



Satyam Makeover
Anand Mahindra's Challenge



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**SHE GETS HER WAY,
FINALLY**

Indira Gandhi used stealth and guile to wean India off socialism. Twenty five years after her death, Pranab Mukherjee gives her brand of socio-capitalism legitimacy

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THE SAVIOUR

How do you prevent babies from dying in large numbers in rural India? Public healthcare remains inadequate, but Dr. Abhay Bang has a simple solution to this complex problem



Dinesh Krishnan

Gadchiroli is one of Maharashtra's poorest districts. And right in the middle, between the tribal and non-tribal, Naxal and non-Naxal parts of the district, sits a group of tribal huts: Dr Abhay Bang's community health and research campus.

In 1988, when he moved here after a Masters in public health from Johns Hopkins University, poverty and negligible healthcare meant that around 121 of 1,000 babies did not survive their first year. This number, known as the Infant Mortality Rate (IMR), was much higher than the national average of 80. Bang tackled the problem by applying a Gandhian concept learnt during a childhood spent in Gandhi's Sevagram Ashram at Wardha. Called *Arogya Swaraj* (freedom in health), it calls for people to take responsibility for their own health.

He enlisted barely-educated village women — called *Arogyadoots* (health messengers) — to deliver babies at home. In 1994, his non-profit, Society for Education, Action and Research in Community Health (SEARCH), started training these women to identify and treat the most common neonatal diseases. "Their motivation is great because they live in the same community," he says. And their salaries are performance-based, with pay cuts for not following standard practices

By 1997-98, the IMR halved, at a cost of just \$5.3 per child, according to results published by Bang and his gynaecologist wife, Rani, in *The Lancet* in 1999. (In

comparison, it took 25 years to halve the national IMR.) Today, the district's IMR is 29, compared to a national average of 55.

Paving the Way

Arogyadoots undergo an arduous selection and training process, to help them identify and treat diseases like sepsis, pneumonia, asphyxia and low birth weight. They are equipped with an innovative home-made doctor's kit: oxygen pumps for asphyxia, an abacus to record heartbeats, 200-watt bulbs and warm bags as incubators. They are re-trained every few months and monitored by doctors regularly.

Gaining the trust of the local people was a big hurdle. "When we first tried to give vitamin injections to babies, parents threatened us saying they would call the police," says Anjana Vikhe, and Arogyadoot in Bodali village.

Bang also had to grapple with superstition. Like feeding pregnant women used bus- and train-tickets in the belief that it would ease their babies' passage into the world, and not clothing babies for months because of the fear that they would not live long, not realising it made babies cold and often fatally sick.

Test Drive

The Planning Commission has set a target of bringing national IMR to 30 by 2012. The "Gadchiroli model" is emerging as the best way to get there: the Commission wants to take home-based neonatal care nationwide. But, can the results of the lifetime commitment of one organisation be replicated? Bang is confident that if done well, the model can halve IMR in three years anywhere.

To find out, the government planned two replication studies. The ANKUR project, launched in 2001 by SEARCH, replicated the model with other NGOs in seven Maharashtra districts. Here too IMR halved in three years. The second trial, by the Indian Council of Medical Research in five states in 2003, worked through the government healthcare system. The results are awaited.

THE GADCHIROLI MODEL

THE MAN

Dr. Abhay Bang, founder of non-profit, Society for Education, Action and Research in Community Health (SEARCH)

THE MODEL

Train women with primary education from within the community to deliver home-based neonatal care.

RESULTS

▶ 50 percent drop in infant mortality rate (IMR) within three years. Today, IMR is 29, compared to a national average of 55.

▶ IMR halved in three years during a replication study in seven districts in Maharashtra.

TAKING IT FORWARD

▶ Planning Commission targets reducing national IMR to 30 by 2012.

▶ Andhra Pradesh, Chattisgarh and Karnataka governments will use their funds from the Commission to roll out this programme this year.

BUDGET HIGHLIGHTS

▶ The National Rural Health Mission to get Rs. 2,057 crore over and above the Rs. 12,070 crore provided in the Interim Budget.

▶ Allocation for the Rashtriya Swasthya Bima Yojana increased 40 percent to Rs. 350 crore; all families living below the poverty line will be brought under the scheme.

It has also been tried in Pakistan, Bangladesh and Zambia. Results from Zambia are awaited; in Bangladesh IMR reduced 34 percent in two years. In a pilot project in Pakistan, IMR fell by a lower 28 percent in three years. (Bang says this was because they used government health workers who did not get additional incentives.)

Dileep Mavalankar, associate professor at IIM Ahmedabad, documented the

Maharashtra study. "This model is good as long as it is under a NGO set up," he says. "Under the government, training, selection and supervision become hard."

This year may well be the biggest test for the Gadchiroli model. The Health ministry's Accredited Social Health Workers (ASHAs) cadre and Chattisgarh's trained tribal health workers called *Mitanin* are both based on the *Arogyadoots*. Andhra Pradesh, Chattisgarh and Karnataka have taken a cue from the Planning Commission and will use their funds to roll out this programme this year. They will train their ASHAs and *Mitanins* to administer home based neonatal care.

"We hope to achieve the same results but the population of Gadchiroli is around three and a half lakh and the population of Chattisgarh is more than two crore," says Ajay Pandey, the state's special secretary for health and family welfare. Chattisgarh's IMR fell to 61 in 2005 (from 95 in 2000) thanks to the enlisting of 60,000 *Mitanins*, who are often uneducated tribal women working in isolated hamlets.

Teaching uneducated women to administer antibiotics remains contentious.

Chattisgarh wants to teach only the better educated *Mitanins*, while others learn simpler things.

In Karnataka, where the model will be implemented in seven backward districts over the next two years, treatments for asphyxiation and sepsis will also not be taught. "Giving injections is a very skilled job," says Mohan Raj, project director for Reproductive and Child Health for the Karnataka State government. "We have a large public health system, unlike Gadchiroli, and we want ASHAs to identify such babies and refer them to hospitals." Here, ASHAs will be trained to teach basic hygiene and healthcare.

At the very least, the Gadchiroli model can supplement the health set up in states where the public health system is better. "Governments should not try to plug a hole cheaply with this," says IIM's Mavalankar. Bang agrees. He says that community-based solutions will supplement an overstretched medical system. ■