justice and equity, for peoples' rights to livelihood, health, education and housing. Health is situated in the midst of all these issues, not as an isolated entity. ASHWINI's intervention seeks to address the question of health and disease in the context of related issues like livelihood, education and culture.

2.2 Profile of Beneficiaries

The 25000 odd tribals of the Gudalur valley in the Nilgiri Mountains of Tamil Nadu in South India are an exploited marginalised community. These simple people once inhabited the dense forests in the area. They are now classified by the Government as “Primitive tribes”. These forests were taken over by the Government at the time of independence and converted into a sanctuary, thereby taking away all the rights of the tribals to the forest, including collection of forest produce.

From a lifestyle that was totally dependant on the forest for food, housing and health care, they were thrown into the mainstream society, a culture that was totally alien to them. Illiteracy combined with a total lack of understanding of the capital economy, made them vulnerable to exploitation by the large numbers of people who migrated here from the plains. A lack of understanding of the legal processes led them to lose their land to aggressive settlers. Malnutrition and disease became rampant and people were dying from simple, preventable illnesses.

ACCORD (Action for Community organisation Rehabilitation and Development) was set up in 1986 to help the people understand what was going on around them, to help them to hold on to their land which they were fast losing. ACCORD initiated a people’s movement consisting of village level “sangams” that coalesced into the Adivasi Munnetra Sangam (AMS).

ASHWINI (Association for Health Welfare in the Nilgiris), was formed in 1990 to provide health care to the people. The 20 bedded Gudalur Adivasi Hospital was set up to complement the extensive community health program that had been initiated in 1987 by ACCORD. A separate trust, the Viswa Bharathi Vidyodaya Trust (VBVT) was set up to address the education needs of the community. ASHWINI works closely with these sister organisations and all three work with the organised tribal community represented by the AMS.

15000 tribals who are members of the AMS are the primary beneficiaries of the project. They belong to five main tribes – Paniya, Bettakurumba, Kattunaicken, Mullakurumba and Irula. The Paniyas were once enslaved and were released from slavery at the time of independence. The Kattunaickens who are a minority are hunter gatherers and eke out a living from collecting forest produce. Today their heath situation is the most precarious of the lot. The Mullakurumbas are relatively better off, as they own some land and have enough food to eat. The Bettakurumbas are expert elephant trainers and some of them work with the forest department.

2.2.1 Economic profile

An economic survey using a detailed household study conducted in 2004, showed that the average annual income per family is Rs. 26734. This varied between different tribes, ranging from Rs. 34706 in Mullakurumbas to Rs. 23354 in Kattunaickens. For the majority population, 71.5% of income source is daily Wages, while Mullakurumbas earn about 32% of income from agriculture.

47% of total expenditure is on food items, 25% being for purchasing rice alone. Most of the adivasis in Gudalur spend their earnings on a daily basis and the habit of saving is non existent. Only 1% of income goes for any kind of investment.

The economic status of the adivasis is quite precarious making them vulnerable. Their hand-to-mouth existence can pose serious threat to their livelihood in the face of catastrophic health expenditures.

2.2.2 Literacy Profile

A survey in 2000 found that the overall literacy rate was as low as 25% with that of the women being only 19%. It was also found that only 737 children went to school, many of them being

from the Mullakurumba community. This was in spite of having eleven residential schools exclusively for adivasis in the Taluk. Thus it was obvious that the majority of the adivasis had, for all practical purposes, given up on schooling.

Sustained intervention by sister organisation Vidyodaya has led to a remarkable increase in the school going population. It will be some years before children complete school and acquire any higher education.

2.3 The health work and its impact so far

2.3.1 Preventive and Curative health care

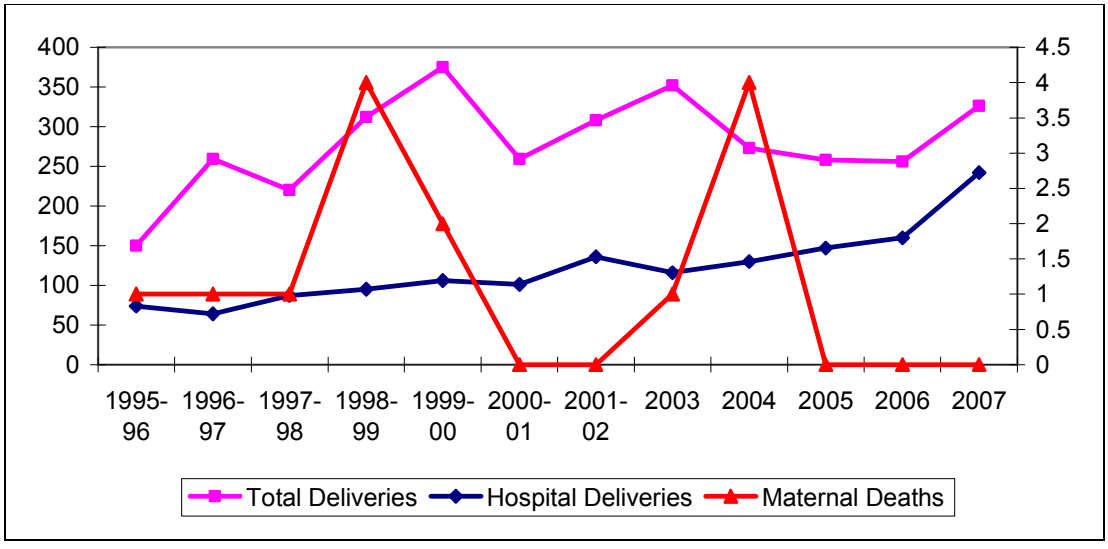
When the health intervention was started among the adivasis of Gudalur valley in 1987, the health situation of the people was critical. The infant mortality was as high as 250 per 1000. Deaths from preventable diseases like diarrhoea, anaemia and tuberculosis were common place. Many mothers died from pregnancy related causes.

The health intervention centred around the training of village health workers (HWs). Mobile clinics visited the villages regularly. Apart from formal training, these visits were used to build the confidence of the HWs.

The Gudalur Adivasi Hospital was set up to offer secondary level curative care. Equipped with a simple labour room and operation theatre, most needs of the people were met by the hospital. Youngsters from different tribes with some schooling were trained at the hospital as nurses and health animators (HAs). Others were trained in administration, accounting, pharmacy etc.

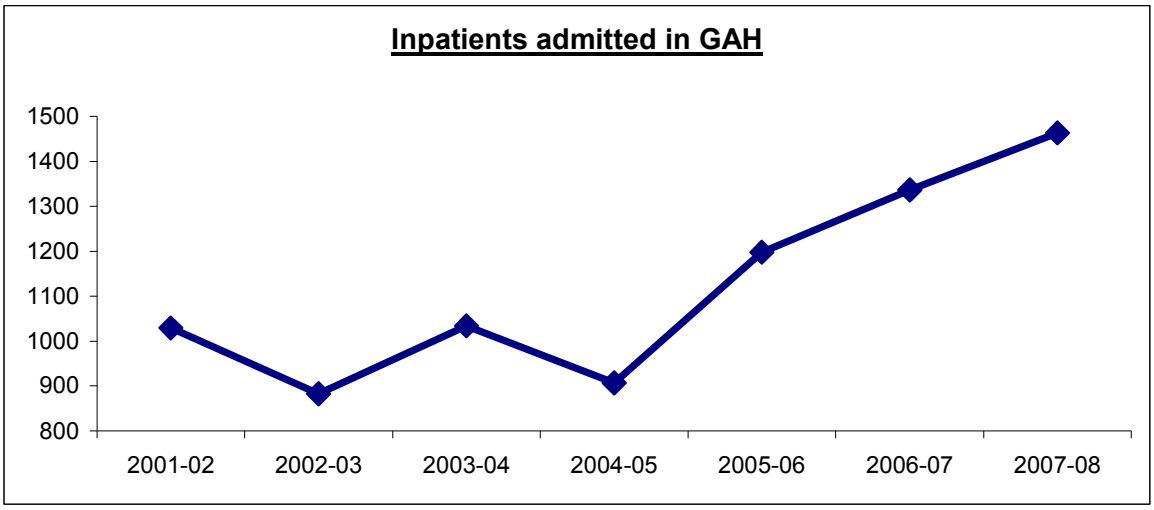
As the health seeking behaviour of the people improved, the mobile clinics were replaced with 8 area centres from which the trained Health Animators provided health care. The hospital became staffed almost entirely by tribals.

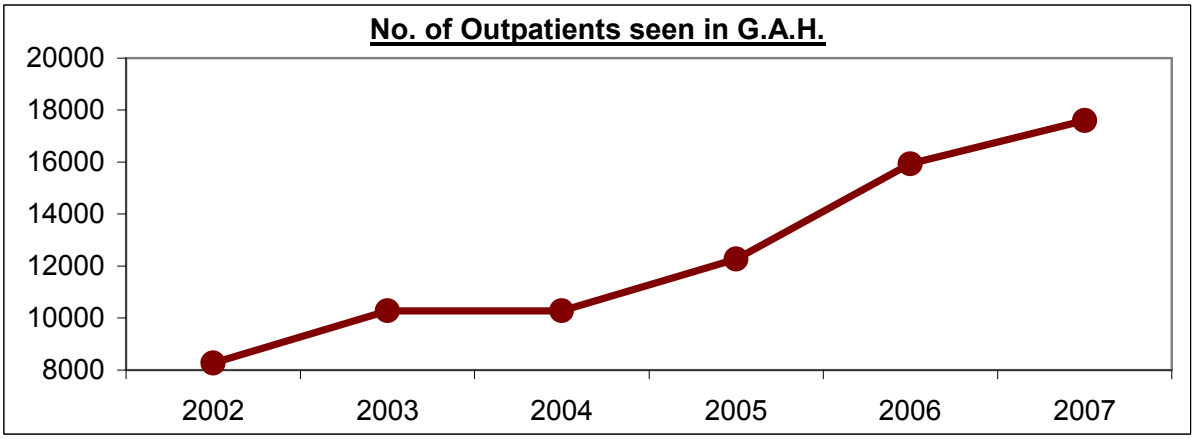
The major impact was on improving the health seeking behaviour of the people. From “lying down to die”, they now came to the area centres and the hospital in large numbers. Deaths from preventable illnesses became rare. The population covered by the health programme has increased from 8240 in 1995 to over 15000 in 2008.



The number of deliveries being conducted in the hospital has been steadily increasing.

The Gudalur Adivasi Hospital became the hub, backing the community health programme with dependable, good quality curative care. More people started accessing GAH, both as inpatients and outpatients.





2.3.2 Community Participation

From the day of inception, every attempt was made to ensure that there would be participation of the community in as many aspects of the program as possible.

ASHWINI as a society is managed through a general body and an executive committee elected by the General Body. Initially the General Body was made up of doctors and other professionals working with the adivasis, but gradually adivasis, who are members of the AMS, were inducted into the General Body. Today the majority of the General Body are adivasis. The General Body appoints an Executive Committee and all the present Executive Committee members are adivasis.

The General Body through its Executive Committee oversees the policy and direction of the entire health care system. A Working Committee, consisting of staff members, takes care of the day-to-day needs of the entire health programme and is slowly emerging as the Think-Tank regarding the organisational aspects of ASHWINI's health programme.

The mechanisms in place to involve the larger community in Governance are as follows:

All discussions regarding direction, expansion of the work, new plans etc that are initiated by the health team in response to the needs identified in the community is brought up for discussion at the "All Team"" comprising of the staff of all sectors of work. The team then takes the discussions to the eight areas. Opinions are sought from the community at area level Thalivers (Leaders) meetings, village level community meetings, volunteers and youth meetings etc.

Decision making is an elaborate process and due importance is given to the views of the community.

Health volunteers from many villages have come forward to get trained in various aspects of health care and have shown a keen interest in taking responsibility for the health of their villages. This has been one of the most positive responses form the community and needs to be built on.

2.3.3 Social equations

The other major impact has been the improvement in the self esteem of the people. The tribal staff have proved to themselves, the community and to the world at large that they are capable of a lot more than manual labour. The non tribal patients coming to the hospital respect them. They are the role models for the younger generation. The program has helped to change the social equations in a big way.

While Adivasi women once hid from non-tribals, Health Animator Uma does not hesitate to ask her well-dressed, chain-smoking non-tribal co passenger in the public transport to kindly put out his cigarette as it bothers her. No arrogance, no censure- Just a firm request, but one which anticipated compliance!

2.3.4 Health Financing

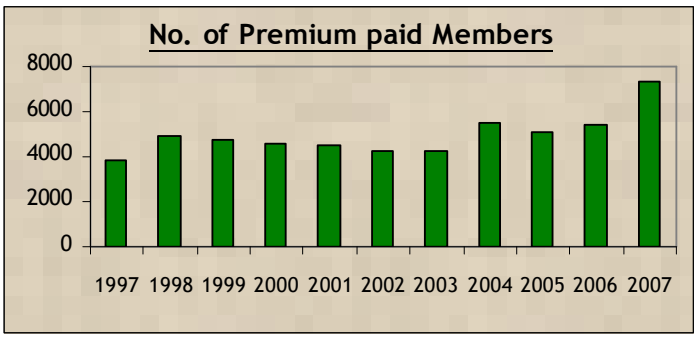
We started the mutual health insurance program in 1992. The objectives of this insurance program were:

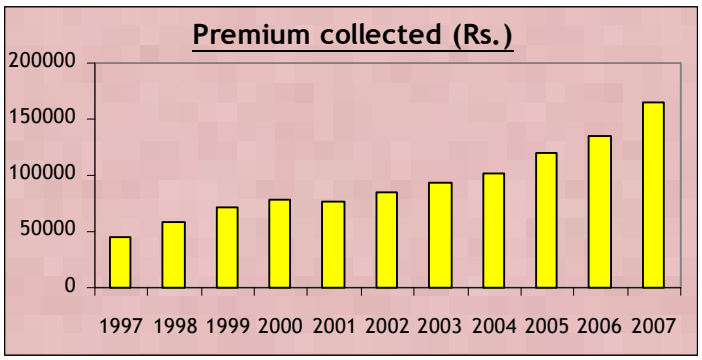
"*To encourage people to feel ownership over the health care delivery system, by contributing to it. This will give them the right to make suggestions or question decisions. "Welfare systems" lead to dependency and are detrimental to developing the self esteem of the people. Moreover, insurance in the long term will also help to provide financial sustainability to the program*."

In 1992, the premium collected was Rs 4 per person. This was increased gradually over the years to Rs 25 per person per year in 2007. ASHWINI reinsures the people with an insurance company – currently Royal Sundaram Alliance Insurance Company. While ASHWINI provides all health services to the people, the insurance company reimburses the hospitalization costs within a claim limit negotiated each year.

SRTT started supporting the program in 2002. The major achievements of the program in the last 5 years have been:

- The setting up of good documentation systems that make analysis easy.
- The training of one tribal staff to do the administration of the program.
- An increasing awareness about insurance in the community leading to more participation. The contribution by the people has been steadily increasing.





- Critical analysis by the team to try to understand the issues behind non participation.
- Negotiating with the insurance company and designing a package that best suits the community's needs.
- Networking with organisations all over India and sharing experiences.
- Influencing the Government to implement a user friendly insurance scheme.
- Publications in journals.

2.3.5 Partnership with Government

Another important impact of our work has been our ability to build partnership with the Government for implementing health programmes for the adivasi community. The Government is convinced that ASHWINI could effectively implement Government Programs so that the benefits reach the adivasis.

During the last few years, the Government of Tamilnadu has chosen ASHWINI as their partner for implementing the following programmes for tribals in Gudalur valley:

- Mobile Outreach Programme
- HIV – AIDS control programme
- Sickle Cell Anaemia Control Programme
- Bed Grant Programme
- National Tuberculosis Control Programme
- Family Planning Programme

Even though the procedural requirements for implementing these government funded programmes take up quite a bit of our energy, we continue this partnership because of two reasons.

i. To ensure that these programmes are implemented properly in adivasi villages and in the true spirit.
ii. To gain access to the top level policy makers in the Government to influence policy at the design stages of these programmes. The Government is also allocating resources into innovative schemes like the National Rural Health Mission (NRHM), it is crucial that we have our voice heard in the policy-making bodies of the Government.

Resources have been mobilised from the Government for implementing these programmes. We have got a strong foot-hold and we hope to strengthen this partnership during the next few years as well.

SRTT had conducted a detailed mid term review of the Insurance program in 2006. The major **recommendations of the review team** were as follows:
"While most of the recommendations have already been made, it was felt that the review team should present an overview of its impressions and conclusions for SRTT, which has played an important role as catalysts in the development process in India, and has a vision much beyond mere funding of activities.

- *For an economically poor region like Gudalur, which depends critically on its major produce, tea, it is imperative that livelihood issues are at the forefront of any development efforts. The economy has done well whenever the tea prices have been favourable, and badly, when prices have been low. The seasonality in livelihoods affects the long-term welfare of the inhabitants, and is a major area that ACCORD and AMS are working on.*
- *Health and education are intricately related to the socio-economic status of the population in any society, and is a two-way relationship that constantly reinforces each other.*
- *The adivasis of Gudalur are especially at a disadvantage due to the land ownership pattern, and given the history of the region, they continue to be at a relative disadvantage, though major strides have been made by ACCORD and the community to improve their welfare.*
- *Poor health and high out-of-pocket expenses for health affects working capacities as well as economic welfare, and prevents families from making the leap into sustained development.*
- *Thus, the availability of affordable and quality preventive, promotive and curative care is critical in the region.*
- *ACCORD and ASHWINI together are working towards improving the welfare of the adivasis, but recognize that there are poor non-adivasis as well. Given the social dynamics of the region, it is currently the philosophy of these two organizations that throwing open the hospital to non-adivasis – who are in a majority – will jeopardize the health-seeking behaviour of the adivasis, and defeat the whole purpose of setting up a separate tribal hospital in the first place.*
- *Given the economic realities of the region and of the adivasis, offering quality health care at affordable prices, so that the needs of adivasis who require treatment is met, is not feasible*

in a full cost-recovery model. The insurance programme has been tailor-made with low premiums and low caps, to reflect this philosophy.

- *Therefore, any initiative like the GAH will need funds in addition to its income sources, to run the hospital in a way that would maximize demand, and minimizing costs. It is clear that any hike in user fees or premium may bring down demand, as has been seen in the past, and the net effect may actually be to affect the treatment-seeking behaviour of the adivasis.*
- *Thus, SRTT must look at the role of health insurance in its proper context, as a vehicle to increase access to health services, and not merely as a cost-recovery mechanism. It must recognize that to maximize access, the GAH may need to run at less than cost-recovery basis, which in turn implies that subsidies may be required on an on-going basis.*
- *SRTT's support and funding to ASHWINI's programmes, including the insurance programme, has been critical, and enabled ASHWINI to work towards its objectives. It is imperative that such funding continues. In addition, SRTT may like to think of a longer time horizon so that assured funding enables ASHWINI to scale up its various programmes as well offer accessible care to adivasis living far away from GAH, without worrying every year about sustainability."*

3.0 THE PROPOSAL

The primary objective of ASHWINI to establish a health system that is **accessible, acceptable and effective** has been achieved. This system is capable of responding to the growing health needs of the adivasis and their changing social conditions. We need to now focus on making it **owned and managed by the people themselves**. There is more work to be done to make the entire program sustainable. We need to continue to work towards improving peoples' participation.

During the last two decades of health intervention, ASHWINI has managed to bring about a sea change in the health status of the adivasis. The health indicators have captured these impressive results achieved by ASHWINI and the adivasi community during the last twenty years.

Now that the precarious health status has been effectively tackled and people have started believing that they are capable of handling new challenges in the future, our intervention enters the next phase, where the focus will be to ensure that the community is able to manage the Hospital and the community health program.

We will work closely with the health team members and the multi-sectoral area team members during the next three years to achieve this. We will equip this team to involve the sangam leaders and community members, and as a result, will become accountable to the community.

The current project is for the first stage spanning over three years from 2009 to 2011. The main objectives for this 3-year project, detailed description of activities and programmes and budgets are given in the next section.

3.1 Objectives

The major objectives of the project during the next three years will be:

a) To decentralise the community health program to eight units.
b) To equip the eight Area Team members with the necessary skills, systems and knowledge for planning village-specific health interventions and monitoring the progress
c) Train village health volunteers in various aspects of health care so that they can take responsibility for the health of their villages and thereby increase community participation.

d) Set up Institutional Management Systems and train Adivasi team members in Institutional management skills in a systematic way so that they will be equipped to manage The Gudalur Adivasi Hospital.
e) To document the formalised management systems and procedures.
f) To lay the foundation for the senior adivasi team members to become trainers of community leaders and younger team members on management aspects.
g) Involve this team in Networking and Advocacy activities.

3.2 Specific Outputs

The following specific outputs are sought to be achieved at the end of the project period:

a) Each of the eight Area Teams will be in a position to prepare village-specific health plans, targeting the health needs of that village.
b) They will be capable of preparing budgets, checking budget realisation and maintaining accounts.
c) Systems for monitoring the progress of these Area plans and taking corrective measures will be in place.
d) Trained village health volunteers will be available in at least 120 villages and they will take responsibility for specific health issues in the village. They will also participate in other aspects of community development work.
e) A group of adivasi team members would have been trained to take complete responsibility for the management of various sectors of the Gudalur Adivasi Hospital.
f) Operational manuals and documents will be prepared, which document the management systems and administrative procedures involved in the health programme.
g) A group of senior staff would have attended and contributed in meetings with the Government, other NGOs and Policy makers.

3.3 Programs and Activities Planned

The focus of handing over management to the tribal team will be universal to all activities planned. Monitoring and evaluation of all programs will also be done along these lines. Apart from the ongoing health care activities, there will be special interventions to achieve the goal of a decentralised, community managed health care system.

3.3.1 Decentralising the Community Health Program and Establishing a Participatory Health Management System

Although the health team was involved in the planning and implementation of the program in their area, monitoring and evaluation of the health indicators and financial aspects of the health programme etc. were done at the central level.

Components of the Health Plans: The health plans to be prepared by the area teams will have a few minimum components, around which the Health Management System will be developed. Broad outline of these components and desirable outcomes are already being decided after consultation with the entire team. Each area team will give special focus on villages that lag behind in terms of these health indicators.

In this project, we will establish a comprehensive health management system in each of the eight area centres through the following activities.

3.3.1.1 Preliminary Workshop

During the first six months of the project, a preliminary workshop will be organised in Gudalur with the help of external consultants specialised in Community Health systems.

All the health animators and key members of the area teams will participate in this 2-day preliminary workshop. The workshop will cover the following aspects:

- *Review of current systems*: First, a thorough review of the systems being followed at the area centres will be done. This will include an evaluation of the knowledge of the health animators on the rationale behind the systems, the records being kept to monitor the health indicators, their effectiveness, reports being generated at the area centres and their periodicity, the forum in which review of the health indicators is being done currently, etc.
- *Evaluation of team members*: An assessment of the skills of each of the health animators and the training needs for the individual team members will be done during this workshop. While the actual delivery of health services may be the responsibility of the health animators, all the other area team members have an important role in establishing the health management system at the area centres. So, an evaluation of the health knowledge of the other area team members, 'soft' issues like team spirit, cooperation between the area team members etc. will also be done during this workshop.
- *Goal Setting*: This workshop will also be used to set long-term goals for each of the area team. The process will be formalised and the area teams motivated to take ownership for the same.

Based on the interaction in this preliminary workshop, a detailed training programme for each of the Area Team will be designed. Simultaneously, the framework of the health management system will also be developed, which will contain the important health indicators and the monitoring formats. This should help highlight the problems in each village to the area team, so that corrective actions can be taken by them on their own.

3.3.1.2 Half yearly follow up visits

The preliminary workshop will be followed by half-yearly training programmes by consultants to assess the progress of the area teams and to design plans for the next quarter. Such an intensive interaction will help the area teams understand the nuances of the health management system.

3.3.1.3 Annual Planning Workshops

At the beginning of the 2nd and 3rd years, we will organise Planning Workshops in which the area teams will be trained to come out with interim goals for the next year. This exercise will involve a thorough review of the health status of the villages in their Area, reasons for the some villages falling short on the goals and the possible correction action that can result in improving the health status of that village.

These Annual Planning Workshops will refine the process of preparing village-specific Health Plans by the area teams and will improve the skills of the adivasi team members in doing objective analysis based on facts and figures. The emphasis of these workshops will also be in helping the area teams work collectively towards their common goals, facilitating their division of responsibilities between them and to function as a good sounding board for each other.

3.3.2 Training of Health Volunteers

Health volunteers are the most important resource people at the village level. Training them in different health related issues and giving them skills will go a long way to make health care

available at the village level. They will be given a structured training with a view to encourage them to take more responsibility at the village level. Apart from health related issues they will also be involved in other community matters.

Training curriculum will comprise of the following:

- Under-five care, care of the mother and newborn at the time of delivery, and post natal care
- Detecting and treating minor illnesses
- Detecting tuberculosis and the follow up of patients on treatment
- Detecting patients with mental illness and following up on their treatment.
- Skills to disseminate information about HIV-AIDS
- Follow up of patients with sickle cell disease and counselling for the same
- Concept of the Mutual Health Insurance program and dissemination of financial details.

They will be encouraged to participate in other economic and social activities at the village and area level. The training will be in three phases. The outputs expected at the end of each phase will be defined. The health volunteers will be evaluated at the end of the training period.

Year I : Training Outputs

1. Detecting and reporting pregnancies and deliveries
2. Registering all births
3. Providing supplements
4. Ensuring immunisation of mothers
5. Follow up of children with malnutrition
6. Encouraging immunisation of children
7. Curative care for simple illnesses like fever, diarrhoea, wounds etc.
8. Understanding of health insurance
9. Understanding the symptoms of mental illness, Tuberculosis and Sickle cell disease
10. Participation in village level economic activities.

Year II : Training Outputs

1. Basics of examining a pregnant woman.
2. Providing antenatal care for mothers and detecting high risk pregnancies.
3. Being present at all deliveries in the village and assisting.
4. Care of the newborn
5. Post-partum follow-up and advice regarding contraception
6. Growth monitoring of children, use of weighing scales.
7. Detecting serious conditions like dehydration, failure to thrive, bronchopneumonia and referring to hospital.
8. Follow up of patients with mental illness and knowledge of the side effects of drugs.
9. Give health education regarding TB, HIV and Sickle cell disease.
10. Active participation in village Sangam activities and in the management of the community fund.

Year III : Training Outputs

1. Give health education with confidence.
2. Overall responsibility for health of the mother and child.
3. Capacity to provide basic curative care and supervision of patients with chronic illnesses.
4. Leadership role in village sangams and in the economic activities.
5. Are able to rehabilitate the treated mentally ill patient in the village setting.

3.3.3 Setting up Institutional Management Systems

The second strategy of this project is to set up Institutional Management Systems that are handled by trained adivasi team members. During the last fifteen years, the senior adivasi team members have been exposed to different managerial tasks in a variety of ways. For example, the working committee comprising of a few health animators, a couple of nurses and the accountant met regularly during the last five years and important issues were discussed threadbare. Besides taking decisions on urgent issues, this group also took responsibility to identify aspects that need wider consultation and initiated discussions among different teams, sometimes outside the health sector as well.

During the next phase, it is proposed to make this process little more broad-based and encourage all the health team members to take up the challenge of getting involved in one or two management aspects. For this purpose, the entire activities of the Gudalur Adivasi Hospital including training will be divided into a few small sectors that will function as management units.

This strategy becomes all the more important, given the fact that a new bigger hospital is being constructed right now. (More details are given in a later section). Since the new hospital has the potential and scope to increase its scale of operations in future, it is important that the adivasi team managing the health programme be trained for future challenges.

This strategy will be implemented through the following activities:

3.3.3.1 Identification of Management units and composition of Teams

During the first six months of the project, the health programme will be analysed and divided into small management units. During preliminary discussions, we have identified the following groups:

- In-patient Group: Management of wards, operation theatre, labour room, maintenance of equipments, utilisation of services, preparation of reports on profile of admissions, number of deliveries and surgeries performed, costing of services etc.
- Financial Management Group: Maintenance of accounts, monitoring of budgets and utilisation, auditing, preparation of periodic financial reports, communication and fundraising etc.
- Health Insurance Group: Maintenance of the Insurance database, addition and deletion of members, correspondence with the insurance company related to sending claims and receiving reimbursements, preparation of reports on utilisation of services etc.
- Pharmacy and outpatient services: Ordering drugs and maintenance of stocks, issuing medicines to different units, correspondence with the drug manufacturers, preparation of reports on utilisation of drugs, performance of the out patient department, Laboratory activities, utilisation patterns, Dental department performance, analysing the income and expenses, planning for the future etc
- Government Programmes, Advocacy and Networking: Interacting with the government on various issues related to the programmes that are being implemented now, meeting Government officials, policy makers and other NGOs for advocacy and networking will be taken up by this group.
- Support Services Group : Cleaning and Maintenance, Canteen for the patients, campus and building maintenance, crèche for staff children etc
- Training and Personnel Management Group: Schedule of duties, recruitment of new team members, identifying training needs and organising regular training sessions, salary, PF and other statutory requirements, preparation of staff policy etc.

This classification will be refined after further discussions and the team members will be encouraged to take responsibility for managing one or two of these units. Depending on their individual inclination and skill-set, we will form small teams for managing these units.

3.3.3.2 Structured Training Programme

During the current project, we will have a structured program to give training in management issues and in leadership and communication skills.

During the first 6 months of the project period, a curriculum for the training will be developed. The steps involved in this process are given below:

- Each of the Management Groups will meet at least once in a fortnight to identify issues that need deeper understanding.
- Training inputs will be provided to the members during these interactions on a one-to-one basis
- Milestones will be identified for each group, goals will be set for the project period and progress monitored
- Evaluation of the Management Trainees will be done on an annual basis; and targets for the next year planned based on that.
- Management Reports will be designed to analyse various aspects of each of these units and presentations will be made by each of these groups at least once in six months to the entire team. The emphasis will be in helping each of the management groups to present analytical reports, rather than mere statistical highlights.

3.3.3.3 Exposure Visits

Even though most of the inputs will be given within the organisation, it has been our experience that exposure visit to other organisations is extremely useful in team building and in developing proper perspective about our work. As the hospital needs to continue to function, the staff will do visits in two batches without interrupting the functioning of the programs. The following visits will be organised during the project period:

- Two exposure visits for the entire health staff and trainees in two batches over the three year project period.
- Two visit to other projects nearby will be organised for the village health volunteers.
- Visits to other hospitals to study their management systems and governance mechanisms will be undertaken by small groups of team members with an objective to observe a specific aspect of management.

Learning experience from these visits will also be documented and shared with the entire team.

3.3.4 Documentation and Research

3.3.4.1 Operational Manuals & Documentation of Systems

The process of documenting the systems itself will be a good training mechanism for the senior adivasi team members on the management aspects. During the 3-year project period, operational manuals / documents will be prepared for the following systems:

- Financial and Accounting System
- Pharmacy Management System

- Health Insurance System
- Protocols for management of Wards, Operation Theatre and Labour Room
- Management Information System for Community health programmes
- Management Information System for Hospital Operations

If responsibility for training new members on systems also has to be taken over by senior adivasi team members, then it will help them immensely to have the systems properly documented. Special focus will be given to formalise all the management systems of the organisation, document the procedures into simple operational manuals in Tamil.

Subsequently, the respective management group can revise these manuals, if the procedures are to be changed, on an annual basis.

There will be a systematic recording of all data from the field and hospital with regards to the various programs. All data will be computerised. Analysis of the insurance related data will be done periodically and discussed with the community. Health indicators will be analysed to plan interventions.

At least 4 detailed studies will be done on aspects like:

- The health seeking behaviour of the pregnant woman and pregnancy outcomes in the various tribes.
- The community's participation in the insurance program
- Infant mortality and its causes in depth.
- Compliance of patients with mental illness to medical treatment.

These studies will help to further our understanding of the health situation and to plan better strategies for interventions.

Whenever possible, results from the studies will be published.

ONGOING ACTIVITIES

3.3.5 Community Health program

At present, this is being implemented through eight area centres spread in the two taluks. Each of the area centre covers between 20 and 40 hamlets and serves an average population of 2000. Each Area Centre is manned by trained tribal staff consisting of 2 health animators, 3-5 animators, 1 education coordinator, 1 accountant and 2 savings coordinators. This team coordinates community organisation, health, education, economic activities, legal rights etc. at the village level.

3.3.5.1 Maternal & Child Care Programmes

We will continue to give special attention to this vulnerable group. The focus will be on involving the health volunteers to take more responsibility for each of the activities. The aim will be to ensure that:

- 90% of the ante-natals receive at least 3 check ups during pregnancy.
- 75% of the deliveries will be attended by a trained assistant.
- All couples eligible for Family Planning will be identified, a register maintained and appropriate contraceptives offered to them. The target will be to see that at least 40% of the couples are protected and adopt some family planning method or other.
- There will be no maternal death from direct obstetric cause.

Growth monitoring and Immunisation of all children under five years of age will be done routinely. In the next three years we plan to:

- Encourage health volunteers to take over a major part of growth monitoring using the services of school children in the village for support. At least 40 villages will be able to monitor their children.
- Nutrition supplementation will be given to all malnourished children and children who fail to thrive despite nutrition intervention will be identified and referred to hospital for investigations.
- Immunisation, though done by the Government, will be monitored by us. We will liaison with the Government nurse to ensure at least 90 percent of the adivasi children are covered.
- Routine supplementation of Vitamin A and iron, de-worming of all children will be done. This will help to reduce the high incidence of anaemia in the population.
- By these means we hope to reduce the infant mortality rate to 30 per 1000 (which is currently 40) at the end of 3 years.

3.3.5.2 Health Education

Village health education sessions will be held regularly by the area teams and village health volunteers. Awareness about Mental illness, Substance abuse, HIV, Tuberculosis and other infectious diseases will be given. The meetings will be used as venues to discuss health financing, savings, economic programs etc. School children will be given similar inputs at various gatherings, particularly the library classes and youth meetings organised by Vidyodaya. The ill effects of alcohol will be one of the main topics that will be covered.

- 60 village meetings will be conducted in a year.
- At least 500 children will be motivated each year.

3.3.5.3 Community Mental Health Programme

ASHWINI initiated a comprehensive community based mental health programme in 2005 with the financial assistance of SRTT. The results of this programme are tremendous, especially in creating awareness about mental illness among the community, in screening patients and in designing systems for continuous monitoring of the patients. The next 3 years will be a consolidation and maintenance phase for this programme and it will be integrated with the community health program.

- The patients on treatment will be motivated to continue the treatment. They will be followed up regularly and where required, rehabilitation will be provided.
- There will be adequate stock of medicines so that there is no disruption of supply to patients on treatment. All case records will be maintained.
- Doctors will be involved in the initial diagnosis and treatment planning. The patients will be followed up by the health animators. Consultation with psychiatrist in case of patients not responding to treatment will be undertaken.
- The 120 health volunteers who have completed training will have refresher courses twice a year and will be kept motivated by involving them in all aspects of the work. Detection and treatment of mental illness will be an ongoing topic for training of new health volunteers.

3.3.5.4 Sickle Cell Anaemia control programme

Ashwini initiated a massive programme to control and treat Sickle Cell Anaemia, a disease that is highly prevalent among the adivasis of Gudalur valley. The patients are

incapacitated by this crippling disease as it causes severe pain during crisis and leads to early mortality. The symptoms can be controlled to a large extent by the use of drugs and proper health education and Hospital admissions in crisis situation can be avoided. A Sickle Cell Treatment Centre has been established at Gudalur Adivasi Hospital, which coordinates this elaborate programme.

So far 6150 people have been screened and 140 have been detected to have the Sickle Cell Disease. 20 % of them have the carrier gene and 2% are affected by the disease.

We plan to screen the population systematically concentrating on children and adults below 30 years. 1000 people will be screened each year. Patients identified will be followed up regularly and medications and immunization given to them.

The most important focus of this programme will be to spread the knowledge about this disease to the community through posters, pamphlets, village meetings and presentations. The health volunteers will be given extensive inputs to understand the mechanism of spread of this disease. With proper counselling, this disease can be prevented and controlled. Most aspects of this programme are supported by the Government of Tamilnadu.

3.3.5.5 Communicable disease control programmes

We will continue to work actively to control waterborne diseases and nutritional disorders by educating the volunteers and the community. Specific diseases that will be targeted will be:

Tuberculosis

ASHWINI is part of the Revised National Tuberculosis Control Programme of the Government of India and we are a recognized centre. As part of this, we will screen all people with weight loss, cough or fever of more than 2 weeks, for TB. All children who fail to thrive will be investigated for TB.

Health education will be given in villages and health volunteers will be trained to identify patients and follow up the treatment with DOTS. Records will be maintained at the area centre and the area team will ensure that medicines reach the patients without any interruption. One person will be identified for supervising the intake of medicines by each patient.

HIV and AIDS

ASHWINI is also a recognized centre for the HIV control programme. We run a Voluntary Counselling and Testing Centre (VCTC) at the Gudalur Adivasi Hospital. All pregnant women, patients with Tuberculosis and people with high risk behaviour will be screened for HIV. Extensive health education will be given especially to children studying in high schools and youth groups. Counselling services will also be available. Condoms will be made freely available and health education materials produced.

3.3.5.6 Curative Care in Area Centres & in Mobile Clinics

Curative care will be provided by the Health Animators at seven Area Centres. Four of the area teams will also run Mobile Clinics to reach out to interior villages, as part of the Government of Tamilnadu's Health Systems Project.

Improving the infrastructure at the area centres will be another priority under this project, so that they are better equipped. Only 2 area centres at present have proper buildings. The

other 6 function out of small rented rooms. Land has been acquired in five more Areas and we plan to put up buildings in these areas. Funding support for the land and buildings will be provided by ACCORD.

Out patient clinics by doctors and health animators will be better organized on fixed days. The frequency of doctor led clinics will depend on the number of doctors available and the needs expressed by the area teams. Basic laboratory investigations will be made available at the area centres as well and more medicines will be stocked at the area centre so as to treat patients for simple illnesses nearer to their villages. Patients with chronic diseases will be followed up by the area teams.

3.3.6 Mutual Health Insurance

ASHWINI's Mutual Health Insurance scheme is quite unique and has evolved into a mature system during the last fifteen years. The emphasis has been on mutual help and contributing whatever possible towards the health care costs. It is more a health financing system for all health needs rather than a health insurance in the traditional sense. Apart from "Risk Sharing", this financing mechanism takes into account "Resource Sharing." The most important achievement till now has been our ability to inculcate the habit of saving for future health needs. This was amply illustrated during the in-depth discussion held in the months of May – June, 2008 in various area centres with community leaders and area team members on the future direction of the insurance programme.

When Government of Tamil Nadu came out with a plan under its 'Bed Grant Programme' to reimburse all the costs of providing in-patient care to adivasi patients, we had to redesign the insurance programme. As the insurance was covering inpatient expenses till now, we raised the issue of the need to continue our insurance programme; and if so, what should the premium be used for.

There was an unanimous opinion that

- Our insurance programme should continue, because the current support from Government may not continue indefinitely
- When people pay premium, they feel a sense of ownership and they participate much more in our activities; so, we must continue the programme.
- The amounts collected from the people can be used to meet other expenses related to health care like outpatient care, referral expenses, emergency transport costs, food and other incidental expenses
- In line with the other village-specific plans, costs of accessing health services will also have to take into account issues like economic conditions of the family, distance of the village from the hospital, seriousness or urgency in accessing hospital services etc.

The focus during the next three years will be on decentralising the insurance program so that more decision making happens at the area level in consultation with the community.

- All strategies for premium collection including how much to collect, how to collect and when to collect will be decided by the area teams.
- The focus will be taken away from individual based premium collection and stress will be given to village based programme.
- The community fund that has already been initiated and is presently managed by the women's group will be used for making premium collection more efficient.
- An overall objective of improving premium collection by 15% each year will be set.
- ASHWINI will help the area teams set-up a Health Fund at the disposal of each of the area teams, using the insurance reimbursements from the insurance company and premium collected from the people.

- The “Out of pocket” expenses that are paid by the patient include food and travel costs. For a poor family even these expenses may become a burden and a block to seeking health care. But for a majority, these are affordable expenses. The area team in partnership with the village volunteers will decide to subsidise or write off the costs for these two elements in deserving cases. The area level Health Fund will be used for this.
- The other major expense incurred by patients for health care is when they are referred to higher centres for tertiary care. This benefit will be increased significantly in the next insurance policy. But the onus of referring a patient will be with the area team. They will decide who to refer, how much to reimburse, what is the money to be used for etc. within the claimable limit.
- We will continue our engagement with the insurance company. The terms of the policy will be negotiated with the insurance company every year, based on the needs. We hope that the Government will continue to support us in providing some elements of health care. The policy will fill the gaps and make our system holistic.

In the discussions with the community, it was stressed that awareness about health expenses needs to be communicated to the people and the health insurance programme plays an important role in this direction.

All these components will form part of the Health Plans of all the area teams. Apart from this, if there are any specific issues to be handled by the area teams, they will incorporate them also in their area plans

3.3.7 Curative Care at Gudalur Adivasi Hospital

The proper functioning of The Gudalur adivasi Hospital is central to the success of all other programs.

3.3.7.1 Infrastructure

At present, Gudalur Adivasi Hospital functions out of a modified office building and is proving to be inadequate for the growing needs of the people. As the adivasi community is seeking health care much more proactively during the last two years, the demand for curative care services in the hospital has increased tremendously. Hence, a well-equipped and planned hospital became an acute necessity.

We have designed a new building with enough room for possible expansion in future and the construction started in late 2007. We hope to complete the first phase of the construction by mid 2009 and move the essential parts of the hospital to the new building. The entire construction is expected to be completed in 2010.

The hospital will need to be equipped with some more basic investigative facilities like X ray and other equipment. Funding support for buildings is mainly from friends, small donors and locally raised income. ASHWINI needs financial support to complete the building and to acquire the medical equipments. We are getting in touch with institutional donors in India and abroad for the same.

3.3.7.2 Referral to tertiary care hospitals & visiting Specialists

There is limitation in the treatment that can be offered in Gudalur Adivasi Hospital. Every year, there will be about 100-200 patients needing tertiary care and they will be referred to Medical College Hospitals or other tertiary care hospitals. Treatment costs in such hospitals will be borne by ASHWINI. We will negotiate with the insurance company to include this element also in the insurance policy. As mentioned before, the area teams will take more active role on deciding the referral policy and the financial aspects of this.

Wherever the surgical procedures need not be done on an emergency basis and can be scheduled for a later date, we will invite specialists from other bigger hospitals to come and offer treatment in Gudalur. Our experience during the last two years in inviting doctors from Bangalore and Chennai to perform paediatric, gynaecological and general surgeries in our hospital has been extremely positive. These doctors have volunteered to conduct these surgeries. This has helped reduce the costs tremendously for the patients as well. The nurses and other health staff gain from such interactions. We will continue to organise such visits during the next three years as well and build the pool of such volunteer doctors.

3.3.7.3 Heart Surgeries

ASHWINI has set up a separate Heart Fund with the help of Charities Advisory Trust in UK. As the expenses related to this programme are very high, they could not be considered as part of the insurance programme. Patients with correctable cardiac lesions needing surgeries are being referred to appropriate institutions. Expenses for such surgeries are being met from the Heart Fund.

We will continue this programme during the next three years as well and will mobilise more resources for the Heart Fund.

3.3.7.4 Training of new Trainees

If the senior team members have to go one notch up in taking responsibility for managing the health programme, it is possible only if some of their current responsibilities in delivering services or other routine activities are handed over to other members of the team. Depending on the need for staff, the trainees will be selected. Ten trainees will undergo training for 4 years in various subjects.

3.3.8 Networking and Advocacy

During the last five years, significant efforts have been invested in networking and advocacy activities. One of the important results of this effort has been the recognition gained by ASHWINI from the Government. Our inputs have influenced the Government of Tamilnadu in designing the the Bed Grant Programme, Mobile Outreach Programme and the Sickle Cell Anaemia Control Programme that are specifically targeted at the health care needs of the adivasi community.

As we have laid the foundation for this interaction with the Government, we will strengthen this by encouraging our adivasi team to interact more frequently with the district and State level officials of the Government. Visits will be organised to Ooty and to Chennai for the adivasi team members to present their views on the Government funded health care programmes to the senior officials of the health department.

We will continue to share the unique features of our health intervention with other groups by publishing articles in magazines, inviting other community groups / NGOs to visit us and by participating in partners meetings organised by other agencies like Skillshare India Trust.

3.3.9 Communication and Fundraising

Annual reports will be widely circulated to friends, donors, Government officials and other organisations. Donors will be kept informed of the progress in the work periodically. They will be encouraged to visit the project to see and participate in the activities here.
Another focus during this phase will be to involve the adivasi team much more in fundraising activities and in communication with the donors.

ASHWINI has a partnership with Give India, the online donation portal for fundraising purposes. Websites will be kept updated and improved to further communication. Apart from appeals and direct communication, the following activity will be used as a major fundraiser.

Medical Student Elective program

This will be an important source of income. The four week training course for medical students will expose them to the functioning of a rural community based health system. The students will be charged fees for these activities.

3.3.10 Monitoring Indicators

As described before, the main focus of this phase of our work will be on decentralising the planning and monitoring of the health intervention. One of the goals for this project is to establish a participatory monitoring system that is easy to understand for the adivasi area teams and will throw up problem areas immediately, so that suitable corrective action can be taken.

As far as the implementation of the current project is concerned, the outputs will be monitored using the following indicators :

1. Health Management System Training
    - Number of workshops held
    - Number of participants in the workshops
    - Village-specific health plans prepared
    - Achievement of targets against health plans by the area teams
2. Institutional Management Training
    - Number of workshops held
    - Number of participants in the workshops
    - Independent responsibilities taken by adivasi team
    - Exposure visits made to other institutions
3. Health Insurance Program:
    - Number of people subscribing
    - Amount of money collected from the people
    - No of insured people accessing curative care
    - No of people insured with the Insurance Company
4. The Curative Care program:
    - No of out patients seen in area centres
    - No of outpatients in the hospital
    - No of deliveries in the hospital
    - No of surgical procedures in the hospital
    - No of patients referred to tertiary care centres
5. The Community Mental Health Program:
    - No of patients on treatment
    - No of patients cured.
    - No of suicides.
    - No of patients taking treatment regularly.
6. Capacity Building
    - No of health volunteers trained.
    - No of training sessions.
    - No of health volunteers performing expected duties at the village level.
    - No of health animators and staff trained.
7. Health education:
    - Number of health education sessions held in villages.
    - Number of children given health inputs.
8. Maternal and Child Care programs:
    - No of pregnant women receiving proper antenatal care.

- No of children with complete immunisation
- Maternal mortality
- Neonatal and infant mortality

9. HIV AIDS Program:
    - Number of people sensitised about the disease.
    - Number of people screened at the Voluntary Counselling Centre.
10. Tuberculosis Control Program:
    - Number of people screened for TB.
    - Number of patients successfully completed treatment.
11. Sickle cell disease program:
    - Number of people screened for sickle cell disease
    - Number of patients on regular treatment.
    - Number of patients admitted with sickle crisis.
12. Dental program:
    - Number of people screened for dental illness.
    - Number of patients treated.
    - Number of dental health education sessions given.

4.0 SUSTAINABILITY PLAN

Sustaining the Process

Building the capacity of the community will have the most sustainable impact on the health of the people. After withdrawal, the changes brought about will not regress. The programme will be owned by the adivasi community, and the knowledge and awareness of the community will sustain the health status of the villages. In keeping with ASHWINI's ideology, the community would have been built up to take more responsibility for the running of the program.

Sustainability of Human resources

At the end of the 3 year period we will have 120 health volunteers in place who will take responsibility for the health of their village. The awareness in the villages regarding reproductive and child health, mental illness and other chronic diseases will be much better. The area centres will act as nodal points from where all activities will take place. They will be better equipped to provide care. At the end of the program, the health seeking behaviour of the tribals would have increased.

Ensuring that all the skilled staff for the program is from the community will ensure sustainability of manpower.

Financial Sustainability

Dialogue with the Government and creating awareness about the responsibilities of the Government in the community, will ensure more utilisation of Government services. With the Government taking responsibility for the inpatient care of the tribals, sustaining the curative care work is very much more feasible.

Capacity building and preventive health care programs where we are investing in the community, will have to be supported by external donors for a longer term.

ASHWINI is setting up special funds for recurrent and high expense interventions like cardiac surgeries, sickle cell disease and diabetes. A corpus fund is also being raised to meet the some of the core costs in the long term. Programs like the Medical Student Elective will also provide long term revenue.

5.0 CONCLUSION

AMBIKA - From an Adivasi Girl to a Leader …

Ambika is a Mullukurumba girl from Kappakunnu. Seventeen years ago when she joined ASHWINI as a Nurse Trainee, she was just another adivasi girl. Today, she had gone miles ahead of most of her friends and villagers – she has become an important person in the community, deciding the policies of the health programme that affects more than 15000 adivasis of Gudalur. She tries to analyse the pattern of admissions among the tribal patients, calculates the average costs of treatment of a tribal patient and compares it with those of private hospitals, monitors the performance of the fellow staff in the hospital and motivates the new adivasi trainees. For an adivasi girl who has not completed her studies in the School successfully, this is a tremendous achievement.

But Ambika's transformation, though remarkable, is not unique. Many Adivasi youth of AMS have opted to tread on this path of working for their community. They continue to do so despite heavy, often seemingly insurmountable, odds. This dedication has made them the important leaders of ASHWINI. Today they have been entrusted with the enormous responsibility of managing the health programme - And they are coping well with that. Our efforts are to support them in this task and equip them with the necessary managerial skills!

ASHWINI has been able to bring about significant changes in the health and the lives of the adivasis of the Gudalur valley in the last two decades. SRTT has been an important and significant partner in this process. We hope that this support will be continued during the next critical phase as well, as we work towards making the adivasi community take responsibility for their own health.