livelihoods
today and tomorrow

July 2009

Primary Healthcare

Rains have come. Just that! Almost certain, it is a drought across! Some hope that we can cope with this, along with the recession.

The **International Day of Cooperatives** reminds us that there is no way forward for the poor but to get together as collectives around their needs. Cooperative farming, whether they want to go, and how, is a matter to be decided and taken up by the groups of farmers in their groups themselves. Let us not forget principles of cooperation. The needs of the farmers – seeds, inputs, extension support, remunerative minimum support prices, storage, market etc., have to be addressed in any case, for everybody. Taking up drinking water plants on scale through SHG Federations, PRIs, Civil Society or Government itself needs to remain open and to be facilitated accordingly.

The **World Population Day** – in the context of population in general and the poor and the old in particular – gently hinted that we have to change our strategies to cope with this growing reality.

25 June 2009 – Michael Jackson becomes 'immortal'. Extremely shocking to the world! More than a billion participated directly/indirectly in the final farewell memorial service to the 'greatest entertainer' and the 'American legend'! He lives on spreading love and joy!

After air, water and food, the people need health to live. Health expenditure is next only to food expenditure, when it comes to poor. Lots of us slip into poverty with health disasters and get stuck over there. For the families who live by the day, health means work; health means income. Otherwise it is starvation; or debts. May be because of this, it is said – poor are never ill. While ill, there is more expenditure and there is no income. While recuperating/recovering from illness, and immediately thereafter, there is no 'space' possibly to get nutrition and nutrients. In their physical, economic and emotional circumstances, they ignore the early symptoms and get into major mishaps later. This explains partly why the first loans in the groups of the poor go for food and health needs. Next loans go for paying the high cost existing debts. When there is insurance (or someone is picking up costs), many 'non-existent' diseases come out. They bear many of their diseases in their stride, in the absence of facilities, infrastructure and financial stamina, and live with less productive lives with age and old-age showing up much earlier. Their ill-health is a function of lack of facilities; tiresome hardships and burdensome works; inadequate nutrition and nutrients, and vaccines, during the pregnancy, infancy and childhood; going to bed half-hungry and not having balanced diets; risky occupations/lives, accidents, migration, quacks, incomplete treatments, getting to work without complete/adequate cure and rest, habits, life-styles, non-availability of safe potable water, non-affordable (cost and time) hygiene, difficulties in coping with fluctuating climates and climate changes, etc. All these contribute to the current reality of the poor in health in general and primary health in particular.

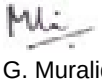
However, in 1.2 billion strong India, a large number of people who live on providing services in primary health include – doctors, nurses, compounders, health assistants, pharmacists, anganwadi workers, health 'volunteers', medicine dispensers/medical shops, quacks, herbal/ayurvedic doctors, dais, diagnosis people, medical companies, etc. In government itself, an estimated one-million plus people work. Service providers outside may be another 2.5 million, at the least. It is in this context, the seventh sector, explored by 'livelihoods', is "primary health ".

The innovator and distributor of Jaipur foot, Dr PK Sethi is a God of disabled! Foundation for Revitalization of Local Health Traditions, FRLHT, takes steps to identify and spread alternative heath and medicine processes/efforts. Dr. HR Sudarshan of Vivekananda Girijan Kalyana Kendra and Karuna Trust, is enhancing the health, education and livelihoods status of the tribals, and is an inspiration to all those who work with the marginalized. Arole doctor couple's Jamkhed fame Community-based Health Program shows ways of offering sustainable health locally. David Werner's 'Where there is no doctor' continues to be the handbook of all health workers and community workers.

Food Security Bill, Right to Universal Education Bill, National Livelihoods Mission, Rs.10,000+ Billion Budget for the year, despite a 5%+ (in GDP) deficit are news that sustain hopes for better life for the poor. However, some in depth thinking before freezing them helps. We welcome G8's announcement of Rs.1,000 Billion for global food security.

As Umasankari, Samyukta and Lakshmi, with all of us, cope with the final journey of organic farmer and campaigner, Narendranath, micro-finance leader, SKS fame Seetharama Rao joins him. May their souls rest in peace.

In the times of uncertain livelihoods portfolios of the poor and not-so-poor, 'livelihoods' campaigns meta-fishing for them to see and work for better tomorrow on their own. With the faith that you join us in our campaigns/yatras, I remain.



G. Muralidhar

the 'livelihoods' team

livelihoods

Inside ...

'livelihoods' team

Editor in Chief	G Muralidhar
Senior Editor	T Nirmala
Working Editors	K Bharathi
	Ira Rambe
Edit Associates	B Madhusudhan
	V Muralidhar
	M Vijaybhasker Srinivas
	K. Sridevi
	S. Rekha
	Nilendu Mukherjee
Cartoonist	G Dayanand

For Private Circulation only

For enquiries contact:

AKSHARA Network for Development Support Services,

HIG II B-25 F-6, APHB Colony, Baghlingampally, Hyderabad - 500044

Mobile: 09347802302

www.aksharakriti.org

akshara@aksharakriti.org

Response

Thanks for sending me the copy of Livelihood. I enjoyed the story of Buddha in this issue. But still feel the intervention of Elephant is not appropriate. Since there is not consultation with the beneficiary or Participant namely Buddha. We always think what is right for the beneficiary and do that.

Chidambaram. CT

I wish to compliment the entire AKSHARA team for continuously bringing out your Livelihood Magzines. I got an opportunity to read the May, 09 edition of 'Livestock Livelihoods' which I downloaded from Solution Exchange and found it very informative and motivating. I specially liked the articles on 'Dr. B.V.Rao, Goats in W.B and Livestocks'. Also the picture of 'melting iceberg' was in itself food for thought. I request you to kindly include my email in your regular mailer, so that I too associate myself with developmental developments through your magazine.

Deepak Upadhyay

Thank you for forwarding the Livelihood document for June '09. Through this we get extensive coverage on so many aspects of developments taking place around us and equips us to be updated with lots of information. My regards to the entire Akshara team.

Edwin

There's a place in your heart
And I know that it is love
And this place could be much
Brighter than tomorrow.
And if you really try
You'll find there's no need to cry
In this place you'll feel
There's no hurt or sorrow.
There are ways to get there
If you care enough for the living
Make a little space, make a better place.
Heal the world
Make it a better place
For you and for me and the entire human race
There are people dying
If you care enough for the living
Make a better place for
You and for me.

If you want to know why
There's a love that cannot lie
Love is strong
It only cares for joyful giving.
If we try we shall see
In this bliss we cannot feel
Fear or dread
We stop existing and start living
Then it feels that always
Love's enough for us growing
Make a better world, make a better world.

News

World Bank Provides More Support To Boost Incomes Of Poor Farmers In Uttar Pradesh: On June 30, 2009, the World Bank approved a US$197 million IDA credit to increase the agricultural productivity of barren lands in Uttar Pradesh. The Third Uttar Pradesh Sodic Lands Reclamation Project builds on the achievements of the first two such projects in the state which have already helped reclaim more than 250,000 hectares of unproductive land. More than 425,000 poor families have benefited so far, experiencing three- to six-fold increase in crop yields. In the third phase of support, a further 130,000 ha of predominantly barren and low productivity sodic lands in about 25 districts will be reclaimed. This will help improve food security for thousands of poor farming families.

Nalbari Farmers Resume Cultivation After 25 Years: Thousands of farmers in Borigog-Barbhag block, in lower Assam's Nalbari district, joined hands to dredge a 15-km stretch of a water channel that got blocked, thereby flooding farmlands across 50 villages. For 25 years, farmers had abandoned work on their waterlogged lands. Now they are back in business and busy planning two crops a year.

Union Budget 2009-'10: Union Budget for the year 2009-10 has been presented to the Parliament on 6th July 2009 by the Union Finance Minister Pranab Mukharjee.

World Bank Support for Modernising Old, Polluting Coal-Fired Power Plants In India: India's power shortage is an obstacle to the country's development. Over 400 million do not have access to electricity; and sixty percent of Indian industries are forced to generate their own power. The World Bank has approved a US$180 million loan to the Government of India, to renovate and modernize old, inefficient and polluting coal-fired power plants, with a cumulative capacity of 27,000 MW, or almost one-fifth of India's installed power capacity of 145,000 MW.

Majuli Faces Red Alert: Majuli in Assam, situated bang in the middle of the Red River, the Brahmaputra and the largest freshwater island in Asia, waits in trepidation for another monsoon. This place is poised at the brink of another monsoon. And for its inhabitants, another disaster. Severe monsoon flooding is an annual ritual here, with homes inundated, standing crops destroyed and a heavy toll on humans. With the landmass eroding at roughly 7 sq km a year, Majuli's 1.70 lakh residents are fast losing their lands and livelihoods.

National Sample Survey Organization - NSSO Survey From July 1: The 66th national sample survey will be conducted across the country from July 2009 to June 2010. The present survey will focus on family expenditure to determine the average lifestyle of people, the level of poverty and unemployment.

SGSY Renamed As National Rural Livelihood Mission (NRLM): The Swarna Jayanti Swarozgar Yojna (SGSY) has been renamed as National Rural Livelihood Mission (NRLM). With this the scheme will be made universal, more focussed and time bound for poverty alleviation by 2014. Accordingly, a target has been fixed to enrol 50% of rural women in self-help groups over the next five years. Finance Minister Shri Pranab Mukherjee, during his budget speech on 6 July 2009, announced setting up of rural mega clusters in Bengal and Rajasthan. This move would enhance the skill of rural artisans Rural mega clusters are to be set up in Bengal and Rajasthan.

Jadugoda, No Expansion Until Promises Are Met: The uranium mining and processing facility in Jadugoda, in the East Singbhum district of Jharkhand, severely indicted for its health impact on local communities, is all set for expansion. A public hearing was held on May 26. But the hearing was as skewed as the environmental health and safety reports submitted by UCIL (The Uranium Corporation of India Limited), claim activists.

Youth Policy For Future Perfect - State Hopes To Stop Migration For Better Opportunities: With an aim to eradicate unemployment and ensure their all-round development, the state department of AP of art, culture, sports and youth affairs has decided to formulate and implement a youth policy this year. Before implementing the policy, the department will seek suggestions from school and college students, government officials and gram sabha members through regional workshops. Elaborating on the benefits of the policy, P.C. Mishra, the director of the state youth affairs and sports department said they would organize livelihood programmes and also form youth clubs. Remedial classes, vocational courses apart from training in poultry, fisheries, carpentry also falls under the purview of the policy.

First Community Radio Station Run By Women: One of Gujarat's biggest Women-based NGO, SEWA, will be first to run a community radio station (CRS) exclusively by women, as Information & Broadcasting Ministry has granted permission to Mahila SEWA Trust for establishing a radio station. SEWA, which is into radio programme production for last four years, will have its own radio station with a 10-km radius. However, the NGO has decided to keep its base at its training centre at Manipur village in Sanand taluka.

Aravind Eye Hospital, Madurai: Worldwide, 45 million people still suffer from preventable or reversible blindness. Twelve million are in India alone, where the extreme sun and a genetic predisposition are blamed. Many people lose their sight—and livelihood—by their early 50s. Aravind's founder, Dr. Govindappa Venkatswamy had retired from a government hospital in 1976 and set out to tackle "needless" blindness. Aravind is the world's largest eye care centre, a one-stop shop that even makes many of the lenses and instruments used by its surgeons. The surgical error rate is low. The big difference at Aravind is that its patients are among the world's poorest people. Aravind Eye Care System today is the

largest and most productive eye care facility in the world.

New Priorities - Development Takes A Backseat As States Combat Extreme Weather: Spending on disaster management has exceeded spending on agriculture and rural development in some states. A World Bank report said extreme weather events like floods, cyclones and droughts forced Maharashtra, Orissa and Andhra Pradesh to spend more on relief and damages than on development schemes between 2002 and 2007. Therefore, the future might be worse if steps are not taken to combat climate changes.

Agartala Wants Malls, Multiplexes - But Not With Urban Renewal Funds, Says Centre; Reject Its Plan: The centre said no to Tripura's plan to build urban complexes saying they do not qualify for central assistance. In 2006, the state government sent a city development plan to the Union urban development ministry seeking funds to build malls, multiplexes and town halls in the capital city, Agartala. "The construction of the town halls, that too three, in a small town like Agartala (measuring less than 65 sq km) is not only outside the ambit of JNNURM but is also not justified," said the Indian Institute for Public Administration.

Over half of school dropputs are from minorities- Report: Nearly two decades after World leaders pledged to provide educaion for all irrespective of caste and gender, the promise remaiins unfulfilled and more than half of the World's children out of school belong to minorities or indigenous people, according to a new report. About 50 to 70 percent of the world's 101 million children out of school are from minorities or indigenous peoples, London-based Minority Rights Group International (MRG) said in a new report. In developing countries such as India, Bangladesh, Ethiopia, Kenya, Nigeria and Pakistan which have the largest number of school dropouts, the disparity is maximum as minority and indigenous populations enjoy far less access to schooling than the majority groups, says the report titled "the State of the World's Minorities and Indigenous Peoples 2009". The annual MRG report, which was prepared this year in collaboration with UNICEF, says that the Millennium Development Goal on education will not be met by the 2015 deadline if policies are not properly targeted to the needs of minorities and indigenous peoples.

New report- Climate change, hunger two top global challenges for farmers:

Oxfam International released a report recently which says that as the weather changes, millions of people in areas suffering food scarcity will have to give up traditional crops, possibly leading to social upheavals such as mass migrations and conflict over water resources. The report, "Suffering the Science: Climate Change, People and Poverty," said that more than 1 billion people, or about one in six people on earth, go hungry today. Without action most of the gains of fighting poverty in the world's poorest countries over the last 50 years will be wiped out, "irrecoverable for the foreseeable future." Oxfam said it prepared a study for the Institute of Development Studies by surveying farmers around the world, who report that changing seasonal patterns were already affecting their ability to plan the sowing and harvesting of crops. The results, it said, were "strikingly consistent across entire geographies."

Centre asks DDA to submit slum revamp plan: Taking the Delhi Development Authority to task for the slackened pace of slum redevelopment, the Centre has asked the authority to submit the detailed rehabilitation and in-situ development plan for around 500 slum clusters in the city. The plan, which will be drawn up for around 500 of a total of 1,000 slum clusters falling under the DDA, will entail on-site development through the construction of multi-storeyed dwelling units. A part of the land could also be used for commercial activities. To speed up the process and keep construction costs low, the central government may ask the central public sector realty firm National Buildings Construction Corporation (NBCC) to undertake the construction of these houses for the poor. According to official data, around 1,000 slum clusters — consisting of three lakh households with a population of around 16 lakh — occupy 1,800 acre of DDA land.

Measure poverty by income, not by calories-Sen: The government may be keen to ensure food security for the poorer sections of the society, but the below-poverty-line debate continues unabated with consensus on the issue among the policy planners remaining elusive. Adding a new dimension to the issue, Planning Commission member Abhjit Sen has argued that evaluation of poverty should be done on the basis of income rather than calorie intake. Sen reasoned that if one factored in calorie intake of 2,400 for rural areas and 2,100 for urban areas, then 64 per cent of urban India and 80 per cent of rural India would be below the poverty line. A rural development ministry panel had said that 50 per cent of Indians are below the poverty line considering the criterion of calorie intake and suggested that they be covered under BPL schemes. As per the plan panel's estimation in 2004-05, India has 30 crore people living below the poverty line. But according to the rural development ministry's 2002 poverty census, India had over 40 crore poor people. Again the World Bank on basis of 1.25 dollars per day believes that India has 45 crore poor people. So clearly there is no consensus on the quantum of populace living below the poverty line.

India Outsources Agriculture: India is leasing land in Ethiopia to grow food to meet its domestic demand and boost exports. The government invested US $4 billion (Rs 19,000 crore) on agriculture, horticulture and sugar estates in the African country where land is cheap. Indian analysts have criticized the move: "Leasing land in Africa does not make economic sense especially because its political situation is unstable, " said Himanshu, Assistant Professor with Jawaharlal Nehru University, New Delhi.

RIP: Sitarama Rao , MF leader. ■

July 4 - International Day of Cooperatives

Cooperatives play an important role in economic, social and cultural development. The United Nations recognizes and reaffirms this role in the achievement of social policy objectives as shown in various resolutions specific to cooperatives and the biennial publication of the Secretary-General's report on the role of cooperatives in social development.

International Day of Cooperatives 2009: "Driving global recovery through cooperatives"

Based on the principle of cooperation, Cooperatives help to pioneer new ethics and values in business and economics. A Cooperative is an autonomous association of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through a jointly owned and democratically controlled enterprise. Cooperatives are based on the values of self-help, self-responsibility, democracy, equality, equity and solidarity. In the tradition of their founders, cooperative members believe in the ethical values of honesty, openness, social responsibility and concern for others.

Cooperatives can contribute to human security in general terms. In Argentina, 58 per cent of rural electricity in 2005 was provided by cooperatives without which the agricultural sector, responsible for 6 per cent of the GDP, would be compromised and jobs in rural communities would be lost. In Colombia, Saludcoop, a health cooperative, provides health care services for 15.5 per cent of the population. In Ethiopia, 900,000 people in the agriculture sector are estimated to generate part of their income through cooperatives. In France, 9 out of 10 farmers are members of agricultural cooperatives; cooperative banks handle 60 per cent of the total deposits and 25 per cent of all retailers in the country are cooperatives. While in Japan 9.1 million family farmers are members of cooperatives which provide 257,000 jobs. In India, the needs of 67 per cent of rural households are covered by cooperatives. And in Switzerland, the largest retailer and largest private employer is a cooperative. In New Zealand 22 per cent of GDP is generated by cooperative enterprise and in Vietnam 8.6 per cent of GDP is attributed to cooperatives. Many other examples could be cited.

Experience has shown that cooperatives can be highly resilient in crisis and conflict, particularly in building cooperation and solidarity and restoring dignity through self help initiatives in situations of tension, post-conflict and post-natural disaster situations.

Therefore, to increase the awareness of cooperatives around the world and promote the movement's ideals of international solidarity, economic efficiency, equality and world peace, the International Cooperative Alliance (ICA) first celebrated International Cooperative Day in 1923 on the first Saturday of July. ICA is an umbrella group of organizations encompassing 760 million members of cooperatives in 100 countries that was formed in 1895. In 1994 the United Nations recognized and reaffirmed that cooperatives have an important role to play in economic, social and cultural development and proclaimed a UN International Day of Cooperatives. The UN requested all its member governments to join with their cooperative movements to celebrate the day. Since then both the ICA and UN Days are celebrated on the same day - *the first Saturday in July every year.*

2009 International Day of Cooperatives theme focuses on recovery rather than crisis. It aims to highlight the role that cooperatives have in not only promoting economic growth, but also in promoting ethical values which have been severely challenged during the financial and food crisis. It underlines that cooperatives can effectively contribute to global economic recovery and that they will do so in respect of the Cooperative Values and Principles which guide their operations. The theme also allows stakeholders to address the response of the cooperative movement to crisis - financial, food, values. However, it is key to be reminded that cooperatives serve their members needs in both good and bad times whether it be economically, socially and/or culturally. They are not tools to address crisis, but a sustainable form of enterprises that outlive crisis and drive recovery.

India has the world's highest number of agriculture cooperatives - some 446,000, with a membership of 182 million. While Mondragon (Cooperatives in Spain's Basque region) is internationally the most famous network of cooperatives, two of the other widely celebrated success stories are from India - Amul and SEWA (Self Employed Women's Association), both based in the state of Gujarat in Western India. The story of Amul began with just two dairy cooperatives and 250 liters of milk per day. This led to the formation of the Gujarat Cooperative Milk Marketing Federation which now has the capacity to collect and process over six million liters of milk a day. This milk is marketed as cheese, butter, yoghurt, ice-cream and chocolates under the brand-name 'Amul'. SEWA was born in 1972 as a cooperative for women street vendors, and later expanded with a SEWA Cooperative Bank in 1974. Today, SEWA is a huge network of cooperative efforts in diverse spheres. The driving energy for this work has come from the firm conviction that "if the poor are organized and build up their strength, then socially responsible marketing can strengthen the local economy". Therefore, International Days should be taken as occasions to kick start processes to re-energize and revitalize the spirit of cooperation and cooperatives in India.

The International Day aims to strengthen and extend partnerships between the international cooperative movement and other actors, including governments, at local, national and international levels to contribute a better human security. ■

Legend

'Jaipur Foot Doctor' Sethi

Pramod Karan Sethi, turned around the lives of millions of below-the-knee amputees with a simple, cheap and easily-made prosthesis that he and his co-designer - a semi-literate craftsman with a genius for innovation - called the Jaipur Foot. Sethi was a qualified surgeon but he stumbled into orthopaedics while working at the Sawai Man Singh Hospital in Jaipur, Rajasthan. The institution with which he remained associated until his death. He attributed his success with the Jaipur Foot to the fact that he was not a qualified orthopaedic surgeon and was not, therefore, hampered by established ideas.

In today's world, where it is difficult for an able bodied person to make a living; in such a scenario life for a person who is differently abled is riddled with challenges. If a person is disabled his/her life changes dramatically. It makes them dependent on others even to do routine daily activities. This dependency brings with it lack of self confidence and self respect. People could become disable either by birth or when they meet with accidents. Where the disability affects the foot, Jaipur Foot is a boon. This artificial foot is accessible to all - even the poor - as its price is affordable. This has enabled many people to continue with daily activities without being dependent on others.

Pramod Karan Sethi, the sixth of the eight children of Dr. Nihal Karan Sethi and Maina Jain, was born November 28, 1927 in the holy city of Benares (Varanasi), Uttar Pradesh. He chose to teach, and sought to make modern science available to Indian students at an under-graduate level.

Sethi graduated from Sarojini Naidu Medical College in Agra in 1949 with bachelor degrees in medicine and surgery, and with honours in surgery and six other subjects. In 1952 he applied for a fellowship at Royal College of Surgeons in Edinburgh, Scotland, and was allowed to enter on the basis of his outstanding record without repeating his under-graduate examinations as was customary. He received his F.R.C.S. from Edinburgh in 1954. After medical training in India and Edinburgh he became a lecturer in surgery at the Sawai Man Singh Hospital.

In 1958 he was asked to set up an orthopaedic department, even though that was not his speciality. Although Sethi did not have orthopaedic training, Principal of the college - one of his former teachers - prevailed upon him to take the job.

Sethi began to notice that many amputees were discarding traditionally-made artificial feet in favour of crutches so they could sit on the floor to eat and socialise. More sophisticated traditional artificial limbs can cost thousands of pounds and are often less durable, less flexible, and certainly less suited to Asians accustomed to sitting cross-legged on the floor.

Then with the help of his friend Ramchandra he started making artificial foot. After frustration and failure, they achieved ultimate success, after few years. During the Afghan war in the late 1970s, the International Committee of the Red Cross favoured the Jaipur foot because of its durability, flexibility, ease of manufacture and repair, and above all, its cheapness. The Jaipur Foot enables amputee farmers to work in mud and paddy fields, and is so flexible that wearers can quickly learn to walk with a normal gait. It normally lasts for about five years.

In India alone 72,000 amputees - mostly victims of accidents - wear the device. It can be worn with open-toe sandals, comes in different shades of skin colour, and at a quick glance is virtually undetectable. The Jaipur foot is priced very less so that even poor people can wear it. Dr. Sethi insisted on the less cost as he had no interest in becoming wealthy.

It can be made anywhere in less than an hour using everyday tools and small amounts of rubber, wood and aluminium. It has improved the lives of poor landmine victims across the world, especially in Cambodia and Afghanistan, who could never have afforded a traditional prosthesis.

Sethi presented his first scholarly paper on the Jaipur Foot at the Association of Surgeons in Bangalore in 1970. The Western India Orthopaedic Society presented him with a gold medal in 1973 and the following year international recognition was secured when he was asked to give the lead talk at the First World Congress of Prosthetics in Montreux, Switzerland. He appeared in the Guinness Book of Records for helping so many amputees gain mobility.

In 1981 Sethi was awarded the Ramon Magsaysay Award, the "Asian Nobel." He became an even bigger celebrity after a hugely popular film star, Sudha Chandra, wore the Jaipur foot when she danced in a successful 1986 Bollywood movie, Nache Mayuri. Young doctors, trained by him, have imbibed his philosophy of "indigenizing and demystifying" the delivery of services to the handicapped and have helped spread his ideas.

To work meaningfully with the artisans Sethi believes that doctors must free themselves of professional arrogance and share their knowledge with the craftsman. "The Jaipur experience," he has written, "demonstrates that the major difficulty resides in persuading the medical profession to demystify its knowledge and participate in the program with conviction and enthusiasm." He adds, "If we adopt a general policy of exhorting artisans and learn how to communicate to them our requirements they are perfectly capable of rising to the occasion and producing results with work

Dr. Sethi has served tirelessly to the poor in the Sawai Mansingh Hospital at Jaipur as an orthopaedic surgeon. His greatness is in his service as a doctor as well as the values he holds - empathy and concern towards the poor. ■

'Jamkhed' Model

Comprehensive Rural Health Program (CRHP), popularly referred to as the 'Jamkhed' model has been a pioneer in developing the philosophy, principles and practice of comprehensive community health. The model has become internationally known as a successful, sustainable approach of building the capacity of communities to address their own health needs. The improvements are sustainable, and by the community. People from all over the world come to learn from the staff and villagers about this project.

The extremely poor and drought-prone area of Jamkhed in Maharastra was constantly plagued by high rates of malnutrition, infectious diseases, maternal deaths, and occupational injuries. People lacked knowledge of basic health and access to appropriate curative care. Social injustices such as the low status of women and caste-based prejudices contributed significantly to this chronic state of ill health throughout the village communities. In spite of all these issues prevailing in Jamkhed, the community in this area was found to be the most welcoming of outsiders with their spirit of cooperation and enthusiasm towards participatory development. This greatly helped Dr. Raj and his late wife Dr. Mabelle Arole, committed to serving and uplifting India's rural poor and marginalized population, to establish the health project in Jamkhed under the name 'Comprehensive Rural Health Project (CRHP)' in 1970.

CRHP's mission is to empower communities, especially poor, women and marginalized people, to attain health in its totality. Its value-based approach transforms villages into capable and caring communities that work together to improve the health and well-being of everyone. The project's role is to facilitate and support building the capacity of the communities to enable them to assess their own problems, analyze causes, and develop appropriate action to solve them.

Initially, CRHP was covering 8 villages with a combined population of 10,000. The project rapidly expanded in its early years reaching out to a larger number of village communities. Eventually over 300 villages with a combined population of 500,000 are participating with CRHP through the selection, training and support of Village Health Workers (VHWs) and through the formation of Community-Based Organizations (CBOs) such as Farmers' Clubs, Women's Clubs (Mahila Vikas Mandals) and Self-Help Groups (SHGs).

The model of CRHP, popularly called the Jamkhed Model, was designed to operate through a three-tier approach towards health and development. At the first-tier is the community. Once a village agrees to participate and becomes a partner in development with CRHP, a Village Health Worker (VHW) is selected and receives extensive training at the CRHP training centre. The second tier is the CRHP's Mobile Health Team (MHT), which acts as a liaison between each project village and CRHP. The MHT provides periodic support for all health and development activities when needed and conducts extensive project monitoring. The third tier is the hospital and training centre located in CRHP's Jamkhed compound.

The implementation of a comprehensive community-based primary health care also entails working to improve the environment and sanitation, providing clean drinking water, education in health, legal, social, agricultural and other areas of local interest. In this context CRHP undertook four main programs. Adolescent Girls Program (AGP) is taken up under CRHP to address issues relating to gender inequity and low status of women. Girls are encouraged to participate in health education classes, are given books and provided with high-protein and nutritious food, etc. The second program is Child Development Program for self-esteem, health & development of children. Activities like learning through play and creativity, nutritious meals, building healthy relationships & eliminating negative cultural influences, a hostel for these children whose parents migrate seasonally are taken up. The third is the Appropriate Technology program. Through this program locally available resources including people and material are utilized to empower communities with tools that are useful and beneficial to their development process. And the fourth is Environment and Sanitation program which focuses on working with individual community to improve personal and domestic hygiene.

Beside the above projects, CRHP with its wealth of experiences and lessons learned over the years founded the Jamkhed Institute for Training and Research in Community Health and Population in 1992 to formalize the training that had been provided over the years. The training centre receives both national and international participants. To date, over 2,000 international (from over 100 countries) and 9,000 national health and development workers have been trained in diploma, certification, short-term exposure courses and custom tailored training.

The impact of CRHP seems to be on every aspect of healthy life–social, economic, physical, and spiritual. About 80% of health problems are effectively taken care of and monitored by the villagers themselves by well-trained and confident VHWs who succeeded in reducing the birth rate to 25 and the death rate to 8 per 1000 population. This project also led to the coming up of similar projects in India and abroad. The comprehensive health care focussing on improving the overall quality of life through complete participatory processes for over 35 years and its strong impact on development of society can be seen as the success of CRHP. Jamkhed, in spirit and action, believes in making people self reliant where the community is enabled and empowered to work for its own development. ■

Entrepreneurs! Collectives!

India is praying for monsoon showers, with drought in the horizon!

The temperatures have cooled down, with the flowing monsoon with occasional showers and some drizzles. Reservoirs are still almost empty. The power cuts and water supply cuts continue, all over.

Arguably the greatest entertainer of the history, Michael Jackson, calls it a day on 25 June 2009. Amidst controversies around his life earlier and now around his death, MJ could 'entertain' more than a billion people all over the world, and inspire a good percent of them! His final message – spread love, and therefore, joy; heal the world.

As we live the month, International Day of Cooperatives (4 July – first Saturday of July) and World Population Day (11 July) pass by.

Delhi High Court has set aside application of Section 377 of Indian Penal Code for Consensual Sex amongst adults irrespective of their sex and sexual orientation. Supreme Court and Government of India are mulling over it.

Perspectives

G. Muralidhar

Meanwhile, Cabinet has approved the Bills for Food Security Act and Right of Universal Education Act. We have to see the discussions that ensue and the final shape they take. Yashpal Committee (Committee to Advise on the Renovation and Rejuvenation of Higher Education) Report has been submitted. The Committee recommends merger of UGC and AICTE and creation of National Commission for Higher Education and Research, with a Constitutional Status. They discuss - mushrooming engineering and management colleges, and Deemed Universities, with some notable exceptions, have largely become, mere business entities dispensing very poor quality education. It further highlights –

> Besides making people capable of creating wealth they have a deep role in the overall thinking of the society and the world as a whole. This job cannot be performed in secluded corners of information and knowledge. It would be silly to deny the practical role of experts in areas of science, technology, economics, finance and management. But narrow expertise alone does not make educated human beings for tomorrow. Indeed, speaking more seriously, one could almost say that most serious problems of the world today arise from the fact that we are dominated by striations of expertise with deep chasms in between.
>
> …. Hidden in small places, in obscure schools, colleges and universities, there are potential geniuses to be discovered. Many of them could be the great knowledge creators of tomorrow. We have to discover and implement ways that would not put useless hurdles in their path.
>
> …. Stand-alone single discipline institutions should try to broaden themselves to provide a more wholesome education to their students and thus qualify for the title of a degree giving university.
>
> …. in order to enrich our higher education we might invite from abroad a substantial number of potentially great academics and scientists to work with our students and teachers.

A report that can make a huge difference! Government of India responded that it would implement the same in toto.

We hear that Government is contemplating, rather seriously, a National Rural Livelihoods Mission (NRLM). It can take the responsibility for enhancing livelihoods of the poor, thereby reducing poverty, and improving National Rural Employment Guarantee Act provisions and implementation, and Skill Development Mission and creating jobs for the youth, and integrating them with the community institutions and collectives. It is expected that the mandate of organizing poor women (50% now, i.e. 40-50 million of them, as indicated in the Budget) into SHGs, their higher order federations at village, block, district, state and national levels, will be with the NRLM. It is also time to hire 25,000 development workers/professionals, @1 per 10000 families, to really begin the processes of bottom-up planning, facilitating the people in their communities and neighborhoods to analyze their current reality/livelihoods situation, identify the gaps and opportunities, plan and consolidate them to develop district plans, state plans and national plan. Further, 2.5 million development community leaders/animators can be nurtured and be involved with the communities in the process now and later in facilitating community collectivization processes.

2009-10 Budget Papers submitted to Parliament quote Gandhi on the cover page – "Democracy is the art and science of mobilizing the entire physical, economic and spiritual resources of various sections of the people in the service of the common good of all". Budget is one tool of this democracy in that pursuit. In difficult times, exciting times, and challenging times, like the times NOW, one area of concern is sourcing and inducting the dominant talent that can mobilize these physical, economic and spiritual resources and apply them for the common good. Second set of human resources that need to be identified and nurtured is the entrepreneurs from within the community. We should appreciate that the human beings are multi-dimensional and no one solution will suffice all.

The Budget focuses on some goal posts, in the domain of inclusive development –

- Slum free India in five years
- Direct transfer of subsidy to farmers in due course
- Improved NREGA for all with Rs.100 a day as a real wage for 100 days for each working adult
- National Food Security Act -25 kgs of rice/wheat a month at Rs.3 a kg to poor
- Pradhan Mantri Adrash Gram Yojana in 1000 villages with 50%+SC population
- National Rural Livelihoods Mission, restructuring SGSY, focused on organizing 50% of all women into SHGs, bank linkages and interest subsidy

- Rs.500 Crore to Rashtriya Mahila Kosh as corpus
- National Mission on Female Literacy to reduce female illiteracy by half in three years
- Universalization of the Integrated Child Development Services Scheme to every child under the age of six, in three years
- Interest-free education loans to access higher education, reaching out to 5 lakh students
- Implementation of Unorganized Workers Social Security Act. It may be noted that the unorganized or informal sector of our economy accounts for 92% of the employment in the country.
- Mega handloom cluster each in West Bengal and Tamil Nadu, one powerloom mega cluster in Rajasthan and one mega cluster each for Carpets in Srinagar and Mirzapur.
- Rashtriya Swasthya Bima Yojana (RSBY) for all BPL families
- Eight National Missions towards adapting to Climate Change and enhancing the ecological sustainability
- Unique Identification Authority of India (UIDAI) for providing unique identity numbers to each and every Indian resident
- Goods and Services Tax (GST) from 2010
- The Budget Estimates 2009-10 provide for a total expenditure of Rs.10,20,838 crore
- The revenue deficit as a percentage of GDP is projected at 4.8%. The fiscal deficit as a percentage of GDP is projected at 6.8%.

Lots of encouraging intentions in Budget and we have to wait and watch how they unfold during the year. On the other hand, railway budget remained passenger friendly.

Collectives, Employment, Education, Economy, Environment, Entrepreneurship, Human Resources and Marginalized Communities continued to hog the most of our time during the month.

It has been re-confirmed - Entrepreneurship and Enterprises are not very different from leadership and organizations. The stages of the group/team/organization – form, storm, norm, perform, followed by deform or reform/transform are equally applicable to enterprises. The groups/teams/organizations require leaders/leadership to lead them and the enterprises require entrepreneurs/entrepreneurship to deliver. The threshold competencies, the entrepreneurs and their facilitators require, include – tenacity, self-control, strategic influencing, concern with impact, initiative, critical information seeking, and the ability to see big picture and at the same time dig deeper. Entrepreneurs may have to have results orientation and the facilitators – development orientation. Facilitators may also shift between being 'karta' and 'akarta'. Both of them need to have People's Skills and Team Management Skills.

The processes for taking the bright (but poor) minds and helping them to be future leaders have also been very similar. The competencies they look for include – drive, conviction, resilience, emotional intelligence, integrity, optimism, openness. These are similar to those applicable to entrepreneurs, business leaders and social entrepreneurs.

Social Entrepreneurs are slightly different from other entrepreneurs, in terms of their basic orientation of creating social value, not necessarily economic value. One broad definition I liked the best is – social entrepreneur is an innovative, social value creating change agent, in the constant pursuit of opportunities, not limited by her/his current resource endowment, with a sense of accountability. The successful social entrepreneurs - all successful development facilitators, public service providers and political leaders are social entrepreneurs in some degree – are dreamers, decisive, doers, determined, dedicated, devoted, detail-hungry, in-charges of destiny, concerned about sustained dollars (revenue), and distributors of ownership. They are focused, fast (in decisions, not hasty), flexible, forever innovating, flat (organization), frugal, friendly, fun (place), and founders (supportive co-founders).

Not just the poor, the entrepreneurs need to be in collectives. The facilitators need to be in their networks. The leaders need other leaders to be in groups. The social entrepreneurs are social animals and they need to find other social entrepreneurs so that they grow, perform and transform.

It comes back again - we need to acknowledge that some are potential entrepreneurs, some are potential self-employed service providers (individually and/or in groups), and some are potential job holders in enterprises or with the service providers, promoted by entrepreneurs or community collectives. They need to be supported differently. The facilitators, therefore, have to first focus on understanding the current reality and appreciating the gaps and opportunities, together with the communities and the potential entrepreneurs, job-seekers, best practitioners and opinion makers. Then they need to build the vision for the community (in groups) and the entrepreneurs, and support them in realizing the vision(s).

Social Business, no matter what you say or do, is a matter of joy. And we, the thinking and sensitive individuals, should pursue joy. Then, we need to pursue getting more and more people into this. We need to pursue the existing social business leaders to scale-up. Here, we need to reconcile that some are good to initiate and deliver the prototypes, pilots, etc.; some are good in taking them to scale; some are good to manage and maintain them; some are good to implement 'exit'/'wrapping-up'/'winding-up'. Some of them, rarely, can transform themselves to play these multiple roles. We need to figure these various people and pursue them differently. They also have to be nurtured to learn and acquire capabilities to deliver. They need to learn to pursue significance. They also need to be oriented to ecological, economic and social integrity that helps the poor, marginalized and disadvantaged. They need to become, and remain biased in favour of this. They need to be exposed to the functioning of the businesses. After all social business is a business too!

We belong together, yet we are not identical. We need to be together so that we meet each other's needs, yet we play our own roles within the team. We may be a facilitator, leader, entrepreneur, employee in an enterprise, manager of a collective or an active member.

Whatever we are, we need to pursue meta-fishing, beyond fishing to survive. We need to become enterprising and entrepreneurial (within/without). We need to be in collectives, teams, groups. We need to learn and mentor learning. Tirelessly! Persistently! Repeatedly! Again and Again! ■

Primary Healthcare

Health is an important dimension of well being. Health is instrumental in generating higher incomes as it increases people's productivity. Therefore preserving good health of people and quickly recovering in the case of ill-health are development goals and measures of successful development. However health wise the picture of India is miserable. There is a huge gap in the provision of primary health care services to the people, especially to the poor. "livelihoods" took a look into the delivery of primary health care services to the poor and its impact on their livelihoods...

Health is an important dimension of well-being. As the saying goes "If wealth is lost, nothing is lost. If health is lost is everything is lost". A healthy individual can live and enjoy a fruitful life. A healthy individual has a higher capacity to work and thus contribute to the growth of society and the nation. In India, where many people earn their livelihood using physical power, being healthy is often a question of survival. Health is also instrumental in generating higher incomes as it increases people's productivity. Therefore, preserving good health of people and quickly recovering in the case ill-health are development goals and measures of successful development.

Given its importance, good health is now recognized as a human right. On the 12th of September, 1978, the International Conference on Primary Health Care held in Alma-Ata, in the erstwhile USSR, adopted the 'Declaration of Alma-Ata' which proclaimed a positive view of health as complete physical, mental and social well being and a human right. The declaration envisaged primary health care as the first level of contact between individuals and families on one hand and their country's health system on the other. According to this declaration, primary health care was to have its basis in the community it served; and the notion of primary health care included maternal and child care including family planning, immunization against major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, provision of essential drugs, education concerning prevailing health problems and ways to deal with them, provision of adequate food and nutrition and adequate supply of clean water. India is among the countries ratifying this declaration.

- Over a quarter of all Indians fall into poverty as a direct result of medical expenses in the event of hospitalization.
- Cost associated with medical treatment is the most important cause of rural indebtedness, next only to dowry.
- Annually, 1.5 million deaths and loss of 73 million workdays are attributed to water-borne diseases.
- The total expenditure on health in India as a percentage of GDP is almost 5%, with 75% of it being private health expenditure.
- Of this, 97% is spent out-of-pockets and that too in the absence of any significant contribution by health insurance.

In India, the protection of human right of good health is provided by the Public Primary Health Care System (PPHCS), which been developed as a three tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC). These are the three pillars of Primary Health Care System. While Sub Centres are the most peripheral contact point between the Primary Health Care System and the community, PHC is the first contact point between village community and the Medical Officer. Manpower in PHC includes a Medical Officer supported by paramedical and other staff. CHCs provide specialized medical care services like that of the Surgeons, Obstetricians, Gynaecologists, Physicians and Paediatricians.

When the right to good health is not provided for, as is in the case of most people living in poor developing countries, people are reduced to penury by illness. For such persons, illness is a permanent threat to their income earning capacity, and also leads to a spurt in expenditure that pushes them into extreme poverty, from which they can never recover. Besides the direct costs for treatment and drugs, the household also loses the income from both the person who is ill and persons who support such persons. In India, over a quarter of people fall into poverty as a direct result of medical expenses in the event of hospitalization. Costs associated with medical treatment is the most important cause of rural indebtedness, next only to dowry.

The progress in India with respect to providing for the right to health is miserable. According to a recent UNICEF report, in our country, one woman dies every seven minutes due to child birth complications. One million children born in India are dying every year before they become 28 days old. The infant mortality rate is 60 per 1000 live births. Maternal mortality rate in India is 254 per 100,000 live births and is one of the highest in the world. Malaria and Tuberculosis claim more than 500,000 lives every year. There are an estimated 4 million HIV positive cases in India and their numbers are expected to grow rapidly. India is one of the four countries worldwide where polio has not yet been successfully eradicated and one third of the world's tuberculosis cases are in India.

Though safe water and sanitation facilities are important for leading a healthy life, these are far away for millions of Indians even today. About 80% of sickness in India relates to waterborne infections. Annually, 1.5 million deaths and loss of 73 million workdays are attributed to waterborne diseases. One in every four persons dying of waterborne infections is an Indian.

Even though primary health care provided by the government is free, in India many households incur substantial expenditure on health from their own pockets as the public primary health care facilities are not accessible to millions of households even now. With the shortage of PHCs, and the staff, infrastructure and equipment in such PHCs, many people are forced to accessing health care facilities from private health care providers.

With the poor falling through the cracks in PPHCS, they spend a very high proportion of their household income compared to the rich towards treatment of illness. One occurrence of common illness like viral infections, jaundice, old age health conditions like cataract, or reproductive health requirements can plunge people into poverty. To pay for medical care, people often borrow at high interest rates. Sometimes they even sell their productive assets. This pushes them deeper into poverty, from which recovery is a gargantuan exercise. There are hardly any health insurance and risk coping mechanisms available for the poor in India. While a number of health insurance schemes are available to the organized sector, the unorganized masses that do not have insurance coverage are driven into the arms of the exploitative private sector.

This situation of high spending on health by the poor is not limited to one particular state or region. Across the country and across the communities - rural, urban and tribal - the picture remains the same. In rural areas, poor people work in

HR gaps in Delivery of Primary Healthcare

At Sub center level

Shortfall in the posts of HW (Female)/ANM of the total requirement – 12.6%

Shortfall in the posts of HW (Male) of the total requirement – 55.4%

Shortfall in case of Health Assistant (F) – 32.8%

Shortfall in case of Health Assistant (M) – 28.8%

Sub centers without a female health worker/ ANM – 5%

Sub centers without a male health worker – 28.8%

Sub centers without both female and male health worker – 4.7%

At PHC level

Shortfall of doctors at PHC level – 7.8%

PHCs without a doctor – 5.6%

PHCs without lab technician – 40%

PHCs without a pharmacist – 17%

At CHC level

Shortfall of surgeons of the total requirement – 59.2%

Shortfall of Obstetricians and Gynecologists – 46.4%

Shortfall of Physicians – 56.6%

Shortfall of Pediatricians – 51.9%

Shortfall of other specialists – 64.8%

(As on March 2007)

the most hazardous conditions and live in abysmal living conditions. Unsafe and unhygienic birth practices, unsafe drinking water, poor nutrition, sub-human habitats, and degraded and unsanitary environments are challenges to the public health system. The majority of rural deaths, which are preventable, are due to infections and communicable, parasitic and respiratory diseases. Infectious diseases dominate the morbidity pattern in rural areas (40% rural: 23.5% urban).

Health situation of urban poor is not very different. The urban poor mostly comprising of migrant population live in unhealthy conditions. Most of them live in slums with no sanitation facility, access to safe drinking water and clean environment. They are more prone to diseases, as they are already under stress trying to cope with new surrounding, food habits, work culture, and totally a new way of life. They are worst affected with no access to public health facilities. Two basic points have to be proved to access public health facility, the *first* is that they belong to /residents of that ward/ area and the *second* that they are eligible to be enrolled under BPL list. As both these are not easy for the slum dwellers to prove they are unable to access public health facilities even though they need it the most.

Another issue with PPHCS in India is that it concentrated only on curative health care and in one system of medicine, ignoring completely the practices adopted by the people. Poor people of India in general, and rural and tribal populations in particular, have their own beliefs and practices regarding health. There has been no effort to validate the efficacy of these practices and encourage/ conserve the good practices among them. As is well known, some tribal groups still believe that a disease is always caused by hostile spirits or by the breach of some taboo, and therefore seek remedies through magico-religious practices. Similarly, some rural people have continued to follow rich, undocumented, traditional medicine systems, in addition to the recognized cultural systems of medicine such Ayurveda, Unani, Siddha and Naturopathy, to maintain positive health and to prevent disease. Further, the naturally existing healthy environment has been endangered by the socioeconomic, cultural and political onslaughts, arising partly from the erratic exploitation of human and material resources.

To compound the woes of PPHCS, Government spending towards public health is not adequate and is showing a decreasing trend. The current public spending on health in India is less than one percent of GDP which is 18th lowest in the world. The total expenditure on health in India as a percentage of GDP is almost 5%, with 75% of it being private health expenditure. Of this, 97% is spent out-of-pockets and that too in the absence of any significant contribution by health insurance. In comparison, the most developed countries, public sector accounts for the major share of health expenditure. For example, in the UK more than 85 percent of the total health expenditure is borne by the public sector. The United States is the only developed country where the share of private sector is more than the public sector. Even in the USA the public sector accounts for about 45% of the total health expenditure, and the balance is mainly borne by the insurance sector. Among developing countries, India is one among the few where private sector dominates the health sector. The National Health Policy 2002 proposes to raise public expenditure on health as a percentage of GDP from the present 0.9 percent to 2.0 percent by 2010. This is still very low given the burden of disease in India in the present and in the future, even with the current conservative estimates of HIV/AIDS infected people in India. In the case of medical research, a similar trend is observed. While 20% of research grants are allocated to studies on cancer, which is responsible for 1% of deaths, less than 1% is provided for research in respiratory diseases, which accounts for 20% of deaths. Short fall in government expenditure has severely affected the infrastructure and health services. Though there is considerable progress in the number of Sub centres, PHCs and CHCs, they are suffering with huge manpower deficit.

Another factor affecting the health expenditure of people is the spread of the PHCs. Though India is predominantly rural, majority of health centres are located in urban areas. There are only 585 rural hospitals compared to 985 urban hospitals in the country. The availability of primary health care facilities in tribal and backward areas of the country is minimal or absent. Even though there are sub centres and PHCs in these areas, they are suffering with a critical problem of staff shortage as the medical personnel do not want to work in remote rural and tribal areas. Apart from these issues, many PHCs suffer with lack of even basic infrastructure, drugs and vaccines. It is sad to see many rural PHCs not having anti-rabies vaccines and medicine for snake bite whereas these incidents are very common in rural areas.

More over quality control mechanisms are absent in India's health system. Private sector is largely unregulated and even in the public sphere there is little public enforcement to ensure appropriate standards. The Medical Council of India, the main body overseeing standards of care, has no process in place whereby the competence of doctors is assessed respect to current standards of care when they renew their registration. In a 2005 study, World Bank reports that "a detailed survey of the knowledge of medical practitioners for treating five common conditions in Delhi found that the typical quality doctor in a public primary health centre has a more than 50-50 chance of recommending a harmful treatment". The competence rating of India's public health care system

doctors is below Tanzania's. To worsen the situation, unannounced visits by government inspectors showed that 40% of public sector medical workers could not be found at the workplace.

What is more pinching the pockets of the poor, in addition of the above gaps in PPHCS, is the quality of the services offered in the system. Due to bad quality, many people, though they cannot afford it, are opting for private health care providers. According to National Family Health Survey II, only a third of low income households reported using a government health facility. According to a World Bank study, 79 percent of all outpatient care among the poor is provided by the private sector. Clearly, it is the poor quality of care provided by the public health system which pushes people towards making greater use of costlier health care facilities provided by the private sector.

The present system of health care also lacks scope for the involvement of the community, and for grassroots level health workers to take ownership of the programs and integrate them with overall development. As a result, the basic requirements of decentralized people based, integrated curative, preventive and promotive services have been totally undermined by the 'vertical programs'.

As health contributes much to the country's economic growth by increasing productivity of the people, governments should take measures to ensure qualitative preventive as well as curative health care service to each and every citizen at free of cost. First and foremost, the governments have to win over the trust of poor people that it can efficiently and effectively provide quality health services. Improvements to PPHCS are more critical as the burden on PPHCS in future is likely to increase with the aging population, mental illness and non-communicable diseases adding to the cause of concerns.

Ineffective access to health care services is a serious threat to country's economic growth. To continue the high growth achieved in recent years, India needs to scale up, reorient and reform its public health system, especially in the provision of primary health care services with particular focus on women's and children's health.

Several interventions related to PPHCS are required to promote and sustain secure livelihoods of the poor. As the bulk of the Indian population lives in rural areas, provision of essential health services through sub-centres and PHCs is crucial for any access to health care services for most people. Number of these centres should be increased and required staff should be positioned at each centre. Since many nongovernmental organizations (NGOs) already work closely with the poor, Governments may opt to support them to deliver health services to poor and vulnerable segments of society.

Facilities available in the rural areas need to be improved. Most of the medical personnel do not want to work in rural areas because of the lack of even basic facilities like drinking water, electricity, good education for their children, etc., in these areas. Abdul Kalam's PURA (Providing Urban Amenities in Rural Areas) provides an answer to this problem. The governments cannot push people to work in harsh conditions without providing proper facilities. Hence governments should invest in improving the facilities in rural areas if they have a serious concern towards people's health and economic growth.

Education plays an important role in improving health conditions of a community. There is lack of knowledge about

Livelihoods Around Health

- ASHA Workers
- Anganwadi workers
- Female Health workers
- Male health workers
- Bedside patient assistants
- Geriatric care specialists
- Nurses, ANMs etc
- Allopathic doctor
- Naturopathy doctors
- Homeopathy doctors
- Hakims
- Siddha doctors
- Gyms
- Physiotherapy centres
- Masseurs
- Aroma therapy centres
- Yoga centres
- Health food- Traditional cuisine
- Herbal gardens
- Cultivation of medicinal plants
- Collection of NTFP
- Micro enterprises
- Pharmacists
- Medical representatives
- Staff of Pharmacy companies

National Rural Health Mission

Health care was one of the seven thrust areas of National Common Minimum Programme (NCMP) of UPA Government, wherein it was proposed to increase the expenditure in health sector from current 0.9 % of GDP to 2-3% of GDP over the next five years, with main focus on Primary Health Care. The National Rural Health Mission (NRHM) has been conceptualized and the same is being operationalised from April, 2005 throughout the country, with special focus on the following 18 states: Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttar Pradesh and Uttaranchal.

The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care, especially to poor and vulnerable sections of the population. It also aims at bridging the gap in Rural Health Care through creation of a cadre of Accredited Social Health Activists (ASHA) and improve hospital care, decentralization of programme to district level to improve intra and inter-sectoral convergence and effective utilization of resources. The NRHM further aims to provide overarching umbrella to the existing programmes of Health and Family Welfare including RCH-II, Malaria, Blindness, Iodine Deficiency, Filaria, Kala Azar T.B., Leprosy and Integrated Disease Surveillance. Further, it addresses the issue of health in the context of sector-wise approach addressing sanitation and hygiene, nutrition and safe drinking water as basic determinants of good health in order to have greater convergence among the related social sector Departments, i.e. AYUSH, Women & Child Development, Sanitation, Elementary Education, Panchayat Raj and Rural Development.

one's own body, about common vector borne, and water borne diseases, and also about preventive and curative measures. Due to lack of validation of traditional methods, people are increasingly depending on Allopathic and other doctors. Persons in the higher income group do not have faith in the traditional practices, and do not use the same. This is a result of the traditional practices not getting validated, and even when validated not receiving adequate publicity. In their quest to modernize, other groups also imitate the westernized higher income group. Education helps reduce health inequalities because it enables people to obtain safer, better jobs, have better health literacy, take preventive health care measures, avoid riskier health behaviours, and demand more and better quality health services. Hence investing in education is a must if we want to create healthier India.

NGO's have played a significant role by demonstrating models of providing both preventive and curative health programs. They have mobilized community resources in innovative ways to improve the health of the poor. These approaches have included intensive training of community based health workers, the involvement of traditional healers, and local delivery of services. Some of these projects have achieved dramatic results by reorganizing existing health resources to better meet the needs of poor clients. These initiatives need to be scaled up across the country. They need to continue playing this role as well as pressurize government to adapt a viable model to ensure good health for its population.

Health insurance is emerging to be an important financing tool in meeting health care needs of the poor. Neither market mediated nor government provided insurance is an appropriate way of reaching the poor. Community Based Health Insurance (CBHI) is more suitable arrangement for providing insurance to the poor. Health insurance scheme for the poor should take care of not just the inpatient or hospital care but also of the outpatient care. It is often suggested that insurance be provided only for inpatient care and that outpatient care be left outside the ambit of insurance. The reasons given are: that people can, by and large, afford out-patient care because it is relatively inexpensive; it is the inpatient care that pushes them into poverty trap; that administratively it is difficult to include outpatient care; and, that out-patient care would lead to cost escalation. Ideally, both inpatient care and outpatient care be covered, and the decision of whether or not a patient needs hospitalization be professionally made and should not be a function of whether or not the patient has health insurance cover.

Most importantly it is necessary to resurrect, conserve and validate the traditional medical knowledge of communities and improve the skills of traditional healers in the rural remote areas so that they can address immediate health needs of the people living in those areas.

Therefore, if we are concerned about poverty reduction and economic growth, we have to invest substantially in people's health now. Thankfully, the National Rural Health Mission is offering some hope. People are also increasingly becoming health conscious. At least now the governments, NGOs and CSOs should react and saturate availability of health infrastructure, and provide health insurance to each and every citizen of the country, apart from training community resource persons in health and related aspects. Further, we should invest our time, money and energy in reorienting and reforming our public health system. ■

‘I Never Let Myself Down’

Optimistic and hardworking, Pandar Mashna’s dream is to own a business. Having migrated from his native village in Nanded district, Maharashtra to Hyderabad, he faced several hardships to sustain himself in the unknown place. ‘livelihoods’ interviewed him to learn his trials and tribulations in sustaining himself in Hyderabad and his learnings during this time.

Q: What is your name? Why did you shift to Hyderabad?

A: My name is Pandar Mashna. I am from Wazaer village, Nanded district in Maharashtra. I came to Hyderabad in 2004 when I was 15 years old to find work. I had to find ways to support my family economically and was determined to search some work. Hyderabad is the city nearest to my place - a city where jobs are available. I heard that a lot of people from my district migrated to this place and could find work. Having heard this, I also decided at that time to come to Hyderabad.

Q: What is your education?

A: I completed my primary education from Zila Parishad Vidalaya in Wazaer and completed 10th from Lal Bahadur Vidalaya, Wazaer. I am now studying Intermediate first year in distance mode. I study when I get some time.

Q: How many family members do you have?

A: There are four members in our family. My father is 42 years old, my mother is 34, I am 20, and my younger brother is 18.

Q: What is your father and tell more about your family?

A: My father is a wage labour. Earlier, he leased in some land, on which he used to produce jowar and cotton. I used to help him in various farm related activities after my school. From this small agriculture and wage labour, we could manage to earn Rs.3,000 per month. But gradually income started declining due to various reasons and responsibility shifted on to me to earn and sustain the family.

Q: What was the problem you faced in first few months after coming to Hyderabad? Did anyone help you in Hyderabad?

A: I had no idea about the city when I first came. As I knew no one, I had no place to stay and sleep. With this, I faced lot of problems initially for food and sleep. These situations hardened me. At that time, I could only think of getting some work. I have lots of dreams and so I could never let myself down in any circumstances. Getting work was tough as I was a stranger to the city. Within a few days of my arrival, I was fortunate to develop contact with two good people in Hyderabad. This helped me get some regular work and a place to stay, and put the initial hardships behind me. I still approach them for any guidance and help.

Q: What is your condition now?

A: I started working at a shop. In the beginning, I used to earn Rs.600. Now I am earning Rs.2,500 per month by working in two shops. In the shop, I supply food to the customers, take care of food items, bring required goods from the market, etc. Starting at 5.30 a.m., I work till 11.00 p.m. To save on the time required to travel, I have chosen to work for two shops that are near to each other. As I have to spend very little time on travel, I have some more time to work every day and this gives me an opportunity to earn a little more money by the end of the month.

After I settled down, I brought my family to Hyderabad. My brother has also started also contributing to the income of our family. At present, everything is going smooth. I am unmarried and want to remain unmarried for another three to four years.

I am trying to save some money for my education and future requirements. Saving is my main concern now as it will help me to start my own business. I am trying hard to fulfil my dreams.

Q: Tell us about any difficult situation you faced after coming here and your learnings from that incident.

A: Once, my mother fell ill, and her situation deteriorated by the day. When I took her to a doctor, he dropped the bombshell - the estimated cost of my mother’s treatment was Rs.20,000. That time, my income was very less but I managed that amount from one well wisher of mine and I promised him to pay Rs.3,000 per month. My mother was thus saved. I had to work hard to repay the debt and also taking care of my family at the same time. Therefore, I started working overtime and also started taking more responsibilities in the work that I was doing. That helped me out to pay back my dues gradually.

This incident made me realise that I could take up multiple works and earn a little more. Further, this also taught me the need for savings. I also learned many things from this experience, like always be good to people; be polite; help people in their needs and problems, etc. But more importantly, the incident showed that I could - with some more perseverance - achieve my dream. If I was able to raise Rs.20,000 loan and pay it off, I can save enough to start my own shop.

Q: Are you still continuing with the same job?

A: My dream is to start my own shop. For that I need to learn more and develop my skills; I need to understand business from my shop owners. Hence, I have been working for last five years in the same field. ■

The Divine Tree 'Neem'

Neem (Azadirachta indica, syn. Melia azadirachta L., Antelaea azadirachta (L.) Adelb.) is a tree in the mahogany family Meliaceae. It is one of two species in the genus Azadirachta, and is native to India, Myanmar, Bangladesh, Sri Lanka and Pakistan growing in tropical and semi-tropical regions. Neem is a fast-growing tree that can reach up to a height of 15-20 m (about 50-65 feet), and rarely to 35-40 m (115-131 feet). It is ever green, but in severe drought it may shed most or nearly all of its leaves. The branches have white and fragrant flowers, normally each branch bears from 150 to 250 flowers. The fruit is smooth which varies in shape from elongate oval to nearly round, and when ripe is 1.4-2.8 x 1.0-1.5 cm.

The Neem is a life giving tree, especially for the dry coastal, southern districts. It is one of the very few shade-giving trees that thrive in the drought prone areas. Neem can grow in many different types of soil, but it thrives best on well drained deep and sandy soils. It is a typical tropical to subtropical tree and exists at annual mean temperatures between 21-32 °C. It can tolerate high to very high temperatures and does not tolerate temperature below 4 °C .

All parts of the tree (seeds, leaves, flowers and bark) are used in different medical preparations. In East Africa it is also known as Mwarobaini, which means the tree of the 40, as it is said to treat 40 different diseases. Neem oil is used for preparing cosmetics (soap, shampoo, balms and creams), and is useful for skin care such as acne treatment, and keeping skin elasticity. Practitioners of traditional Indian medicine recommend that patients suffering from chicken pox sleep on Neem leaves. Neem gum is used as a bulking agent and for the preparation of special purpose food (those for diabetics). Aqueous extracts of Neem leaves have demonstrated significant anti diabetic potential. Traditionally, teeth cleaning were conducted by the chewing of slender Neem branches. Neem twigs are still collected and sold in markets for this use, and one often sees youngsters in the streets chewing on Neem twigs. A decoction prepared from Neem roots is ingested to relieve fever in traditional Indian medicine. Neem leaf paste is applied to the skin to treat acne. Neem blossoms are used in Andhra Pradesh to prepare "Ugadi Pacchadi". Extract of Neem leaves is thought to be helpful as malaria prophylaxis despite the fact that no comprehensive clinical studies are yet available.

Neem derivates neutralise nearly 500 pests worldwide, including insects, mites, ticks, and nematodes, by affecting their behaviour and physiology. Neem does not normally kill pests right away; rather it repels them and affects their growth. Neem oil has been found to be an effective mosquito repellent. As Neem products are cheap and non-toxic to higher animals and most beneficial insects, it is well-suited for pest control in rural areas. Moreover, the Neem tree is of great importance for its anti-desertification properties and possibly as a good carbon dioxide sink.

In several parts of peninsular India, Neem seed is a source of income for the poor. The fruit (seeds), available mostly as

Inputs	Pre-processing	Processing	Marketing
♦ Broom (to sweep) ♦ Jute bags/Bamboo baskets (for collection) ♦ Shed (to store) ♦ Wire mesh (to filter) ♦ Tractor (for crushing, to carry seeds/Products to market place) ♦ Labour-Days (to carry out the entire process)	♦ Collection of ripe Neem seeds ♦ Store them in a dry place.	♦ Keep the seeds on a dry floor ♦ Dry the seeds ♦ Remove the dirt from it ♦ Crush the seeds under tractor ♦ Collect the fine Neem powder in a bag ♦ Store it in a dry place. ♦ Extract oil out of the seed.	I.Sell the seeds to a middleman or an organization II.Sell the Neem powder to farmer, middlemen, and different organizations. (This pays more than selling the dried seeds directly) III. Extract oil and sell (to fetch more income).

Gaps in Neem seeds collection:

- No institutional credit support
- Collectors don't know about quality and its management.
- Collection by sweeping: lot of impurities get collected.
- No gunny or carry bags for easy carrying of the produce to home.
- No infrastructure facilities such as godowns for storage and drying platforms for drying the produce.
- Not insisting on the use of standard weights while selling in the village
- Low price for the produce
- Payment is not always in terms of cash (non-cash payments), in case of cash payments it is likely to be delayed.
- Distress or tie-up sales
- No collective selling
- Not selling in the wholesale market
- Market information of the commodity is not known to the collectors.
- Though the people are using neem leaves and fruit for many purposes, they are not aware of the scientific benefits of the pulverized neem powder, oil and de oiled cake. Therefore they are not worrying of processed value addition.
- Not using neem as bio-fertilizer despite their awareness of its benefits/ usefulness.

Interventions for Neem seed collectors

- Providing access to institutional credit
- Providing collecting bags or baskets, water cans, and drying sheets
- Addressing food security through PDS, RCL or through convergence with any other scheme.
- Demonstrations of better collecting practices
- Infrastructure development such as godowns, drying platforms, procurement centers, transportation facilities etc.
- Proper drying and cleaning.
- Imparting knowledge of various products and intermediate products of the commodity and their market value.
- Imparting market information including market demand, rates, grading practices, etc.
- Collective selling and using weights.
- Providing information of how to deal with the market agents and agent commission and training on accounts and cost and benefit analysis of their produce.
- Providing information of neem powder and oil companies and linkages with the companies directly.
- The neem collectors can directly sell the processed product to the fertilizers dealers and they can use in their own fields which would cost them less than the market price.
- Propagating the uses and best practice of neem powder and oil.

common property resource, are collected by the poor, dried and sold. Some people sell it after cleaning the fruit by removing filth and other waste. A few collectors process the Neem seeds into seed powder or crush it to obtain Neem oil. Where Neem oil is obtained using industrial process, the de-oiled cake is obtained as a by-product and can be used as organic pesticide or as insecticide. The selling of the seeds can take place soon after drying and cleaning to the middlemen or they can sell after crushing the seeds into fine powder directly to farmers, middlemen and to organizations. In a week a person can collect 100 to 150 kg of Neem seeds and can earn Rs.300 to Rs.400 per week. The importance of the activity of collection and sale of Neem seeds arises from the fact that most people engaged in this activity are old and infirm persons. Some times, children engage in this activity in their free time.

Some Best Practices in Neem Seed Collection:

- Hand picking and taking care to avoid dust
- Drying and storing
- Cleaning and drying
- Demanding for weights and high rate for commodities
- Collective selling to whole sellers
- De-pulping and using powder as bio-fertilizers

There is a lot of demand for Neem seed from industries situated in north India. States from peninsular India are the suppliers. Several interventions are possible to benefit the Neem seed collectors and small processors. ■

FRLHT

Foundation for Revitalization of Local Health Traditions (FRLHT), with its vision to revitalize Indian medical heritage, is contributing towards better health situation in India and doing it by enhancing the quality of health care and medical relief in rural and urban India and globally by creative application of India's rich health sciences .

Biogeographically, India is situated at the tri-junction of the Afro-tropical, the Indo-Malayan and the Paleo-Arctic realms. Because of its proximity to all three realms, India possesses a unique assemblage of characteristic elements of biodiversity of each of them. India ranks tenth in the world and fourth in Asia in biodiversity where 47,000 species of plants and 89,000 species of animals are found. With this biodiversity condition, India has many valuable herbs and medicinal combinations. The creation of healthcare using these herbs and medicines has been practiced since long time and now it has become one of the healthcare systems in India – the traditional healthcare system.

Along with other healthcare systems, India's traditional healthcare system has enormous contemporary relevance and therefore must occupy the rightful space and be available to the Indian and global community. Foundation for Revitalization of Local Health Traditions (FRLHT) took up interventions towards making this happen. FRLHT with its vision "to revitalize Indian medical heritage", is doing it by creative application of India's rich health sciences via research, post graduate education, training and Community services. Applying this knowledge to community health services, FRLHT is enhancing the quality of healthcare and medical relief in rural and urban India and globally.

FRLHT, a registered Public Trust and Charitable Society, started its activities in March 1993. The Ministry of Science & Technology recognizes FRLHT as a scientific and industrial research organization. The Ministry of Environment and Forests and the Ministry of Health have designated FRLHT as a National Centre of Excellence for medicinal plants and traditional knowledge, and Ayurvedic Geriatrics respectively.

FRLHT has identified three thrust areas to fulfil the vision. These are **demonstrating** contemporary relevance of theory and practice of Indian Systems of Medicine [D], **conserving** natural resources used by Indian Systems of Medicine [C] and **revitalizing** social processes (institutional, oral and commercial) for transmission of traditional knowledge of health care for its wider use and application [R]. It has articulated specific programmes and sub-programmes under these thrust areas.

Under the first thrust area "Demonstrating contemporary relevance of theory and practice of Indian systems of medicine", FRLHT engages in major programmes such as assessment and documentation of local health practices prevalent in different rural and urban communities. It also has a major programme related to interpretation of traditional medical theories and practices with the use of scientific laboratory tools. Other programmes under this thrust area include creation of traditional knowledge databases and development of methodologies for trans-disciplinary medical research.

In the second thrust area "Conserving natural resources used by Indian Systems of Medicine", FRLHT concentrates on research programmes involving studies related to making an inventory of medicinal plants in different forests, threat assessment, saving species on the verge of extinction and sustainable harvest. Under this thrust area, FRLHT also undertakes other important programmes related to efforts towards development of databases and establishment of a bio-cultural herbarium and raw-drug repository of the plants of India.

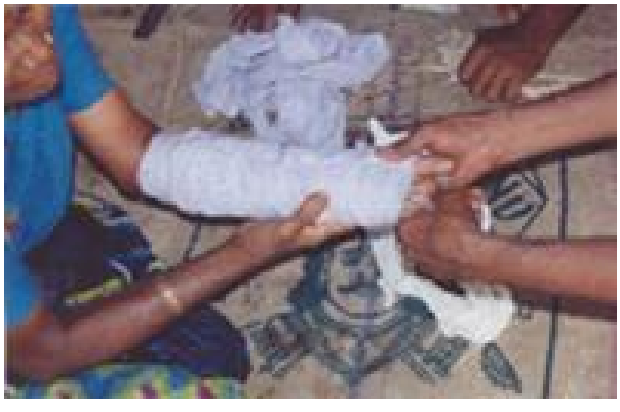
The third thrust area deals with the "Revitalization of social processes" (institutional, oral and commercial) for transmission of traditional knowledge of health care and the main programmes under this thrust area are building decentralized associations of folk healers and self-help women groups, home herbal gardens and promoting community-owned enterprises. A major initiative under this thrust area for influencing institutional processes is the development of a research hospital, pharmacy and a post-graduate training institute and University affiliated PhD degree programs.

Under these three strategic thrust areas, FRLHT also takes up the following programmes: establishing Indian Institute of Ayurveda and Integrative Medicine (IIAIM); creating home remedies; establishing laboratory; doing conservation and research with its in-situ initiative for Medicinal Plant Conservation Areas (MPCA); establishing Bio-Geo Resources Repository; creating multi-faceted information on medicinal plants of India (in the form of computerized databases, specialized reports, information products, websites and trade bulletins); creating Ethno-medicinal Garden (provides a visual introduction to several hundred species of medicinal plants from various bio-geographic regions of the country); developing need based training courses and educational events that serve as supportive means in the process of conservation and revitalization of Indian Medical Heritage; sensitizing the social process for successful promotion of folk healers and their useful practices by conferring the awards; initiating the need to

develop a nationally-coordinated programme to assist colleges of traditional medicine and other competent institutions in surveying, collecting and computerizing medical manuscripts from different regions in the country and abroad; and partnering with Community Owned Herbal Enterprises named Gram Mooligai Company Limited (GMCL) to provide an assured market support to the medicinal plant produce of the shareholders.

Indian Institute of Ayurveda and Integrative Medicine (IIAIM) was established in 2008. It is a specialized medical research & education wing of FRLHT. IIAIM will initiate MS and PhD programs in “Integrative Health Sciences”. It will be guided by the holistic principles of the traditional health sciences, use traditional pedagogic concepts, cutting edge IT tools & an epistemologically informed interface with bio-medical sciences.

Home remedies hold the promise for self-reliance in primary health care for millions of households in India and thus making possible the dreams of ‘people’s health in people’s hands’ and ‘health for all’ a reality in the near future. FRLHT created Homestead Herbal Gardens (HHG) of medicinal plants for primary health care and primary veterinary care that have been initiated across the states of Karnataka, Kerala and Tamil Nadu facilitated by women self-help groups and reputed NGOs. 1.5 Lakhs HHGs have been established so far. HHG package consists of training on the use of 20 carefully selected medicinal plants for relieving primary health-related complaints at the household level as a first response. The HHG programme has been targeted at resource-poor rural women and their families in general and also their livestock. The HHG also facilitated awareness on the role of home remedies for preventive, promotive and curative care for primary health and also helped the rural households to save on the primary health care-related expenses through use of home remedies as a first response to a health problem at the household level.



The importance of FRLHT laboratory lies in the fact that all the activities are oriented towards Traditional Knowledge with a modern approach. It has been established for demonstrating the contemporary relevance of traditional health practices, development of traditional knowledge based medicines and for standardization of medicinal plant and product quality. It has been recognized as a certifying body by the department of ISM&H, Govt. of India. FRLHT is engaged in "inter-cultural research" on strategically chosen aspects of Traditional Knowledge in order to build bridges of understanding between Indian and Western systems of medicine.

FRLHT’s herbarium houses 35,000 voucher specimens comprising of 2096 species spread across 150 families that have been collected from all parts of India. The Raw-drug library has 1088 raw drug samples from 360 medicinal plant species obtained from market surveys carried out in 10 major and minor trade centres in India.

FRLHT periodically produces educational and communication material based on the research. A number of videos, CDs, booklets, brochures, stickers, etc., have been produced, including a regular bimonthly magazine titled “Heritage Amruth” carrying researched articles on traditional health care practices.

Sensitizing the social process is important for successful promotion of folk healers and their useful practices, since they hold the key to health security of millions. The sustainability of the effort for revitalization depends mainly on the stakeholders of traditional knowledge, who are at village level - the Paramparik Vaidyas and knowledgeable households. Promotion of Taluka level Paramparik Vaidya Parishads (Associations) all over India is one of the strategies to achieve the goal of revitalization of local health traditions. FRLHT has been conferring Paramparik Vaidya Rathna Award to the folk healers in recognition of their services rendered to the rural communities in their region. The National Medicinal Plant Board, Government of India has instituted Vanaushadhi Pandit Award since 2003. Both the awards consist of a Panchaloha Statue of Dhanawantri and a cash award of Rs. 10,000/-.

In recognition of FRLHT's pioneering work in the area of conservation of medicinal plants and local health traditions, Ministry of Environment & Forests, Govt. of India has made it an ENVIS (Environmental Information System) Centre on medicinal plants, whose conservation is of concern in the country. A data-driven website (http://envis.frlht.org.in) has been developed and is available for public access. A user of the website can search the database on names (botanical and vernacular names), natural distribution, threat status of medicinal plants in trade, and the name of the system of medicine in which the plant is used. The database contains information on 860 traded medicinal plant species of India.

Besides the recognition from many quarters, FRLHT also won many awards such as the Norman Borlaug award, the Equator Initiative Prize, the International Cultural Stewardship and the Anchor Better Interiors Excellence Award, etc.

In India, where the health situation is pretty bad, models being pioneered by FRLHT have a high relevance. Health costs break the back of the poor and push several non-poor households into poverty. Using medicinal extracts from locally available plants can contribute to reducing the medical costs of the poor to a large extent. Strengthening such practices can create a good safety net for the poor and not-so-poor. There in lies the importance of the work of FRLHT to support and sustain livelihoods of the poor. Further, the sheer size and scale of the innovations of FRLHT can have a high impact on the health situation in India. ■

Health as a Resource for Development

Health is central to human happiness and wellbeing. *Health* is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". Better health makes an important contribution to economic progress, as healthy populations are more productive, and save more.

Health is a form of human capital like education and skills but unlike the others it cannot be accumulated and is subject to large and unpredictable risks. The livelihoods of the poor depend on it. When poor become ill or injured the entire household can become trapped in a downward spiral of lost income and high healthcare costs. The poor suffer worse health and die younger. They have higher than average child and maternal mortality, higher levels of disease, severely limited access to health care and social protection. And gender inequality disadvantages further effect the health of poor women and girls.

Today India is facing a new threat from non-communicable diseases even before it has been able to address the challenges posed by communicable diseases. Diabetes, heart disease and hypertension, once considered the diseases of the rich, are not sparing even the poor who continue to be more vulnerable to TB, Malaria, HIV and waterborne disease.

In India there is a greater reliance on private delivery of health infrastructure and health services thus denying adequate access to the poor. There is no equal access to health care by those in equal need.

Healthcare system in India is mostly confined to Urban India in the form of large hospitals. Though primary healthcare infrastructure exists in rural areas, it is largely defunct. Poor seek healthcare very late in the course of illness due to lack of education, non-availability of services and difficulty in accessing the services. When they do seek healthcare they are constrained by the costs (real and perceived) and inadequacy of the services. Indirect costs of treatment like loss of wage also constrain poor from availing healthcare. While a primary health center per 25000 population is clearly inadequate, delivery of primary health care service is further hampered by shortage of doctors and medicines. There are only 6 doctors per 10000 population in India when compared with 17 per 10000 in the United States.

Public spending on health is among the lowest in India. Per capita expenditure on health in India is less than $30 and 70% of it is spent from the household income. Global health expenditure per person per year is estimated to be $630 out of which only 18% is spent out-of-pocket.

Investing in health is recognized as an important means of economic development and a prerequisite for poor people in developing countries to break out of the circle of poverty.

India faces a huge gap in terms of availability of number of hospital beds per 1000 population. While the world average is 3.96 hospital beds per 1000 population, India has only a little over 0.7 hospital beds per 1000 population. Public funding in India has been hovering around 1% of the GDP and there is an immediate need to increase it to 3% to build infrastructure and train more personnel.

Also the focus needs to shift from clinical and curative services to preventive and promotive services. This would reduce the over all expenditure on health and reduce the risks for the poor. Equity, user friendliness (especially of timings and distances) and universalisation should be the guiding principles while expanding and strengthening the primary health care system. Mental health has been neglected for long in our country and a community based program to detect psychological illness early and provide support services is the need of the hour to help rural poor manage the changes in the economic and social environment around them.

The strategies of prevention of disease and promotion of health actually cost less and also decrease the expenditure on the costly clinical and curative services. People from the community need to be trained to promote health; nurses and nurse practitioners should be trained to manage minor illnesses, support and monitor people with chronic diseases, identify major illnesses and refer them to a doctor early. This would actually decrease the need for a large number of doctors, whose training is very expensive.

India has a plurality of health care systems as well as different systems of medicine. These should be appropriately leveraged for providing universal access. NGOs, government and private players should work together to bring safe drinking water and sanitation facilities within the reach of the poor. Increased awareness about health and nutrition through education and promotion of healthy lifestyles are the areas where NGOs have a greater role. Overall development, education and higher income levels also have a key role in improving the health status of the less privileged.

Good health contributes to development through a number of pathways, which partly overlap but in each case add to the total impact:

Higher labour productivity: Healthier workers are more productive, earn higher wages, and miss fewer days of work than those who are ill. This increases output, reduces turnover in the workforce, and increases enterprise profitability and agricultural production.

Improved human capital: Healthy children have better cognitive potential. As health improves, rates of absenteeism and early school drop-outs fall, and children learn better, leading to growth in the human capital base.

Higher rates of national savings: Healthy people have more resources to devote to savings, and people who live longer save for retirement. These savings in turn provide funds for capital investment.

Demographic changes: Improvements in both health and education contribute to lower rates of fertility and mortality. After a delay, fertility falls faster than mortality, slowing population growth and reducing the "dependency ratio" (the ratio of active workers to dependants). This "demographic dividend" has been shown to be an important source of growth in per capita income for low-income countries.

Higher rates of domestic and foreign investment: Increased labour productivity in turn creates incentives for investment. In addition, controlling endemic and epidemic diseases, such as HIV/AIDS, is likely to encourage foreign investment, both by increasing growth opportunities for them and by reducing health risks for their personnel.

As investments in health lead to development through multiple pathways, all the entities interested in development and poverty reduction must come together and develop a coordinated plan of action to make the required investments a reality. ■

Dr K. Srinivas

NTR Trust, Hyderabad

Revolutionary Farmer 'Naren'

Gorrepati Narendranath, who is fondly called as Naren by kith and kin, is a role model to many people who are engaged in farmers' struggle, agricultural workers' struggle and in the struggle against untouchability. He is one of the founding members of National Alliance for People's Movement in Andhra Pradesh.

Born in 1954, Naren is a Post Graduate in Sociology from Delhi University. He started his career as a bank employee, but he was not satisfied with that comfortable job and tried to search for a job which can give him more satisfaction. At that point of time he happened to read the book 'One straw revolution' written by Masanobu Fukuoka which changed his life for ever. He decided to be a farmer and along with his wife Umashankari, came back to his native village Venkatapuram, located in Chittoor district of Andhra Pradesh.

Naren with wife Umasankari

Even though he is the son of an IAS officer he chose to live the simple life of a small dry land farmer in a small and remote village. He started agriculture in 32 acres of land. But in the initial years that area suffered with severe drought conditions and all the investment Naren put on agriculture had evaporated in very short span of time. But Naren did not quit. He continued farming and his many experiments with organic farming methods. Apart from farming, he was actively involved in civil rights movements in Andhra Pradesh and was the Vice President of Human Rights Forum (HRF) until his last breath.

His leadership for the Bhu Samskranala Karyacharana Udyamam (Forum for Land Reforms) in Chittoor district has brought a lot of organizations together for the implementation of landforms in Chittoor district, distributing thousands of acres of land to landless poor. He led the farmers movement against the electricity charges in Chittoor district which resulted in the sanction of free electrify to the farmers in Andhra pradesh. Narendranath wrote a number articles and books on farmers' and workers' problems both in Telugu and English.

He was actively involved in all campaigns against displacement in Andhra Pradesh such as in the cases of Srisailam and Nagarjuna Sagar dams in late seventies as also the current struggle against the Polavaram dam, and SEZ struggles in Nellore, Chittoor and also in East Godavari districts.

Naren had dedicated himself to the cause of People's Movements, the quest for alternatives, especially organic farming, promoting biodiversity and organizing farm workers for the last 25 years. He has been passed away on 5th July, 2009.

Naren is really one of the few extraordinary persons of the country and an inspiration to many development workers. We regret his death and we pray his soul may rest in peace. ■

Budget 2009-2010

After months of recession, downward looking markets and upward looking commodity prices, budget was something that everybody was looking forward to. Recognising economic recovery and growth as a cooperative effort, budget preparation meetings had participation by both Central and State Governments Financial heads. This is intended to become an annual feature.

It was anticipated that the outcome of recent economic survey would have an influence on the budget. People were closely watching whether government would keep up the promises made during election campaigns. People also had questions about whether the government would be able to sustain much acclaimed National Rural Employment Guarantee Scheme (NREGS).

The budget was presented on 6th of July, 2009. Inclusive development is the mantra of United Progressive Alliance (UPA) government and the budget is presented in tune with this spirit. Budget estimates a whooping expenditure of Rs.10,20,838 crore, an increase of 37% in Non-plan and 34% in Plan expenditure over the previous year. Fiscal deficit as a percentage of GDP is projected at 6.8% compared to 2.5 % in the previous year.

Prime Minister feels that the budget is essentially a rural development-oriented budget. A record increase in allocation for national rural employment guarantee fund, irrigation benefit schemes, Bharat Nirman programme, will primarily benefit rural areas and reduce the gap between Bharat and India.

Market has responded negatively by showing downward trend on the day budget was released. Their expectation of special packages to salvage them from the economic crisis has not been met by the government. To counter the negative fallout of the global slowdown on the Indian economy, Government has responded by providing three focused fiscal stimulus packages in the form of tax relief and increased expenditure on public projects along with RBI and taking a number of monetary easing and liquidity enhancing measures.

Rs.120 crore were allocated to set up **Unique Identification Authority of India** online data base with identity and biometric details of Indian residents and provide enrolment and verification services across country. First set of unique identity number are expected to be rolled out in 12 to 18 months.

In tune with its inclusive growth agenda budget allocation on flagship programs like Bharat Nirman, NREGA, the Jawaharlal Nehru National Urban Renewal Mission, the National Rural Health Mission have seen substantial increase. Critiques say that we need to understand whether it is real increase in allocation or a necessary raise in tune with the growth in percentage of population that would get added into the beneficiary list.

Many people opine that as in the case of last year's budget, this budget is also a mixed bag of new initiatives and non focus on certain critical issues. There is criticism about not focusing on development of children who constitute 40% of the population and stimulation packages to artisans like weavers. For our understanding we have focused on few sectors pertaining to fulfilling of basic needs of the poor.

Inclusive Growth is the mantra of the new government. Budget is presented in line with this spirit. The highlights of the budget 2009-10 are

- ***Unique Identification Authority of India***
- ***National Food Security Act***
- ***National Food Security Mission***
- ***National Rural Livelihoods Mission***
- ***Right to Education Bill***
- ***National Mission for Female literacy***

Food security:

Government proposes to introduce **National Food Security Act.** It out lines entitlement of 25 kilo of rice or wheat per month at Rs.3 per kilo to every family living below the poverty line. Details of the Act has not been worked out nor has the time line for implementation been set. Prime Minister has also expressed concern over ensuring food security to all BPL people not covered by the estimates of Planning Commission. Government proposes to put Food Security Bill on the website of the Department of Food and Public Distribution for public debate.

Rs.1,350 crore is allocated for **National Food Security Mission** to increase production and productivity of wheat, rice and pulses on a sustainable basis. The plan is to disseminate improved technology and farm management practices. One needs to wait and see whether farmer friendly approach would be adopted in the implementation.

Rs. 45 crore has been allocated for computerisation of PDS operations. Let us hope this would plug in administrative loopholes.

Livelihoods:

Highlight of this year's budget is 144% (sum of Rs.39,100 crore) increase in allocation for **NREGS**. Owing to its success of benefiting more than 4.47 crore households till now, government plans to implement the scheme in all the districts. The plan is also to converge this program with schemes relating to agriculture, forests, water resources, land resources, rural roads.

National Rural Livelihood Mission came about by restructuring Swarnajayanti Gram Swarozgar Yojana, to eradicate poverty by 2014-15 and make SGSY universal in application. In addition to capital subsidy, interest subsidy to poor households will be provided for loans up to Rs.1 lakh.

Rs. 2350 crore has been allocated for establishing **micro-enterprises** in rural areas. At least 50% of the Swarozgaries will be SCs/STs, 40% women and 3% disabled.

To encourage micro, small and medium enterprises Rs. 144 crore has been allocated under **Credit Support Programme** without collateral. Rs.4,000 crore has been allocated to encourage lending to Micro and Small Enterprises.

Rs.823 crore is allocated for **Prime Minister's Employment Generation Programme.** Though there is no substantial focus or plan towards reviving and rehabilitating weavers and other artisans, Rs.340 crore is allocated for Handloom Schemes, and another Rs.220 crore for handicrafts schemes. There is no plan or budget allocation towards much needed enhancing capacities of poor families towards moving into better paying livelihoods.

Agriculture, animal husbandry, dairying and fisheries:

The focus is on increasing credit flow and debt relief. Allocation under **Rashtriya Krishi Vikas Yojana** has been stepped up by 30%. Agriculture credit flow is set to increase to Rs.3,25,000 crore. Interest subvention scheme for crop loans is to be continued. Additional subvention of 1% to be paid for farmers with good repayment record. Additional allocation of Rs.411 crore allocated for Interim Debt Relief for Farmers. Time given for repayment of loan under Debt Waiver and Debt Relief Scheme has been extended to 31st December, 2009.

Task force is to be set up to examine the issue of debt taken in some regions of Maharashtra. A special package worth Rs.75 crore for farming in 31 suicide prone districts was announce. This needs to be extend to other areas. Adequate budget to plan interventions to prevent farmers from suicide is more important.

Allocation under **Accelerated Irrigation Benefit Programme** is increased by 75%. Rs.1584 crore is allocated for Agricultural Research and Education and Rs.252 crore for World Bank Aided National Agricultural Innovation Project.

Government intends to move towards a nutrient based fertilizer subsidy regime, farmers using innovative fertilizer products be given direct subsidy. Rs.400 has been allocated towards **National Land Records Modernisation Programme**. Hope this process would ensure clear titles for poor farmers.

Housing and infrastructure for the poor:

Finally there is an integrated approach towards development of the village infrastructure. The allocation for Bharat Nirman programme is being hiked by 45%. The project covers six schemes, including rural roads, drinking water and sanitation in villages. Allocation towards rural housing and electrification has been increased by more than 40%. Rs.8,000 crore is allocated to **Accelerated Rural Water Supply Programme** to provide safe drinking water to all rural habitations, and Rs.1200 crore for Total Sanitation Campaign. A new scheme Pradhan Mantri Adarsh Gram Yojana with an allocation of Rs.100 crore is launched for integrated development in 1000 villages with more than 50% scheduled caste population. Rs.10 crore is allocated for empowerment and brining accountability in Panchayats.

Education:

Education budget has gone up by Rs.7,000 crore, i.e. an increase of about 14%. Out of this, Rs.900 crore is allocated for '**Mission in Education through ICT'**, Rs.2000 crore for higher education (basically towards IITs, IIMs and university grants). Spending on school education under Sarva Shiksha Abhiyan and Midday Meals has remained same.

It is believed that the UPA government is going to table **Right to Education Bill. National Mission for Female Literacy** is to be launched to reduce female illiteracy by half in three years with focus on minorities, SC, ST and other marginalized groups. However no budgetary allocation has been made towards them.

Health:

Health budget is up by Rs.4,000 crore. Government proposes to bring all BPL families under the **Rashtriya Swasthya Bima Yojana,** and 40% increase in the budget is made towards this. The scheme is expected to empower poor families by giving them freedom of choice for using health care services from an extensive list of hospitals including private hospitals. The flagship programme of UPA government, the **National Rural Health Mission** has got an increase to achieve goal of "health for all".

Empowerment of weaker sections:

Women: Rs.59 crore is allocated for Relief to and Rehabilitation of Rape Victims after repeated reminders by the Supreme Court. Corpus of Rashtriya Mahila Kosh to be increased from Rs.100 crore to Rs.500 crore. Government aims to enrol at least 50% of all rural women as members of SHGs over the next five years.

SC/STs and Minorities: Special Central Assistance for Scheduled Castes Component Plan would benefit about 6 lakh beneficiaries. Plan outlay of Ministry of Minority Affairs is enhanced by 74%.

Children: The promise to universalise ICDS, by extending services to every child under the age of six by March 2012 has been long-standing. The increase in allocation to Rs.6,705 crore for the ICDS is welcome. Thought should be given not just about sanctioning new ICDS centres, but making them operational and staffed by trained personnel.

Un-organised sector: Government has recognised importance of providing social security for occupational groups like weavers, fisher-folk, toddy tappers, leather and handicraft workers, plantation labour, construction labour, mine workers, bidi workers and rickshaw pullers. However no budgetary allocation has been made towards this.

To conclude, despite being reviewed as citizen-friendly, scratching the surface of the Union Budget 2009-10 throws up shortfalls. We must realise that economic growth is meaningless unless it reaches 70% of India`s poorest. Budget allocation for key areas like education and health is around 3% and 1% respectively. Economic Survey has mooted the idea of providing food coupons to poor people to address the issue of diversion of food grain and deficiencies in the targeted PDS, including non-availability of fair price shops, leakages and failure in price stabilisation. Government could have considered such measures which are not just budget matters but require policy changes. ■

National Health Policy 2002

In a country as large as India with a wide variety of socio-economic settings, it is evident that national health programmes have to be designed with enough flexibility to permit the State public health administrations to craft their own programme package according to the needs. Some of the policy initiatives outlined in the earlier National Health Policy (NHP) 1983 have yielded results, while, in several other areas, the outcome has not been as expected.

The main objective of NHP-2002 is to achieve an acceptable standard of good health amongst the general population of the country. The objective is to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Overriding importance would be given to ensuring a more equitable access to health services across the social and geographical expanse of the country. The emphasis is on increasing the aggregate public health investment through a substantially increased contribution by the Central Government. It is expected that this initiative will strengthen the capacity of the public health administration at the State level to render delivery of effective services. The contribution of the private sector in providing health services would be enhanced, particularly for the population group which can afford to pay for the services. Primacy will be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation. Emphasis will be laid on rational use of drugs within the allopathic system. Increased access to tried and tested systems of traditional medicine will be ensured. Within these broad objectives, NHP-2002 will endeavour to achieve the time-bound goals mentioned in the table.

Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kala Azar	2010
Eliminate Lymphatic Filariasis	2015
Achieve Zero level growth of HIV/AIDS	2007
Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
Reduce Prevalence of Blindness to 0.5%	2010
Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
Increase utilization of public health facilities from current Level of <20 to >75%	2010
Establish an integrated system of surveillance, National Health Accounts and Health Statistics	2005
Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%	2010
Increase share of Central grants to constitute at least 25% of total health spending	2010
Increase State Sector Health spending from 5.5% to 7% of the budget Further increase to 8%	2005 2010

Broadly speaking, NHP – 2002 focuses on the need to enhanced funding and an organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. Also, the Policy is focused on those diseases which are principally contributing to the disease burden – TB, Malaria and Blindness from the category of historical diseases; and HIV/AIDS from the category of 'newly emerging diseases'. This is not to say that other factors contributing to the disease burden of the country will be ignored; but only that the resources, as also the principal focus of the public health administration, will recognize certain relative priorities. This Policy broadly envisages a greater contribution from the Central Budget for the delivery of Public Health services at the State level.

The public health investment in the country over the years has been comparatively low, and as a percentage of GDP it has declined from 1.3 % in 1990 to 0.9 % in 1999. The overall expenditure i.e. both public spending and out of pocket expenditure in the Health sector is 5.2% of the GDP. Out of this, about 17% is spent on public health, the balance being out-of-pocket expenditure. The central budgetary allocation for health has been stagnant at 1.3%, while that in the States has declined from 7.0% to 5.5 %.

Given these statistics, it is no surprise that the reach and quality of public health services has been below the desirable standard. On the other side, access to, and benefits from, the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. This is particularly true for women, children and the socially disadvantaged sections of society. The NHP-2002 has been formulated taking into consideration these ground realities in regard to the availability of resources.

The Policy highlights the expected roles of different participating groups in the health sector. Further, it recognizes the fact that, despite all that may be guaranteed by the Central Government for assisting public health programmes, public health services would actually need to be delivered by the State administration, NGOs and other institutions of civil society. The attainment of improved health levels would be significantly dependent on population stabilisation, as also on complementary efforts from other areas of the social sectors – like improved drinking water supply, basic sanitation, minimum nutrition, etc. - to ensure that the exposure of the populace to health risks is minimized.

Any expectation of a significant improvement in the quality of health services, and the consequential improved health status of the citizenry, would depend not only on increased financial and material inputs, but also on a more empathetic and committed attitude in the service providers, whether in the private or public sectors. In some measure, this optimistic policy document is based on the understanding that the citizenry is increasingly demanding more by way of quality in health services; and the health delivery system, particularly in the public sector, is being pressed to respond. In this backdrop, it needs to be recognized that any policy in the social sector is critically dependent on the service providers treating their responsibility not as a commercial activity, but as a service, albeit a paid one. In the area of public health, an improved standard of governance is a prerequisite for the success of any health policy. ■

Importance of Dialogue for Non-profits

In several circumstances, the effectiveness of the organisation depends on the interpretation of mission and value statements of the organisation by the members of the organisation. Open dialogue on various activities can improve the shared meaning.

During routine interactions and visits to friends houses, I noticed that there are important differences in the behaviour of children between those belonging to joint families and to nuclear families. One particular behaviour that is most relevant to development organisations appears to be the manner in which the children tolerated ambiguity in the values and the grey areas in some of the actions. Probably an important contributing factor for this difference lies in the reactions that set in among the family members to a wrong done by the child and resultant parent's rebuke.

I here narrate the differences that I noticed about two families: a joint family of nine members (5 adults and 4 children) and a nuclear family of three members (2 adults and 1 child). In the nuclear family, this was a one event affair. The mother tried to explain what was wrong with the child's behaviour for a little while. Some grumbling of the child was quelled with force. No further discussions ensued. In contrast, in the joint family, some discussion was there on the child's behaviour as well as the appropriateness of the punishment given to the child. There was some discussion, though only when the patriarch or the head mother was not in the hearing distance, even on the question whether the child had done some wrong. Some more discussions were on the question of gravity of the wrong committed by the child. On the issue of appropriateness of punishment, some said the behaviour did not warrant as strong punishment as given, while others felt that the punishment given was very light. The discussions went on for a few days after the incident.

Child psychologists may have studied several such instances to identify the effect of these variations on the child's behaviour. But one important aspect that I observed was that the children in the household where discussions ensued after rebuke developed a sense of proportion of the wrong and also developed the capacity to assess the acceptability of their behaviour in grey areas.

This difference seems to be very important for NGOs, which are mission focussed organisations. In other words, there can be only one rationale for every activity or set of activities (project or program): to contribute to the mission. But, unlike a measurable entity like 'profit', meaning of mission is not always clear. Even the boundaries cannot be stated with certainty – they only need to be felt.

An example might clarify. An organisation had a mission to 'develop – socially and economically - the tribal communities living in remote, forest areas'. As exposure to outside world could contribute to social development and could ignite several new ideas among the community, a staff member of the organisation proposed to take some members from this tribal community to the headquarters of the State, by road and train. In addition to exposing the travelling group to various facilities in state headquarters, the journey also would expose the group to bus and train for the first time in their life. Many among the staff negated the idea on saying that there is no meaning in taking the community to distant places when they are not even exposed to the nearby places. The member proposing the trip argued, “The shift in exposure brought about by such sudden change can bring in a lot of transformation in them, which is not so easy with incremental exposure.”

Because several activities can contribute to achievement of mission, various stakeholder groups can bring in several priorities into the organisation. This could put a lot of stress and strain on the organisational resources – particularly on the human resources. Such pressures can only be evened out when the mission is clarified at the feeling level across the length and breadth of the organisation. Therefore, it is important for a mission driven organisation to adopt processes that contribute to clarification of the mission at the feeling level, and to developing shared meaning to the mission. Such processes can include encouraging a dialogue about all disagreements in the organisation relating to various processes, projects and policies.

But will encouragement to such dialogue slow down implementation of projects? Not if the organisation has learnt to act on the decision with the full awareness that the decision could be found to be wrong in the discussions that happen after that. The organisation should first take the decision of the person who is responsible for making the decision and start implementation. The discussion should continue to happen even after the implementation has started and should not have any impact on the pace of implementation. Further, it must be understood that the questioning the rationale of activity based on missions and values articulated should not be construed as a revolt on the authority – neither by the person questioning, nor by others who support his views, and even by the top management. In other words, having discussion should not be construed as ‘leaderless situation’. The opposite is very true - very powerful leaders are required to execute the decision and yet encourage the discussions.

The discussions should happen even if there is no conclusion. It is these discussions that contribute to value-clarification. Probably, out of these discussions, some stories or similes would emerge. Repeated over time, these stories could become the light houses to guide the actions.

However as an organisation grows big or becomes mature, bureaucracy could set in and scuttle the dialogue. Further, there is also the danger of the dialogue resulting in clearly fixing the boundaries of the mission and values of the organisation. The scope for innovation and experimentation would then be very less.

Hence, the management of the mission driven organisations needs to encourage such dialogue. And it has to build the capacities of the staff and its own capacities to engage in such a dialogue without affecting the progress of work in the organisation. ■

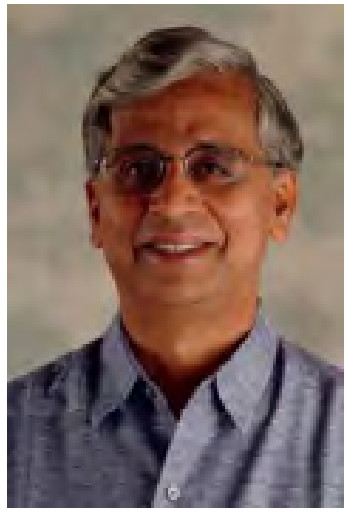
Painters

Shining Livelihoods

Typists

Declining Livelihoods

Dr + Social Worker : Sudarshan



Dr Hanumappa Sudarshan is a renowned doctor known for his excellent service to mankind particularly the elusive tribal communities. Dr. Sudarshan made his profession as a medium for social work. Born in Yemalur on the outskirts of the city of Bengaluru on 30 December 1950, Sudarshan became a medical doctor by qualification and dedicated his life to social development in India. Initially, his focus was the upliftment and welfare of tribal people of Chamarajanagar district of Karnataka.

Dr Sudarshan began his medical practice from the health institution of Ramakrishna Mission. Through this institution he traveled across several places. With his strong will to provide medical help to the rural and tribal communities, he practiced medicine in the Himalayas, at Belur Math in West Bengal and also other remote areas. In 1980 he established Vivekananda Girijana Kalyana Kendra (VGKK). The main focus of the Kendra is to offer progressive development in the sector of health, education as well as livelihood security and biodiversity conservation to the tribes of Chamarajanagar and Mysore district of Karnataka.

VGKK services today crossed the boundaries of Karnataka state and spread across the country. The Kendra covers the tribes of Tamil Nadu, Arunachal Pradesh and Andaman & Nicobal Islands through its 20,000 volunteers. The organization has always had a tribal youth as its President. Presently, Jadeya Gowda one of the first few children taught by Dr. Sudarshan is the President. He went on to do a graduation and post-graduation in agriculture and is presently doing his PhD at the University of Agricultural Sciences, Bangalore.

VGKK has been successfully carrying out several programs in the tribal areas in education, health, community organization, revitalization of traditional medicines, bio-diversity conservation, sustainable agriculture, rehabilitation of displaced tribals, low cost housing, social forestry, tribal cooperatives and promotion of appropriate technology. VGKK runs school for 450 students belonging to tribal communities of BR Hills. The curriculum of the school mainly concentrates on environmental issues, tribal values and culture along with other subjects. They also conduct vocational trainings through which 16 type of craft works are being taught. As a result of the efforts of VGKK, about 60% of the Soliga tribe now get a minimum of 300 days of employment per year from the Forest Department of Karnataka and other agencies. VGKK also has a system of cooperatives which employ the tribals directly and it has also made an effort towards sustainable extraction of non-timber products and creation of tribal enterprises to process them.

In 1986, Dr Sudarshan started Karuna Trust in Yelandur. Karuna Trust is an organization involved with integrated rural development and is affiliated to VGKK. The prevalence of leprosy in Yelandur Taluk of Chamarajanagar district was the motivation behind starting the trust. Other focus areas of this trust are education and livelihood improvement. Karuna Trust runs 25 Primary Health Care (PHC) Centers in all the districts of Karnataka and 9 PHC's in the state of Arunachal Pradesh. The flagship intervention of the organization is to promote Public Private Partnership with NGOs on a non-profit basis to achieve primary health care.

As a part of India Literacy Project, Karuna Trust has created the first integrated model of education in the state providing access to anganwadis and schools to all children in the age group 0-14. As acknowledged by the Block Education Officer, the Yelandur block has only 105 children out-of-school.

Dr Sudarshan has held many positions of significance in his career, prominent among them being the chair of the *Task Force on Health and Family Welfare* organised by Government of Karnatka, the *Task Force on Public Private Partnership* organised by National Rural Health Mission (NRHM) of Government of India and Institute of Health management & Research (IHMR), Bangalore. He was also a member of *Working Group 6 on Macroeconomics & Health* organised by the World Health Organisation and was also a Steering Group member of the Planning Commission on the Empowerment of Scheduled Tribes in India's 11th Five Year Plan. He has also been the Vigilance Director for the Karnataka Lokayukta, an ombudsman organization. During his tenure, he made regular visits and raids to several government departments and earned critical acclaim for this.

In the year 1994, Dr. Sudarshan was felicitated with the Right Livelihood Award, for showing how tribal culture can contribute to a process that secures the basic rights and fundamental needs of indigenous people and conserves their environment. Other awards include the Padma Shri Award (2000) and the Rajyotsava State Award for social work (1984), given by the Government of Karnataka. He is also an Ashoka Fellow.

Dr. Sudarshan's work has been acknowledged by none other than the former President Dr. A P J A Kalam, who also visited the area in October 2006. The following excerpt from Dr. Kalam's address at the residential tribal school of Kalinga Institute of Social Sciences at Bhubaneswar on 29th Nov 2006, speaks for itself. "Recently, I visited BR Hills in Karnataka and I found substantial new developments have taken place in this area. I can see a “New Tribal Hospital” and education environment, and that the earning capacity of the tribal citizens has been increased with the technology resource centre as a base. Previously, they were selling honey at Rs. 6 a kg., whereas now they are selling it at Rs. 60 per kg. In the rural complex, solar lamps, health insurance, and quality schools are available. Dr. H. Sudarshan is an inspiring architect of this societal transformation." ■

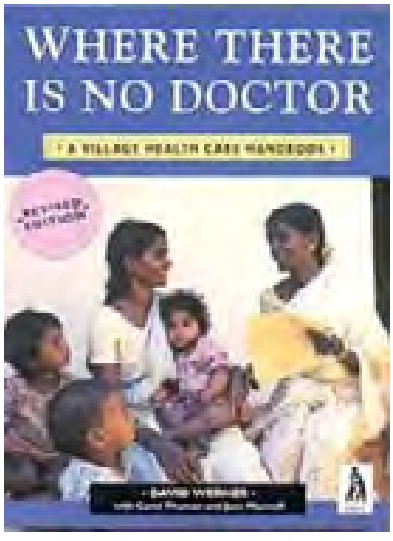
Books

Book Summary

Name: **When There Is No Doctor**

Publisher: **Macmillan Education Ltd**

Author: **David Werner**



Home health care manuals are a dime a dozen, but this one is in a league by itself. It brings together modern concepts of public health and personal health care into a usable and understandable format. This book does exactly what it promises to do: give the average, medically untrained person a good sense of how to look at a health care situation and respond to it intelligently.

Using simple language and hundreds of drawings, the book provides information about recognizing, treating and preventing common illnesses and injuries. But it is far more than simple first aid information. It covers a wide range of subjects that affect the health of the villager - from diarrhea to tuberculosis, from helpful and harmful home remedies to the cautious use of certain modern medicines. Special importance is placed on cleanliness, a healthy diet, vaccination, childbirth and family planning.

The diagnostic charts are very straightforward and make it easy for a lay person to distinguish between diseases which can be easily confused. The treatments described are completely appropriate for village conditions. There is considerable emphasis on preventative health care and on health education. Anyone familiar with village life in underdeveloped countries will acknowledge that this book is an extraordinary achievement.

Clearly, apart of informed self-care is knowing one's own limits. Therefore, guidelines are included not only for what to do, but for when to seek help. The book points out those cases when it is important to seek or get advice from a health worker or doctor. But because doctors or health workers are not always nearby, the book also suggest what to do in the meantime. Even for the very serious problems.

Where there is no doctor was first written in Spanish for farm people in the mountains of Mexico where, 27 years ago, the author helped form a health care network now run by the villagers themselves. With more than 2 million copies, this book has been translated into more than 80 languages and is used by village health workers in over 100 countries.

Today in over-developed as well as underdeveloped countries, existing health care system are in a state of crisis. Often, human needs are not being well met. There is too little fairness. Too much is in the hands of too few. Let us hope that through a more generous sharing of knowledge, and through learning to use what is best in both traditional and modern ways of healing, people everywhere will develop a kinder, more sensible approach to caring-for their own health and for each other.

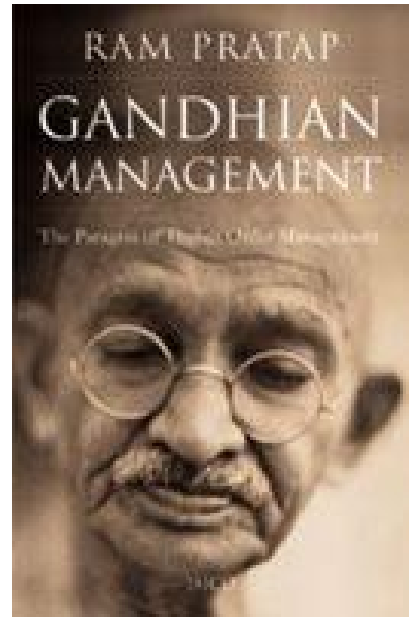
This book is written for anyone who wants to do something about his or her own and other peoples health. However, it has been widely used as a training and work manual for community health workers. Both WHO and UNICEF buy this book for their field offices. For this reason, an introductory section has been added for the health worker, making clear that the workers first job is to share her knowledge and help educate people. This book also has been written primarily for those who live far from medical center, in places where there is no doctor. But even where there are doctors, people can and should take the lead in their own health care. So this book is for everyone who cares. ■

New Books

Name: **Gandhian Management**

Publisher: **Jaicobooks**

Author: **Ram Pratap**



Name: **Explore Rural India**

Publisher: **Roli Books**

Author: **UNDP**

Health Schemes

Andhra Pradesh: Rajiv Aarogyasri Health Insurance Scheme

Rajiv Aarogyasri is an innovative scheme, being implemented for the first time in the country in Andhra Pradesh from 1st April, 2007 with a unique Community Health Insurance benefit. The scheme provides financial protection of up to Rs. 2 lakhs in a year to BPL families for the treatment of serious ailments requiring hospitalization and surgery. This scheme is operational in Anantapur, Mahabubnagar, Srikakulam, Chittoor, Ranga Reddy, East Godavari, West Godavari and Nalgonda districts and is available to all BPL families (all holders of white card under the targeted public distribution system) in the above districts. The scheme proposes to improve access for the targeted communities to quality medical care for treatment of identified diseases involving hospitalization, surgeries and therapies through an identified network of health care providers. The scheme provides coverage for the systems like Heart, Lung, Liver, Pancreas, Renal diseases, Neuro-Surgery, Paediatric Congenital Malformations, Burns, Post -Burn Contracture Surgeries for Functional Improvement, Prostheses (Artificial limbs), Cancer treatment (Surgery, Chemo Therapy, Radio Therapy), Poly-trauma (including cases covered under MV Act) and Cochlear Implant Surgery with Auditory-Verbal Therapy for Children below 6 years (costs reimbursed by the Trust on case to case basis). All the pre-existing cases of the above mentioned diseases are covered under the scheme. The benefit on family is on floater basis i.e. the total reimbursement of Rs.1.50 lakhs can be availed of individually or collectively by members of the family. An additional sum of Rs 50,000 is provided as buffer to take cares of expenses if it exceeds the original sum i.e. Rs 1.50 lakhs per Individual / family. Cost for Cochlear Implant Surgery with Auditory Verbal Therapy is reimbursed by the Trust up to a maximum of Rs.6.50 lakhs for each case.

Jharkhand: Health Centres for Pahariya Primitive Tribes

Pahariya is a Primitive Tribe living in parts of Jharkhand. They are very poor and face social exclusion. For their health care, Government of Jharkhand has started health centres in those areas where members of this Tribe are living. Free medical check-up and free medicine is provided for to the needy persons. This scheme was introduced on 1st April 2002 and is valid up to 31st March 2011.

Kerala: Comprehensive Health Insurance Scheme (CHIS)

This is a scheme implemented by the Government of Kerala to cover all families other than the absolute poor families. (The absolute poor families, identified as per the guidelines issued by the Planning Commission, are covered under the Rashtriya Swastya Bima Yojana (RSBY).) The non-RSBY population will be divided into two categories: (a) those belonging to the BPL (Poor) list of the State Government but not to the list as defined by the Planning Commission and (b) the APL families that belong neither to the State government list nor to the list prepared as per guidelines of the Planning Commission. The total outlay for the project is Rs. 4300.00 lakh. The scheme was introduced on 4th July 2008 and is valid up to 31st March 2010.

Manipur: Health Scheme for MOBC

This is a State Sponsored Programme with State Government bearing the whole Scheme cost/proposed cost. Under this scheme financial assistance is given to Minorities and OBC communities in the treatment of diseases. Depending upon the severity of the diseases (major, moderate, minor etc) a lump sum of Rs.4,000 to Rs20,000 per patient is given under this scheme. Minorities and OBC patients who are admitted and treated in Government recognized Hospitals/Health Centre, etc., and whose annual income is below Rs.22000 are eligible. The scheme was introduced on 1st of September 2001 and is valid up to 30th September 2012.

Orissa: Health Package Scheme for Handloom Weavers

Government of Orissa introduced a Health Package Scheme for handloom weavers during 1992 to 1993. The health package scheme for handloom weavers intends to ameliorate some of the health problems related to the profession of handloom weaving, such as tuberculosis, asthma, inflammation of alimentary system and different types of eye problems. Cost of medical expenses for weavers who are members of Handloom Societies or attached to Handloom Corporations would be reimbursed up to a maximum of Rs 1,500 per weaver per annum. The medical treatment should be duly certified by a qualified medical practitioner of the State Government. A handloom weaver may get his eyes tested in a hospital belonging to State Government or Central Government or Public Sector Undertaking or from a qualified optician or optometrist. The cost of reimbursement by the Government would be limited to Rs 150 for the cost of spectacles and Rs 40 for the cost of testing. This reimbursement would be available only once in five years. One bore well will be provided for every 50 weaver households with a maximum expenditure of Rs 35,000. A woman weaver or a woman belonging to a weaver household will be entitled to a lump sum grant, of Rs.500 per delivery, twice in her lifetime. Ordinarily specialized health care would not be supported unless they are specifically related to the profession of handloom weaving. This scheme was introduced on 1st January 1992 and is valid up to 2nd January 2012. ■

Story

Take a Step Up

Each of our troubles is an invitation for us to steps to grow up. We can get out of the deepest wells just by not stopping, never giving up! Shake it off and take a step up.

One day a farmer's donkey fell into a well.
The animal cried piteously for hours as the farmer tried to figure out what to do.
Finally, he decided the animal was old, and the well needed to be covered up any way;
It just wasn't worth it to retrieve the donkey.

He invited all his neighbours to come over and help him.
They all grabbed a shovel and began to shovel dirt into the well.
At first, the donkey realized what was happening and cried horribly.
Then, to everyone's amazement he quieted down.

A few shovel loads later, the farmer finally looked down the well.
He was astonished at what he saw.
With each shovel of dirt that hit his back, the donkey was doing something amazing.
He would shake it off and take a step up.

As the farmer's neighbours continued to shovel dirt on top of the animal, he would shake it off and take a step up.
Pretty soon, everyone was amazed as the donkey stepped up over the edge of the well and happily trotted off!

Life is going to shovel dirt on you, all kinds of dirt
The trick to getting out of the well is to shake it off and take a step up.
Each of our troubles is a stepping stone. We can get out of the deepest wells just by not stopping, never giving up!
Shake it off and take a step up. ■

Top 10 Causes of Death : 2001-03

(Resource: Report of Causes of Death:2001-03, Office of Registrar General, India)

Children - 1-4 years	
Causes of death	*Percentage*
Ill-defined conditions	4.5
Unknown fever	3
Digestive diseases	1.7
Congenital anomalies	7
Diarrhoel diseases	24
Respiratory infections	23
Other infections	16
Unintentional injuries	8
Malaria	7
Nutritional deficiencies	4.8

Children-1-14 years	
Causes of death	*Percentage*
Motor vehicle accident	4
Ill-defined conditions	5
Malaria	9
Respiratory infections	10
Other infectious and parasitic diseases	15
Unintentional injuries:other	16
Diarrhoeal diseases	17
Congential anomalies	2.9
Digestive diseases	1.7
Cancers	2.9

Persons- 15-24 years	
Causes of death	*Percentage*
Cardio vascular diseases	6.3
Diarrhoeal diseases	6.2
Maternal conditions	13
Tuberculosis	7
Motor vehicle accident	12
Symptom signs and ill-defined conditions	7
Uninentional injuries:other	12
Intentional self-harm	16
Malaria	4.7
Other infectious and parasitic diseases	4.8

Persons - 25-69	
Causes of death	*Percentage*
Digestive diseases	5.1
Symptom signs and ill-defined conditions	5
Diarrhoeal diseases	5
Uninentional injuries:other	4.6
Intentional self-harm	3
Malaria	2.8
Caediovascular diseases	25
COPD, Asthma and other respiratory	10
Tuberculosis	10
Malignant and other neoplasms	9

Out of Poverty

Labourer to Entrepreneur

Mallikarjuna Rao is a native of Raipalya village, Pamuru mandal, Prakasam district. He is 27 years old. He studied up to 5th standard. In his childhood, he saw the typical financial conditions in his family. His father was a motor mechanic and his brother was working in a borugula bhatti (kiln that makes fluffed rice).

Despite two of the family members working, it was difficult for the family to get along. Being sensitive to the plight of his family, Mallikarjuna decided to earn money to support the family at an early age of 10 years. Along with some of his friends, he went to Bangalore to earn money. However, he knew no one there and after reaching Bangalore, had to be without food for two to three days.

He engaged himself in the work of cleaning utensils for few years, after a hotel proprietor gave him this work out of pity at the condition of the child. He was later promoted as a supplier in the same hotel. Having been with the same hotel for some years, Mallikarjuna gained recognition for his honesty and the proprietor entrusted him with the entire work related to procurement.

Through all the years, he spent more time in the kitchen and learnt the recipes for various food items, like north Indian, south Indian and fast food items. This gave him the opportunity to grow as the chief chef (master) for 4 years. In all, he worked at the same place for more than 10 years and through this time, he accumulated savings of about Rs.4 lakh.

Having worked in all the departments of the enterprise, he became confident that he could independently engage himself in hotel business. He approached the proprietor with his idea for suggestion. The proprietor too, having seen Mallikarjuna work over the years with dedication, encouraged the idea and motivated him to start his own business. Mallikarjuna costed the enterprise with the help of the proprietor and understood that he had to raise an additional capital of Rs.6 lakh, for which he approached one of his uncles. He established the hotel with an investment of Rs.10 lakh.

All this was about six years ago. Mallikarjuna has since retired a large portion of the debt and is now leading a happy family. ■

Broken Lives

Gambling Caused the Downfall

Seetharamaiah, in his advanced years, lives in Dachepally mandal of Guntur district, Andhra Pradesh. Though educated only up to 10th standard, he was intelligent and articulate. He did not inherit property from his parents. During his youth, he was not interested in working under another person, and hence lost several opportunities to be employed. With the support of persons from his village, he started taking up small contracts like laying roads, building bridges, etc., in his and neighbouring villages. Over the years, he started taking contracts in the neighbouring mandals also.

His business increased and he started making good profits out of the contracts. He became popular in the official circles. He built several houses in his street (since named after him as Seetharamaiah Street) and gave them for rent. These properties were in addition to the 10 acre land that he got from his in-laws.

Though having come up the hard way, he did not consider education as important. He did not pay attention to the education of his two sons and two daughters; and rather, he asked both of his sons to assist him in his works. One of the tenants in Seetharamaiah's house, who worked in a cement factory nearby, joined Seetharamaiah's son (educated up to 5th class) in the factory. However, the son had to withdraw himself from working in the factory as Seetharamaiah objected to his son working under some one else. Several well-wishers pleaded with Seetharamaiah to allow his sons to be on their own and become self-reliant. Proud Seetharamaiah did not relent and expressed confidence that if his sons managed his earnings they could live happily.

As years went by, Seetharamaiah became a gambler, and played high stakes. He started selling his houses one by one to pursue his high stake gambling. Though he was absent for several days at length before and after every such sale, the family members knew nothing of his gambling and could not comprehend his behaviour. In the meantime, he performed the marriage of his daughter, for which he had to sell off whatever remained of his wealth. And, in this way, Seetharamaiah lost all his wealth. No employment came in the way of his sons, who were neither skilled nor educated. Nor could they take up any business, as they had exposure to none. None of the family could support Seetharamaiah. The elder son finally settled as a driver and the younger did some small job in the village.

Thus, a self-made man lost his ground and fell into poverty once again. While the reasons for his becoming big in the village were the support of villagers, his intelligence and articulation and planning with respect to the contracts that he handled, the reasons for his downfall were the pride that made him reject education and self-reliance of his children and his becoming addicted to gambling.■

'Yoga'kshemam

Monsoon is still finding its way! Now, we are almost certain that the rains will be below normal this year, not withstanding Varuna Yagnas and Cloud Seeding. Drought is looming large on the horizon.

Budgets are presented to Parliament! Mamata's Railway Budget on 3 July and Pranab's General Budget on 6 July! These are further to vote-on-accounts presented before elections. Ministry after Ministry is announcing their 100-day plans.

Governments still have to act on initiating bottom-up planning processes. Plans for building the cadres that facilitate organizing the poor are still not visible. Union Cabinet has approved the Food Security Bill for introduction in Parliament. We hear about launching **National Livelihoods Mission** and I guess it takes the role of National Poverty Reduction Mission and take responsibility for organizing at least 50% of poor women into SHGs, i.e. about 40-50 million women, based on the poverty figures one works with**.** Some one-third of them are already in the groups. Government has also approved introducing the Bill for Universal Education Rights.

This month was spent broadly on – continued thinking/ planning for support and advocacy of livelihoods thinking/ practice in collectives of the marginalized. Inducting the facilitators of the entrepreneurs from the poor and not-so-poor, 'reading' the 'walk' in sparsely populated regions in Asia, discussing social entrepreneurship, non-timber forest produce and sourcing human 'resources' for enhancing livelihoods occupied the mind and time. The next step towards building and using the network of entrepreneurs to mentor more of them is planned for 1 August. Let us see how it grows! Thinking about the ways to support reducing school drop-outs on one hand and the experiment for building the 'bright' minds into future leaders have been engaging my waking hours.

G Muralidhar

My **struggle with 'silence'** continues, in addition to 'fasting' practice. The fasting, it occurred to me, has to gradually peak up by the fasting day and taper off gradually. I have also begun energy 'spending' practice to make the fasting practice more effective. I need to respond to silent and gentle reminder of reducing stamina.

The memorial service for Michael Jackson, the biggest event in the media history with more than one billion audience, has endorsed our yogic faith in spreading love, and therefore joy all around. His messages, the participants could put forth include - smile, spread smile, make people love each other and one another, make people believe in themselves, universe needs us, influence the people towards the natural flows of the universe.

We may ponder over the following activities, considered as mistakes from the point of view of good health, and take necessary corrections in our practices to make our life fitter and happier -

- Crossing our legs at knees while we sit – think of moving both legs together to one side or crossing at ankles
- Using a hard tooth brush, not changing tooth brush often
- Eating out often
- Skipping breakfast regularly – if you are trying to diet, take light dinner.
- Using high heels, when you want to walk a lot
- Sleeping on a soft bed – try to sleep on a firm mattress, if not on the mat on the floor
- Not using a thin pillow
- Not exercising at least 1/2 hour a day, 3-4 days a week

If we adapt not to do these, if we take time to consider and start responding in our own way, then we are on our way towards lasting joy in life!

If this adaptation is coupled with the following do's, I gather, lasting bliss is guaranteed:

- recognize your joy and anticipate/prepare for it
- surrender your nervous system and relax
- know the processes to seek joy
- allow time for joy to arrive
- use more ways
- channelize all energy and drive towards joy
- share, communicate and work with partners to multiply joy
- be ready for it physically, mentally and emotionally

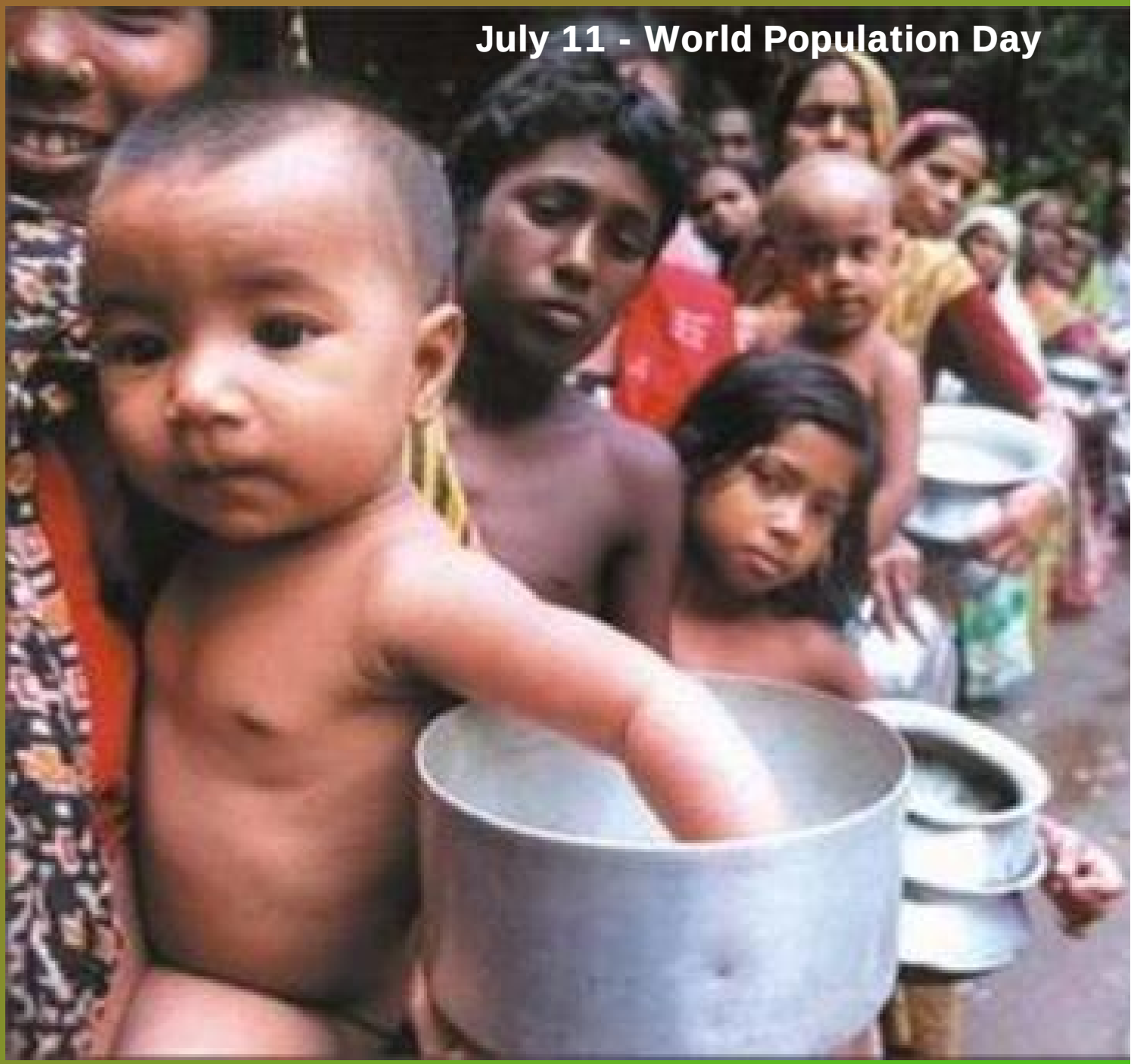
In the forest of the souls together, and through the gentle flows of universe, this month reminds me that we need to spend time, dexterity and energy to create the tension in the string of the bow, sharpen the arrow and sharpen more of them. This may mean we may slow down a bit. As bow exists, string exists, and arrows exist, we need to do this last bit, before they are released. It may take a minute more. Hold on!

Can we do this? **Yes, if we pursue Atma Yoga.** The focus is on the final preparation – sharpening the arrow, building the tension in the string, seeing the eye of the 'bird' for the direction of the flow. Finally, acquire and give it enough momentum to last the duration of the flight. This 'atma' yoga calls for seeking yoga in actions, thoughts and words, feelings and spirit, in the context of this flow. This happens with mastery through discipline and practice.

Krishna guarantees absolute bliss to the atma yogi, the soul, if s/he immerses in relentless yogic practice of flight in the direction in which the Guru has released the soul, setting aside all doubts and dilemmas, and surrendering completely to the will of the Guru. The Guru, residing in the heart with shining lamp to take the yogi towards absolute bliss, **releases the yogi in the direction of flows of the universe and serving all 'life'.** This is 'liberation', Krishna confirms.

Join us in the world of yoga – celebrating surrender in all dimensions of our being to the flows of the souls. You will not regret it. ■

PLAN
TO BEAT POVERTY



Akshara announces a program on Food Security Interventions from 3 - 5 Sept 2009.

livelihoods