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PREM PLAN
PEOPLE'S RURAL HEALTH SCHEME

CASE STUDY

2006

SUBREGIONAL OFFICE FOR SOUTH ASIA, NEW DELHI

Orissa

PREM PLAN
People's Rural Health Scheme

Case Study

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ABBREVIATIONS

AH	Area Hospital
ANC	Ante Natal Care
ANMs	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
CBOs	Community Based Organisations
CHC	Community Health Centre
COPD	Chronic Obstructive Pulmonary Disease
CT	Computerized Tomography
DFID	Department for International Development
DH	District Hospital
ECG	Electrocardiogram
ENT	Ear Nose and Throat
FGD	Focus Group Discussion
GAIL	Gas Authority of India Limited
GEFONT	General Federation of Nepalese Trade Unions
GIS	Geographical Indexing System
GoI	Government of India
HDFC	Housing Development Finance Corporation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
I.O.B	Indian Overseas Bank
IGP	Income Generating Programme
ILO	International Labour Organization
IPCL	Indian Petro Chemicals Limited
IT Act	Income Tax Act
MIS	Management Information System
MKCG Medical College	Maharaja Krishna Chandra Gajapati Medical College
MoHFW	Ministry of Health and Family Welfare
MRI	Magnetic Resonance Imaging
MTP	Medical Termination of Pregnancy
NCMH	National Commission on Macro-economic and Health
NGO	Non-Governmental Organisation
NIC	National Insurance Corporation
NSSO	National Sample Survey Organization

OBC	Other Backward Caste
ONGC	Oil and Natural Gas Commission
PHC	Primary Health Centre
PREM	People's Rural Education Movement
PRHPS	People's Rural Health Promotion Scheme
Prudential-ICICI	Industrial Credit and Investment Corporation of India
RAHA	Raigarh Ambikapur Health Association
RC	Referral Co-ordinator
RCH	Reproductive and Child Health
RHD	Rheumatic Heart Disease
RTI	Respiratory Tract Infection
SC	Scheduled Caste
SEWA	Self Employed Women's Association
SHG	Self Help Group
ST	Scheduled Tribes
STD	Sexually Transmitted Diseases
STEP	Strategies and Tools against Social Exclusion and Poverty
TBAs	Traditional Birth Attenders
UBR	Universal Birth Registration
UMSB	Utkal Mahila Sanchay Bikas
URTI	Urinary Tract Infection
VC	Village Committee
VMD	Village Medical Depot
WHO	World Health Organisation
WHO-I	World Health Organisation-India

EXECUTIVE SUMMARY

Background of the Documentation

According to an estimate of WHO for 1999-2001, more than 80% of total health expenditure in India is private i.e., out of pocket expenditure (WHO 2004 and Devadasan N, Ranson K, Damme WV, Criel B 2004). As per an earlier estimate in 1995 three fourth of per capita health expenditure in India was borne by people themselves (Berman P 1995).

It is estimated that one episode of hospitalisation in India accounts for 58% of per capita annual expenditures, which push 2.2% of the population below the poverty line. (World Bank 2002) As high as 40% of the hospitalised cases in India in 1986-96 had to either borrow money or sell assets to meet hospitalisation costs (NSSO 1998). When confronted with serious health problems the poor had no other way but to mortgage or sell their meagre family property or jewellery or take loans (George A 1997a).

Against this background of health expenditure leading to further impoverishment of the poor, the Government of India introduced certain measures to initiate health insurance for the poor through the Union Budgets 2004-05 and 2004-05. The scheme offered in the 2004-05 budget covered health care costs up to Rs.30, 000 per person per annum, accident cover for Rs.25, 000 and a maximum of Rs.750 for loss of wages at the rate of Rs.50 per day. The amount of annual premium was fixed at Rs. 365 for one person (Rs.1 per day), Rs.547.5 for a family of five (Rs.1.5 per day) and Rs.730 for a family of seven (Rs.2 per day). Families below the poverty line were eligible for a subsidy of Rs.100 per annum towards their premium. This scheme was envisaged to be operated by the four public sector insurance companies, through NGOs and was targeted to enrol 50 lakh families (GoI 2004 & Rao S 2004). The 2004-05 Union Budget restricted the scheme to families below the poverty line and more than doubled the subsidy. As per this a subsidy of Rs.200 was offered for the individual premium of Rs.365, Rs.300 for the premium of Rs.547.5 for families of five and Rs.400 for the premium of Rs.730 for seven member families. A new scheme with a health cover of Rs.10, 000 for a premium of Rs.120 per annum was introduced for members of Self Help Groups (SHG) (GoI 2004 & Rao S 2004).

However all existing diseases and deliveries are not covered under this scheme, as the Mediclaim norms need to be followed. Quality Assurance systems to assure quality of care in health facilities (George A 2002) and cost control measures to prevent induced demand have not been put in place either. Due to various reasons only 4.17 lakh families with a population of 11.62 lakh could be covered in the fist year as against a target of 50 lakh. Probably due to the restricting nature of the policy and poor awareness of the policyholders, claims of only Rs. 28 lakh were settled out of a premium collected of Rs. 19 crores (Rao S 2004).

There are also several initiatives in this direction by state Governments of: Kerala, Delhi, Andhra Pradesh and Karnataka (MoHFW-WHOI 2004). There are also other NGO initiatives in this connection such as the ACCORD in Tamil Nadu, SEWA Rural in Gujarat, RAHA in Chattisgarh, which are some of the precursors to Government activity in this area (Devadasan N, Ranson K, Damme WV, Criel B). PREM-Plan initiative in community health insurance known as People's Rural Health Promotion Scheme (PRHPS), though not a precursor due to its more recent origin, falls within the range of relatively large NGO experiments in community health insurance as it has a membership, which has crossed one lakh persons.

Another notable feature of the PRHPS is its utilisation of the Government sector as the major provider. This is in line with the utilisation pattern of health facilities in Orissa, which presents a

picture of poor development of the private sector, unlike in many other states, where the private sector is more utilised by the people than the Govt. sector. Please see the Introduction of the report for details.

Objectives of the documentation

This study aims to document the systems and procedures of PREM-Plan's micro health insurance scheme for replication, better understanding and feedback for further improvement. Documenting the experience of PRHPS with a large membership base will give valuable insights into the functioning of such schemes and also help the PRHPS managers to have a critical perception of the scheme for its development. We hasten to add however, that this is only a critical documentation of the scheme and not an evaluation.

Methodology

Documentary sources such as forms for membership, claims, etc used by the insurance scheme, current operational documents of membership and benefits, information updates for members, information on referral cases & referral expenditure and data on referral centres, which are maintained by PREM-Plan and UMSB were used for secondary data review and documentation. The methods used for primary data collection from the field are qualitative, viz Key Informant Interviews with managers, key staff, service providers and Focus Group Discussions with PRHPS members. Personal observations of the researchers on visiting the villages and health facilities and interacting with various stakeholders have also been used.

A Profile of PREM-Plan, the Initiator of PRHPS

When People's Rural Education Movement (PREM) was started in 1980 its founders Mr. Jacob Thundiyil and Chacko Paruvanany had the conviction that empowering people was more sustainable than just offering welfare programmes. PREM-Plan's agenda therefore envisioned programmes to enhance literacy along with health care and livelihood programmes. PREM-Plan was aware that all crucial decisions that relate to a community have to be taken by the community itself to ensure the sustainability of programme.

The direct intervention among the diverse communities required organising Community Based Organisations (CBOs) and a strong network for advocacy and lobbying. This was implemented by organising CBOs with federations at apex levels. As a result four state level federations evolved, with strong roots in the operational areas of PREM-Plan. These federations are: Orissa Adivasi Manch, which addresses Adivasi issues, Kalinga Fisher People's Union, which focuses on fishermen and women, Orissa Dalit Manch addressing the issues of Scheduled Castes, and the *Utkal Mahila Sanchay Bikas* (UMSB), which is a federation of Self Help Groups (SHG). Though PREM is actively involved in all development programmes, its role is limited to facilitating the programmes and empowering the people to carry them forward.

Analytical Description and Performance of PRHPS

The community health insurance scheme called People's Rural Health Promotion Scheme (PRHPS) under the banner of Utkal Mahila Sanchay Bikas (UMSB) an organization of women's self help groups was initiated and is being supported by PREM-Plan, based at Berhampur. **This scheme which had a membership of 1,08,589 in 2004-05 has a membership of 87,350 in 2005-06.** As its name indicates it is not just an insurance scheme, but is a comprehensive programme, which covers preventive and promotive health care along with the curative. The scheme forms part of various health related activities of PREM-Plan, which it is undertaking in

its two major project areas of Koraput, in the adivasi areas and in Chilika in dalit localities. The adivasis in Koraput area belong to *Gonds* and *Sama* tribes while dalits of Chilika are of the *Panos* caste.

The PRHPS utilises the Government health institutions from the PHC to the Medical College in varying degrees for its referrals. The scheme has a wide network of peripheral care units called Village Medical Depots (VMD), which are run by trained local persons. Except for serious diseases and emergencies, which cannot be handled at the VMD, other diseases and conditions are treated for three days in these units and then referred to above-mentioned Govt. health facilities. Dependence on private health facilities is not encouraged, though is resorted to in situations where Govt. facilities are not available. PRHPS is also firmly rooted among its membership in the community, with the village committees taking charge of the responsibility of collecting membership, enthusing the people on the slogan of "One for All and All for One". There are regular meetings of UMSB where important decisions on the scheme are taken, information is passed on to the membership and feedback obtained from the people. PREM-Plan is enabling UMSB to take over the responsibility of running the scheme gradually. At the moment in addition to a partial financial support PREM-Plan also provides technical and managerial inputs.

The large membership of the scheme and a strong sense of ownership of the scheme among the members are likely to ensure its sustainability. In Koraput area tribal solidarity binds its membership together and acts as an important factor in strengthening and sustaining the scheme.

The social embedding of PRHPS through the CBOs among adivasis, dalits, fishermen and women helps in ensuring a large membership base, instilling a sense of ownership of the scheme among its members, prompt premium collection and prevention of moral hazards and fraud. Tribal solidarity existing among the adivasis of Koraput area is a major factor in enlisting a large chunk of the scheme's membership, ensuring regular payment of premium and also preventing moral hazards and frauds.

PREM-Plan's development programmes and income generation programmes in particular would be improving the financial and health status of members and also enabling them to pay the premium. As the scheme is set up under the banner of UMSB an apex organisation of self help groups it helps in organising the collection of premium. Self Help groups also provide transport costs to needy patients for utilising the scheme.

PREM-Plan's work in health provides a good background for conducting the health insurance programme as part of an overall programme of health promotion including activities in preventive health.

Preventive health care programmes of PREM-Plan and peripheral care offered through the VMDs help to reduce referral morbidity and thereby reduce the expenditure load on PRHPS. As the scheme is mainly using the Government health sector for referrals it is to some extent insulated from the various exploitative business practices of the private health sector. However the claims ratio of 79.81% in 2004-05 and 80.13% in 2005-06 does not cover administrative costs of the programme, which is currently met by Plan. Therefore an increase in the premium would be necessary.

Recommendations

The Scheme should be able to make proper use of the fresh investments in Orissa's Government health sector made by the World Bank and DFID in terms of infrastructure, equipment and services. The possibility of tying up with Govt's insurance scheme for BPL families for the referral costs need to be seriously considered as the Govt now is offering a substantial subsidy

and a sizeable coverage including accident cover and compensation for loss of wages. The details of this scheme are mentioned in the section on background in this summary.

UMSB needs to be increasingly handed over tasks such as maintaining the Management Information System (MIS) of the scheme, which is currently being done by PREM-Plan.

MIS should be put into more analytical use rather than just for registering membership, paying of claims and for routine accounting. Periodically reports should be taken out and internally analysed by UMSB and PREM-Plan for managerial decision-making. This will also make sure that the data of the membership, referral and accounting sections tally with each other.

PRHPS should build up a brand image of itself. Now the people see it as identical with PREM-Plan while only few providers know about it.

It is necessary to have better rapport with providers in the Government sector. In this connection holding regional meetings of Government providers and explaining to them about PRHPS is likely to make them knowledgeable partners who involve in the scheme.

Mapping of the Services, Human Resources, Infrastructure and equipment in Government facilities in the project districts will help in the speedy referral of patients to the appropriate facilities. This is particularly necessary as the infrastructural, equipment and other additions to Government facilities made by the recent investment from the World Bank and DFID in term of services are not widely known.

Building up a GIS mapping of project villages and the various health facilities in the area will help in assessing the distance required to reach the facilities from different points. The GIS should also spot the availability of different services at these facilities in order to assist in referrals or making alternative treatment arrangements.

An increase of the premium amount without a fall in membership is required for the sustainability of the programme. As mentioned above this was backed by a majority of FGDs, which we conducted also.

Though PREM-Plan had some bad experiences with a public sector insurance company, the PRHPS is now on a growth path both in terms of membership and socially, that it can enter into a fruitful negotiation with public sector insurance companies, which are running this new Government of India scheme.

I. INTRODUCTION

1.1 Background of the Study

According to an estimate of WHO for 1999-2001, more than 80% of total health expenditure in India is private i.e., out of pocket expenditure (WHO 2004 and Devadasan N, Ranson K, Damme WV, Criel B 2004). As per an earlier estimate in 1995 three fourth of per capita health expenditure in India was borne by people themselves (Berman P 1995). It was pointed out that this level of spending by the people is far too high compared to several other countries (Abel-Smith B 1995).

It is estimated that one episode of hospitalisation in India accounts for 58% of per capita annual expenditures, which push 2.2% of the population below the poverty line. (World Bank 2002) As high as 40% of the hospitalised cases in India in 1986-96 had to either borrow money or sell assets to meet hospitalisation costs (NSSO 1998). When confronted with serious health problems the poor had no other way but to mortgage or sell their meagre family property or jewellery or take loans (George A 1997a). In a disaggregated analysis of a study on household health expenditure in Madhya Pradesh, it was found that while the upper most class had to spend only 3.9% of their consumption expenditure on health, the lower middle class had to spend as high as 9.9%, while the lowest class also spent a high 7.9%, which if it is slightly less than the lower middle class it could be only due to poverty induced under-spending. Though in absolute terms the higher classes spent more amounts for health it formed only a small portion of their consumption expenditure, obviously indicating that they could very well afford it. On the other hand the high percentage of health expenditure among the lower classes is not associated with high amounts of health expenditure on their part, which is unaffordable for them. Spending large percentage of consumption expenditure on health by the poor is also likely to reduce the amount spent for food by them, which in turn could lead to or already is leading to a malnutrition-morbidity spiral (George A 1997 a & b).

Against this background of health expenditure leading to further impoverishment of the poor, the Government of India introduced certain measures to initiate health insurance for the poor through the Union Budgets 2004-05 and 2004-05. Though there was an attempt in this direction in the Union Budget 1995-96, which introduced the *Jan Arogya* Scheme (George A 1997 a), these recent measures are much broader in their scope. The scheme offered in the 2004-05 budget covered health care costs up to Rs.30, 000 per person per annum, accident cover for Rs.25, 000 and a maximum of Rs.750 for loss of wages at the rate of Rs.50 per day. The amount of annual premium was fixed at Rs. 365 for one person (Re.1 per day), Rs.547.5 for a family of five (Rs.1.5 per day) and Rs.730 for a family of seven (Rs.2 per day). Families below the poverty line were eligible for a subsidy of Rs.100 per annum towards their premium. This scheme was envisaged to be operated by the four public sector insurance companies, through NGOs and was targeted to enrol 50 lakh families (GoI 2004 & Rao S 2004).

The 2004-05 Union Budget restricted the scheme to families below the poverty line and more than doubled the subsidy. As per this a subsidy of Rs.200 was offered for the individual premium of Rs.365, Rs.300 for the premium of Rs.547.5 for families of five and Rs.400 for the premium of Rs.730 for seven member families. A new scheme with a health cover of Rs.10, 000 for a premium of Rs.120 per annum was introduced for members of Self Help Groups (SHG) (GoI 2004 & Rao S 2004).

However all existing diseases and deliveries are not covered under this scheme, as the Mediclaim norms need to be followed. Quality Assurance systems to assure quality of care in health

facilities (George A 2002) and cost control measures to prevent induced demand have not been put in place either. Due to various reasons only 4.17 lakh families with a population of 11.62 lakh could be covered in the fist year as against a target of 50 lakh. Probably due to the restricting nature of the policy and poor awareness of the policyholders, claims of only Rs. 28 lakh were settled out of a premium collected of Rs. 19 crores (Rao S 2004).

There are also several initiatives in this direction by the state Governments of: Kerala under the *Kutumbasree* programme, of Delhi under the *Arogyanidhi* scheme, and of Andhra Pradesh under the Arogya Raksha scheme (GoI 2004 p.219-20) and the well known *Yashaswini* Scheme of Karnataka (MoHFW-WHOI 2004). There were several NGO initiatives in this connection such as the ACCORD in Tamil Nadu, SEWA Rural in Gujarat, RAHA in Chattisgarh, which are some of the precursors to Government activity in this area (Devadasan N, Ranson K, Damme WV, Criel B). PREM-Plan initiative in community health insurance known as People's Rural Health Promotion Scheme (PRHPS), though not a precursor due to its more recent origin, falls within the range of relatively large NGO experiments in community health insurance as it has a membership, which has crossed one lakh persons.

Another notable feature of the PRHPS is its utilisation of the Government sector as the major provider. This is in line with the utilisation pattern of health facilities in Orissa, which presents a picture of poor development of the private sector, unlike in many other states where private sector is more utilised by the people than the Government sector. In Orissa as per the National Sample Survey (NSS) 52nd Round, as high as 842/1000 hospitalised cases in rural areas during a year were treated in Government hospitals and only 87/1000 cases in private facilities. In the urban areas also 779 out of 1000 hospital cases were treated in the Government institutions as against only 183 in private facilities. For out patient care also 622/1000 cases in rural areas were treated in Government sector, while 378/1000 were treated in private sector. In the urban areas 676/1000 out patient cases utilised Government institutions as against 324/1000 in the private sector (NSSO 1998). PRHPS thus raises the demand of the Government health sector to an extent.

1.2 A Profile of PREM-Plan the Initiator of PRHPS

When People's Rural Education Movement (PREM) was started in 1980 its founders Mr. Jacob Thundiyil and Chacko Paruvanany had the conviction that empowering people was more sustainable than just offering welfare programmes. PREM's agenda therefore envisioned programmes to enhance literacy along with health care and livelihood programmes. Initially three interrelated core issues were addressed viz: raising the literacy level, increasing the political awareness of the rural people and empowering them to demand their rights. PREM-Plan was aware that all crucial decisions that relate to a community have to be taken by the community itself so that a 'dependency syndrome' was not created. This was necessary to ensure the sustainability of programme. Therefore, though PREM-Plan is actively involved in all development programmes, its role is limited to facilitating the programmes and empowering the people to carry them forward.

This was the approach with which PREM-Plan started its work in Mandiapally village in Berhampur. The core group of PREM-Plan embarked on motivation programmes for adult education and awareness building activities in 15 villages of Mohana Block, Ganjam District in Orissa.

1.2.1 PREM-Plan's Social Base and Programmes

The population of PREM-Plan's operational area consists of four diverse groups in its fixed area of operations viz: **1.Adivasis, 2.Scheduled Castes, 3. Small and Marginal farmers and**

4. Marine and inland fishermen. The direct intervention among these diverse communities required organising Community Based Organisations (CBOs) and a strong network for advocacy and lobbying. This was implemented by organising CBOs with federations at apex levels. Groups of women and men were organised separately at the village, sector and block levels. While primary objective of these CBOs was to ensure greater participation of the community and empower them to take their own decisions, these groups also served as forum to raise the awareness as well as literacy levels of the community. They were federated into an apex body for taking up issues of wider concern as well as those that had direct impact on the community. As a result four state level federations evolved, with strong roots in the operational areas of PREM-Plan. These federations are:

- Orissa Adivasi Manch, which addresses Adivasi issues.
- Kalinga Fisher Peoples Union, which focuses on fishermen and women.
- Orissa Dalit Manch addressing the issues of Scheduled Castes, and the
- Utkal Mahila Sanchay Bikas (UMSB), which is a federation of Self Help Groups (SHG)

To address the need of building cadres, young graduates and postgraduates in Orissa were short listed and sent to Bangalore for a short course at 'SEARCH', a training organisation, which deals with institution building, development understanding and NGO management. Among these cadres, many have initiated their own voluntary organisations where they have independence and autonomy of functioning. They still continue to stay as part of PREM-Plan's network and help to strengthen it further. PREM-Plan's network comprises organisations that work together independently. This network of organisations work on different issues. While some of these organisations focus on tribal issues, others work among the fisher folk or dalits. These organisations play advocacy and lobbying roles on their own and join together to collectively address common issues.

Over the years, three clear levels of operations have evolved. Within a small fixed area of operations, PREM-Plan implements programmes directly, while within a wider area, programmes are undertaken in association with the four above mentioned people's organisations. At a third level, mostly advocacy campaigns are organised through PREM-Plan's network partners.

By 1992 PREM-Plan began giving more importance to economic empowerment of target communities. Its activities in this regard include in general, programmes for watershed development, income generation, child development, health programmes and women's development along with a special focus on Income Generating Programme (IGP).

PREM-Plan took on this task without changing its strategy of working through people's organisations. Several initiatives were introduced in the villages where they had a presence. Each village had a Gramya Sangh (men's group), Mahila Sangh (women's group), a Village Committee made up of three representatives each from the men's and women's group. Eight to ten villages were grouped together in a cluster to form a region, which had a regional committee consisting of three representatives from each Gramya Sangh. This regional committee finally elected a Central Committee that was registered as legal body. Central Committee functioned through its office bearers: President, Vice-President, Secretary and Treasurer.

The People's Rural Health Promotion Scheme (PRHPS), the community health insurance programme which is documented here is thus embedded in a network of social organisations and development activities spearheaded by PREM-Plan. These social organisations have been mentioned above already. The various development activities are mentioned below, which is followed by a separate section on health related development activities. This social embedding of PRHPS, ensures better ownership feeling among its members, while various other

developmental programmes of PREM-Plan, such as the SHGs and income earning programmes ensures the prompt payment and collection of premium. The health related programmes provide a general background to launch a health insurance scheme, while public health programmes of PREM-Plan can reduce morbidity due to certain communicable diseases and thereby bring down the expenditure load on PRHPS.

1.2.2 Some of PREM-Plan's Development Activities

Women's Development Programmes

PREM-Plan has organised women in to various Self Help Groups (SHG). In 1992 these groups were federated into an apex body called Utkal Mahila Sanchay Bikas (UMSB), a registered society currently operating in 42 blocks of Orissa and 6 blocks of Andhra Pradesh, where PREM-Plan is functioning. It has 1,950 SHGs with 32,000 members. UMSB has also undertaken several health and development issues like campaign for safe drinking water, anti-alcohol movement, campaigns on violence against women, and on child related issues like child labour and child marriage.

Income Generation Programmes

Some of PREM-Plan's income generation activities include support for turmeric cultivation, fish ponds (prawns), fish vending, promotion and development of various agricultural crops, promotion of weekly markets, petty shops, weaving and handlooms, *kewada* flower gardens, sericulture and *agarbatti* production.

Educational Programme

With support from Plan, PREM initiated a series of activities and programmes for children's education as part of the Child Centred Development programme, the health component of which is mentioned above. In the realm of education this programme included: pre-school education, bridge schools with focus on the girl child, hostels for children from remote villages, education through English medium schools and awareness programmes on child rights.

Disaster Management

PREM-Plan and its network partners coordinated the efforts to rehabilitate and help victims of Super-Cyclone in 1999. PREM-Plan with help from NORAD constructed 150 cyclone resistant houses in Bandhara village where a large number of fisher folk lived and was affected by the cyclone.

1.3 PREM-Plan's Health Programmes

Major Health Interventions of PREM-Plan include:

- Malaria Prevention and Control programme
- Child survival and safe motherhood programme which includes training to traditional birth attendants, Ante-natal camps, Child- to- child health. and
- The People's Rural Health Promotion Scheme (PRHPS)

In addition there are other programmes also which are directly health related or have a bearing on it. Health and related programmes of PREM-Plan are mentioned in a little more detail below.

Malaria Control and Prevention

PREM-Plan initiated a campaign to control and prevent incidence of malaria in about 1000 villages of Gajapati district, Orissa, which is a Malaria prone area, and forms part of PRHPS'

operational area. The main components of the campaign were to improve general hygiene conditions, encourage proper health seeking behaviour, ensure effective mosquito management, and facilitate treatment and eradication malaria. Activities were undertaken both at the local and policy level. One day in a week is observed as Malaria day, when Malaria prevention activities are undertaken.

Pamphlets, posters, cultural programmes and wall paintings in Oriya and Hindi are used as methods of communication to spread awareness about the importance of keeping cow-sheds clean, maintaining drainage systems to prevent stagnation of water, using DDT and Malathis spray to prevent breeding of mosquitoes, making people aware of the benefits of using mosquito nets, neem oil and other mosquito repellents to drive away mosquitoes. People of the project area have been taught to recognize the symptoms of malaria and seek timely medical help. Treatment for malaria requires 10 tablets of chloroquine to be consumed over a specific number of days. However, the policy of the state Government provided for only 4 chloroquine tablets to be given free. The PREM-Plan network successfully lobbied with Government health authorities to give the entire course of 10 tablets free, so that treatment will be complete and effective.

As a result of this programme there is considerable reduction in mosquito population in the adivasi areas of PRHPS operation, which are in the midst of forests. We could feel this directly in our fieldwork, even in villages in the middle of forests, which had very few mosquitoes, considering their location.

Child Centred Health & Development Programme

In 1996, PREM-Plan initiated a child centred development programme in partnership with Plan International, according to which 4000 tribal children of Gajapati and Puri districts in the PRHPS operational area, were covered by a sponsorship programme. This programme focuses on reducing infant and maternal mortality, improving literacy levels, making a joyful learning environment, bringing down drop out rate in schools, reducing child labour and increasing the age at marriage of girls.

Say No to Tobacco Campaign

In order to reduce the dependence of the community on tobacco in its different forms, a campaign was initiated in 10 blocks of Gajapati district. The objectives of 'Say No to Tobacco Campaign' were to increase awareness among communities about the health hazards associated with tobacco usage, motivate communities against consumption and organise diagnostic camps to detect oral and other cancers.

Prevention of HIV/AIDS

PREM-Plan in partnership with NORAD has initiated HIV/AIDS awareness and prevention programme among high-risk groups in six selected blocks of Ganjam district. By stressing the importance of safe sex and monogamous relationship, the programme aims to reduce the vulnerability of communities to HIV/AIDS. Message about the dangers of HIV/AIDS, its spread and the importance of condom use for prevention are disseminated among people through various means.

Eye Care Programme

An eye care programme that covers prevention, treatment and rehabilitation is being conducted. Its components include building awareness about the importance of hygiene, regular eye check ups, identifying cataract and glaucoma cases, treating them, providing the visually impaired with living and earning skills and integrating them into the community.

Universal birth registration

The percentage of registered births among the adivasis, dalits and other marginalised communities was extremely low. In an effort to address this issue, PREM-Plan, and Plan International launched the Universal Birth Registration (UBR) campaign in 2001. So far PREM-Plan has completed this campaign in ten districts of Orissa. PRHPS operational area is also covered by this programme.

People's Rural Health Promotion Scheme (PRHPS)

The community health insurance scheme called People's Rural Health Promotion Scheme (PRHPS) under the banner of Utkal Mahila Sanchay Bikas (UMSB) an organization of women's self help groups was initiated and is being supported by PREM-Plan, based at Berhampur. This scheme had a membership of 1,08,589 in 2004-05, which reduced to 87,350 in 2005-06 and is still one of the large micro-health insurance schemes in India.

As its name indicates it is not just an insurance scheme, but is a comprehensive programme, which covers preventive and promotive health care along with the curative. The scheme forms part of various health related activities of PREM-Plan, which it is undertaking in its two major project areas of Koraput, in the adivasi areas and in Chilika in dalit localities. The adivasis in Koraput area belong to *Gonds* and *Sama* tribes while dalits of Chilika are of the Panos caste. The PRHPS utilises the Government health institutions from the PHC to the Medical College in varying degrees for referrals from its Village Medical Depots (VMD), run by trained local persons. Dependence on private health facilities is not encouraged, though is resorted to in situations where Govt. facilities are not available. PRHPS is also firmly rooted among its membership in the community, with the village committees taking charge of the responsibility of collecting membership, enthusing the people on the slogan of "One for All and All for One". There are regular meetings of UMSB where important decisions on the scheme are taken, information is passed on to the membership and feedback obtained from the people. PREM-Plan is enabling UMSB to take over the responsibility of running the scheme gradually. At the moment in addition to a partial financial support technical and managerial inputs are also provided by PREM-Plan. The large membership of the scheme and a strong sense of ownership of the scheme among the members are likely to ensure its sustainability. In Koraput area tribal solidarity binds its membership together and acts as an important factor in strengthening and sustaining the scheme.

II. METHODOLOGY

2.1 Objectives of the Study

This study aims to document the systems and procedures of PREM-Plan's micro health insurance scheme for replication, better understanding and feedback for further improvement. Documenting the experience of PRHPS with a large membership base will give valuable insights into the functioning of such schemes and also help the PRHPS managers to have a critical perception of the scheme for its development. We hasten to add however, that this is only a critical documentation of the scheme and not an evaluation.

2.2 Methodology

The methodology for this documentation was formulated with some modifications from the guide for undertaking case studies of micro-insurance schemes, developed by the Strategies and Tools against Social Exclusion and Poverty (STEP) programme of the International Labour Organization (ILO, 2000). We have also benefited from the documentation of a similar scheme viz, General Federation of Nepalese Trade Unions (GEFONT), which is a similar scheme in Nepal (Pathak RP, 2004). Documentary sources such as forms for membership, claims, etc used by the insurance scheme, current operational documents of membership and benefits, information updates for members, information on referral cases & referral expenditure and data on referral centres, which are maintained by PREM-Plan and to a lesser extent by UMSB were used for secondary data review and documentation. The methods used for primary data collection from the field are qualitative, viz Key Informant Interviews and Focus Group Discussions. Details of Key Informant Interviews with managers, providers and FGDs are given in **Appendix 4.** The separate guidelines used for Key Informant Interviews of managers and interviews of Providers as well as the FGD guideline used for members of the scheme are given in **Appendix 5.**

Key Informant Interviews with managers and key staff members covered topics like organisational details, membership and coverage, characteristics of the premium, benefit package, ownership and management of the scheme etc. Attempt to clarify regarding the data presented in PRHPS documents were also done through the Key Informant Interviews with managers of the scheme. Altogether 7 key informant interviews were conducted with managers and key staff members.

Provider interviews covered topics like the various services provided in their facilities, their familiarity with the project, their opinion regarding the strengths and weakness of the scheme, scheme's impact on the health of beneficiaries and their suggestions regarding the scheme etc. Nine interviews were conducted with various doctors from PHCs, Dispensaries, CHCs, Area Hospitals, District Hospitals and Medical College to collect information on the services the respective institutions provide and their own views regarding the insurance scheme. The services checklist used for listing the medical, surgical and diagnostic services of the facilities from which providers were interviewed, was formulated by the National Commission on Macro-economic and Health for its study of delivery of health services in India.

Information regarding the views of members was covered through Focus Group Discussions (FGDs) in both Koraput and Chilika. Focus Groups Discussion guideline covered aspects such as history, background and objectives of the insurance scheme as per members' knowledge, the reasons for joining the scheme, opinion regarding coverage/ benefit package/premium/

payment mechanism, utilisation of the services by different gender and social groups, opinion regarding the quality of health care, member's satisfaction from the scheme, views on the future of the scheme and members' suggestions for further improvement. On the whole 10 FGDs were conducted: 6 FGDs in Koraput area, which had a larger, share in membership and 4 in Chilika project area.

The report is also based on the personal observations of the researchers on visiting the villages and health facilities and interacting with various stakeholders.

III. ANALYTICAL DESCRIPTION OF PRHPS

3.1 Organisational Aspects

3.1.1 Initiation & Rationale

The People's Rural Health Promotion Scheme (PRHPS) was started in 2002 January. Jacob Thundiyil and Chacko Paruvanany, the founders of the scheme mentioned that the scheme was aimed at breaking the link between ill health and poverty by ensuring the health care of the adivasis and dalits who are the focal groups of PREM-Plan's development activities. As mentioned already the scheme is embedded in the other health and development activities of PREM-Plan, which are dealt with above. Other existing community health insurance schemes such as RAHA in Chattisgarh and ACCORD in Tamil Nadu *(Devadasan N, Ranson K, Damme WV, Criel B 2004)* have influenced the founders of PRHPS Jacob T and Chacko P to think in terms of initiating a similar scheme with improvisations and modifications for their project area. Both of them had been on exposure visits to the two above-mentioned schemes. The PRHPS is envisaged to be and is being increasingly managed by the people themselves, which will ensure its sustainability. Nalini Abraham Country Health Co-ordinator of Plan India was actively involved in the planning and initiation of this scheme, including organising the exposure visits.

Referral costs of patients from the project area which was reimbursed by Plan was going up steadily and this was one of the pragmatic reasons which prompted PREM-Plan to think in terms of a community based health insurance scheme. Initially PREM-Plan had a tie up with National Insurance Corporation for one year. The delay for reimbursement of the amount spent for treatment and the slow movement of the papers and bills of the scheme made PREM-Plan to think about running a scheme independent of any other insurance company. Besides, the NIC was not covering pre-existing diseases and deliveries either. In addition to the exposure visits, awareness building programmes and training to PREM-Plan staff and UMSB volunteers at the village, regional federation (of SHGs) and apex levels were conducted before launching the scheme.

3.1.2 Government's Role and Relationship with Scheme

There is no direct role for the state or the Central Government in this scheme. However there is a significant indirect role in that the patients of the scheme are referred to the Government health facilities if they are found not to be curable with the medicines provided at the Village Medical Depots (VMD) under the scheme. PREM-Plan was also collaborating with various Government Programmes such as the Malaria Control and TB Eradication programmes. It provided vehicles for the Immunisation Programme, while it has supplied anti malaria tablets when the Government had fallen short of drugs. It had also provided 15 beds to the Orthopaedic ward of the Berhampur medical college, which was thankfully mentioned by the doctors from the medical college.

3.1.3 External support

Plan is providing a progressively declining lump sum grant to the scheme for its first six years as seed fund. After the six years the scheme is expected to be on its own without support from Plan. It has provided Rs. 15 lakh in the first year and Rs. 12 lakh in the second year. In the subsequent years it will provide Rs.10 lakh, Rs. 8 lakh, and Rs. 5 lakh and Rs. 3 lakh. By the 6th year the PRHPS is expected to be self reliant (Table 8). In addition expenditure for capacity building of the volunteers costing Rs. 5 lakh and Rs. 3 lakh over a period of two years and administrative costs of the project are also being borne by Plan now.

Plan is also providing technical support to the scheme. A concrete example being the support of Plan's finance department in advising the investment for PRHPS funds to earn better returns. The Country Health Co-ordinator of Plan and Srinivas Rao, Programme Officer (Health) has been making regular visits to observe the progress of the scheme and give feedback for improvement.

3.1.4 People's Rural Health Promotion Scheme (PRHPS)

The PRHPS enrols as its members only those who belong to the families of PREM-Plan's project areas in Koraput and Chilika. This area covers habitats in the districts of Gajapathi in Koraput area and Puri in Chilika area. Those who are not residing in these two project areas of PREM-Plan are not included. However Mr. Jacob mentioned that PREM-Plan was thinking of starting similar schemes in other areas also. Membership to the scheme is given only if all members of a family are enrolled. This applies for renewal of membership also. Renewal also has to be for all members. There is only one type of membership for which a yellow card is given for each member, with its counterfoil retained with the PRHPS administration for record. There is no separate membership fee apart from the annual premium of Rs.20 per person.

3.2 Socio-Economic Profile of Potential Population and Members

The disaggregated information on membership presented in this section is based on the PREM-Plan database, for which the data was collected by PREM-Plan through a survey and is updated by them. **This data pertains to 2004-05 when the membership was 1,08,589. Though the membership has now reduced to 87,350 in 2005-06, disaggregated figures based on it is not available.** Broad socio-economic patterns of the previous year are unlikely to change, due to the change in membership strength.

The insurance scheme covers 477 villages of which 333 villages are in Koraput area and 144 villages in Chilika area. Total number of households covered is 22,707 out of the 22,992 target households. The total target population of the scheme is 1,09,998 out of which 1,08,589 were members in 2004-05. The whole target population in Koraput area are members of the scheme, while 1409 persons from 285 households more have to be registered in Chilika. Among the 1,08,589 members males and females are almost in equal proportion with 50.2% males and 49.8% females. The number of females in Koraput area is slightly higher than male population, while it is less than the male population in Chilika (Table 1). The former could be because the adivasis accord a higher status to women than the general population.

Table 1: Potential Population and Membership: 2004-05

Target Group and Members	Koraput		Chilika		Total	
	Target	Members	Target	Members	Target	Members
1 Total population	69899	69899	40099	38690	109998	108589
Male	34755	34755	20460	19790	55215 (50.2%)	54545
Female	35144	35144	19639	18900	54783 (49.8%)	54044
2 Total No. of households	14810	14810	8182	7897	22992	22707
3 Total No. of Villages	333	333	144	144	477	477

Table 2 illustrates that a high proportion i.e. 50% (54355) belong to 15-45 age group, while around 27% members belong to 6-14 age group. Below five year old children in the scheme is 9.1% i.e. 2.2% and 6.9% in 0-2 and 3-5 age groups respectively.

Nine percent of members belong to 46-60 age group. Above 60 year old population constituted 5.2% i.e. 13.4% in 61-70 year age group and only 1.8% in above 70 year age group. Health problems affecting the 60+ age group is likely to consume considerable part of the expenditures of PRHPS. Therefore the programme should also aim at certain lifestyle changes for this age group to contain costs.

Table 2 Total Members by Gender and Age Group: 2004-05

	Koraput						Chilika						Grand Total	
	Male		Female		Total		Male		Female		Total			
Age	No	%	No	%	N	%	No	%	No	%	N	%	N	%
0-2	691	1	641	0.9	1332	1.9	550	1.4	482	1.2	1032	2.7	2364	2.2
3-5	2573	3.7	2570	3.7	5143	7.4	1226	3.2	1171	3	2397	6.2	7540	6.9
6-14	10010	14.3	9733	13.9	19743	28.2	4643	12	4444	11.5	9087	23.5	28830	26.5
15-45	17264	24.7	17545	25.1	34809	49.8	9811	25.4	9735	25.2	19546	50.5	54355	50
46-60	2933	4.2	3137	4.5	6070	8.7	2038	5.3	1757	4.5	3795	9.8	9865	9.1
61-70	899	1.3	1097	1.6	1996	2.9	892	2.3	794	2	1686	4.4	3682	3.4
71& above	385	0.6	421	0.6	806	1.2	630	1.6	517	1.3	1147	3.0	1953	1.8
Total	**34755**	**49.7**	**35144**	**50.3**	**69899**	**100**	**19790**	**51.2**	**18900**	**48.8**	**38690**	**100**	**108589**	**100**

Among the 22707 households 51% belong to the Christian community while around 41% households are from the Hindu community. A little over 6% households are Animists, worshipping various spirits and natural objects, who are from the Koraput area, which is a predominantly adivasi area of Orissa. Muslims constitute only 1.2% members of PRHPS, which is due to their low proportion in the area's population. Around 1% of households are Buddhists who too hail from Koraput project area and are refugees from Tibet who have been rehabilitated in the area (Table 3).

Table 3: Distribution of member households by Community: 2004-05

Community	Koraput		Chilika		Total	
	N	%	N	%	N	%
Animist	1444	9.8	-	-	1444	6.4
Buddhist	200	1.4	-	-	200	0.9
Christian	11507	77.7	5	0.1	11512	50.7
Hindu	1658	11.2	7625	96.6	9283	40.9
Muslim	1	0.01	267	3.4	268	1.2
Total	**14810**	**100**	**7897**	**100**	**22707**	**100**

Table 4 brings out that of the 22707 households in the scheme, 48.2% are landless. Around 37% of households has only one acre or less than one acre of land. Landlessness is higher in the Chilika area, where dalits would have been historically prevented from owning land. There were 11% of households with up to two acres of land. The percentage of member households with above two acres of land is marginal (Table 4). The high proportion of landless households and households with extremely small holdings (85%), clearly indicate that most of the PRHPS members are poor.

Table 4: Land holding by member households: 2004-05

Land Holding in acres	Koraput		Chilika		Total	
	N	%	N	%	N	%
<=1	5730	38.7	2592	32.8	8322	36.6
1.1-2	2268	15.3	274	3.5	2542	11.2
2.1- 3	409	2.8	71	0.9	480	2.1
3.1 – 6	332	2.2	37	0.5	369	1.6
7 & above	35	0.2	7	0.1	42	0.2
Landless	6036	40.8	4916	62.3	10952	48.2
Total	**14810**	**100**	**7897**	**100**	**22707**	**100**

The educational level of members has an important influence on their health seeking behaviour. A large chunk i.e. 38.2% of members in the insurance scheme is illiterate. In Koraput project area, which is a tribal belt, 48.3% are illiterate while the corresponding figure for Chilika is 20.1%. The percentage of illiteracy among women is 52.1% in Koraput and 28.4% in Chilika respectively. The corresponding figures for males are 44.5% and 12.1% respectively.

Nearly 27% of total members had primary education. Members with middle school and high school education are 15.8% and 7.5% respectively. The combined percentage of members with school education is 50.1%. Around 2% members have completed intermediate or technical education while 0.8% and 0.2% have completed graduation and post/ Professional courses respectively. A section of 9.1% is children below the school-going age (Table 5).

Table 5: Educational Background of PRHPS Members : 2004-05

Education	Koraput						Chilika						Grand Total	
	Male		Female		Total		Male		Female		Total			
	No	%	No	%	N	%	No	%	No	%	N	%	N	%
Illiterate	15468	44.5	18289	52.1	33757	48.3	2408	12.1	5355	28.4	7763	20.1	41520	38.2
Primary	8410	24.2	7453	21.2	15863	22.7	6878	34.8	6316	33.4	13194	34.1	29057	26.8
Middle	4601	13.2	5211	14.8	9812	14.0	4396	22.2	2999	15.9	7395	19.1	17207	15.8
High school	2394	6.9	850	2.4	3244	4.6	2941	14.9	1950	10.3	4891	12.6	8135	7.5
Intermediate Technical	430	1.2	88	0.3	518	0.7	723	3.7	444	2.3	1167	3.0	1685	1.6
Graduate	156	0.4	40	0.1	196	0.3	554	2.8	167	0.9	721	1.9	917	0.8
PG/ Professional	32	0.1	2	0.006	34	0.05	114	0.6	16	0.1	130	0.3	164	0.2
Children <5 years old	3264	9.4	3211	9.1	6475	9.3	1776	9	1653	8.7	3429	8.9	9904	9.1
Total	**34755**	**100**	**35144**	**100**	**69899**	**100**	**19790**	**100**	**18900**	**100**	**38690**	**100**	**108589**	**100**

According to Table 6 below 43% of PRHPS members are in the category of unemployed/ retired. This data as the rest of the demographic data presented in this section is based on the PREM-Plan database, and therefore we do not know how employment/ unemployment was enumerated in the survey conducted for this database. According to this data set, majority of persons in this category could be unemployed since the number of aged persons in the scheme is comparatively less. Around 19% of members were labourers while 12% of members were farmers. Rural artisans, petty businesspersons and drivers etc constituted less one percent of total members. Children under five years constituted 9% of the population.

Table 6 : Occupation of PRHPS Members: 2004-05

Occupation	Koraput						Chilika						Grand Total	
	Male		Female		Total		Male		Female		Total			
	No	%	No	%	N	%	No	%	No	%	N	%	N	%
Rural Artisans*	176	0.5	127	0.4	303	0.4	217	0.8	117	0.6	334	0.9	637	0.6
Religious Person	80	0.2	5	0.01	85	0.1	33	0.2		0	33	0.08	118	0.1
Farmers	8403	24.2	3957	11.3	12360	17.7	1300	6.6	39	0.2	1339	3.5	13699	12.2
Fishermen	7	0.02	0	0	7	0.01	3192	16.1	70	0.4	3262	8.4	3269	3.0
House wives	0	0	2605	7.4	2605	3.7	95	0.5	7817	41.4	7912	20.5	10517	9.7
Labourers	6323	18.2	9935	28.3	16258	23.3	4115	20.8	692	3.7	4807	12.4	21065	19.4
Servicemen, Teachers	290	0.8	74	0.2	364	0.5	273	1.4	29	0.2	302	0.8	666	0.6
Businessmen, Shop keepers Small Traders	379	1.1	88	0.3	467	0.7	470	2.4	47	0.2	517	1.3	984	0.9
Drivers, Spinners Tailors, Painters	99	0.3	9	0.03	108	0.2	84	0.4	6	0.06	90	0.2	198	0.2
Un employed and retired	15734	45.3	15133	43.1	30867	44.2	8235	41.6	8430	94.7	16665	43.1	47532	43.8
Children <5 years old	3264	9.4	3211	9.1	6475	9.3	1776	9	1653	8.7	3429	8.9	9904	9.1
Total	**34755**	**100**	**35144**	**100**	**69899**	**100**	**19790**	**1.991**	**18900**	**100**	**38693**	**100**	**108589**	**100**

Rural Artisans: Barber, Blacksmith, Brass worker, Gardener, Mason, Butcher, Shoe maker, Washer man, Midwife, Woodcutter, Carpenter, Potter and craftsman

3.3 Feasibility Study

No feasibility study as such was conducted before the programme. The exposure visits to RAHA and ACCORD had given an idea about the strengths and weaknesses of those schemes, which was enriching for the initiators of PRHPS. Certain studies on specific diseases were conducted as part of PREM-Plan's activities in health. These studies on malaria and sickle cell anaemia have also helped in planning the scheme.

3.3.1 Gajapati district Malaria Control Programme

The study on malaria was an impact assessment of the anti-malaria programme conducted in Gajapati district in Orissa. This programme began with 6 Objectives. The table below shows the results of the study with the objectives mentioned in the first column. The project raised the awareness among the households about malaria from 13.6% to 80.3%. In the baseline survey 6256 households used at least one personal protection method. It increased to 26841 by the end of the project. The infection of under five year old children was reduced from 35.8% to 28%, which however was less than the targeted 50% decrease. There was notable decrease in fever deaths also. For details please see table below.

3.3.2 Study of Sickle Cell Anaemia

The screening programme for Sickle cell disease was conducted in some of the blocks of the Gajapati district. Villagers from various blocks like Nuagada, Mohana, and Raigada reported for screening. Among the blocks subjected to sickle cell screening programme, Nuagada showed the highest percentage of sicklers in both adult and 0-5 year age group, which is a high risk group. As regards social incidence, the sicklers' percentage is the highest in the dalit community

of Nuagada block and the lowest among the adivasi community of Mohana block. As it is revealed by the Hb gm% survey most of the people in all the three blocks showed less than 10 gm% of haemoglobin. Clinically such low gm% of haemoglobin is conclusive of prevalence of different causes of anaemia in the community.

Table 7: Malaria Control Programme: Achievements against Objectives

Objectives	Baseline level	Terminal level	Percentage Change	Achievement against objective
1. Awareness on Malaria : **> 75 % of households**	3725 households (13.6%)	21,921 households (80.3 %)	490%	107%
2. Use of At Least One Personal Protection Method **> 60 % of households**	6256 households	26841 households	329%	NA
3. Prevalence of Malaria Infection in Under-Fives **Decrease by 50 %**	35.80%	28.10%	21.50%	43%
4. Incidence of Fever Deaths **Decrease by 75 %**	277 (pre-project year)	169 <5 Child deaths (in project year)	38.90% <5 Child Deaths	48%
5. Documentation of Malaria Endemicity in the District	ACHIEVED : Malaria in Gajapati District Documented			
6. Creation of Innovative Community-Based **Strategy for Malaria Control**	ACHIEVED: The Gajapati District Malaria Control Strategy has been tested and tried; its weaknesses and strengths identified. It is presently being adapted for up-scaling to 3500 villages in 7 tribal districts of Orissa. The Strategy has been documented in CD and Print, to be shared with other Malaria-burdened communities in the world.			

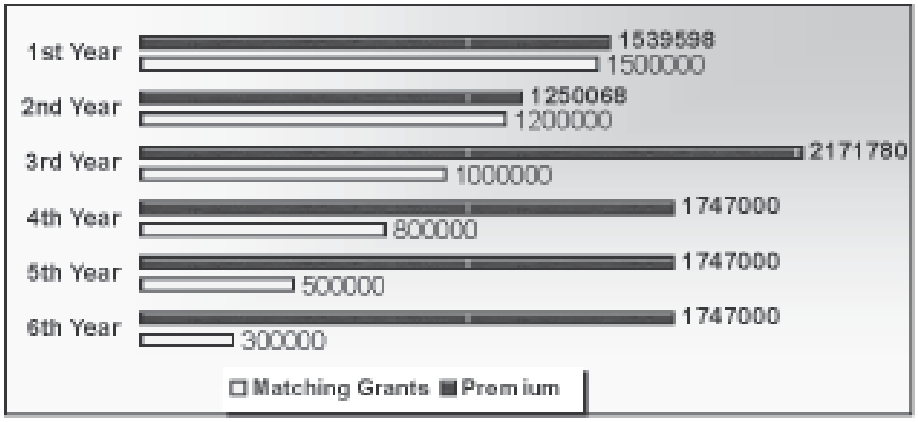
3.4 Financing Mechanism

There is only one type of membership. Paying the premium of Rs.20 per family member enrols all members of a family as members of PRHPS. There is no separate membership fee apart from the premium. Amount paid as premium is consolidated in the account of UMSB and invested mainly in mutual funds (See Table No.9 and **Appendix 3**). The accounts for these are currently maintained at the PREM-Plan office. The UMSB is in the process of setting up its office.

The collection of premium is mainly done during the months of January to March every year. Collection is co-ordinated by the Village Committees (VC) and paid to the sector in charges of PREM-Plan who in turn remit it to the UMSB. The feeling of tribal solidarity ensures the renewal of premium of all families in the adivasi villages, where the scheme operates. The UMSB and PREM-Plan directly deal with the VCs through the sector and cluster in charges of PREM-Plan. The collection of premium is a people's activity, wherein the VCs take the responsibility to make sure that all members renew membership and those who haven't become members also enrol.

To support and stabilize the programme, Plan-International is paying a seed money for six years on a progressively declining basis. The annual amounts collected and projected to be collected as membership and the amounts paid and are to be paid by Plan in this respect are also mentioned in the Figure 1 and Table 8 below. The premium collection for second year shows a decline in the second year as per the figures presented below. These are figures obtained from the MIS of PREM-Plan, which is still getting stabilised. In fact there is not likely to be a decline in membership in the second year as there is practically no dropouts from the scheme. In the 4th year the membership declined from 1,08,589 to 87,350 ie a decline of 19.55%.

Figure 1: Membership Contribution & Support from Plan



Source: *PRHPS - PREM-Plan Data Base. Third Year's contribution is calculated based on the membership data and is not exactly reflected in PRHPS Central Office's financial information. It is also assumed that the membership achieved in the 4th year would not fall further.*

As of now the membership amount is invested mainly in mutual funds, with a small amount in shares and loans. Investments in mutual funds are in both low return - highly secured schemes based on Debts, Govt. Securities and Debentures as well as in high return but relatively less secure equities. Vijaya Bank is the investment adviser to PRHPS. The large PRHPS portfolio of over Rs. 20 lakh that is involved in this investment is attracting other bankers also to make competitive offers of returns on investments. The mutual funds in which the funds are invested include financial companies such as HDFC, TATA, ING Vysya, Prudential-ICICI, Kotak Mahindra and Sahara (Table 9). The detailed investment figures are available in the PREM-Plan database.

Table 8 : Membership Contribution & Support from Plan

Year	Collection from Members (Rs)	Matching Grants from Plan	Total Amount Total (Rs)
1st Year (Premium collected)	15,39,598	15,00,000	30,39,598
2nd Year (Premium collected)	12,50,068	12,00,000	24,50,068
3rd Year	21,71,780**	10,00,000	31,71,780
4th Year	**17,47, 000**	8,00,000	25,47,000
5th Year	**17,47, 000**	5,00,000	22,47,000
6th Year	**17,47, 000**	3,00,000	20,47,000
Total	**1, 02 ,02, 446**	**53, 00, 000**	**1, 55, 02446**

(**Estimated amount with total membership 108589 as on 2004 December)
(Source: PRHPS- PREM-Plan Data Base on Membership)

Table 9: Premium Collection and Investment data

Collection Details	Amount (Rs)	Investment details	Amount (Rs)
FY-03	15,39,598.00	By investment for mutual fund A/c	20,05,000.00
FY-04*	21,71,780.00	By Investment for Share A/c	2,55,950.00
FY-05**	3,42,700.00	By investment for medicine bottle manufacturing expenditure	1,85,000.00
		By Medicine bills payment	6,942.00
		Cash not Transferred from Sectors	9,21,712.00
To Share refunded A/C	1,43,099.00	**Cash at bank**	
To Mutual fund Redemption	2,54,011.21	ING Vysya Bank A/c-25222	8,38,398.87
To Interest Received	6,814.66	I.O.B	1,15,000.00
		ING Vysya Bank A/c-8370	1,00,000.00
Total	**44, 58, 002.87**	**Total**	**44, 58, 002.87**

* *This financial figure based on data provided on membership from PREM-Plan database*
** 2005-06 data on premium collection is not included here as corresponding investment figures required to match this table is not available. The premium figure mentioned here is only partial.
Source: PRHPS- PREM-Plan Data Base April 2005

An amount of Rs. 5 lakh is invested in 8% bonds. Direct exposure to shares is now only to the tune of Rs. 90, 000, which is distributed mainly in IPCL, GAIL, ONGC and Bank of Maharashtra. All these shares except the last one are purchases from public issues, which arose out of disinvestments of highly lucrative petroleum companies in the Government sector. The last one is the public issue of a scheduled commercial bank. Therefore there is no investment in the relatively more risky secondary market, which is prone to wide market fluctuations. It appears that almost all these purchases were from the primary market from new issues, rather than from the relatively more costly secondary market. There is also a small amount of Rs. 1,85,000 given as loan to SHGs under the UMSB, which too is relatively secure as the SHGs have a good repayment history and are affiliates of UMSB. **(See Appendix 3)**

The cost of drug supply to Village Medical Depots is met by the collection of medicine charges from the scheme's members. The revenue from these charges is retained as a revolving fund to finance the drug supply to VMDs. Although 100% charges for medicine costs are collected from members, they are benefited in terms of the low cost and good quality of the medicines. PRHPS purchases in bulk mainly from generic manufacturers and deals only in rational medicines, thus ensuring quality.

Only rational prescriptions based mainly on generic drugs are encouraged by PRHPS. This helps in reducing the cost of medicines. In addition the claims of members for referral care regarding medicines and supplies is mainly met through two medical shops in Berhampur, with whom PRHPS has an agreement to provide cash free services to its members, which is paid in bulk to them every month. The arrangement with these two medical shops helps in reducing moral hazard and induced demand, and thus brings down the expenditure burden on the scheme.

3.5 Benefit Package

The Village Medical Depots (VMD) (See Table 10) deals with a few common ailments such as Fever, Malaria, Loose Motion, Dehydration, Cough, Scabies, and Minor wounds. The people value these depots a lot as these are the only medical help that is accessible to them in their neighbourhood, particularly so in the adivasi areas, with inadequate road and transportation facilities. The medicines dispensed for treating the above mentioned diseases are included in Table 14 in Chapter IV of this report.

If the patient doesn't show any improvement for 3 days after treatment with medicines from the VMD, s/he is referred to a PHC/ CHC/ Area hospital at the sectoral level. From there they are referred to the Berhampur medical college. In the case of emergencies there is a provision for directly approaching the district hospital or the Berhampur Medical College. Diagnostic, Medical & Surgical costs for referrals up to an upper limit which was initially Rs. 3500 was met by PRHPS. This limit is marginally raised to Rs.3600 recently. This upper limit is relaxed in the case of very poor patients who cannot afford the treatment costs. Exceptions are mostly up to about Rs.20,000.

Most of the references are to Govt. institutions. References to private hospitals are made only in situations where Govt. facilities are not existing. Referrals are also made to some hospitals in the voluntary sector in the project area and in some very serious cases to Visakhapatanam in the nearby state of Andhra Pradesh.

Table 10: Benefit Coverage Offered at Various Levels of Health Facilities

Levels of health Care Facilities		Services offered	Coverage
First Level	Village Medical Depots	Fever, Malaria, Lose Motion, Dehydration, Minor Injuries, Cough, Scabies, Safe Delivery and Immunisation. *(Referred to higher facilities if diseases/ conditions not showing significant improvement in 3 days)*	On 100% Payment
Second Level	Sectoral level referrals PHCs, CHCs, Area Hospitals	Any diseases within the capacity of these referral facilities	Maximum of Rs.3500-Rs.3600* for medicines, diagnostics and surgical
Third Level	District Hospitals, Berhampur Medical College and hospitals in Visakhapatanam	Any diseases within the capacity of these referral facilities	Maximum of Rs.3500-Rs.3600* for medicines diagnostics and surgical
	Private hospitals in areas where Govt. hospitals are not available	Any diseases within the capacity of these referral facilities	Maximum of Rs.3500-Rs.3600* for medicines diagnostics and surgical

***Note:** Exceptions at the discretion of PRHPS management in genuinely necessary cases and situations up to a ceiling of about Rs.20,000.*

3.6 Health Care Facilities Utilised

For the PRHPS members of 333 project villages in Koraput area there are only 5 PHCs for primary care. There is one CHC, one Area Hospital and one District Hospital each for first referral care in this area. There is only Medical College, which offers tertiary care to both Koraput, and Chilika areas, known as the MKCG Medical College, named after the erstwhile king of the area. In some cases members from Koraput area also visit two NGO hospitals called Christian hospitals for which are covered under the scheme. Such facilities do not exist in the Chilika area. In that area there are only two PHCs for the members of 144 project villages. There are however 2 CHCs, no area hospital and one district hospital as in Koraput for first referral care. It would be worthwhile to put this data and the distances from specific villages to respective centres on the GIS so that geographical access to various levels in terms

of distance to health facilities and availability of different services can be analysed and highlighted (Table 11).

In order to assess what services are available at the Govt. health institutions of different levels to which the PRHPS patients are referred, a services check list used in the study of Delivery of Health Services by the National Commission on Macroeconomics and Health (NCMH) was administered to a few institutions in the project area. It is found that all PHCs, CHC, Area Hospital and the Medical College visited by the study team are rendering almost all the RCH and communicable disease care services. What is noteworthy as per this set of information, which though has its limitations being based on a very low number of institutions, is that these services are provided at the low end of the health service delivery system. It is found that, Caesarean deliveries are conducted only at the District Hospital and the Medical College and not at the CHC or Area Hospital. Cataract surgeries are also done only at the above-mentioned two centres (Table 12).

Only minor surgeries are done at PHC, CHC and Area Hospital. Major surgeries including abdominal surgeries are done only at district hospital and medical college. Among the major non-communicable diseases; hypertension and Asthma & COPD are treated at relatively lower levels of institutions also. But cardiology, cancer and psychiatric illnesses are attended to only at the Medical College. Neurological surgeries and coma cases are also handled only at the medical college. The situation is the same regarding treatment of urological cases as well. As regards orthopaedics, certain types of surgeries are conducted at the area hospital and district hospital also, in addition to the medical college (Table 12).

Table 11: Referral Facilities in Koraput and Chilika

	Name of Sectors	No. of Villages	PHCs	Dispensaries	CHCs	Area Hospitals	District Hospitals	Medical College	Christian Hospitals(CH)	Other Hospital
Koraput	**Adava**	45	Adava & Birikote		Mohana			MKCG Berhampur	CH Berhampur	
	Mohana	56			Mohana			MKCG Berhampur	CH Berhampur	
	Gilakuta	61		Sikulipadar & Chandiput		Chandragiri		MKCG Berhampur	CH Berhampur	R.Udayagiri
	Primal	42				Chandragiri		MKCG Berhampur	CH Berhampur	R.Udayagiri
	Nuagada	35	Khajuripada				PKD*	MKCG Berhampur	CH Berhampur	Nuagada
	Rayagada	38	Rayagada				PKD	MKCG Berhampur	CH Berhampur	
	Gumma	56	Gumma				PKD	MKCG Berhampur	CH Berhampur & Serango	
	Total	**333**	**5**	**2**	**1**	**1**	**1**	**1**	**2**	**2**
Chilika	**Krishnaprasad**	43	Krishnaprasad					MKCG Berhampur		
	Satpada	45		Panaspada			Puri	MKCG Berhampur		
	Bhramagiri	25			Karanjia		Puri	MKCG Berhampur		
	Konark	31	Kurujango		Konark		Puri	MKCG Berhampur		
	Total	***144***	***2***	***1***	***2***		***1***	***1***		
	Grand total		**7**	**3**	**3**	**1**	**2**	**1**	**2**	**2**

Source: PRHPS- PREM-Plan data base on referral centres
**Parlakhamundi*

Though the incidence of diabetes in India is increasing, diabetic adults and children are managed only at area hospital, district hospital and medical college. STD cases are managed only at the medical college. Dermatological cases are taken care of at some lower level institutions also. Emergency cases including accidents and injuries appear to be handled at all levels institutions.

Though basic dental care and dental extractions are provided at lower level institutions as well, root canal therapy is offered at the Medical College only. The same applies to ENT problems also. Basic ENT care is provided at all levels of institutions, but ear and nose surgeries and even tonsillectomy is conducted at only the medical college.

Regarding the diagnostic tests and examinations; haematology, urine, stool and biochemistry seems to be done at all levels of institutions including the lower ones. Histopathology, Microbiology, Specimen cultures and endoscopy are done only at the medical college. X-Ray is provided from the Area Hospital upwards. ECG and Sonography are available at DH and Medical College. The relatively costly procedures of Doppler monitoring, CT Scan, MRI and angiography are also rendered only at the medical college.

Table 12: Availability of Medical & Diagnostic Services in Referral Centres

Sl. No.	Disease/ Condition	PHC* **N-4**	Dispen-saries **N-1**	CHC Hospital **N-1**	Area Hospital **N-1**	District Hospital **N-1**	Medical College **N-1**
	RCH, Communicable diseases, Eye Care						
1	Ante-Natal Care (ANC)	√	√	√	√	√	√
2	Medical Termination of Pregnancy MTP	√ (3)		√	√	√	√
3	Deliveries	√	√	√	√	√	√
4	Caesarean Section					√	√
5	Hysterectomy					√	√
6	Child Care	√	√	√	√	√	√
7	Diarrhoea	√	√	√	√	√	√
8	Acute Respiratory Infection (ARI)	√	√	√	√	√	√
9	Immunization	√	√	√	√	√	√
10	Tuberculosis	√	√	√	√	√	√
11	Malaria	√	√	√	√	√	√
12	Leprosy	√ (2)	√	√	√	√	√
13	HIV/AIDS						√
14	Basic eye care	√	√	√	√	√	√
15	Cataract Surgery					√	√
	Surgeries						
16	Minor Surgery	√	√	√	√	√	√
17	Major Surgery					√	√
18	Abdominal Surgery					√	√
	Non Communicable Diseases						
20	Cardiology						√
21	Acute myocardial infarction managed					√	√
22	Coronary angiography						√

Sl. No.	Disease/ Condition	PHC* **N-4**	Dispen-saries **N-1**	CHC Hospital **N-1**	Area Hospital **N-1**	District Hospital **N-1**	Medical College **N-1**
23	Hypertension	√ (3)	√		√	√	√
24	Asthma and COPD	√ (3)			√	√	√
25	Cancer						√
26	Psychiatric illness						√
	Dental care						
27	Basic dental care	√		√	√	√	√
28	Dental Extraction			√	√		√
29	Root canal treatment						√
	ENT Diseases						
30	Basic ENT Care	√	√	√	√	√	√
31	Ear surgery						√
32	Tonsillectomy						√
33	Nasal surgery						√
34	**General Medicine**	√	√	√	√	√	√
	Orthopaedics						
35	Open fracture cases managed					√	√
36	Closed fracture cases managed				√	√	√
37	Dislocations managed				√	√	√
38	Orthopaedic surgery under GA					√	√
	Neurology						
39	New cerebro-vascular accident cases						√
40	Coma cases managed						√
41	**Dermatology**				√	√	√
42	**STD**					√	
	Endocrinology						
43	Diabetics on insulin managed – Adults				√	√	√
44	Diabetics on insulin managed- children				√	√	√
	Urology						
45	Prostrate surgery						√
46	Kidney / Ureter surgery						√
47	Scopies						√
48	Lithotripsy						√
	Emergency						
49	First Aid	√	√	√	√	√	√
50	Accidents/Injuries	√	√	√	√	√	√
	Diagnostic Investigations						
51	Haematology			√	√	√	√
52	Urine	√ (2)		√	√	√	√

Sl. No.	Disease/ Condition	PHC* N-4	Dispen-saries N-1	CHC Hospital N-1	Area Hospital N-1	District Hospital N-1	Medical College N-1
53	Stool	√ (2)		√	√	√	√
54	Biochemistry	√ (2)			√	√	√
55	Histopathology						√
56	Microbiology						√
57	Culture of Specimens						√
58	X-Ray				√	√	√
59	ECG					√	√
60	Ultra Sonography					√	√
61	CT Scan						√
62	MRI						√
63	Doppler's						√
64	Endoscopy						√
65	Angiography						√

*Note: * Numbers in brackets show facilities rendering the service*
Source: Interview with providers. The Services Check list used here is based on the check list used by National Commission on Macroeconomics and Health, WHO-MoHFW, New Delhi.

3.7 Referral Morbidity and Expenditure Pattern

On the whole 3391 referral episodes were claimed for payment by the members in the year 2004 for which data is available. Of these only 987 were in the Koraput project area, while 2404 were in the Chilika area. Interestingly when we come to the average claims of both the areas we find that the mean is only Rs.255 for Chilika area, while it is Rs.1136 for Koraput area. The overall mean claim for both the areas together being Rs. 511 (Table 13)

The mean claim is high in Koraput because it is clear from **Appendix 1** that for the adivasis of Koraput, PRHPS is practically the only health provider. Their utilization pattern shows a distribution of small frequencies across a whole range of as many as 228 diseases/conditions/ procedures. On the contrary the utilization pattern in Chilika area is concentrated in a few diseases such as asthma, diarrhoea, dysentery, gastritis, fever, malnutrition, obstetrics, scabies, skin and URTI, which together constitute as much as 66% of their referrals. Their overall utilization is also limited to a much smaller range of 70 diseases only. There are no claims from Chilika for relatively common diseases/conditions/procedures such as abortion, alcoholism, body ache, cataract, deliveries, dental problems/ infection, filariasis, gynaec problems, head ache, heart problem, hydrocil, urinary problems, vision problems, white discharge etc.

Table 13 : Referral Cases and Expenditure: Summary Table 2004-05

Area	No. of Diseases/Conditions	No. of Episodes	Mean Expenditure (Rs.)
Koraput	228	987	1136.3
Chilika	70	2404	254.5
Combined	257**	3391	511.16
Total Referral Cost			**17, 33, 346.1**

Note: Please see Appendix 1 for the Detailed Table.
** Combined data for diseases is not mutually exclusive

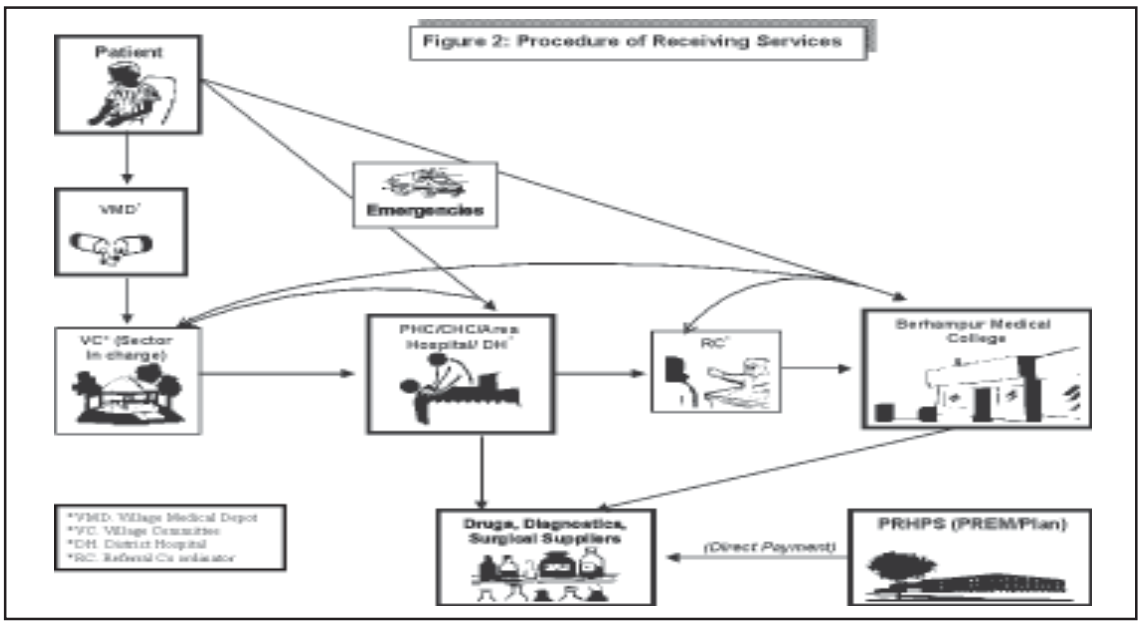
The overall referral expenditure (2004-05) appears to be low at Rs. 17, 33, 346.1 and the mean per episode referral cost at Rs. 511.16. (Table 13) This is due to various reasons. The VMDs are able to control referral morbidity due to timely attention. Most of the referrals are made to the Government health sector, where large part of the services is rendered free. In addition moral hazard is reduced because the referrals are routed through the village committees, who know about the genuineness of individual cases. The agreement of cash free services with the two medical shops also ensure that at Berhampur, which is the main referral centre, there are no possibilities for involving in moral hazard by patients / relatives or induced demand by doctors. Promoting rational prescription and prescription of generic drugs also has contributed in keeping the costs low.

It appears that due to the development of private sector in the Chilika area, which is better developed than Koraput; the members from this area are making a choice between PRHPS and the private sector. The expectation of health care of members from Chilika, seems to be higher and is shaped by the proximity to various health facilities, which they have access, compared to the adivasis living in remote places. They are in fact making less use of the scheme. Though they are making more claims in terms of number of episodes, this is not so far increasing the costs. Thus the mean claim in Chilika area is low mainly because PRHPS does not encourage referrals to the private sector, and also due to other choices which they have, compared to going to Berhampur which entails a high transport cost also for them.

3.8 Procedure of Receiving Services

The patient is first treated at the VMD. After three days if there is no improvement s/he is referred to nearest PHC/ CHC/ Area hospital through the sector offices of PREM-Plan and to the medical college through the Central office of the scheme at Berhampur. A referral request will be considered only if there is a letter from the office bearers of village committee, backing it. But there are no bureaucratic problems in getting these letters. If in case patients cannot produce the letter before the referral, in serious cases, s/he is allowed to produce it at the earliest possible time, while the treatment for referral will be started (Figure 2). In emergencies and for diseases not treated at VMDs, there is a provision for directly sending patients to hospitals and submitting the referral letter from the village committee to the concerned offices of PREM-Plan, which currently act as the PRHPS office. Please see Figure 2 on the process of receiving service.

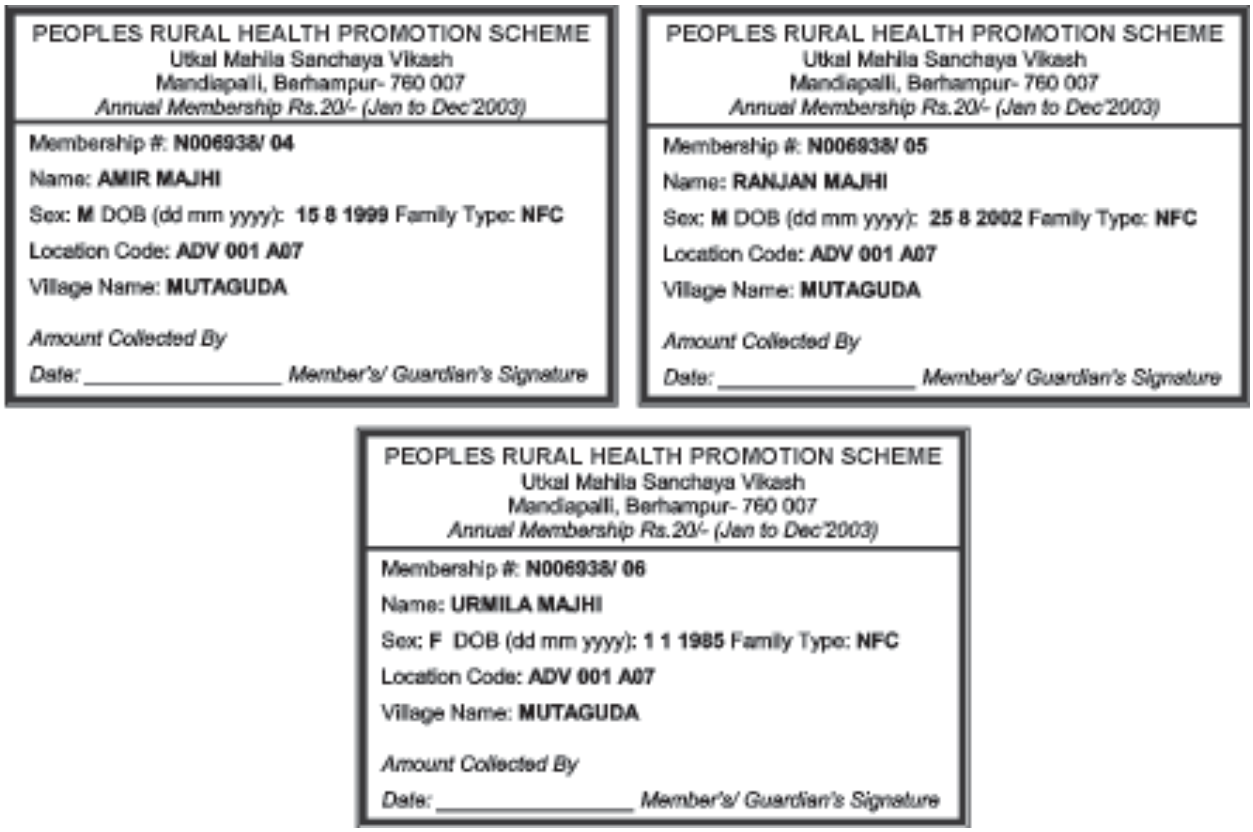
Figure 2: Procedure of Receiving Services



3.9 Insurance Card & Membership Contract

An annual card is issued to every member of the family, whose members are insured. But membership is given and renewed only if it is taken for all members in the family. Membership cannot be taken or renewed for particular members of the family excluding the others, thus preventing adverse selection. Please see membership cards of a family below.

Figure 3 : Membership Cards of Family



3.10 Statutes & Regulations

The UMSB which is the organization in whose name PRHPS is conducted is registered under the Societies Registration Act 1860 and the Income Tax Act 1961. It has registrations under, 80G and 12A of the IT Act. Its accounts are also audited annually. In addition PREM-Plan and UMSB office bearers periodically review the scheme's accounts.

3.11 Control Function

There are weekly meetings of the Village Level Committees, monthly meetings of the Regional Federations of SHGs under UMSB and an annual meeting of the apex organization i.e. UMSB to which, the regional federations are affiliated. The progress of the scheme, it's financial and other aspects are reviewed in these meetings. Audited accounts and annual reports are presented to the apex meetings and also reviewed periodically by the office bearers of UMSB.

3.12 Information System

The daily patient register and drug stock register are maintained at the VMDs. Management Information System (MIS) at the Koraput and Chilika PREM offices maintain demographic information on members based on a census survey of the members and potential members.

They also update information on the membership with deletions of dead members and additions of new born. Referral information including the diseases/conditions of cases referred, expenditures incurred for each case are also maintained. Investment details of the scheme's funds and other accounting details are kept up. This entire MIS is almost completely computerized. Reports which are available from these data sets are however not taken out on a regular basis, except some very basic ones required for example in day to day accounting and payments of claims. These data sets can be put to a much better use in managerial decision-making on the scheme.

3.13 Handling of Adverse Selection, Moral Hazard and Fraud Cases

Adverse selection is taken care of through the full family membership, wherein young and old, sick and healthy gets membership in the scheme. Therefore there is no possibility of any particular section getting selected into the scheme. Moral Hazard is prevented to a large extent as referrals are mainly to the Govt. institutions. But there are allegations that some Govt doctors are taking money from the patients for rendering their services. The community in some cases detects frauds. Some amount of checking of prescriptions is also made at the PRHPS-PREM-Plan central office to ensure that doctors prescribe only rational medicines and inexpensive generics. Examples of doctors being asked by PRHPS to prescribe alternative medicines of the same effect were cited in this respect by the PRHPS-PREM-Plan managers and staff.

3.14 Technical Assistance & Training

Technical support is provided by Plan. It organized the exposure visits for the initiators of the scheme before its commencement. Visits by Plan's health staff and inputs of other consultants of PREM-Plan have also helped the scheme. The individuals running the VMDs were trained in diagnosing and treating for some specific common ailments and in deciding on referrals. Training was also given to sector level and cluster level staff of PREM-Plan in facilitating and supporting members in managing the scheme. They also act as a link between the members and UMSB / PREM-Plan regarding premium collection, referrals etc.

Currently training is also being given to village youth to be posted as Diagnostic and Pharmacy centre staff, at the sector level who will conduct certain less complicated examinations and drug delivery. The latter will deal with a wider range of medicines than the VMD. This will be supportive of the sector level reference to PHC/CHC/ Area hospitals.

IV. PERFORMANCE OF THE SCHEME

4.1 Membership & Coverage

Family members of the PREM-Plan project areas in Koraput and Chilika are eligible to become members of the scheme. The total potential membership is 1,09,998 of which 1,08,589 had become members in 2004-05. Membership is on a voluntary basis, the decision being made by respective families. However, there is social persuasion, particularly in the tribal areas in enrolling all families as members of the scheme. The membership grew from 76,980 in 2003-04 to 108589 in 2004-05 but declined by 19.56% to 87,350 in 2005-06.

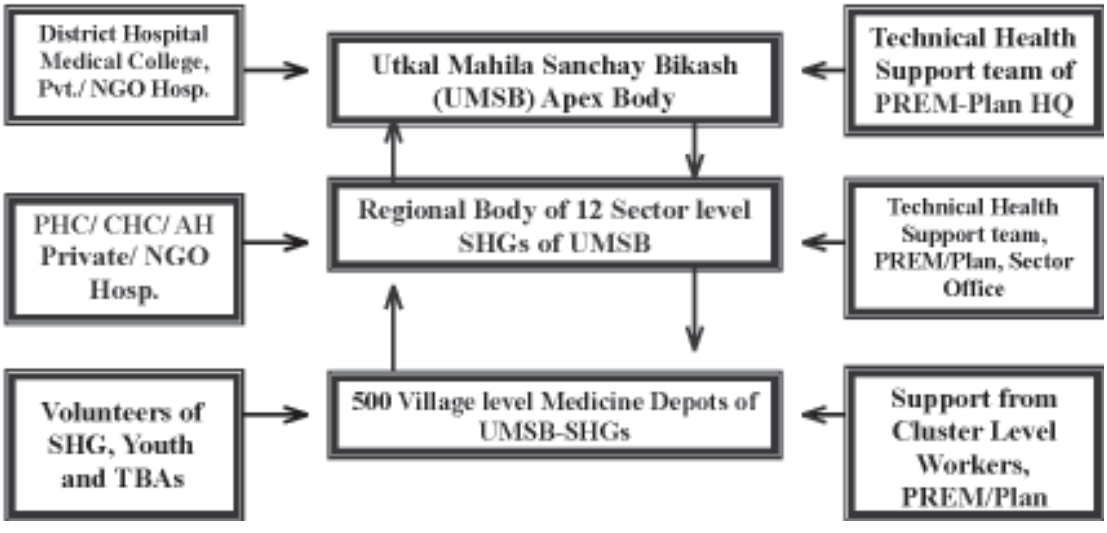
PRHPS has a wide acceptance among the people of the project area, which is reflected in its ability to bring vast majority of its potential population under its reach. However, after an expansion in the initial years, this scheme is also affected by drop outs, though this phase may be got over. But, even after the decline in membership in 2005-06, the scheme has penetrated 79.4% of its potential membership, which is appreciable.

There are many reasons for this penetration. One is that PREM-Plan operates through four CBOs, (mentioned in the section on PREM-Plan's Profile), which have strong roots among the members. In the tribal areas this is further strengthened through tribal solidarity. Second is the village committee, which ensures the collection of the premium with only minimal support from the PREM-Plan staff. Third reason is the strong interface with the UMSB, the apex organization of SHGs, which is also helpful in premium collection and provides loans to members to support their travel costs for referral purposes. Fourth, but no less important is an almost compulsory family membership, which is practiced in the scheme, though technically the membership has to be individual based. An individual cannot take membership or renew premium separately, without doing so for the whole family. In addition to preventing adverse selection, this ensures a large membership base.

4.2 Benefits Offered Presently

The execution of the benefit package and its linkages with UMSB and PREM-Plan at the three levels is presented in the **diagram below** (Figure 4).

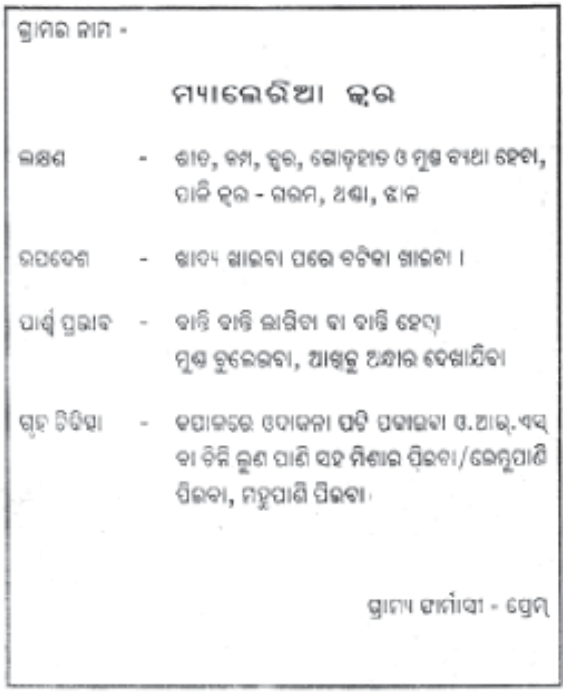
Figure 4: PRHPS PROGRAMME STRUCTURE



Common ailments such as: Fever, Malaria, Loose Motion, Dehydration, Cough, Scabies, and Minor wounds are dealt with by the VMDs, which are run by trained local women from SHGs or by village youth. Safe delivery kits are also supplied by the VMDs, which provide immunisations as well. The chart and Table 14 below show a summary of the medicines that they dispense for respective diseases.


ପ୍ରୋରୋକୁଇନ୍ ବଟିକା =○

ବୟସ	ଦିନ କ୍ରମ			
୦ - ୧ ବର୍ଷ	ପ୍ରଥମ ଦିନ	◡	×	×
	୨ୟ ଦିନ	◡	×	×
	୩ୟ ଦିନ	◡	×	×
୨ - ୩ ବର୍ଷ	ପ୍ରଥମ ଦିନ	○	×	×
	୨ୟ ଦିନ	○	×	×
	୩ୟ ଦିନ	◡	×	×
୪ - ୬ ବର୍ଷ	ପ୍ରଥମ ଦିନ	○○	×	×
	୨ୟ ଦିନ	○○	×	×
	୩ୟ ଦିନ	○	×	×
୭ - ୧୨ ବର୍ଷ	ପ୍ରଥମ ଦିନ	○○○	×	×
	୨ୟ ଦିନ	○○○	×	×
	୩ୟ ଦିନ	○◡	×	×
୧୩ ବର୍ଷ ଓ ଉର୍ଦ୍ଧ୍ୱ	ପ୍ରଥମ ଦିନ	○○○○	×	×
	୨ୟ ଦିନ	○○○○	×	×
	୩ୟ ଦିନ	○○	×	×
ଗର୍ଭାବସ୍ଥା	ପ୍ରଥମ ଦିନ	○○○○	×	×
	୨ୟ ଦିନ	○○○○	×	×
	୩ୟ ଦିନ	○○	×	×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ଲକ୍ଷଣ - ଶୀତ, ବମ, ଜ୍ୱର, ମୋଡ଼ହାତ ଓ ମୁଣ୍ଡ ବ୍ୟଥା ହେବା, ପାଟି ତୁଉ - ଗରମ, ଥଣ୍ଡା, ଝାଳ

ଉପଦେଶ - ଖାଦ୍ୟ ଖାଇବା ପରେ ବଟିକା ଖାଇବା ।

ପାର୍ଶ୍ୱ ପ୍ରଭାବ - ବାନ୍ତି ବାନ୍ତି ଲାଗିବା ବା ବାନ୍ତି ହେବା ମୁଣ୍ଡ ବୁଲେଇବା, ଆଖିରୁ ଅନ୍ଧାର ଦେଖାଯିବା

ଗୃହ ଚିକିତ୍ସା - ତରାଜରେ ତୋଜନା ପରି ପଖାଳରା ଓ.ଆର୍.ଏସ୍ ବା ଚିନି ଲୁଣ ପାଣି ସହ ମିଶାର ପିଇବା/ଜେମୁପାଣି ପିଇବା, ମହୁପାଣି ପିଇବା

ଗ୍ରାମ୍ୟ ସାମ୍ବାସୀ - ପ୍ରେମ୍

Table 14: Diseases treated in Village Medical Depots & Drugs Used

Sl. No.	Diseases	Proposed Medicine
1	Fever Cases	Paracetamol
2	Malaria	Chloroquine
3	Lose Motion	Metronidazole / Furazolidin
4	Dehydration	ORS Packet
5	Minor Injuries	Tincture Iodine, Plaster, Spirit, Band aid, Gauge, Cotton and Dressing set
6	Cough	Herbal Remedy
7	Scabies	Benzin Chloride Solution
8	Safe Delivery	Safe Delivery Kits (Disposable)
9	Immunisation	Card and Weighing machine

The curriculum adopted for training VMD volunteers and their drug distribution chart with dosages for various ages and timings are given as **Appendix 2 & 6.**

Since no other accessible form of health care is available in their surroundings, people in the adivasi areas are quite happy with the services now provided at these VMDs. It appeared that most of the ailments affecting them were treated at the VMDs and cured, with only a few referrals. VMDs under the scheme thus amount to a large exercise in peripheral health care as

it is catering to the whole one lakh plus members of the scheme. The success of the VMD is also because of the effective public health programmes being conducted by PREM-Plan in the area. These are the programmes on safe drinking water and sanitation, nutrition programme for mother and child, malaria and TB eradication, counselling for sickle cell anaemia and health education & training. The person running the VMD maintains a patient register, which notes down date-wise the symptoms, disease treated and the drug dispensed for each case.

If a disease is not subsiding in three days, the patient is referred to the PHC/ CHC/ Area Hospital, which ever is nearby. Depending on the seriousness of the disease and its emergency nature, they are also referred to higher institutions. To be eligible for referral service the patient/ relatives has to produce a referral letter from one of the office bearers of the Village Committee. So far there have not been any major cases of moral hazard or fraud, as the Village Committee acts as a gatekeeper and the high degree of ownership of the scheme among the adivasis prevent it from happening. There is also a provision for directly approaching PHC/ CHC/ Area hospital or the Berhampur Medical College in the case of diseases not treated at the VMDs and in emergencies. In the normal case referral to the Medical College has to be from the sector level i.e., after approaching PHC/ CHC/ Area Hospital.

For referral treatment the medical, diagnostic and surgical cost to the tune of around Rs. 3500 is met by the PRHPS. However in the case of very poor patients with serious health problems, there have been instances of paying above this amount also. Berhampur Medical College with which PREM-Plan has established a very good relationship has been a major referral centre under the scheme.

The drugs, which are prescribed by the doctors for members of PRHPS, are to be purchased from two designated shops in Berhampur without any payment by the members. PRHPS reimburses these shops on a periodic basis, thus making a cash free arrangement available for the members. This arrangement keeps a check on inflating the drug costs by the doctors or patients. However PRHPS does not have such an arrangement with medical shops in the smaller towns, where patients approach the PHC/ CHC/ Area hospitals.

4.3 Additional Benefits to be Offered

It is the above-mentioned lacuna that it addresses to overcome currently by setting up the Sector level diagnostic and pharmacy centres, which are now dispensing drugs beyond what are currently dispensed by the VMDs. These centres are delivering a larger range of medicines than the VMDs, and also conduct several simple examinations of blood, urine and stools. This facilitates the members of the scheme who cannot come from remote places to Berhampur for their diagnostic and drug requirements. The benefit limit of the scheme has also been raised marginally from Rs.3500 to Rs.3600.

4.4 Claim Rate

The claims ratio in 2004-05, based on the referral expenditure of about Rs. 17, 33,346 and the membership of 10,8589 with a premium of Rs. 20 was 79.81%. In 2005-06, it has marginally risen to 80.13%. But the claims ratio will be much higher if the administrative costs now born by Plan are also taken into consideration. The costing of the different items of expenditure under administrative costs is being estimated by PREM-Plan, but is currently not available. There are several items of expenditure under this, which are shared by this scheme and other activities of PREM-Plan. Some examples in this respect will be the salaries of programme staff, MIS staff, accounting staff etc who contribute their time to PRHPS, but work on other programmes of PREM as well. There are also common overheads for PRHPS and other PREM-Plan programmes.

4.5 Costs and Revenues

The scheme offers coverage of only referral costs. Here again most of the referrals are to the Government hospitals, where large part of the treatment is free. Only those medicines, diagnostics and surgicals, which are prescribed for outside purchase by the health providers in these institutions need to be covered by PRHPS. Since in Berhampur the main referral town, scheme allows only cash free drug purchases through its two designated shops, chances of moral hazard is considerably reduced.

At the VMD level the services of the trained volunteers who run the depots is not paid for. However, the management is aware that they will have to be paid at least a token remuneration in the long run. This could also add to the future costs. The cost of medicines dispensed through the VMDs is fully recovered from the members. Timely treatment at the VMDs is helping in reducing referral morbidity substantially.

The main revenues of the scheme are the premium amounts and the contribution from Plan, which has already been described. Of these the premium collection is invested to earn returns for running the scheme once the Plan funding ceases. Plan's contribution is currently used for paying the referral costs. Plan also provided a seed fund to initiate the bulk purchase of medicines for the VMDs. As the cost of drugs dispensed through VMDs is recovered fully from the members this amount from Plan has become a revolving fund.

V. VIEWS OF PRHPS MEMBERS, MANAGERS AND PROVIDERS

5.1 Views of Members

5.1.1 Background Characteristics of the Focus Groups

Focus Group Discussions were conducted in different villages of Koraput and Chilika project areas. Altogether 10 FGDs were conducted i.e. six in Koraput and four in Chilika. All the 6 FGDs conducted in Koraput were among adivasis. In Chilika 3 groups belonged to Schedule Castes while 1 group was OBC. All the FGDs were mixed gender groups with comparatively equal proportion of males and females. Most of the participants were from the age group of 17-30 and 31-45. The participation of members in the 46-65 age group was relatively less, while only a few people aged above 65 were there in the FGDs. This is a reflection of the latter group's population also. The average size of the groups was 14. In 4 FGDs, 6-10 members were illiterate while 12 members of two groups were illiterates. In 5 groups 1-5 members each had primary level education, while in 6 groups 1-5 members had schooling up to secondary level. Discussants in FGDs with intermediate, graduation or post graduation was miniscule in number. Most of the group members were poor labouring people. In 3 groups all were agricultural labourers while 7-10 members in 2 FGDs did other manual work. Thirteen to fourteen members in 2 groups and 5-6 members in other 2 groups were farmers. Seven members each in 4 FGDs were housewives.

5.1.2 Views of Members on Various Aspects of the PRHPS

Those who had utilized the service facilities of PRHPS expressed their positive feelings towards the services. All participants in the groups were members of the scheme. They cited their individual experience, where in the patients coming from even far off areas were making use of the services of the scheme.

All the groups knew about the PRHPS, its objectives and when it was established. In their perception the objective of the scheme was its slogan: "one for all and all for one". It is worthwhile to mention some of the comments made by the groups in this regard.

What Members Know of PRHPS

"Yes we know the programme very well. We are staying in an inaccessible area where there is no health facility at all. We are exploited when any disease occurs. We are exploited by the doctors, compounders and village quacks. But now we also get many facilities through this scheme by paying Rs.20. Now we are able to go to hospital and seek treatment with a little less difficulty. Even though we have no money we are getting treatment. We have a medicine depot at our village. Now exploitation by village quacks and private doctors has decreased and our money is saved".

(FGD Koraput)

"Now we can avail the health services at our doorstep in the village itself. Good relations are also getting established among the community members through this scheme. Narayan Bohi's son, Deepak, was treated for bone rupture. We avail medicines for common diseases like cold, fever, cough etc also from the village medical depot".

(FGD Chilika)

The reasons to join in the scheme were discussed among the various groups. Many groups mentioned that the main reason was the financial burden caused by the medicinal expenditure and exploitation on the part of doctors, quacks and moneylenders from whom they had borrowed money at high interest for treating serious illnesses. The members' reasons for joining the scheme are mentioned in the box below in their own words.

Why They Joined PRHPS

"The people of village were suffering from malaria and other diseases. The patients were not getting medicines properly and expenditure was high in different hospitals. Now some medicines are available in our village. In emergencies we are going to medical college after taking medicines from the VMD. We joined in this scheme to save our children from worm infestation and nutritional deficiency and to take care of pregnant women. The collected money is deposited safely in a special fund with the help of PREM, which will be of help for future". (FGD Koraput)

"In our village one person had gone through a stomach operation. Another person was suffering with paralysis stroke. The scheme helped in both cases."

"As we are staying in Chilika lake area it is difficult to travel to other places. We are getting primary health care at the village level and major treatment at the district headquarter hospital. We are getting maximum facilities by paying a premium of Rs.20/- only. Previously we were not able to get quality treatment due to financial hardships". (FGD Chilika)

Beneficiaries in the groups were asked regarding the coverage and benefit package of the scheme at various facilities. Almost all the groups mentioned that they got medicine for malaria, diarrhoea, fever and other minor diseases from VMDs. The discussants mentioned in the groups that they got most of their health problems treated at the VMD. For serious cases they went to Adava PHC, Mohana CHC or Berhampur Medical College. They purchased medicines as per doctors' prescriptions. They mentioned that they paid travel expenses by themselves. This is not met by PRHPS. Several groups suggested that if PRHPS supplied medicines in the health centre, it would be better because they mentioned that doctors were taking money from them and also prescribed too many medicines, which they considered unnecessary. Few groups mentioned that cotton and medicine for skin diseases were not available in VMDs. Almost all groups mentioned that X-ray facility or laboratory for investigations was not available in PHCs or CHCs. The process of care seeking under PRHPS in Chilika is mentioned in the box below in the people's words.

Process of Seeking Care Under PRHPS: Members' Perception

"The Village Development Committee and the Self Help Groups (SHG) manage the Village Medical Depot through the trained health volunteer of the village. The health volunteer provides the medicines for common diseases that she knows. This saves us from the expenditures usually incurred in treatment in far off places. Expectant mothers get checked up and receive medicines every month at the health camps. For treatment of diseases, beyond the capacity of the health volunteer, we move to the nearest health centre. If it is beyond its capacity to handle, then the patient is shifted to the Berhampur Medical College. As a rule, the VDC has to apply to the sector-in-charge with the endorsement of the village volunteer/cluster manager. After the sector-in-charge endorses the application, one can get the medicines. A woman was not able to get her bill reimbursed because of her ignorance of the procedures. At times, some patients get treated in private clinics because of the

negligence and inefficiency of the Government health centres. Four members among our community were treated in some private clinics. People resort to the private clinics because of the absence of doctors in the PHC. Travel cost also constrains some from going to the Berhampur (Government) Medical College. Services provided under the scheme are enough and we are happy with them. In times of emergency, our SHGs (that have 40 members each) extend financial support for travel and other expenditures for treatment".

(FGD from Chilika)

5.1.3 Opinion Regarding the Premium and Payment Mechanism

All the groups knew how premium was collected, what happened to it afterwards and also how to utilise the scheme. Groups mentioned that the collected money was deposited in UMSB account, which would be utilized at a later stage for illness claims. None of the groups mentioned any difficulties regarding the payment of the premium. Almost all the groups mentioned that they paid the premium during January to February, which was the harvesting season for them. They describe the process of premium collection in the following manner: "We are paying Rs.20 yearly for membership. After the village meeting the fee is collected. The collected money is deposited in the UMSB account by the village president and secretary." "Every year one has to pay Rs.20/- towards membership fee. For newborn babies also we pay premium after birth registration. Fees are collected through the VC in 8-10 days after a discussion on the matter".

5.1.4 Utilization of Services by Members

It was mentioned by all the groups that the members of the scheme got treatment irrespective of caste, tribe or creed. Particularly the pregnant women, children and aged members utilised the scheme more. Regarding the accessibility of services the most mentioned problem was logistics. Other than the financial cost for travelling, problems of terrain and absence adequate spread of roads and transport facilities in the hilly areas are the barriers for accessing health services. The non-availability of doctors in Government facilities and irregular timing of doctors were problems for patients coming from far off places. It is worthwhile to quote some of their comments in this regard, which are mentioned in the box below.

The Distance Constraint

"The distance from our village to PHC is 8 km. District hospital is 38 km away and the Medical College is 158 km away. Serious cases are taken to Paralakhamundi district hospital by bus or tractor. From the insurance scheme we are getting the cost of medicines. Travelling and food expenses have to be borne by us. If doctor is not there we have to wait long till s/he arrives and this causes additional expenditures".

(FGD from Koraput)

"All (of us) are poor. We are paying for travel, food expenditures and treatment costs in private facilities. The distance to hospital is 20 km from our village. We have to take patients by auto-rickshaw because bus stand is 8 km away from the village".

(FGD from Chilika)

5.1.5 Opinion Regarding the Quality of Care

Almost all groups mentioned that they were satisfied with the services rendered by PRHPS at village level and with the management of the programme. It was mentioned by some FGDs that the infrastructure in the lower level Government hospitals is not good. Sometimes patients have to lie on floor. Many groups pointed out the lack of necessary drugs in the PHCs and CHCs. According to the groups infrastructure and equipment are also not sufficient at PHC and

district level. Another area of major concern expressed in several FGDs was that the doctors and other staff of hospitals are charging money. In one FGD it was mentioned that Doctors demand up to Rs.1000/- for delivery cases. When the members were not dealing with the two designated medical shops and diagnostic centres with which PRHPS maintained an account, they had to produce the bills for reimbursement. Lack of proper understanding about this process was causing delay in reimbursement sometimes up to one month. This delay mainly applied to usage of the scheme in smaller towns and rural areas.

Most of the groups said that they were satisfied with the scheme. Groups mentioned that the services provided by village volunteers and various other workers of PREM-Plan were satisfactory. Some groups mentioned that travel cost should be reimbursed and Traditional Birth Attendants (TBA) should be trained well to conduct deliveries in the villages.

5.1.6 Opinion Regarding the Future of the Scheme and Suggestions

All the groups unanimously mentioned that the programme should continue. The groups suggested that even if PREM-Plan withdrew the support they would try to run the scheme with the help of the village committee for which they said rules and regulations would be prepared at the village level. Six FGDs out of the ten mentioned that for the future sustainability of the scheme, they were ready to pay even a higher amount as premium. These groups were ready for an increase of Rs. 10/- in the annual premium. Several groups mentioned that better training should be provided to health workers, ANMs and TBAs.

5.2 Views of the Managers

Managers of the scheme are thinking in terms of extending the scheme to other project areas of PREM-Plan. If there is substantial membership addition that will come to the scheme, it will economically strengthen the scheme further. Marginal additions will however only add to the existing expenditure load of the scheme.

There is also a thinking to increase the premium of the scheme. This would be necessary as the claims ratio now is 80.13%, excluding the administrative costs of the scheme. Since administrative costs are also met by Plan now, it is not getting reflected in the costs of the scheme. As it is necessary to be prepared for the withdrawal of Plan, it is necessary to prepare the membership also for an increase in premium. Six of the ten FGDs conducted among members were ready for an increase in premium of Rs.10. All groups want the scheme to be continued and run even without Plan support.

5.3 Views of the Health Providers of the Scheme

Nine doctors from various Government facilities were contacted for their views regarding the insurance scheme. Doctors from Berhampur Medical College, Paralakhamundi district hospital and from various other hospitals like Area Hospital, CHC and PHC were interviewed in this regard.

Among the 9 doctors interviewed, 6 of them knew to some extent about PREM-Plan whereas 3 were not aware. Some of them appreciated PREM-Plan's programmes on malaria control, immunisation and ANC. Doctors from Koraput project area were very much supportive and sympathetic of PREM-Plan's work among the adivasis. They felt that they should also be part of such a social service activity. Their co-operation with PRHPS is based on this attitude of theirs.

The interviewed doctors mentioned that patients irrespective of gender, caste and age were approaching them. Doctors in primary and secondary level hospitals said that most of the patients who visited the facilities were with acute illnesses.

Even though many doctors were not directly aware about PRHPS, they mentioned that there was improvement in the health of the people due to various activities of PREM-Plan, which includes this scheme. Doctors who knew about PREM-Plan's activities observed that the health awareness of the poor people had increased. People, they said, were showing interest to come to facilities for treatment. Some doctors mentioned that people came with an identity card for treatment, which they said was not necessary to see as a Government doctor. These doctors were obviously not aware of PRHPS, and did not know that the card was the scheme's membership card. An orientation programme at regional levels for the Government doctors will help clarify these matters and also ensure the better co-operation of the doctors for the scheme.

Many doctors working in the district hospital and other lower level facilities suggested that a formal briefing of the programme to doctors is necessary. They were asking for some information on the scheme. It appears that this demand from the providers need to be met as it will provide an opportunity for the providers to interact with the management and staff of the scheme, get to know more about it and ensure their involvement in the scheme.

Doctors mentioned that they also should be included in PREM-Plan's health camps in villages in which they were ready to contribute technically. We however learnt from the management that some doctors were in fact involved in PREM-Plan's health camps. Some of the doctors interviewed had also suggested that pregnant women should be encouraged by PREM-Plan to come to Government facilities for deliveries.

5.4 Future Sustainability

The claims ratio based on present membership of 87350 works out to 80.13%. But this will be much higher if the administrative costs now born by Plan are also taken into consideration. Thus an increase of the premium amount without a fall in membership is required for the sustainability of the programme. As mentioned above this move was backed by a majority of FGDs, which we conducted also. People cherish the scheme and value it. They want to continue it even after Plan withdraws.

No investment plan as such has been drawn up for the amount collected as premium. Discussions with the management gave the impression that they would like to reap the benefit of additional income for the scheme, which was available from mutual funds compared to the meagre interest from bank deposits. The same trend of more investment in mutual funds, but less direct investment in shares is likely to continue.

The management sees the need for increased co-operation with the Govt. health facilities so that the investments made by DFID and the World Bank in the health sector of Orissa in terms of equipment, infrastructure and services could be made better use of.

Management also realises the need to provide more services which are directly managed by the scheme for treatment and diagnosis, and to that extent they are about to introduce diagnostic centres run by a pathologist and a pharmacy run by a pharmacist at the sector level for basic diagnostic tests and for dispensing a larger range of medicines than those dispensed at the VMDs. Cost of these new services to be introduced is being estimated by PREM-Plan. The diagnostic centres run by the pathologists will help in early detection of diseases. Now the adivasis particularly have to travel long distances even for simple diagnostic tests. At present

PRHPS has a cash free arrangement for its members only with two medical shops in Berhampur; and a reimbursement scheme for members from who buy medicines from other smaller towns. With the pharmacies directly run by PREM-Plan, this scheme can be extended much further. There is also a thinking to run a medical shop through which all drugs mentioned in referral prescriptions can be supplied, so that expenses can be further reduced and rational drug use promoted.

In addition it is also planned to have more health prevention programmes particularly of an educational nature. Encouraging some of the time tested tribal health practices is another intervention being thought of. Already some herbal medicines and traditional practices are promoted, but this is not in a very organised manner.

VI. CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The social embedding of PRHPS through the CBOs among adivasis, dalits, fishermen and women mentioned in the introduction helps in ensuring a large membership base, instilling a sense of ownership of the scheme among its members, prompt premium collection and prevention of moral hazard and fraud. Tribal solidarity existing among the adivasis of Koraput area is a major factor in enlisting a large chunk of the scheme's membership, ensuring regular premium payment and preventing moral hazard and fraud.

PREM-Plan's development programmes and income generation programmes in particular would be improving the financial and health status of members, which in turn is also enabling them to pay the premium.

As the scheme is set up under the banner of UMSB an apex organisation of self help groups it helps in organising the collection of premium. Self Help groups also provide transport costs to needy patients for utilising the scheme.

PREM-Plan's work in health provides a good background for conducting the health insurance programme as part of an overall programme of health promotion including activities in preventive health.

Preventive health care programmes of PREM-Plan and peripheral care offered through the VMDs help to reduce referral morbidity and thereby reduce the expenditure load on PRHPS.

As the scheme is mainly using the Government health sector for referrals it is to some extent insulated from the various exploitative business practices of the private health sector, though the Govt doctors also are not totally free of such practices.

However the claims ratio of 80.13% does not cover administrative costs of the programme, which is currently met by Plan. Therefore an increase in the premium would be necessary.

The Scheme should be able to make proper use of the fresh investments in Orissa's Government health sector made by the World Bank and DFID in terms of infrastructure, equipment and services.

The possibility of tying up with Govt scheme for the referral costs need to be seriously considered as the Govt now is offering a substantial subsidy and a sizeable coverage including accident cover and compensation for loss of wages.

6.2 Recommendations

UMSB needs to be increasingly handed over tasks such as maintaining the Management Information System (MIS) of the scheme, which is currently being done by PREM-Plan.

MIS should be put into more analytical use rather than just for registering membership, paying of claims and for routine accounting. Periodically reports should be taken out and internally analysed by UMSB and PREM-Plan for managerial decision-making. This will also make sure that the data of the membership; referral and accounting sections tally with each other.

PRHPS should build up a brand image of itself. Now the people see it as identical with PREM-Plan while only few providers know about it.

Hold regional meetings of Government providers and explain to them about PRHPS to make them knowledgeable partners who involve in the scheme

Mapping of the Services, Human Resources, Infrastructure and equipment in Government facilities in the project districts will help in the speedy referral of patients to the appropriate facilities. This is particularly necessary as the infrastructural, equipment and other additions to the Government facilities made by the recent investment from the World Bank and DFID in terms of services are not widely known.

Building up a GIS mapping of project villages and the various health facilities in the area will help in assessing the distance required to reach the facilities from different points. The GIS should also spot the availability of different services at these facilities in order to assist in referrals at different facilities.

The Government of India has recently launched a new health insurance scheme, including a significant subsidy component, thus reducing substantially the amount to be paid by members for a very sizeable coverage. Though PREM-Plan had some bad experiences with a Govt. run insurance company, the PRHPS is now on a growth path both in terms of membership and socially, that it can enter into a fruitful negotiation with the Govt insurance companies, which are running this new Government of India scheme. A few other organizations have already done this and even succeeded to get insurance companies extend their coverage to pre-existing diseases and deliveries as well. This will resolve the problems of future sustainability of the scheme and ensure its further development.

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APPENDIX

APPENDIX -1

Referral Morbidity and Expenditure Pattern*

Sl. No.	Name of Disease	Koraput		Chilika		Total	
		Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost
1	Abscess	12520.8 (8)	1565.1			12520.8 (8)	1565.1
2	Abdominal pain	11497.6 (16)	718.6	8489.8 (22)	385.9	19984.2 (38)	525.9
3	Abdominal Pain with fever			2450.7 (9)	272.3	2450.7 (9)	272.3
4	Abortion	3696.6 (1)	3696.6			3696.6 (1)	3696.6
5	Acute Bronchitis	317.3 (1)	317.3			317.3 (1)	317.3
6	Alcoholism	3174.1 (1)	3174.1			3174.1 (1)	3174.1
7	Allergy	490.2 (3)	163.4			490.2 (3)	163.4
8	Ameobic colitis	493.4 (1)	493.4			493.4 (1)	493.4
9	Ameobiosis	110.5 (1)	110.5	198 (1)	198	308.4 (2)	154.2
10	Anemia	5586.9 (11)	507.9	2774.2 (13)	213.4	8373.6 (24)	348.9
11	Anexoria	163.75 (1)	163.75	2163.6 (18)	120.2	2327.5 (19)	122.5
12	Anxiety	1417.04 (1)	1417.04			1417.04 (1)	1417.04
13	Anus problem	58.2 (1)	58.2			58.2 (1)	58.2
14	Acid Peptic Disease (APD)	1087.6 (4)	271.9			1087.6 (4)	271.9
15	Appendicitis	2821 (2)	1410.5			2821 (2)	1410.5
16	Acute Respiratory Infection (ARI)	348.7 (1)	348.7			348.7 (1)	348.7
17	Arthritis	12441.8 (7)	1777.4			12441.8 (7)	1777.4
18	Asthma	6063.2 (13)	466.4	17505 (75)	233.4	23566.4 (88)	267.8
19	Back pain	5592.4 (11)	508.4	795.3 (11)	72.3	6386.6 (22)	290.3
20	Barthroid of SC	2811.95 (1)	2811.95			2811.95 (1)	2811.95
21	Bear biting	5778.4 (1)	5778.4			5778.4 (1)	5778.4
22	Birth asphyxia			622 (4)	155.5	622 (4)	155.5
23	Blood cancer	1472.5 (1)	1472.5			1472.5 (1)	1472.5
24	Blood Vomiting	4233.6 (8)	529.2			4233.6 (8)	529.2
25	Body Ache	937.8 (2)	468.9			937.8 (2)	468.9
26	Bone T.B.	15283.6 (4)	3820.9			15283.6 (4)	3820.9
27	Brain Hemorrhage	7960.2 (2)	3980.1			7960.2 (2)	3980.1
28	Brain injury	2699 (1)	2699			2699 (1)	2699
29	Brain Tumour	212 (1)	212			212 (1)	212
30	Breast Abscess	5219.8 (1)	5219.8			5219.8 (1)	5219.8
31	Breast Cancer	12593 (5)	2518.6			12593 (5)	2518.6
32	Breast Tumour	4667.2 (8)	583.4			4667.2 (8)	583.4
33	Bronchitis	1235.2 (2)	617.6	10092.1 (43)	234.7	11326.5 (45)	251.7
34	Burning	430.5 (1)	430.5	8946 (21)	426	9376.4 (22)	426.2
35	Cancer	46393.2 (12)	3866.1			46393.2 (12)	3866.1
36	Carcinoma of Stomach	19264.9 (1)	19264.9			19264.9 (1)	19264.95
37	Carcinoma spine	55 (1)	55			55 (1)	55

Sl. No.	Name of Disease	Koraput		Chilika		Total	
		Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost
38	Cardiac Problem	248.5 (1)	248.5			248.5 (1)	248.5
39	Cat Bite	610.45 (1)	610.45			610.45 (1)	610.45
40	Cataract	1875.6 (4)	468.9			1875.6 (4)	468.9
41	Cervical spondolitis	1009.2 (2)	504.6	1403 (5)	280.6	2412.2 (7)	344.6
42	Cellulites			25862.2 (7)	3694.6	25862.2 (7)	3694.6
43	Chronic Duodenal Ulcer (CH. DU. Ulcer)	150 (1)	150			150 (1)	150
44	Chest pain	8650.2 (26)	332.7	2618 (20)	130.9	11270 (46)	245
45	Chest problem			298 (2)	149	298 (2)	149
46	Chirlitis	69.25 (1)	69.25			69.25 (1)	69.25
47	Cholostrol	278 (1)	278			278 (1)	278
48	Chronic scabis	200.25 (1)	200.25			200.25 (1)	200.25
49	Caesarean section	8041.65 (1)	8041.65			8041.65 (1)	8041.65
50	Colics	1803 (6)	300.5			1803 (6)	300.5
51	Common cold			2317.5 (45)	51.5	2317.5 (45)	51.5
52	Collitis	3670.85 (1)	3670.85			3670.85 (1)	3670.85
53	Cough	3783 (15)	252.2	364.7 (7)	52.1	4147 (22)	188.5
54	Cough & Cold/fever	1606.8 (6)	267.8	3203.7 (59)	54.3	4812.6 (65)	74.04
55	Cough & Chest pain	626.8 (2)	313.4			626.8 (2)	313.4
56	Chronic Renal Failure (CRF)	696.3 (1)	696.3			696.3 (1)	696.3
57	Chronic Problem	364.85 (1)	364.85			364.85 (1)	364.85
58	Chronic Rheumatism	381.2 (1)	381.2			381.2 (1)	381.2
59	Chronic Supporative Otitis Media (CSOM)	734.4 (4)	183.6			734.4 (4)	183.6
60	Cyst	88 (1)	88			88 (1)	88
61	Cellulitis of left leg	0 (1)	0			0 (1)	0
62	Deaf	164 (1)	164			164 (1)	164
63	Delivery	6769.8 (6)	1128.3			6769.8 (6)	1128.3
64	Delivery (complicated)	6752.7 (1)	6752.7			6752.7 (1)	6752.7
65	Dental caries	387.9 (3)	129.3			387.9 (3)	129.3
66	Dental Infection	102.35 (1)	102.35			102.35 (1)	102.35
67	Dental Problem	494 (5)	98.8			494 (5)	98.8
68	Devilpro swelling	873.8 (1)	873.8			873.8 (1)	873.8
69	Diabetics	5099.4 (9)	566.6	3059 (10)	305.9	8158.6 (19)	429.4
70	Diarrhoea	286.6 (1)	286.6	53254.5 (195)	273.1	53527.6 (196)	273.1
71	Dysentery	244.9 (1)	244.9	15782.4 (128)	123.3	16034.7 (129)	124.3
72	Dog bite	8140 (11)	740			8140 (11)	740
73	Dry cough	140 (1)	140			140 (1)	140
74	Dysfunctional Uterine Bleeding (DUB)			37196 (5)	7439.2	37196 (5)	7439.2
75	Ear infection/ problem	2763 (6)	552.6	728 (7)	104	4043.7 (13)	311.05
76	Ectopic pregnancy	4034.6 (1)	4034.6			4034.6 (1)	4034.6
77	ENT	95.84 (1)	95.84			95.84 (1)	95.84

Sl. No.	Name of Disease	Koraput		Chilika		Total	
		Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost
78	Epilepsy	6029.1 (9)	669.9	3690.5 (11)	335.5	9720 (20)	486
79	Esinophilia	371.1 (1)	371.1			371.1 (1)	371.1
80	Exalive	78.25 (1)	78.25			78.25 (1)	78.25
81	Exema	1523.6 (4)	380.9			1523.6 (4)	380.9
82	Eye Infection/ problem	11835.4 (17)	1696.2	3442.6 (14)	245.9	32280.3 (31)	1041.3
83	Eye injury	398.2 (2)	199.1			398.2 (2)	199.1
84	Eye problem	526.8 (4)	131.7			526.8 (4)	131.7
85	Fever	23454 (45)	521.2	406406 (319)	127.4	64100.4 (364)	176.1
86	Fever & Anemia	895.2 (1)	895.2			895.2 (1)	895.2
87	Fever & Cough	378 (2)	189			378 (2)	189
88	Fibrosis	2653.5 (5)	530.7			2653.5 (5)	530.7
89	Filaria	2718.6 (6)	453.1			2718.6 (6)	453.1
90	Fistula	14298.9 (3)	4766.3			14298.9 (3)	4766.3
91	Food Poisoning			416.1 (3)	138.7	416.1 (3)	138.7
92	Fracture	1951.2 (4)	487.8	2866 (4)	716.5	4816.8 (8)	602.1
93	Fractured Leg			1988 (2)	994	1988 (2)	994
94	Fungal infection	580.4 (2)	290.2			580.4 (2)	290.2
95	Gastritis	63258 (26)	243.3	54074 (190)	284.6	60393.6 (216)	279.6
96	General Weakness	4352 (16)	272			4352 (16)	272
97	Gland T.B.	194.8 (1)	194.8			194.8 (1)	194.8
98	Gynec problem	798.2 (2)	399.1			798.2 (2)	399.1
99	Hai Not Bords	3715.9 (1)	3715.9			3715.9 (1)	3715.9
100	Hand & Ear Problem	114 (1)	114			114 (1)	114
101	Hand Burning	13298.45 (1)	13298.45			13298.45 (1)	13298.45
102	Hand fracture	23806.2 (11)	2164.2			23806.2 (11)	2164.2
103	Hernia	9613 (1)	9613	15325.1 (7)	2189.3	24938 (8)	3117.25
104	Head injury	12007.6 (4)	3001.9			12007.6 (4)	3001.9
105	Head Problem	164.2 (1)	164.2			164.2 (1)	164.2
106	Head Reeling	3068.4 (6)	511.4			3068.4 (6)	511.4
107	Headache	5281.9 (17)	310.7			5281.9 (17)	310.7
108	Headache & Fever	447.8 (1)	447.8			447.8 (1)	447.8
109	Hearing Defect	75 (1)	75			75 (1)	75
110	Heart Problem	602.4 (2)	301.2			602.4 (2)	301.2
111	Hematoma	849.1 (1)	849.1			849.1 (1)	849.1
112	Hemophiliasis			1748 (4)	437	1748 (4)	437
113	Hepatitis	15811.8 (3)	5270.6			15811.8 (3)	5270.6
114	Hepatitis B	5488.43 (1)	5488.43			5488.43 (1)	5488.43
115	Hepatosplenomagly	294.8 (1)	294.8			294.8 (1)	294.8
116	Hip Problem	8239.4 (2)	4119.7			8239.4 (2)	4119.7
117	Herpes	62.65 (1)	62.65			62.65 (1)	62.65
118	HRD (Heart Related Diseases)	1114 (5)	222.8			1114 (5)	222.8
119	Hydrocil	19563.3 (9)	2173.7			19563.3 (9)	2173.7

Sl. No.	Name of Disease	Koraput		Chilika		Total	
		Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost
120	Hypertension	8262 (9)	918	4633.6 (16)	289.6	12895 (25)	515.8
121	Infertility	2015.2 (2)	1007.6			2015.2 (2)	1007.6
122	Indigestion			2997.5 (55)	54.5	2997.5 (55)	54.5
123	Injury	2199.5 (5)	439.9	5707.6 (19)	300.4	7908 (24)	329.5
124	Limb Injuries	3992.7 (3)	1330.9	2150 (4)	537.5	61432 (7)	877.6
125	Joint Pain	200.3 (1)	200.3	3726 (30)	124.2	3927.7 (31)	126.7
126	Keratitis	930 (2)	465			930 (2)	465
127	Kidney Disorder			4938 (4)	1234.5	4938 (4)	1234.5
128	Keloid Cyst	9144 (6)	152.4			9144 (6)	152.4
129	Leg Fracture	24516 (9)	2724			24516 (9)	2724
130	Leprosy	2655.6 (2)	1327.8			2655.6 (2)	1327.8
131	Liver abscess	12175.2 (1)	12175.2			12175.2 (1)	12175.2
132	Liver Disease/Problem	19651.2 (8)	2456.4	4306.5 (15)	287.1	23957.49 (23)	1041.63
133	Loss of Weight	90 (1)	90			90 (1)	90
134	Loss of appetite			182 (2)	91	182 (2)	91
135	Low Back Pain	1746.4 (2)	873.2			1746.4 (2)	873.2
136	LT. Hand Fracture	657 (2)	328.5			657 (2)	328.5
137	M. Balunma	121.5 (1)	121.5			121.5 (1)	121.5
138	Malaria	110022.3 (81)	1358.3	1634.6 (11)	148.6	111651.2 (92)	1213.6
139	Malnutrition	51.75 (1)	51.75	48781.2 (156)	312.7	48827 (157)	311
140	Mass Abdomen	648.5 (1)	648.5			648.5 (1)	648.5
141	Mental Disorder	16625.5 (25)	665.02			16625.5 (25)	665.02
142	Metatarsal Fracture	2882.6 (1)	2882.6			2882.6 (1)	2882.6
143	Mild tenderness			1383.3 (9)	153.7	1383.3 (9)	153.7
144	Molar Pregnancy			798 (1)	798	798 (1)	798
145	Mouth Infection	795.8 (2)	397.9			795.8 (2)	397.9
146	Mouth Ulcer	195 (1)	195			195 (1)	195
147	Multiple Injuries	1091.75 (1)	1091.75	5548.4 (22)	252.2	6640.1 (23)	288.7
148	Multiple Boils	2332.7 (1)	2332.7			2332.7 (1)	2332.7
149	Multiple Pains	209 (1)	209			209 (1)	209
150	Muscle Pain	155.4 (1)	155.4			155.4 (1)	155.4
151	Myeloma	3249.25 (1)	3249.25			3249.25 (1)	3249.25
152	Nasal Bleeding/problem	8711.4 (6)	1451.9			8711.4 (6)	1451.9
153	Nephrotic syndrome	3991.2 (2)	1995.6			3991.2 (2)	1995.6
154	Nefritic syndrome			3265 (1)	3265	3265 (1)	3265
155	Neuritis			1008.8 (4)	252.2	1008.8 (4)	252.2
156	Neurosis			474 (3)	158	474 (3)	158
157	Night Blindness	334.5 (1)	334.5			334.5 (1)	334.5
158	Nose Infection	196 (1)	196			196 (1)	196
159	Nose inflammation			931.8 (6)	155.3	931.8 (6)	155.3
160	Nuratitis	64 (1)	64			64 (1)	64
161	Obstetric case			25093.4 (74)	339.1	25093.4 (74)	339.1

Sl. No.	Name of Disease	Koraput		Chilika		Total	
		Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost
162	Orchitis Lt. Side	113.4 (1)	113.4			113.4 (1)	113.4
163	Orthopaedics	821.4 (2)	410.7			821.4 (2)	410.7
164	Orthopaedic problem			3644.3 (11)	331.3	3644.3 (11)	331.3
165	Ovarian Tumour	3685.8 (2)	1842.9			3685.8 (2)	1842.9
166	Pain	18246.6 (27)	675.8			18246.6 (27)	675.8
167	Pain in leg			286 (2)	143	286 (2)	143
168	Pal	71.1 (1)	71.1			71.1 (1)	71.1
169	Paralysis	16064.4 (11)	1460.4			16064.4 (11)	1460.4
170	Peri Anal Abscess	170 (1)	170			170 (1)	170
171	Bells Palsy	309.6 (1)	309.6			309.6 (1)	309.6
172	Peptic Ulcer	475.7 (1)	475.7	10367.7 (7)	1481.1	10844 (8)	1355.5
173	PHD	405.2 (1)	405.25			405.2 (1)	405.25
174	PHY	711 (1)	711			711 (1)	711
175	Pharyngitis			4957.5 (15)	330.5	4957.5 (15)	330.5
176	Piles	7809.9 (7)	1115.7	996 (5)	199.2	8805.6 (12)	733.8
177	Palmbar Fareitis	55.1 (1)	55.1			55.1 (1)	55.1
178	Plemal Effasea	797.4 (1)	797.4			797.4 (1)	797.4
179	Para Nasal Sinuses (PNS)	630.4 (2)	315.2			630.4 (2)	315.2
180	Pneumonia			1406 (2)	703	1406 (2)	703
181	Post Inflamentary	95 (1)	95			95 (1)	95
182	Post Natal Care	79.18 (1)	79.18			79.18 (1)	79.18
183	Post Partum Haemorrhage (PPH)	1893 (1)	1893			1893 (1)	1893
184	PPRP	11052.75 (1)	11052.75			11052.75 (1)	11052.75
185	Pregnancy	1006.4 (2)	503.2			1006.4 (2)	503.2
186	PRHAPS	600.15 (1)	600.15			600.15 (1)	600.15
187	Psoriasis	709.2 (2)	354.6			709.2 (2)	354.6
188	Purening	201.6 (1)	201.6			201.6 (1)	201.6
189	Pyaria	210 (2)	105			210 (2)	105
190	Rheumatic Heart Disease (RHD)	2345.6 (4)	586.4			2345.6 (4)	586.4
191	Rectum Prolapse			3077 (2)	1538.5	3077 (2)	1538.5
192	Rhinosporidiosis	705.95 (1)	705.95			705.95 (1)	705.95
193	Rheumatism	292 (1)	292	2006.9 (7)	286.7	2299.2 (8)	287.4
194	Rib Fracture	1086.4 (2)	543.2			1086.4 (2)	543.2
195	Rt. Foot Pain	1378.4 (2)	689.2			1378.4 (2)	689.2
196	Rt. Hand Fracture	2360.6 (2)	1180.3			2360.6 (2)	1180.3
197	Rt. Leg. Puledup	500.8 (1)	500.8			500.8 (1)	500.8
198	Respiratory tract Infection (RTI)	788 (1)	788			788 (1)	788
199	Scabies	230.65 (1)	230.65	13944 (112)	124. 5	14181.5 (113)	125.5
200	Scabies & Cough	141.45 (1)	141.45			141.45 (1)	141.45
201	Scabies & Fever	527.7 (1)	527.7			527.7 (1)	527.7
202	Scabis	232.4 (2)	116.2			232.4 (2)	116.2
203	Septic	2843.75 (1)	2843.75			2843.75 (1)	2843.75

Sl. No.	Name of Disease	Koraput		Chilika		Total	
		Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost
204	Scorpion bite			163 (1)	163	163 (1)	163
205	Sickle Cell Anaemia	12620.4 (13)	970.8			12620.4 (13)	970.8
206	Sinusitis	2636.1 (9)	292.9	5241.6 (42)	124. 8	7879.5 (51)	154.5
207	Skin & Dental Problem	857.3 (1)	857.3			857.3 (1)	857.3
208	Skin Diseases	242 (1)	242	60940 (220)	277	61172.8 (221)	276.8
209	Skin Infection	3040.2 (6)	506.7			3040.2 (6)	506.7
210	Skin Infection & Anaemia	48 (1)	48			48 (1)	48
211	Snake Bite	22511.85 (3)	7503.95			22511.85 (3)	7503.95
212	Spine Infection	236.5 (1)	236.5			236.5 (1)	236.5
213	Spinal Injury	3941.4 (2)	1970.7			3941.4 (2)	1970.7
214	Sponalishis	66.6 (1)	66.6			66.6 (1)	66.6
215	Spondolisis	4565.45 (1)	4565.45			4565.45 (1)	4565.45
216	Spondilitis			495 (2)	247. 5	495 (2)	247.5
217	Sprain	2631.3 (3)	877.1			2631.3 (3)	877.1
218	Sprain & T.B.	680.4 (2)	340.2			680.4 (2)	340.2
219	Sprain (Pain)	638 (2)	319			638 (2)	319
220	Sprodnis Lellbo ? (clarify)	572.48 (1)	572.48			572.48 (1)	572.48
221	Stomach Pain	5799 (2)	2899.5			5799 (2)	2899.5
222	Stomach Upset			492.8 (7)	70.4	492.8 (7)	70.4
223	Stomatitis			574.2 (9)	63.8	574.2 (9)	63.8
224	Stone in Penis	147 (1)	147			147 (1)	147
225	Substance	1712.9 (1)	1712.9			1712.9 (1)	1712.9
226	Swelling of Body	941 (2)	470.5			941 (2)	470.5
227	Swelling	320.76 (1)	320.76			320.76 (1)	320.76
228	T.B.	192889.9(133)	1450.3	11602.8 (44)	263.7	204488.1(177)	1155.3
229	(T.B. Gland)	214 (1)	214			214 (1)	214
230	T.ORPSIS	293.5 (1)	293.5			293.5 (1)	293.5
231	Thyroid Problem	9602.4 (2)	4801.2			9602.4 (2)	4801.2
232	Throat Fracture	20194.65 (1)	20194.65			20194.65 (1)	20194.65
233	Throat Pain	325.05 (1)	325.05			325.05 (1)	325.05
234	Tinea Infafating	173.5 (1)	173.5			173.5 (1)	173.5
235	Tinea Infection	134.3 (1)	134.3			134.3 (1)	134.3
236	Tonsil	1803.9 (3)	601.3	1486.2 (6)	247.7	3289.5 (9)	365.5
237	Tsloso Palsy	98.35 (1)	98.35			98.35 (1)	98.35
238	Tumour	217.4 (1)	217.4			217.4 (1)	217.4
239	Tumour Carpisis	112.1 (1)	112.1			112.1 (1)	112.1
240	Typhoid			1404 (52)	270	14040 (52)	270
241	Urinal Problem	4612.2 (3)	1537.4			4612.2 (3)	1537.4
242	Urine & Stool Retention	2967.9 (1)	2967.9			2967.9 (1)	2967.9
243	Upper Respiratory Tract Infection (URTI)	578.4 (2)	289.2	24752.3 (127)	194.9	25335.6 (129)	196.4
244	Uterus Problem	393.3 (1)	393.3			393.3 (1)	393.3

Sl. No.	Name of Disease	Koraput		Chilika		Total	
		Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost	Total Cost & Episodes	Average Cost
245	Urinary Tract Infection (UTI)	1421.8 (2)	710.9	8469 (30)	282.3	9888 (32)	309
246	UTRI	1417.65 (1)	1417.65			1417.65 (1)	1417.65
247	V.B.P	712 (1)	712			712 (1)	712
248	Vaginal Problem	1250 (2)	625			1250 (2)	625
249	Viral Laratun	514 (1)	514			514 (1)	514
250	Virtigo	1089.9 (1)	1089.9			1089.9 (1)	1089.9
251	Vision Problem	327.2 (1)	327.2			327.2 (1)	327.2
252	Vocal Cord Problem	7340.8 (1)	7340.8			7340.8 (1)	7340.8
253	Vomiting	614 (4)	153.5			614 (4)	153.5
254	Waist Pain	167 (1)	167			167 (1)	167
255	White Discharge	797.6 (1)	797.6			797.6 (1)	797.6
256	Worm Infestation	429.3 (3)	143.1			429.3 (3)	143.1
257	Wound	4423.2 (2)	2211.6	1000.8 (8)	125.1	5424 (10)	542.4
	Total	**1121528.1 (987)**	**1136.3**	**611818 (2404)**	**254.5**	**1733346.1(3391)**	**511.2**

Note

** The above list is taken from PREM-Plan MIS on Referral Morbidity. There are some words which could not be clarified.*

APPENDIX - 2

Life Skill Management Curriculum
MID-WIFE TRAINING SYLLABUS

Time period: 10 days.

Subject:

1. Health Education - General
2. Primary health care (Malaria-Diarrhea-ARI.
3. Traditional health care (TBA-Safe delivery).
4. First Aid
5. Reproductive Health
6. Immunization and Growth monitoring
7. Low cost nutrition food.
8. Safe drinking water.
9. Identification of medicine.
10. Disease wise treatment.
11. Minimum level of learning (Assessment)

1. Health Education General:

CONTENTS: **Resource Person:**

- ❑ Personal Hygiene
- ❑ Drinking Water and Sanitation
- ❑ Use and uses (BBC)
- ❑ Knowledge on Vaccination
- ❑ Knowledge on Community Based disease and their management
- ❑ Balanced food and nutrition
- ❑ Promotion of Herbal Remedies.
- ❑ Tree Plantation (Neem, Mango, Jack Fruit, Banana, Orange & etc.)

Method: Lecture, Body Language, Flip Chart, case studies

2. Primary Health: Common diseases in the community:

CONTENTS:

- ❑ Anemia
- ❑ Nutritional Anemia
- ❑ Water Born Disease (Scabies, Worm infestation)
- ❑ Diarrhea
- ❑ Malaria
- ❑ Acute Respiratory Infection
- ❑ Sickle Cell Anemia
- ❑ Tuberculosis

The above subjects will be taught in the following way:

i. Causes
ii. Sign and Symptoms
iii. Prevention
iv. Treatment
    1. Home based Treatment.
    2. Institute based Treatment.

Method: Flipchart, Body Language, Case Study, Audio/Video

3. Traditional Health Care (TBA-Safe Delivery):

CONTENTS: Resource Person:

- ❑ Medicinal Plantation
- ❑ Identification of Medicinal Plants and its Uses
- ❑ Role of TBAs on safe delivery

Method: Case Study, Practical, Video Cassette, Demo

4. First Aid:

CONTENTS:

- ❑ Dressing and Bandage
- ❑ Dealing with incidental & accidental case
- ❑ Stage Vs Management
- ❑ Use of Rational Drugs
- ❑ Care and Counseling

Method: Chart, Practical, Demo, Video/Audio Visual

5. Reproductive Health Courses:

CONTENTS:

- ❑ Health
- ❑ Knowledge on HIV/AIDS
- ❑ Diseases causes through STD/RTI
- ❑ Safe Marriage Age
- ❑ Health Education on Postnatal Period
- ❑ Care for mother/child after 7 days.
- ❑ Importance on Universal Immunization

Method: Audio Visual, Flip Chart

6. Immunization and Growth monitoring:

CONTENTS:

- ❑ Health and Hygiene (Personal & Protection)
- ❑ Importance of routine immunization.
- ❑ Coverage of vaccination
- ❑ Colostrums feeding, breast feeding practices

- ❑ Weaning food practices.
- ❑ Nutrition Level: (0-3 yrs, 0-5 yrs)
- ❑ Record and Documentation.
- ❑ Pre School Care
  - ● Home Based Intervention
  - ● Institute Based Intervention

Home Based: Father, Mother and Family Members
Institute Based: Child Centered Interventions

Method: Chart, Body Language, Audio/Video, Demo and etc.

7. Low cost Nutrition food:

CONTENTS:

- ❑ Homemade baby food preparation.
- ❑ Importance of balanced food.
- ❑ Use of local available nutritional foods.
- ❑ Various methods for food preparation.

8. Safe drinking water:

CONTENTS:

- ❑ Use of drinking water.
- ❑ Fluorination of drinking water.
- ❑ Use of portable drinking water.

Methodology: Demonstration, posters

9. Identification of medicines.

CONTENTS:

- ❑ Compositions for Common medicines.(RDT)

10. Disease wise treatment.

CONTENTS:

- ❑ Sign and symptom of different common diseases.
- ❑ Administration of doses (side effects & risks).
- ❑ Different dose charts.
- ❑ Different registers

Methodology: Different formats, charts & practices.

APPENDIX - 3

INVESTMENT OF PRHPS 2004-2005

Sl. No.	Date of Investment	Name of the Payee	Total Amount (Rs.)	Purchase NAV (Rs.)	No of Unit Allotted	Current NAV (Rs.)	Current Value (Rs.)
1	25.03.05	HDFC\monthly income plan - mutual fund	40000.00	10.31	3,879.35	10.311	40,000.00
2	25.03.05	HDFC\monthly income plan - mutual fund	40000.00	10.31	3,879.35	10.311	40,000.00
3	19.04.04	TATA mutual fund MIP PLUS fund	40000.00	10.3	3,950.73	*	40,707.00
4	19.04.04	TATA mutual fund MIP PLUS fund	40000.00	10.3	3,950.73	*	40,707.00
5	19.04.04	ING Vysya MIP fund PLAN-A	40000.00	10.12	3,951.16	*	40,087.32
6	19.04.04	ING Vysya MIP fund PLAN-A	40000.00	10.12	3,951.16	*	40,087.32
7	19.04.04	FI India MIP Grouth – B	40000.00	16.11	2,482.58	16.29	40,110.72
8	19.04.04	FI India MIP Growth – B	40000.00	16.11	2,482.58	16.29	40,110.72
9	12.09.04	ING Vysya a domestic opportunity fund	45,000.00	10.23	4,398.83	*	45,927.75
10	12.09.04	ING Vysya a domestic opportunity fund	45,000.00	10.23	4,398.83	*	45,927.75
11	28.10.04	Prudential ICICI Emerging Star	100,000.00	10.22	9,779.95	*	102,982.88
12	06.10.04	TATA Floating Rate Fund	250,000.00	10.3	24,279.86	*	250,000.00
13	06.10.04	FT Floating rate income fund - FT	250,000.00	11.71	21,348.55	11.71	250,089.67
14	13.10.04	8% Savings Bond 2003 (Taxable)	500,000.00				500,000.00
15	22.11.04	TATA DIVIDEND YLELD FUND (GROWTH)	90,000.00	10.23	8,801.95	10.6	93,286.58
16	21.10.04	KOTAK EQUITY FOF (GROWTH)	45,000.00	11.2	4,018.58	*	44,011.75
17	18.10.04	TATA EQUITY P/E FUND (GROWTH)	45,000.00	12.97	3,761.32	*	44,009.64
18	09.12.04	TATA INSTRUCTURS FUND	45,000.00			*	45,000.00
19	09.12.04	SAHARA MIP CAP FUND	45,000.00			*	45,000.00
20	09.12.04	HDCF PRUDENCE FUND	45,000.00			*	45,000.00
21	09.12.04	TATA BALANCE FUND	45,000.00			*	45,000.00
22	09.12.04	KOTAK MNC	45,000.00			*	45,000.00
23	09.12.04	HDFC CAPITAL BUILDER FUND	45,000.00			*	45,000.00
24	09.12.04	FT BLUECHIP FUND	45,000.00			*	45,000.00
		TOTAL	**2005000**				**2013046.1**

APPENDIX - 4

Details of Key informant interviews with Managers/Providers and FGDs Conducted

Sl. No.	Key informant Interviews with Managers	Interview with Health care Providers	FGDs & Name of Villages	Project Area
1	Mr. Jacob Thundiyil President PREM-Plan	CHC, Mohana	Hidikama	Koraput
2	Mr. Chacko Paruvanany, Secretary PREM-Plan	Government Area Hospital, Chandragiri	Paniganda	Koraput
3	Mr. Tirupati Misra Project Director PREM-Plan Chilika	Govt. Dispensary, Naugada.	Gudisahi	Koraput
4	Mrs. Samjukta Tripathi, President UMSB	PHC, Khadiripada	Paleri	Koraput
5	Mr. Manoj Panigrahi Referral Co-ordinator PRHPS	PHC, Gumma	Sandang	Koraput
6	Dr. Gunakar Rauth GVH In charge	District Hospital, Paralakhemundi	Tuburda	Koraput
7	Dr. Lakshman Rahul	CHC, Krishnaprasad	Majhi Khatiakudi	Chilika
8		CHC, Bramhagiri	Nathapur	Chilika
9		MKCG Medical College, Berhampur	Jagannathpur	Chilika
10			Bhagalangi	Chilika

APPENDIX - 5

CASE STUDY ON MICRO HEALTH INSURANCE : PREM, ORISSA, INDIA
Key-informant interview guideline for scheme's managers

Form Number			

Name of Organization	
Name of the respondent	
Age	
Sex	
Designation	
Education	
Caste/ Tribe & Community	
Membership status	
Years of involvement with the health insurance scheme	
Date of interview	

Section 1: Organizational details

Q. #	Question	Codes
1.	Were you involved during the initiation of the scheme?	1. Yes 2. No
2.	When was the micro health insurance scheme initiated?	
3.	What were the reasons for its initiation? (financial reason, donor driven or members initiative)	1. 2. 3.
4.	What were the main objectives of the scheme?	1. 2. 3.
5.	Who designed the scheme? (Formal insurance company? NGO? Donor? Consultants, Scheme members?)	1. 2. 3.
6.	Is there any role for the government?	1. Yes 2. No
7.	If yes, what is the role?	1. 2. 3.
8.	Is there any support from the external agencies?	1. Yes 2. No
9.	If yes, what kind of support? (1.Technical, 2.Financial, 3.Other) Please give details of 1, 2 & 3	1. 2. 1.
10.	Was there any feasibility study done before the initiation of the scheme?	1. Yes 2. No

Q. #	Question	Codes	
11	If yes, what were the major findings of it? Which of those findings were implemented	1. 2. 3.	
12.	Who were the key people connected to the decision making process while developing the scheme?	1. 2. 3.	
12 a	Could you describe the processes that were involved in planning and launching the scheme		
13.	Before the implementation of the scheme, whether the information was disseminated among the members or not?	1. Yes 2. No	
14.	If yes, How?		
15	Was the implementation preceded by training of staff?	1. Yes 2. No	
16	If yes, what type of training? How many persons were trained?	Type of training	trained
17	Have there been any changes in the scheme from its inception?	1. Yes 2. No	
18	If yes what are the changes?	1. … 2. … 3. …	
19.	What are your Suggestions for further improvement of the scheme?		
Section 2 : Membership and coverage			
20.	Who are eligible for enrolment in the scheme? (Eligibility criteria)	1. … 2. … 3. …	
21.	What is the overall size of the potential population?		
22.	Does the scheme want to emphasize any special segment of the potential population?	1. Yes 2. No	
23.	If yes, who are they?	1. …2. …3. …	
24.	Has this priority been changed over time	1. Yes 2. No	
25.	Are any groups left out (purposefully excluded from the scheme?)	1. Yes 2. No	
26.	If yes, who are they?	1. … 2. …	
27.	Are people outside the target group also enrolled in the scheme?	1. Yes 2. No	
28.	What is the unit of membership?	1. Individual 2. Family 3. Others please specify	
29.	What is the nature of enrolment: voluntary or mandatory?	1. Voluntary 2. Mandatory	

Q. #	Question	Codes
30.	Does the scheme cover only the people who are enrolled or others are also covered?	1. Only the enrolled 2. Others also covered
31. 32.	If others are also covered, who are they and how are the costs met? Is there any defined period in a year for enrolment?	Who are they…… How the cost are met ….. 1. Yes 2. No
33.	If yes, what is it?	———————-
34.	Does it coincide with any festivals, harvest season or important events in the organization?	
35.	Is there any waiting period to utilize the benefit package?	1. Yes 2. No
36.	If Yes, what is the waiting period?	————————————
37.	What are the main economic activities of the target group?	1. … 2. … 3. …
38.	What is the economic status of the target group in terms of occupation? (Data on this regard collected for other studies)	
39.	What is the social status of the target population? (Data in this regard collected for other studies)	1. Caste status 2. Tribe 3. Community
40.	How many have enrolled in the scheme till date? (Data in this regard could be collected from various records)	1. Absolute #: … Percentage: … 2. By age …. 3. By sex ….. 4. By residence… 5. By social class
41.	Suggestions for improving the membership?	
Section 3 : Characteristics of the premium		
42.	What form of premium is it? Flat rate, income related, risk related, mixed?	1. … 2. … 3. …
43.	How much is the premium per individual/ (in Rs.)	
44.	How frequently is the premium paid?	1. Weekly 2. Monthly 3. Yearly 4. Others …..
45.	Do you have any flexibility in the premium payment?	1. Yes 2. No
46.	If yes, what sort of flexibility do you have?	1. Paying in instalment 2. Advance payment 3. Payment in kind 4. Grace period (for how many days/ weeks/months) 5. Others ——
47.	Are some families/individuals exempt (i.e. allowed to join without paying the premium)? Why?	

Q. #	Question	Codes
48.	What happens to those who cannot afford to pay the premium?	
49.	Who collects the premium?	
50.	Is there any formal mechanism of receipts, registers, etc?	
51.	What would be the approximate administrative load in collecting the premium? In terms of person-days?	
52.	How do you manage/ utilize the collected premium fund?	1. Fixed Deposit 2. Loan disbursement with high interest rate 3. Invest in other income generating activities 4. Others————
53.	Can those who did not pay their premium in time (defaulters) use the insurance scheme?	1. Yes with penalty ——- 2. Yes, without penalty 3. No
54.	Any specific measures to ensure premium payment regularly?	
55.	Is there any co-payment mechanism?	1. Yes 2. No
56.	For what services does one have to pay co-payment? (Attach separate list if necessary)	1. … 2. … 3. …
57.	What type of co-payment – flat rate, per service, per item.	
58.	What is the mechanism of co-payment?	1. Kind/cash 2. At the time of service 3. Before or after the service 4. Others
59.	Are there any exemptions from co-payment?	1. Yes 2. No
60.	If yes who are the recipients of exemption from co-payment?	
61.	Suggestions for improvement regarding premium?	
Section 4: Benefit package		
62.	What is the benefit package? (Adjust according to the services/ treatment provided at Village Medicine Depots, Sector Level Health service at PHCs/ Private Hospitals etc., and Referral services at district level based on the Annexure)	1. Emergency service 2. Out patient service 3. In patient service4.Chronic care 5. Major illness 6. Drugs 7. Laboratory services 8. Maternity services 9. Transport cost
63.	What is the basis of development of this benefit package? (Rationale behind the package)	
64.	Do you have any preference / restrictions on benefit package?	1. Yes 2. No

Q. #	Question	Codes
65.	If Yes, what are they?	1. Based on Sex _____ 2. Age _____ 3. Disease condition _____
66.	The benefit package covers which levels of the health system?	1. Preventive care 2. Primary care 3. Secondary 4. Tertiary care
67.	Which services are excluded from the benefit package?	
68.	Have there been any changes in benefit package over time? (Specify the time and type of change.)	
69.	Who provides the benefit package?	1. Direct —- 2. Indirect —-
70.	Are there co-payments/ deductibles ceilings or any other forms of cost sharing, at the time of use or at other times? List by level of health care system., Village Medicine Depot, Sector Level health service and referral service at district level)	
71.	Does a referral mechanism exist for utilizing service from the Govt. / Private sector?What is the mechanism for utilization of these benefits? Is there a defined point of contact with a gatekeeper function? For example, does the person first have to be referred by the sector level contact person of PREM before proceeding to referral hospital / centre- hospital?)	
72.	Are there any restrictions regarding the types of pharmaceuticals that can be prescribed (e.g. rational drug lists, list of generics, etc)?	
73.	Is there any indication of moral hazard? Initiated by provider and or by user?(Describe specifically with evidence)	
74.	Is there any indication of adverse selection? (If so, describe with evidence)	
75.	Are there quality/ price checks on the provider – e.g. standard treatment guidelines, cost guidelines, generic prescription pattern and essential drug list etc.?	
76.	Are there any steps to prevent moral hazard or adverse selection? If yes, describe.	
77.	Which are the other health related activities of PREM that supportive of the micro health insurance programme (eg, programmes in drinking water, sanitation, malaria prevention etc.)?	
78.	Which are the non-health related activities of PREM that supportive of the micro health insurance programme (eg, micro credit, literacy)?	
79.	What is the level of consumer satisfaction with the benefit package?	1. Highly satisfied 2. Satisfied 3. Neither Satisfied nor Dissatisfied 4. Not satisfied 5. Very Dissatisfied

Q. #	Question	Codes
80.	Reasons for satisfaction or dissatisfaction	1. … 2. … 3. …
81.	Suggestions for improving the benefit package?	
Section 5 : Ownership and management		
79	Who manages the fund?	
80	What is the extent of autonomy from PREM's framework for the management of the fund?	
81	Do scheme managers have special training or skills?	
82	What are these?	
83	How are collected funds held and utilized? (Bank/ invested/ held without investing?	1 Deposit in fixed/current account 2 Loan disbursement with high interest rate 3 Invest in other income generating activities 4 Micro-credit to members/others 5 Others————
84	Can fund's managers decide to invest to increase capital of fund? (Autonomy)	
85	Are the funds subjected to Government accounting and reporting practices?	
86	Is the fund used for other activities related to health? eg. Drinking water, sanitation, other public health activities	
87	Is the fund used for activities other development activities (not directly related to health)?	
88	Did the insurance scheme ever take a loan to fund the scheme? If yes, the purpose of the loan, its source and the conditions?	
89	What is the cost recovery rate of the scheme? (Attach the cost recovery table)	
90	Who is responsible for the administration of the various aspects of the scheme? (Attach extra page if needed)	1. Enrolment of members—- 2. Collecting premium—- 3. Processing claims—- 4. Processing reimbursements- 5. Financial management—- 6. Contract with providers—-
91	What is the administrative load in enrolling members and collecting the premium? Processing the claims? Processing the reimbursements? Financial management? Contract with providers?	
92	What would be the approximate administrative costs? (Attach the detail in a table)	
93	Do you have any Management Information System (MIS) to facilitate in day to day management of the insurance scheme?	1. Yes 2. No

Q. #	Question	Codes
94	If yes, what is the data that is entered and what is the output that is generated? And with what periodic frequency? (Collect forms/formats used) If no, why?	
95	What are the components of the Management and information systems in place – Staff trained in collecting and maintaining requisite data on computers, Required Computer Hardware and software?	
96	What are the mechanisms to ensure the flow of information from the membership to the management?	1. 2. 3.
97	What are the mechanisms to ensure the flow of information from the management to membership?	1. 2. 3.
98	How are the providers paid? ?	1. Fixed salary 2. Fee for service decided by the providers 3. Fee for service decided jointly by PREM and the providers 4. Others —
99	What are the types of providers approved by PREM?	1. Medical College 2. District Hospital 3. PHC/CHC 4. Corporate/ Large Private Hospitals 5. Large Voluntary Hospitals 6. Private Nursing Homes 7. Small Voluntary Hospitals/ Nursing Homes 8. Clinics of private practitioners 9. Vol. Health Centres run by paramedics 10. Others —-
100	Who supervises/ monitors the providers?	
101	What is your opinion about the quality of health care providers? In Terms of: Qualifications of doctors, Other Personnel, Infrastructure, Diagnostic/ Medical/ Surgical Equipment & Instruments, Cleanliness, Behaviour of Doctors/ Staff	
102	Who provides the additional funds for the health care services (i.e. assuming that they are not fully financed by the insurance scheme)?	
103	What information if it was available would have helped you when you started the scheme?	
104	If you were given another chance to start afresh, how would you go about it?	
105	Who supervises the scheme's management/ administration?	
106	Suggestions for improvement of management and ownership?	

APPENDIX - 5 Cont...d

CASE STUDY ON MICRO HEALTH INSURANCE : PREM, ORISSA, INDIA
Key Informant interview - Providers

Form Number			

Name of the Institution	Also mention Govt. or Private
Age	
Sex	
Employment status	
Designation	
Education	
Caste/ Tribe/ Community	
Date of interview	

Q. #	Question	Codes
1.	Are you familiar with PREM's Micro Health Insurance Scheme	1. Yes 2. No →
2.	If yes, what are the strengths and weaknesses of the scheme?	Strengths and weaknesses
3.	Do you have any problem in management of referral cases from PREM's Micro Health Insurance Scheme	1. 2. 3.
4	As a Govt. sector health provider what aspects of the scheme has encouraged you to co-operate with the scheme? Which do you find are the discouraging aspects?	
5	As a private sector health provider what aspects of the scheme has encouraged you to co-operate with the scheme? Which do you find are the discouraging aspects	
6	What kind of patients usually come to you or are referred to you in terms of	1. Children, Young , Adult, Old 2. Male, Female 3. Acute, chronic, disease specifics
7	How do you assure the membership status of the referred patients?	1. .... 2. .... 3. ....
8	What is your opinion regarding the cost of the care?	1. Too high 2. OK 3. Too low
9	Do the patients get any subsidies?	1. Yes 2. No
10	If yes, who provides it and how much?	1. PREM's Micro Health Insurance Scheme —— 2. Hospital ——

Q. #	Question	Codes
11	Does PREM's contribution cover the cost of care?	1. Yes 2. No
12	If no, what could be the mechanism for future sustainability?	1. …. 2. …. 3. ….
13	How do you get the cost reimbursed? (Payment modality)	1. Instant on the spot payment per case 2. Lump sum amount in defined time period 3. Others———————-
14	Have you noticed any change in beneficiaries' behavior due to scheme?	1. Utilization of health service (Is over utilized by some members of the scheme? If yes, what kind of services) 2. Health seeking behaviors 3. Compliance in appointment keeping, drug use etc.
15	Do you think that the scheme has contributed to improve or worsen the quality of care? (Mention reasons for your views)	
16	What is the impact of the scheme on beneficiaries' health?	
17	Is the issue of preventive health addressed under the scheme?	1. Yes 2. No
18	If yes, how is it addressed?	
19	Are you satisfied with the referral mechanism?	1. Yes 2. No
20	What is your suggestions regarding the insurance package?	Participation with PREMReferral mechanismBenefit Package Service utilization Payment modality/financial burdenContribution and sustainability

Services Provided by the Facility

	What services are provided by your medicine depot / hospital to the members of the scheme?	Yes	No	Comm.
	RCH, Communicable diseases, Eye Care	√	X	
1	Ante Natal Care (ANC)			
2	Medical Termination of Pregnancy MTP			
3	Deliveries			
4	Caesarean Section			
5	Hysterectomy			
6	Child Care			
7	Diarrhoea			
8	Acute Respiratory Infection (ARI)			
9	Immunization			
10	Tuberculosis			

11	Malaria			
12	Leprosy			
13	HIV/AIDS			
14	Basic eye care			
15	Cataract Surgery			
	Surgeries			
16	Minor Surgery			
17	Major Surgery			
18	Abdominal Surgery			
	Non Communicable Diseases			
20	Cardiology			
21	Acute myocardial infarct managed			
22	Coronary angiography			
23	Hypertension			
24	Asthma and COPD			
25	Cancer			
26	Psychiatric illness			
	Dental care			
27	Basic dental care			
28	Dental Extractions			
29	Root canal treatments			
	ENT Diseases			
30	Basic ENT Care			
31	Ear surgery			
32	Tonsillectomy			
33	Nasal surgery			
34	**General Medicine**			
	Orthopaedics			
35	Open fracture cases managed			
36	Closed fracture cases managed			
37	Dislocations managed			
38	Orthopaedic surgery under GA			
	Neurology			
39	New cerebro-vascular accidents cases			
40	Coma cases managed			
41	Dermatology			
42	STD			
	Endocrinology			
43	Diabetics on insulin managed – Adults			
44	Diabetics on insulin managed- children			
	Urology			
45	Prostrate surgery			
46	Kidney / Ureter surgery			

47	Scopies			
48	Lithotripsy			
	Emergency			
49	First Aid			
50	Accidents/Injuries			
	Diagnostic Investigations			
51	Haematology			
52	Urine			
53	Stool			
54	Biochemistry			
55	Histopathology			
56	Microbiology			
57	Culture of Specimens			
58	X – Ray			
59	ECG			
60	Ultra Sonography			
61	CT Scan			
62	MRI			
63	Doppler's			
64	Endoscopy			
65	Angiography			

APPENDIX - 5 Cont...d

Focus Group Discussion Guidelines

CASE STUDY ON MICRO HEALTH INSURANCE, FOCUS GROUP DISCUSSION (FGD) GUIDELINES FOR BENIFICIARIES

Form Number			

Name of organization	
Location: District /Ward No.	
Name of Scheme	
Types of beneficiaries	
Name of Facilitators & Recorders	1
Date of Discussion	2

S.No.	Name of the Participants	Sex	Age	Education	Occupation	Membership status
1						
2						
3						
4						
5	ADD MORE ROWS					

	Guidelines	Codes
1.	**History, background of the scheme**,(Do you know the scheme? When and how the scheme was established? What were the objectives of the scheme? Do you think the objectives are achieved or not? To what extent? In what aspects?	
2.	**What are your reasons for joining the scheme?**	
3.	**Opinion regarding the coverage, the benefit package** (What are the services covered at Village Medicine Depot, Sector level health service i.e. PHCs, CHCs, Private Hospitals, Clinics, Dispensaries and Referral service i.e. Medical College, District Hospitals, Private Hospitals? What short of benefits are there? Where do you go for availing the services? Are the services adequate to address your need?)	
4.	**Opinion regarding the characteristics of the premium, and payment mechanism** (How much do you pay for membership, premium etc? How often do you pay? Who collects the premium? How often? Do you pay the premium at the festival/ harvest time or during any campaigns organised by PREM/UMSB.)	
5.	**Utilization of the service by different gender and social groups/ strata** (Who actually utilizes the services in terms of gender social groups/ strata: male, female, children, pregnant women, old, tribe and rural. Which is the mostly represented locality.)	
6.	**Opinion regarding the access to the service** (Financial, cultural and geographical access the service affordable? Can you get to the facility when needed, travel time, distance and waiting time etc? Is the service acceptable and adequate?)	

	Guidelines	Codes
7.	**Opinion regarding the quality of health care** (Do the facilities have necessary infrastructure & equipment? What is the status of drug supply? What about, qualifications, numbers and availability of the doctors and other staff? What is the financial situation of the health care structure?	
8.	**Level of patient's satisfaction from the scheme:** (Attitude towards the care provider, service facilities, benefit package, cost sharing and the process of availing the claims?)	
9.	Are your personal expectations of health care for you and your family fulfilled through the scheme?	
10.	Future of the scheme according to you: what would be the future in the normal course? What should be as per your expectations?	
11.	Specific Suggestions for improvement of the scheme	

Appendix 6

Village Pharmacy Dose Chart

FEVER TREATMENT- PARACETAMOL							
Symptoms	Disease	Age	# Days	Morning ❍	Afternoon ●	Night ●	Total
Raising Temperature Raising pulse rate Headache Pain all over body Snezzing Watery Nasal discharge	Any Fever	0-1 yrs	Day1	1 (125mg) 8 Dps.	1 (125mg) 8 Dps.	1 (125mg) 8 Dps.	24 Drops Per day(1 Bottle)
			Day2	1 (125mg) 8 Dps.	1 (125mg) 8 Dps.	1 (125mg) 8 Dps.	
			Day3	1 (125mg) 8 Dps.	1 (125mg) 8 Dps.	1 (125mg) 8 Dps.	
		2-3 yrs	Day1	1(125mg)	1(125mg)	1(125mg)	9 Tabs (125 Mg.)
			Day2	1(125mg)	1(125mg)	1(125mg)	
			Day3	1(125mg)	1(125mg)	1(125mg)	
		4-6 yrs	Day1	1/2 (500 mg.)	1/2 (500 mg.)	1/2 (500 mg.)	4 & 1/2 Tabs (500 Mg.)
			Day2	1/2 (500 mg.)	1/2 (500 mg.)	1/2 (500 mg.)	
			Day3	1/2 (500 mg.)	1/2 (500 mg.)	1/2 (500 mg.)	
		7-12 yrs	Day1	1(300to600mg)	1(300to600mg)	1(300to600mg)	9 Tabs (500 Mg.)
			Day2	1(300to600mg)	1(300to600mg)	1(300to600mg)	
			Day3	1(300to600mg)	1(300to600mg)	1(300to600mg)	
		13 yrs & above	Day1	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	9 Tabs (500 Mg.)
			Day2	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	
			Day3	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	
REF : DOSES Park's Textbook of Social Preventive Medicine, 15th Editn.		Pregnancy	Day1	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	9 Tabs (500 Mg.)
			Day2	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	
			Day3	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	1 (.5gm to 1 gm)	
		Remarks	Admn.	EACH TABLET ORALLY AFTER FOOD , TILL SYMPTOMS PERSIST			
			Side Effect	NAUSEA, RASHES, LEUKOPENIA			
			Home Remedies	COLD SPONGING,TULASI LEAF JUICE&HONEY			

Appendix 6 cont...

Village Pharmacy Dose Chart

MALARIA TREATMENT- CHLOROQUINE							
Symptoms	Disease	Age	# Days	Morning ○	Afternoon ●	Night ●	Total
FEVER CHILL RIGOR MYALGIA HEADACHE	MALARIA	0-1 yrs	Day1	1/2	X	X	1 & 1/4 Tab (250 Mg.)
			Day2	1/2	X	X	
			Day3	1/4	X	X	
		2-3 yrs	Day1	1	X	X	2 &1/2 Tab (250 Mg.)
			Day2	1	X	X	
			Day3	1/2	X	X	
		4-6 yrs	Day1	2	X	X	5 Tabs (500 Mg.)
			Day2	2	X	X	
			Day3	1	X	X	
		7-12 yrs	Day1	3	X	X	7 & 1/2 Tabs (500 Mg.)
			Day2	3	X	X	
			Day3	1 & 1/2	X	X	
		13 yrs & above	Day1	4	X	X	10 Tabs (500 Mg.)
			Day2	4	X	X	
			Day3	2	X	X	
REF : DOSES Park's Textbook of Social Preventive Medicine, 15th Editn.		Pregnancy	Day1	4	X	X	10 Tabs (500 Mg.)
			Day2	4	X	X	
			Day3	2	X	X	
		Remarks	Admn.	EACH TABLET ORALLY AFTER FOOD			
			Side Effect	NAUSEA,VOMITING,HYPOGLACEMIA,OPTIC NURITITIS			
			Home Remedies	COLD SPONGING,DRY SPONGING & COLD SPONGING			

Appendix 6 cont...

Village Pharmacy Dose Chart

GASTRO ENTERTITIS TREATMENT- METRONIDAZOLE							
Symptoms	Disease	Age	# Days	Morning ○	Afternoon ●	Night ●	Total
	LOOSE MOTION	0-1 yrs	Day1	X	X	X	X
PAIN ABDOMEN			Day2	X	X	X	
MUCUS WITH STOOL			Day3	X	X	X	
MUCUS WITH BLOOD		2-3 yrs	Day1	1/2 tsf. (100 mg)	X	1/2 tsf. (100 mg)	1 Bottle (30 Ml.)
TENDER ABDOMEN			Day2	1/2 tsf. (100 mg)	X	1/2 tsf. (100 mg)	
LOSS OF APPETITE			Day3	1/2 tsf. (100 mg)	X	1/2 tsf. (100 mg)	
		4-6 yrs	Day1	1/2 (of 200mg)	X	1/2 (of 200mg)	3 Tabs
			Day2	1/2 (of 200mg)	X	1/2 (of 200mg)	
			Day3	1/2 (of 200mg)	X	1/2 (of 200mg)	
		7-12 yrs	Day1	1 (200mg)	X	1 (200mg)	6 Tabs
			Day2	1 (200mg)	X	1 (200mg)	
			Day3	1 (200mg)	X	1 (200mg)	
		13 yrs & above	Day1	2 (200mg)	X	2 (200mg)	12 Tabs
REF : DOSES			Day2	2 (200mg)	X	2 (200mg)	
Park's Textbook of			Day3	2 (200mg)	X	2 (200mg)	
Social Preventive		Pregnancy	Day1	X	X	X	X
Medicine, 15th Editn.			Day2	X	X	X	
			Day3	X	X	X	
		Remarks	Admn.	ORALLY TWICE A DAY AFTER FOOD			
			Side Effect	NAUSEA,LOSS OF HAIR & CARCINOGENETIC			
			Home Remedies	JAI PHAL WATER			

Appendix 6 cont...

Village Pharmacy Dose Chart

WORM INFASTATION -ALBENDAZOLE							
Symptoms	Disease	Age	# Days	Morning ○	Afternoon ●	Night ●	Total
PAIN ABDOMEN LOSS OF APPETITE LOOSE MOTION FACIAL PALLOR FACIAL OEDEMA TENDOR ABDOMEN REF : DOSES Park's Textbook of Social Preventive Medicine, 15th Editn.	WORM INFASTATION	0-1 yrs	Day1	X	X	NOT ADVISABLE	X
			Day2	X	X	NOT ADVISABLE	
			Day3	X	X	NOT ADVISABLE	
		2-3 yrs	Day1	X	X	1/2 tab. / syp.	1 Bottle Single Dose
			Day2	X	X	X	
			Day 15	X	X	1/2 tab. / syp.	
		4-6 yrs	Day1	X	X	SINGLE DOSE (TAB 400MG)	2 Tabs
			Day2	X	X		
			Day 15	X	X	RPT 2 ND DOSE	
		7-12 yrs	Day1	X	X	SINGLE DOSE (TAB 400MG)	2 Tabs
			Day2	X	X		
			Day 15	X	X	RPT 2 ND DOSE	
		13 yrs & above	Day1	X	X	SINGLE DOSE (TAB 400MG)	2 Tabs
			Day2	X	X		
			Day 15	X	X	RPT 2 ND DOSE	
		Pregnancy	2nd TRIMESTAR	X	X	SINGLE DOSE (TAB 400MG)	1 Tab
			ONWARDS	X	X		
				X	X		
		Remarks	Admn.	ORALLY WEEKLY ONCE & REPEAT AFTER 15 DAYS			
			Side Effect	NAUSEA,ABDOMINAL PAIN,LOSS OF HAIR			
			Home Remedies	NEEM LEAF,POWDER,PASTE &TURMERIC			

Appendix 6 cont...

Village Pharmacy Dose Chart

VOMITTING CONTROLL TREATMENT- ANTI EMETIC - DOMPERIDONE							
Symptoms	Disease	Age	# Days	Morning ❍	Afternoon ●	Night ●	Total
NAUSEA VOMITTING	VOMITTING	0-1 yrs	Day1	1/4 Tab. (5 drops)	1/4 Tab. (5 drops)	1/4 Tab. (5 drops)	1 Bottle
			Day2	1/4 Tab. (5 drops)	1/4 Tab. (5 drops)	1/4 Tab. (5 drops)	
			Day3	1/4 Tab. (5 drops)	1/4 Tab. (5 drops)	1/4 Tab. (5 drops)	
		2-3 yrs	Day1	1/4 Tab (5ml)	1/4 Tab (5ml)	1/4 Tab (5ml)	2 & 1/4 Tabs (2 Tabs)
			Day2	1/4 Tab (5ml)	1/4 Tab (5ml)	1/4 Tab (5ml)	
			Day3	1/4 Tab (5ml)	1/4 Tab (5ml)	1/4 Tab (5ml)	
		4-6 yrs	Day1	1/2 Tab	1/2 Tab	1/2 Tab	2 & 1/4 Tabs (2 Tabs)
			Day2	1/2 Tab	1/2 Tab	1/2 Tab	
			Day3	1/2 Tab	1/2 Tab	1/2 Tab	
		7-12 yrs	Day1	1Tab (5mg)	1Tab (5mg)	1Tab (5mg)	4 & 1/2 Tabs (4 Tabs)
			Day2	1Tab (5mg)	1Tab (5mg)	1Tab (5mg)	
			Day3	1Tab (5mg)	1Tab (5mg)	1Tab (5mg)	
		13 yrs & above	Day1	1 (10 mg)	1 (10 mg)	1 (10 mg)	9 Tabs
			Day2	1 (10 mg)	1 (10 mg)	1 (10 mg)	
REF : DOSES Park's Textbook of Social Preventive Medicine, 15th Editn.			Day3	1 (10 mg)	1 (10 mg)	1 (10 mg)	
		Pregnancy	Day1	1 (10 mg)	1 (10 mg)	1 (10 mg)	9 Tabs
			Day2	1 (10 mg)	1 (10 mg)	1 (10 mg)	
			Day3	1 (10 mg)	1 (10 mg)	1 (10 mg)	
		Remarks	Admn.	EACH TABLET THRICE DAILY ORALLY BEFORE FOOD (Till Symptoms Persist)			
			Side Effect	DRY MOUTH,DIARHOEA,HEADACHE,RASHES			
			Home Remedies	A COMBINATION OF LEMON WATER			

Appendix 6 cont...

Village Pharmacy Dose Chart

ANAEMIA TREATMENT - IRON							
Symptoms	Disease	Age	# Days	Morning ❍	Afternoon ●	Night ●	Total
Pallor weakness Loss of appetite	ANAEMIA	0-1 yrs	Day1	Elemental Iron (3-4 Drops)	Elemental Iron (3-4 Drops)	Elemental iron(3-4 Drops)	1 Bottle
			Day2	Elemental Iron (3-4 Drops)	Elemental Iron (3-4 Drops)	Elemental iron(3-4 Drops)	
			Day3	Elemental Iron (3-4 Drops)	Elemental Iron (3-4 Drops)	Elemental iron(3-4 Drops)	
		2-3 yrs	Day1	1/2 tsf.	1/2 tsf.	1/2 tsf.	1 Bottle
			Day2	1/2 tsf.	1/2 tsf.	1/2 tsf.	
			Day3	1/2 tsf.	1/2 tsf.	1/2 tsf.	
		4-6 yrs	Day1	1 tsf. (5 ml)	X	1 tsf. (5 ml)	1 Syp.
			Day2	1 tsf. (5 ml)	X	1 tsf. (5 ml)	
			Day3	1 tsf. (5 ml)	X	1 tsf. (5 ml)	
		7-12 yrs	Day1	1 Tab	X	1 Tab	6 Tabs
			Day2	1 Tab	X	1 Tab	
			Day3	1 Tab	X	1 Tab	
REF : DOSES Park's Textbook of Social Preventive Medicine, 15th Editn.		13 yrs & above	Day1	1 Tab	X	1 Tab	6 Tabs
			Day2	1 Tab	X	1 Tab	
			Day3	1 Tab	X	1 Tab	
		Pregnancy	Day1	1 Tab	X	1 Tab	6 Tabs
			Day2	1 Tab	X	1 Tab	
			Day3	1 Tab	X	1 Tab	
		Remarks	Admn.	ORALLY TWICE A DAILY (TAB/ SYP)			
			Side Effect	NAUSEA,VOMITING,PAIN ABDOMEN,STAINING OF TEETH,METALIC TASTE			
			Home Remedies	GREENLEAFS, GREEN VEGETABLES,DAL,TOMATO & Etc.			

Appendix 6 cont...

Village Pharmacy Dose Chart

ORAL REHYDRATION THEARAPY - ORS							
Symptoms	Disease	Age	# Days	Morning ❍	Afternoon ●	Night ●	Total
LOOSE MOTION VOMITING DEHYDRATION	DEHYDRATION	0-4 Months 4-11 Months	Day1	UNDER 5 Kg. (200 - 400 ORS IN Ml.)			SOS
			Day1	5 - 7.9 Kg. (400 - 600 ORS IN Ml.)			
			NOTE	ORS THERAPY (For all Ages) During 1st 4 Hour			
		12 - 23 Months	Day1	8 - 10.9 Kg. (600 - 800 ORS IN Ml.)			SOS
			Day2	8 - 10.9 Kg. (600 - 800 ORS IN Ml.)			
			NOTE	ORS THERAPY (For all Ages) During 1st 4 Hour			
		2 - 4 Yrs.	Day1	11 - 15.9 Kg. (800 - 1.200 ORS IN Ml.)			SOS
			Day2	11 - 15.9 Kg. (800 - 1.200 ORS IN Ml.)			
			NOTE	ORS THERAPY (For all Ages) During 1st 4 Hour			
		5 - 14 years	Day1	16 - 29.9 Kg. (1.200 - 2.200 ORS IN Ml.)			SOS
			Day2	16 - 29.9 Kg. (1.200 - 2.200 ORS IN Ml.)			
			NOTE	ORS THERAPY (For all Ages) During 1st 4 Hour			
REF : DOSES Park's Textbook of Social Preventive Medicine, 14th Editn.		15 Yrs & Above	Day1	30 Kg. & ABOVE (2.2 - 4 Ltrs. ORS)			SOS
			Day2	30 Kg. & ABOVE (2.2 - 4 Ltrs. ORS)			
			NOTE	ORS THERAPY (For all Ages) During 1st 4 Hour			
		Pregnancy	Day1	30 Kg. & ABOVE (2.2 - 4 Ltrs. ORS)			SOS
			Day2	30 Kg. & ABOVE (2.2 - 4 Ltrs. ORS)			
			NOTE	ORS THERAPY (For all Ages) During 1st 4 Hour			
		Remarks	Admn.	1 SACHET OF ORS TO BE MIXED WITH 1000 Ml. OF WATER			
			Side Effect	ORS THERAPY (For all Ages) During 1st 4 Hour			
			Home Remedies	RICE WATER AND SALT,SOLUTION OF WATER,SUGAR &SALT,BOILED RICE WATER			

Appendix 6 cont...

Village Pharmacy Dose Chart

DERMATITIES - TREATMENT (BENZYL BENZOATE)							
Symptoms	Disease	Age	# Days			Night ●	Total
ITCHING PIMPLES RED RASHES	SCABIES	0-1 yrs	Day1 Day2 Day3	TO BE APPLIED WHOLE/ALL OVER BODY EXCEPT FACE AND NECK AFTER TAKING BATH AND TO BE WASHED AFTER 24 Hrs.			1 Bottle (50 Ml.)
		2-3 yrs	Day1 Day2 Day3	TO BE APPLIED WHOLE/ALL OVER BODY EXCEPT FACE AND NECK AFTER TAKING BATH AND TO BE WASHED AFTER 24 Hrs.			1 Bottle (50 Ml.)
		4-6 yrs	Day1 Day2 Day3	TO BE APPLIED WHOLE/ALL OVER BODY EXCEPT FACE AND NECK AFTER TAKING BATH AND TO BE WASHED AFTER 24 Hrs.			1 Bottle (100 Ml.)
		7-12 yrs	Day1 Day2 Day3	TO BE APPLIED WHOLE/ALL OVER BODY EXCEPT FACE AND NECK AFTER TAKING BATH AND TO BE WASHED AFTER 24 Hrs.			1 Bottle (100 Ml.)
REF : DOSES Park's Textbook of Social Preventive Medicine, 15th Editn.		13 yrs & above	Day1 Day2 Day3	TO BE APPLIED WHOLE/ALL OVER BODY EXCEPT FACE AND NECK AFTER TAKING BATH AND TO BE WASHED AFTER 24 Hrs.			1 Bottle (100 Ml.)
		Pregnancy	Day1 Day2 Day3	TO BE APPLIED WHOLE/ALL OVER BODY EXCEPT FACE AND NECK AFTER TAKING BATH AND TO BE WASHED AFTER 24 Hrs.			1 Bottle (100 Ml.)
		Remarks	Admn. Side Effect Home Remedies	LOCALLY APPLY KEEP OUT FROM CHILDREN & RED RASHES APPLY OF NEEM,MUSTARD OIL & TURMERIC PASTE			

Appendix 6 cont...

Village Pharmacy Dose Chart

MULTI VITAMIN TREATMENT							
Symptoms	Disease	Age	# Days	Morning ○	Afternoon ●	Night ●	Total
Pain Joint Pain Muscular Pain Weakness	GENERAL WEAKNESS	0-1 yrs	Day1		x	3 to 5 drops	Drops
			Day2		x	3 to 5 drops	
			Day3		x	3 to 5 drops	
		2-3 yrs	Day1		x	8 to 9 drops	Drops
			Day2		x	8 to 9 drops	
			Day3		x	8 to 9 drops	
		4-6 yrs	Day1	1/2 Tab	x	1/2 Tab	3 Tabs
			Day2	1/2 Tab	x	1/2 Tab	
			Day3	1/2 Tab	x	1/2 Tab	
		7-12 yrs	Day1	1 Tab	x	1 Tab	6 Tabs
			Day2	1 Tab	x	1 Tab	
			Day3	1 Tab	x	1 Tab	
REF : DOSES Park's Textbook of Social Preventive Medicine, 15th Editn.		13 yrs & above	Day1	1 Tab	x	1 Tab	6 Tabs
			Day2	1 Tab	x	1 Tab	
			Day3	1 Tab	x	1 Tab	
		Pregnancy	Day1	1 Tab	x	1 Tab	6 Tabs
			Day2	1 Tab	x	1 Tab	
			Day3	1 Tab	x	1 Tab	
		Remarks	Admn.	1 TAB AT MORNING & 1 TAB AT BED TIME AFTER FOOD			
			Side Effect	BLACK STOOL,			
			Home Remedies	GREENLEAFS, GREEN VEGETABLES,DAL,TOMATO, EGG, MILK & Etc.			

Appendix 6 cont...

Village Pharmacy Dose Chart

DIGESTIVE TREATMENT (ANTACID)

Symptoms	Disease	Age	# Days	Morning ❍	Afternoon ●	Night ●	Total
Indigestion Pain abdomen	Indigestion	0-1 yrs	Day1	x	x	x	Drops
			Day2	x	x	x	
			Day3	x	x	x	
Nausea Heart burn Loss of Appetite		2-3 yrs	Day1	x	x	x	Drops
			Day2	x	x	x	
			Day3	x	x	x	
		4-6 yrs	Day1	1/2 Tab	x	1/2 Tab	3 Tabs
			Day2	1/2 Tab	x	1/2 Tab	
			Day3	1/2 Tab	x	1/2 Tab	
		7-12 yrs	Day1		x	1 Tab	3 Tabs
			Day2		x	1 Tab	
			Day3		x	1 Tab	
REF : DOSES Park's Textbook of Social Preventive Medicine, 15th Editn.		13 yrs & above	Day1	1 Tab	x	1 Tab	6 Tabs
			Day2	1 Tab	x	1 Tab	
			Day3	1 Tab	x	1 Tab	
		Pregnancy	Day1	1 Tab	x	1 Tab	6 Tabs
			Day2	1 Tab	x	1 Tab	
			Day3	1 Tab	x	1 Tab	
		Remarks	Admn.	ORALLY AFTER FOOD & SOS			
			Side Effect	CONSTIPATION, RENAL FAILURE			
			Home Remedies	FRY & DRY PANMADHURI, JUANI			

Appendix 6 cont...

Village Pharmacy Dose Chart

ANTI BIOTIC DOSSAGE CHART (CO - TRIMAXOZOLE - SLPH / TRIM (200 / 40 Mg.)							
Symptoms	Disease	Age	# Days	Morning ○	Afternoon ●	Night ●	Total
FEVER COMMON COLD SNEEZING COUGH	ARI (Accute Respiratory Infection) PNEUMONIA	0-2 Months (Wt. 3.5 Kg.)	Day1	Syp (2.5 Ml)	X	Syp (2.5 Ml.)	1 Bottle
			Day2	Syp (2.5 Ml)	X	Syp (2.5 Ml.)	
			Day3	Syp (2.5 Ml)	X	Syp (2.5 Ml.)	
		2 - 12 Months (Wt. 6-9 Kg.)	Day1	1/2 Tab.	X	1/2 Tab.	3 Tabs
			Day2	1/2 Tab.	X	1/2 Tab.	
			Day3	1/2 Tab.	X	1/2 Tab.	
		1 - 5 Yrs. (Wt. 10 - 19 Kg.)	Day1	3/4 Tab.	X	3/4 Tab.	4 & 1/2 Tabs
			Day2	3/4 Tab.	X	3/4 Tab.	
			Day3	3/4 Tab.	X	3/4 Tab.	
		6-12 yrs	Day1	1 Tab.	X	1 Tab.	9 Tabs
			Day2	1 Tab.	X	1 Tab.	
			Day3	1 Tab.	X	1 Tab.	
REF : DOSES Park's Textbook of Social Preventive Medicine, 15th Editn.		13 yrs & above (Wt. 40 Kg.&Ab.)	Day1	2 Tabs.	X	2 Tabs.	12 Tabs
			Day2	2 Tabs.	X	2 Tabs.	
			Day3	2 Tabs.	X	2 Tabs.	
		Pregnancy	Contra	X	X	X	X
			Indicated	X	X	X	
				X	X	X	
		Remarks	Admn.	ORALLY TWICE A DAY			
			Side Effect	DIARRHOEA,NAUSEA,ABDOMINAL PAIN,LOSS OF HAIR			
			Home Remedies	NEEM LEAF,POWDER,PASTE &TURMERIC			