Health Sector Reform

and

Sexual and Reproductive Health:

A Training Manual

Modified version of the “The Right Reforms?” Training Manual
Prepared for the short course for MPH students conducted in
Achutha Menon Centre for Health Science Studies,
Sree Chitra Tirunal Institute for Medical Sciences and Technology
Kerala, India

5-10 February 2007

Adaptation by TK Sundari Ravindran and Ranjani K Murthy
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Health Sector Reform and Sexual and Reproductive Health
Trivandrum, February 5-10 2007

Course objectives and structure

Since the 1990s, health sector reforms have been introduced by many developing countries. These reforms are meant primarily to address the large resource crunch experienced by the health sector, and also aim to improve health system efficiency. In many instances, the content of health sector reform has been determined by international pressures (as part of structured aid to countries), more subtle influence by donors, or by national governments influenced by the internationally dominant thinking on the benefits of privatisation in health.

Sexual and reproductive health and rights have been promoted over the past 15 years. This has been in part, address some of the most important causes of preventable death and illness among women in poor countries. Sexual and reproductive ill-health accounts for at least 20 per cent of the global burden of ill health for women of reproductive age and some 14 per cent of men. Of all human development indicators, those for sexual and reproductive health reveal the largest gaps between low income and developed countries and the starkest inequities between rich and poor people within countries. Further, upholding people’s right to sexual and reproductive health would contribute significantly to meeting the MDGs related to health and gender equity.

This course explores the impact of health sector reforms on sexual and reproductive health services. Participants will leave with a critical understanding of the impact of health sector reforms across various regions of the world, and be able to develop research to inform, advocate for or intervene in services in a ways that increase the likelihood that reforms meet national health goals, work to improve the health system and meet local imperatives.

Objectives

By the end of the course, participants will

• Be acquainted with basic concepts of sexual and reproductive health and rights
• Have an understanding of health sector reforms, and variations in their scope (national, sub national, regional) and nature (sectoral, system wide) across regions and countries
• Have an understanding of health systems, their characteristics and functions
• Have conceptual tools to examine the consequences of reforms for the health sector in different contexts
• Have knowledge of global trends in health sector reforms in financing, public-private interactions and decentralisation and be acquainted with the Indian scenario.
• Critically analyse the implications of specific types of reforms (financing, public-private interactions and decentralisation) on sexual and reproductive health services

The course is of six days duration. It is divided into three modules. The first module introduces concepts of sexual and reproductive health and rights and challenges inherent in the provision of sexual and reproductive health services (one day). The second module is the core module on health sector reform, and provides an overview of health sector reform processes in developing countries, and specifically in Indian states. It covers specific aspects of reform relevant to the Indian context: financing reforms and public-private partnerships; priority-setting; decentralisation and accountability. The third module focuses on policy advocacy and concludes with an examination to be completed by course participants.

Target audience
Health Researchers; health systems researchers; health service providers and managers; Women’s health and rights advocates.

Credits
The course has been offered as a short course at the Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Kerala, India. It offers the following recognition:
• Part of the Health Policy-2 module in the current MPH degree (attend course, complete assignment and pass exam)
• Certificate of competence (attend course and complete all assignments satisfactorily)
<table>
<thead>
<tr>
<th>Session no.</th>
<th>Topic</th>
<th>Objectives Participants will:</th>
<th>Format of activities</th>
<th>Time:</th>
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</thead>
</table>
| Session 1  | Introduction | • Begin to feel at ease with each other  
• Be introduced to each other and to key facilitators  
• Discuss their expectations, anxieties and contributions to the workshop and reach consensus on ground rules that will apply during the workshop | a) Ice breaking exercise involving participants as well as facilitators  
b) Brainstorming on expectations; group contract is made  
c) Facilitator presents workshop objectives and structure and briefing on logistics and administrative issues | 45 mins  
15 mins  
15 mins |
| Session 2  | Sexual and reproductive health and rights | • Develop a shared definition of sexual health and reproductive health  
• Get an overview of sexual and reproductive health issues in India  
• Deepen understanding of rights in general; and sexual and reproductive rights in particular  
• Review international instruments related to sexual and reproductive health and rights and make the link to MDGs  
• Be able to apply concepts of ‘Right to health’ and a rights-based approach to SRH to assess sexual and reproductive health interventions, programmes or policies | a) Brainstorming on participants’ understanding of sexual and reproductive health and its determinants; summary  
b) Group exercise: reading and plenary presentation including SRH situation in their states/countries. Discussion of main issues emerging  
c) Clarification of definitions: Reproductive and sexual rights  
d) Input by facilitator (International instruments, Right to Health and Rights-based approach to SRH  
e) Brief exercise (work in pairs) to apply the ‘rights’ framework to assess sexual and reproductive health interventions, programmes or policies | 30 mins  
90 mins  
30 mins  
30 mins  
45 mins |
### Session 3: SRH service provision
- Understand factors that influence availability, affordability, acceptability and quality of sexual and reproductive health services
- Be able to identify gaps between the status of SRH service provisioning in one’s country as compared to the commitments made in the ICPD and ICPD +5.

**Activities**
- Large group exercise led by facilitator to assess factors influencing access (making the link to rights-based approach)
- Discussion with participants on what they know about commitments made in ICPD and ICPD+5 targets
- Small group data-exercise
- Report-back next morning and discussion

**Duration**
- 30 mins
- 30 mins
- 30 mins+ homework

### Session 4: Health sector reforms: Context, nature and scope and framework for assessment of its implications/impact
- Be able to list health system functions and characteristics
- Have explored factors that led to health sector reform
- Have an understanding of the variations in nature and scope of HSR across different countries and regions
- Develop tools for analysing the implications of HSR for sexual and reproductive health services

**Activities**
- Brief introduction and exercise on health systems
- Film on India’s health services system and Plenary discussion including on participants’ experiences with HSR in their states/countries
- Global context of reforms and framework for assessing its implications for SRHR
- Case study: Health sector reform in Kerala

**Duration**
- 30 mins
- 90 mins
- 60 mins
- 90 mins

### Session 5: Financing reforms
- Understand the term financing and the different mechanisms of financing
- Have a framework for evaluating different financing mechanisms for sexual and reproductive health services
- Get an in-depth understanding of the functioning of community-financing schemes and their prospects and limitations

**Activities**
- Brief introduction and exercises on financing
- Input by resource person
- Detailed simulation exercise to illustrate functioning of community financing

**Duration**
- 90 mins
- 90 mins
- 90 mins

### Session 6: Priority-setting
- Gain a basic understanding of “priority setting” as a technical concept
- Gain an understanding of the WDR-93 approach to priority setting and implications for SRH services
- Appreciate alternative approaches to priority setting

**Activities**
- Brief input by facilitator
- Simulation exercise in priority-setting to develop an essential services package and discussion

**Duration**
- 30 mins
- 60 mins
### Session 7: Decentralisation
- Be introduced to the concept of decentralisation and analyse the implications of decentralisation for SRH services
- Be acquainted with the decentralisation experience in Kerala and its consequences for delivery of health care services

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<th>Activity</th>
<th>Time</th>
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<tbody>
<tr>
<td>Input by facilitator and exercises in buzz groups</td>
<td>45 mins</td>
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<tr>
<td>Role play and discussion</td>
<td>60 mins</td>
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<tr>
<td>Resource person presentation and discussion</td>
<td>90 mins</td>
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### Session 8: Public-private interactions in SRH
- Understand the meaning of the term PPI and be acquainted with the different forms of PPI in SRH services in their states/country
- Have analysed the actual/potential impact of PPIs on equity, efficiency, quality and accountability of SRH services

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<th>Activity</th>
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<tbody>
<tr>
<td>Introduction to PPIs and table</td>
<td>45 mins</td>
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<tr>
<td>Debate on public-private partnerships</td>
<td>45 mins</td>
</tr>
<tr>
<td>Input on forms of PPIs</td>
<td>30 mins</td>
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<tr>
<td>Group work, report back and summary by facilitator</td>
<td>90 mins</td>
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### Session 9: Health systems accountability and community participation
- Have an understanding of health accountability to community underpinning World Bank initiated HSRs and rights based groups.
- Be familiar with accountability mechanisms and the extent to which marginalised people/women hold accountable health policy makers, managers and providers within and outside HSRs in Asia
- Have examined the role of financial contribution by clients, community participation, and community health structures in strengthening health/SRH accountability
- Be able to outline what can be done to strengthen SRH service accountability further in the context of reforms and outside

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<tr>
<th>Activity</th>
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<tr>
<td>Brainstorming and input on accountability</td>
<td>15 mins</td>
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<tr>
<td>Buzz group discussions on two perspectives on accountability and summary</td>
<td>60 mins</td>
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<tr>
<td>Group exercise to discuss accountability mechanisms</td>
<td>90 mins</td>
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<tr>
<td>Consolidation by facilitator</td>
<td>15 mins</td>
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### Session 10: Issues for policy advocacy in Health Sector Reform and Sexual and Reproductive Health
- Come up with a list of priority issues for advocacy in HSR and SRH
- Know what advocacy is and the steps involved in planning for advocacy
- Be able to apply a framework for identifying factors that affect policy development and implementation (Context-Processes-Actors), in order to advocate strategically

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<tr>
<th>Activity</th>
<th>Time</th>
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<tbody>
<tr>
<td>Plenary discussion to identify advocacy issues</td>
<td>45 mins</td>
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<tr>
<td>Introduction to advocacy concepts and framework</td>
<td>45 mins</td>
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<tr>
<td>Application exercise: Small group discussion of a case study on policy advocacy in HSR, report-back in plenary and summary</td>
<td>90 mins</td>
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### Session 10: Closing session
- Consolidate what they have learnt on the course
- Evaluate course content and methodology

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<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>Consolidation – group exercise</td>
<td>60 mins</td>
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<tr>
<td>Individual written evaluation of the course</td>
<td>30 mins</td>
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<tr>
<td>Distribution of certificates</td>
<td>10 mins</td>
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Health Sector Reform and Sexual and Reproductive Health
Trivandrum, February 5-10 2007

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<th>Spontaneous sharing, fun exercise for taking leave</th>
<th>20 mins</th>
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Session 1: Introduction

Objectives

By the end of the session, participants will

- Begin to feel at ease with each other
- Be introduced to each other and to key facilitators
- Discuss their expectations, anxieties and contributions to the workshop and reach consensus on ground rules that will apply during the workshop
- Be briefed on logistical and administrative matters concerning the course.

Session duration: 1 hr 15 minutes

Session Plan

This session consists of three activities.

Activity 1: 45 minutes
The first activity is introduction by participants. Participants are asked to take a few minutes to introduce themselves at length: to go beyond their names and job descriptions, and introduce their families, describe their likes and dislikes, hobbies and part times, hopes and aspirations. Time to be allocated is about 2-3 minutes per participant. Participants may be asked to write down what they will say, so that there is control over time.

Activity 2: 15 minutes
Participants are distributed cards in two colours (say) green and pink. Each person has to write down 2-3 expectations from the course in the green card and 2-3 fears: things they would not like to happen in the course in the pink card. This should take no more than 5 minutes. Collect the cards, pin them on a bulletin board and categorise them according to themes. Summarise the main expectations and fears. Based on the fears expressed, make some ground rules for the course. For example, encouraging active participation by everyone; limit the number of sessions that may consist of one-way participation (e.g. no more than one lecture a day); keep mobile phones in silent mode; begin and finish the day on time; etc. (5 minutes).

Activity 3: 15 minutes
The Course co-ordinator makes a power point presentation of the objectives and structure of the course, and answers any questions that participants may have. This is followed by a briefing on logistical and administrative issues.
Session 2: Sexual and reproductive health and rights

Objectives

By the end of the session, participants will:

- Develop a shared definition of sexual health and reproductive health
- Get an overview of sexual and reproductive health issues in India
- Deepen understanding of rights in general; and sexual and reproductive rights in particular
- Review international instruments related to sexual and reproductive health and rights and make the link to MDGs
- Be able to apply concepts of ‘Right to health’ and a rights-based approach to SRH to assess sexual and reproductive health interventions, programmes or policies

Session Duration: 3 hrs 30 mins

Session Plan

This session is divided into two main parts. The first part focuses on Sexual and reproductive health, and the second part on sexual and reproductive rights.

Part 1: Sexual and reproductive health

There are two main activities in this session.

Activity 1: 15 minutes

1. Begin with a brainstorming on what participants understand by reproductive health and sexual health. Write down all the points they make on the board. Probe for positive definitions (i.e. more than diseases and problems)

2. Now distribute Handout 1 with these definitions. Review these definitions with participants very quickly, as many of them may be familiar with these.

3. Ask the following question:

Are there any major differences between sexual and reproductive health issues and other health issues? If yes, what are these differences?

Try to elicit the following answers:
- Most sexual and reproductive health needs are not related to diseases; for example, sex education, antenatal care, delivery care, contraception and practice of safe sex, etc.
- Gender, social norms and laws (marriage and divorce laws, laws pertaining to abortion and contraception) are major social determinants of SRH, much more than in the case of other health issues; in fact, many social and cultural norms can directly contribute negatively to many SRH problems (for e.g. early marriage, marriage to an unknown person, female responsibility for contraception, honour killings, tacit condoning of sexual coercion within marriage)
- Access to and utilisation of SRH services also influenced significantly by gender norms
- Because many SRH needs are not diseases, demand for these services depends crucially on cost of services.
- Many of the SRH services are currently and almost always have been available mainly through the private sector (e.g. gynaecological morbidity, delivery care by dais, infertility treatment etc.)

Activity 2: 90 minutes
1. Participants have been assigned chapters for reading from the report on Reproductive Health Profile in India (Essential Reading). This has been sent to them prior to their arrival at the course. Divide participants into groups according to the chapter assigned to them. Give them about 30 minutes to work in their groups.

   Their task is to:
   - Identify the range of needs or problems within this aspect of sexual/reproductive health (do maximum of 3)
   - Write each need/problem on a separate card in bold letter. On the same card, note for each need/problem:
     - Extent of the need or problem (prevalence or incidence rates, mortality or morbidity rates)
     - Correlates/underlying factors/risk factors

2. Ask each group to come and put up their cards and explain what they have written. There are 5 groups and each group should be give 6-7 minutes for presentation. Discussion can come after all presentations are completed. Presentations and discussion should be completed within 60 minutes.

3. A brief (5 minute) pulling things together would be adequate.
4. Draw attention to the essential reading on sexual and reproductive health and MDGs. Point out that although SRH does not feature explicitly in any MDG, promoting SRH is vital to the achievement of MDGs.

**Part 2: Sexual and reproductive rights**

There are three main activities in this part of the session.

**Activity 1: 30 minutes**

1. The session starts with a brainstorming on what participants understand by ‘rights’ – 5 minutes.
2. Get participants to discuss in buzz groups of 3 or 4, and come up with one instance per group of a violation of rights, with a focus on sexual and/or reproductive rights. Write these down on the board.
3. Now draw attention to the Universal Declaration of Human Rights in their file folders. Give them a few minutes to read the UDHR and identify which right was violated. Do this only in one or two cases, just as preparation for the last exercise.
4. Go through Handout-2 on the Right to Health

**Activity 2: 30 minutes**

5. Ask participants to read
   a. definitions of sexual and reproductive rights (Handout-3)
   b. the IPPF Charter on sexual and reproductive rights (Essential Reading)

   and to share their immediate thoughts on the linkages between sexual and reproductive rights and international human rights law.

6. Make a presentation with the following points: What are human rights; what is guaranteed in the right to health; SRR are not new rights, they are rights that already exist in the Universal Declaration, and reaffirmed and expanded upon in subsequent treaties; that states have an obligation to respect, protect and fulfil these rights; the Indian scenario

**Activity 3: 45 minutes**

7. Do an exercise to apply the ‘rights’ framework to assess sexual and reproductive health interventions, programmes and policies. Distribute Handout -4 to participants, give a few moments to work individually with it and then ask for answers and discuss these in the plenary.
Session 2. Handout 1

Reproductive health

Reproductive health is a state of physical, mental and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of women and men to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, and the right to appropriate health care services that enable women and men to go safely through their reproductive life spans.

Sexual health

Sexual health is a state of physical, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Sexuality

Sexuality is a central aspect of being human throughout life. It encompasses sex and gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural and ethical factors.

1 www.rho.org/html/definition.htm
2 WHO draft working definitions, October 2002
Session 2. Handout 2

The Right to Health

Rights = Benefits or privileges one obtains from being human

The ‘Right to Health’ as elaborated in the general comments of the Committee for Economic, Social and cultural rights of the United Nations:

The right to health in all its forms and at all levels contains

(a) Availability.
- Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.
- The underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs,

(b) Accessibility.
- Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. (7)

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.


**Information accessibility**: accessibility includes the right to seek, receive and impart information and ideas (8) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) **Acceptability**.
All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) **Quality**.
Scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

**Rights-based approach to sexual and reproductive health**

The ‘rights-based’ approach describe a strategy for promoting sexual reproductive health based on an acknowledgement that sexual and reproductive health are human rights, and that services should be provided in such a way as to:

- Uphold equity and equality, including gender equity and equality
- Respect, protect and fulfill human rights including sexual and reproductive rights
- Provide client-centred sexual and reproductive health care
- Ensure accountability and transparency
Reproductive rights

“...reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government - and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world’s people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.”


Sexual rights

“The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal
relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."

Session 2. Handout 4

Apply the ‘rights’ framework to assess the following sexual and reproductive health interventions, programmes and policies (or absence of policies). What rights do they uphold or violate, directly or indirectly?

1. According to a country’s population policy, communities which have the highest rate of acceptance of contraception will be given preferential treatment in sanction of development projects, while ‘poor performers’ will be denied sanctions.
2. Health facilities require women who want to have an IUD inserted or to undergo tubal ligation, to have their husbands come and sign a consent form. Husbands do not need the consent of their wives for receiving condoms or undergoing vasectomy.
3. The HIV prevention strategy in country X requires all commercial sex workers to register and get a card permitting them to operate, provided they undergo tests for STIs and HIV, and are found to be infection-free.
4. Sex education in schools is not approved country Y, because the government believes that this runs contrary to the country’s culture.
5. Abortion is a criminal offence in country A, and is not available except to save the life of the woman.
6. In an effort to make the family planning programme cost-effective, the public health facilities in this country offer only terminal methods to those with two children, only IUDs to those with one child, and pills and condoms to those who have yet to start a family. No contraception is available from the public sector to those who are unmarried.
7. A woman in labour is turned away from this private hospital because they consider the case ‘too risky’ and they ask that she be taken to the government hospital more than 50 km away.
8. A new social health insurance scheme is introduced in this country, covering all employees in the formal sector and their legal dependants.
9. Ever since user fees were introduced in the local health facilities, the proportion of persons with a reproductive health problem who did not seek health care because they could not afford it increased from 20% to 44%. Among women in the poorest section of the population group, the increase was from 40% to 86%.
10. As part of the efforts to raise finances for running this teaching hospital, a new ‘private’ ward has been opened for those who can afford to pay. The private ward has better rooms and amenities, and 24 hour nursing care.
11. Free availability of pills and condoms have now been replaced with social marketing.
12. All couples who are about to be married are required to undergo mandatory HIV tests in this country.
13. In this health facility in a rural area, which is the only source of health care in a radius of about 60 km, there is only one medical officer and a nurse regularly available. No more than 3-4 basic drugs are available most of the time. The examination table has been unusable for a long time, there are not even gloves available. Women going for antenatal care and those with a reproductive health problem do not get a gynaecological exam.

14. The government of this country has introduced a new policy banning traditional birth attendants from conducting deliveries, as part of their Safe Motherhood programme.

15. A married woman files a case against her husband for rape. The court dismisses the case on the grounds that there is no such thing as rape within marriage.
Session 3: SRH Service provisioning

Objectives

By the end of the session, participants will:

• Understand differences in SRH outcomes across a few Indian states.
• Understand availability of and access to SRH services in different states, and factors that may have a bearing on these.
• Be able to identify gaps between the actual SRH outcomes and service access and ICPD+5 targets.

Session Duration: 3 hrs

Session Plan
This session consists of three activities. The first activity makes linkages with the right to health and discusses various aspects of service provisioning. The second activity introduces participants to the main commitments made in the International Conference on Population and Development (ICPD) and ICPD+10 regarding the provisioning of SRH services, and the 17 SRH indicators across which progress is being globally monitored. The third activity is an exercise in which participants analyse data from Indian states to identify gaps between SRH outcomes and service access and ICPD+5 targets.

Activity 1: 30 minutes

Distribute Handout-1 on Access to sexual and reproductive health services, and ask a participant each to read hand out defining the terms distance, availability, affordability, appropriateness, and quality.

Following this, put up on a power point (or distribute as a handout) statements contained in Box 1. Read out each statement and invite participants to say which aspect of access is reflected in the statement. For example,

“I had a terrible itch in my vagina, but I did not go to the PHC as there were no women doctors there”

This depicts lack of access due to lack of acceptability of services available.
Box 1. Statements on different dimensions of access to SRH services

- I had a terrible itch in my vagina, but I did not go to the PHC as there were no women doctors there.
- The sub center does not function. It takes Rs 10 to get to PHC, Rs 20 for lunch, and I miss my wage earnings. How can I go for ANC check up?
- My baby was born pre term and died. I had eminent pre eclampsia due to high pressure. The VHN regularly examined me physically, but I later learnt that she should have checked my pressure as well. She was not provided with the equipment.
- The sub center is 10 km away. There is only one bus in the morning, and it is before the time my children leave for school. How can I go for my anti-tetanus injection?
- My mother died of cancer of the breast. We did not know about it till it was in an advanced stage

Activity 2: 30 minutes

Distribute Handout-2 on the range of SRH services as envisioned in the ICPD Programme of Action, and read these with the participants.

Ask participants whether any of them attended the conference and what they know about the ICPD. Build on this, and make a presentation on the main aspects of ICPD and ICPD+5 in terms of the vision of a 'rights' respecting and comprehensive SRH services.

Activity 3: 2 hrs + time spent on homework
This activity starts in the last part of the last session on day 1, and continues through the morning of day 2.

Task 1: 30 minutes
Distribute Handout-3 on ICPD and ICPD+5 Indicators, and go through the indicators with participants, providing explanations where needed. Explain that they are about to do a group exercise comparing the achievements of Indian states in provisioning SRH services, against ICPD and ICPD+5 targets.

Divide participants into five groups. Distribute Handout-4 and data sheets on Indian states from NFHS-3. Each group has to compare one state assigned to it with the recently formed state of Chattisgarh, and answer specific questions about the data (given in the Handout).

Participants start working on the group exercise and carry it over as homework.
Task 2: 60 minutes

The following morning, each group presents its analysis of the data and responses to the questions in Handout-4 (10 -12 minutes per group).

Task 3: 30 minutes

Summarise the major findings. This requires prior preparation on the part of the facilitator, who will have to fill in the data analysis sheets to draw out major points.

Some of the highlights from the data given in this exercise include:

- On seven indicators no data is available showing lack of commitment to monitor ICPD. On several indicators only partial data is available.

- Data is not available for prevalence of STI/RTI, FGM and infertility – aspects of sexual and reproductive health that have usually been neglected, and which ICPD sought to bring into the range of SRH services.

- On all but one SRH indicator on which data is available Chattisgarh performs the worst (other than one- Anaemia in pregnant women- wherein Haryana is the Worst)

- On some indicators Gujarat or Maharashtra perform best (maternal mortality, skilled attendance, institutional delivery, ANC, modern methods of contraception)on others Punjab does best (AIDS awareness, female nutrition, fertility rates, male contraception, unmet need for contraception)

- Overall maximum gap (based on data available) between achievement and target are in Maternal mortality ratio, male contraception, Institutional delivery, and nutrition of women.
Session 3. Handout 1

Access to Sexual and Reproductive Health Services

An individual’s access to SRH services is determined by factors such as distance, availability, affordability, and the appropriateness and quality of services as perceived by users. While these factors affect both women and men, there are important differences by gender that cut across social groups.

The term *distance* is self-explanatory. What distance is acceptable may vary with the nature of SRH service, the background of the client, the terrain and socio-cultural norms.

*Availability* is determined by whether the SRH services are available in the country, in the public or private health care system, and at which level of health care.

*Affordability* is determined by the cost of SRH care (including transport and under-the-table (bribe) payments), as well as the person’s earnings. The services that are affordable for one economic or other group (including gender) may not be affordable for another.

*Appropriateness* refers to whether the services meet the SRH needs of the people, in particular those from marginalised groups.

*Quality* refers to whether the SRH services are provided according to standards set by international organisations, in particular WHO.

Source: Adapted from http://w3.whosea.org/women/chap7_3.htm
The ‘full range of reproductive health care services’ under ICPD as envisaged in the Programme of Action includes:

- family planning counselling, IEC and services
- IEC and services for prenatal care, safe delivery and postnatal care
- prevention and appropriate treatment of infertility
- abortion, including prevention of abortion and the management of complications arising from abortions
- treatment of reproductive tract infections, sexually transmitted infections and other reproductive health conditions
- IEC and counselling as appropriate on human sexuality, reproductive health and responsible parenthood.

The above services should be provided through the primary care system. In addition, the definition of ‘comprehensive’ reproductive health services includes referrals for further diagnosis and treatment as required for family planning services, complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancers and cancers of the reproductive system and sexually transmitted infections including HIV/AIDS.
Session 3. Handout 3

ICPD Programme of Action and ICPD+5 reproductive health goals and the 17 indicators

<table>
<thead>
<tr>
<th>Global indicator</th>
<th>ICPD goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total fertility rate</td>
<td>While the Programme of Action does not quantify goals for population growth, structure and distribution, it reflects the view that an early stabilisation of world population would make a crucial contribution to realising the overarching objective of sustainable development. <em>ICPD+5, 21st Special Session, Agenda Item 8, §7</em></td>
</tr>
</tbody>
</table>
| 2. Contraceptive prevalence             | Assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice. *ICPD Principle 8, 7.12, 7.14 (c), 7.16*  
Provide universal access to a full range of safe and effective family planning methods, as part of comprehensive sexual and reproductive health care. *ICPD 7.2, 7.4, 7.6, 7.16 (a)*  
By 2005, 60% of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods. *ICPD+5, 21st Special Session, Agenda Item 8, §53* |
| 3. Maternal Mortality Ratio             | Countries should strive to effect significant reductions in maternal morbidity and mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. Disparities in maternal mortality within and between countries, socio-economic and ethnic groups should be narrowed. *ICPD 8.21* |
| 4. Antenatal care coverage              | Expand the provision of maternal health services in the context of primary health care. These services should offer prenatal care and counselling, with special emphasis on detecting and managing high-risk pregnancies. *ICPD 8.17, 8.22* |
| 5. Births attended by skilled health personnel | All births should be attended by trained persons. *ICPD 8.22*  
All countries should continue their efforts so that globally, by 2005 at least 80% of all births should be assisted by skilled attendants, by 2010, 85%, and by 2015, 90%. *ICPD+5, 21st Special Session, Agenda Item 8, §64* |
<table>
<thead>
<tr>
<th>Global indicator</th>
<th>ICPD goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Availability of basic essential obstetric care</td>
<td>Expand the provision of maternal health services in the context of primary health care. These services should offer adequate delivery assistance and provision for obstetric emergencies. ICPD 8.22</td>
</tr>
<tr>
<td>7. Availability of comprehensive essential obstetric care</td>
<td>By 2005, 60% of primary health care and family planning facilities should offer, directly or through referral, essential obstetric care. ICPD+5, 21st Special Session, Agenda Item 8, §53</td>
</tr>
<tr>
<td>8. Perinatal mortality rate</td>
<td>Within the framework of primary health care, extend integrated reproductive health care and child health services, including safe motherhood, child survival programmes and family planning services, particularly to the most vulnerable and under-served groups. ICPD 8.17</td>
</tr>
<tr>
<td>9. Low birth weight prevalence</td>
<td>To improve the health and nutritional status of women, especially of pregnant women, and of infants and children. Interventions to reduce low birth-weight should include the promotion of maternal nutrition and the promotion of longer intervals between births. ICPD 8.15(b), 8.17, 8.20 (b)</td>
</tr>
<tr>
<td>10. Positive syphilis serology prevalence in pregnant women</td>
<td>Prevent and reduce the incidence of, and provide treatment for, sexually transmitted infections, including HIV/AIDS. ICPD 7.29. By 2005, 60% of primary health care and family planning facilities should offer prevention and management of reproductive tract infections, including STIs and barrier methods to prevent infection. ICPD+5, 21st Special Session, Agenda Item 8, §53</td>
</tr>
<tr>
<td>11. Prevalence of anaemia in women</td>
<td>Countries should implement special programmes on the nutritional needs of women of childbearing age, and give particular attention to the prevention and management of nutritional anaemia. ICPD 8.24</td>
</tr>
<tr>
<td>12. Percentage of obstetric and gynaecological admissions owing to abortion</td>
<td>Women should have access to quality services for the management of complications arising from abortions. ICPD 8.25</td>
</tr>
<tr>
<td>13. Reported prevalence of women with female genital mutilation (FGM)</td>
<td>Countries should take steps to eliminate violence against women. Governments should prohibit female genital mutilation wherever it exists and give vigorous support to efforts among non-governmental organisations and religious institutions to eliminate such practices. ICPD 4.4(e), 4.22</td>
</tr>
<tr>
<td>14. Prevalence of infertility in women</td>
<td>Prevent and reduce the incidence of, and provide treatment for, sexually transmitted infections, including HIV/AIDS, and the complications of sexually transmitted infections such as infertility, with special attention to girls and women. ICPD 7.29. By 2005, 60% of primary health care and family planning facilities should offer prevention and management of reproductive tract infections, including STIs and barrier methods to prevent infection. ICPD+5, 21st Special Session, Agenda Item 8, §53</td>
</tr>
<tr>
<td>Global indicator</td>
<td>ICPD goal</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 15. Reported incidence of urethritis in men               | Prevent and reduce the incidence of, and provide treatment for, sexually transmitted infections, including HIV/AIDS.  
ICPD 7.29  
By 2005, 60% of primary health care and family planning facilities should offer prevention and management of reproductive tract infections, including STDs and barrier methods to prevent infection.  
ICPD+5, 21st Special Session, Agenda item 8, §53 |
| 16. HIV prevalence in pregnant women                      | HIV infection rates in persons 15-24 years of age should be reduced by 25% in the most affected countries by 2005 and by 25% globally by 2010.  
ICPD+5, 21st Special Session, Agenda item 8, §70 |
| 17. Knowledge of HIV-related prevention practices         | By 2005 at least 90% of young men and women, aged 15-24, should have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.  
ICPD+5, 21st Special Session, Agenda item 8, §70 |

Source: [http://www.who.int/reproductive-health/publications/RHR_01_10/RHR_01_10_annex1_en.html](http://www.who.int/reproductive-health/publications/RHR_01_10/RHR_01_10_annex1_en.html)
Session 3. Handout 4

Questions for group exercise

Your group has been assigned Chattisgarh and one other state for which you have to examine the status of sexual and reproductive health services. Using data from the NFHS-3 list out data for as many indicators as possible from the 17 indicators identified in ICPD and ICPD+5.

1. Which state is doing better and/or worse on each SRH component? Why do you think this is the case?
2. On which of the 17 indicators are data available? For each state, on which indicators is there the biggest gap between the target and achievement? On which indicators is the gap smallest? What do you think are some of the reasons for these patterns? I
3. Has either of the states fully met the targets? Taking all the 17 ICPD indicators together, which state is doing better and which worse?
### Recording sheet: POA and ICPD+5 goals

<table>
<thead>
<tr>
<th>Global Indicator</th>
<th>Target</th>
<th>Availability of data</th>
<th>Performance of states</th>
<th>Reasons for difference Across states</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>C H G M P</td>
<td></td>
</tr>
<tr>
<td>1. Total fertility rate</td>
<td>No specific target</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Contraceptive Prevalence</td>
<td>Universal access to contraception</td>
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<td></td>
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<tr>
<td></td>
<td>Right to have children by choice</td>
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</tr>
<tr>
<td></td>
<td>By 2005, 60% of primary health care (PHC) and family planning (FP) centers offering widest range of safe methods</td>
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</tr>
<tr>
<td>3. Maternal mortality ratio (MMR)</td>
<td>Reduction in MMR and morbidity by one half of 1990 levels by the year 2000, and a further one half by 2015</td>
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<tr>
<td></td>
<td>Disparities within countries on MMR should be reduced</td>
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<tr>
<td>4. Antenatal care (ANC) coverage</td>
<td>Expand the provision of ANC in PHCs, with special emphasis on managing high risk pregnancies</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Global Indicator</td>
<td>Target</td>
<td>Availability of data</td>
<td>Performance of states</td>
<td>Reasons for difference across states</td>
</tr>
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</tr>
<tr>
<td>5. Births attended by skilled health professional</td>
<td>By 2005 at least 80% of all births should be assisted by skilled attendants, By 2010 85% By 2015 90%</td>
<td>CHGMSP</td>
<td>C H G M P</td>
<td></td>
</tr>
<tr>
<td>6 and 7. Availability of - basic essential obstetric care - comprehensive essential obstetric care</td>
<td>By 2005, 60% of PHC and FP facilities should offer directly or through referral, essential obstetric care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Perinatal mortality rate</td>
<td>Reduce perinatal mortality rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Low birth weight prevalence</td>
<td>To improve the health and nutritional status of women, especially of pregnant women, infants and children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To increase intervals between births</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Positive syphilis serology prevalence in pregnant women</td>
<td>By 2005, 60% of PHC and FP facilities should offer prevention and management of RTIs, including STIs, and barrier methods to prevent infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Global Indicator</strong></td>
<td><strong>Target</strong></td>
<td><strong>Availability of data</strong></td>
<td><strong>Performance of states</strong></td>
<td><strong>Reasons for difference across states</strong></td>
</tr>
<tr>
<td>---------------------</td>
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<td>-----------------------------------------</td>
</tr>
<tr>
<td>11. Prevalence of anaemia in women</td>
<td>Implementation of special programmes on the nutritional needs of women of child bearing age</td>
<td>C H G M P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. % age of obstetric and gynaecological admissions owning to abortion</td>
<td>Women should have access to quality services for management of complications arising from abortions</td>
<td>C H G M P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Reported prevalence of women with female genital mutilation (FGM)</td>
<td>Governments should prohibit FGM wherever it exists and give support to NGOs and religious institutions working on it</td>
<td>C H G M P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Prevalence of infertility in women</td>
<td>By 2005, 60% of PHC and FP facilities should offer prevention and management of RTIs, including STIs, and barrier methods to prevention infection</td>
<td>C H G M P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Reported incidence of urethritis in men</td>
<td>Same as above</td>
<td>C H G M P</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Global Indicator

<table>
<thead>
<tr>
<th>Global Indicator</th>
<th>Target</th>
<th>Availability of data</th>
<th>Performance of states</th>
<th>Reasons for difference across states</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. HIV prevalence in pregnant women</td>
<td>HIV infection rates in persons 15-24 years of age should be reduced by 25% in the most affected countries by 2005 and by 25% globally by 2010</td>
<td>?</td>
<td>C H G M P</td>
<td></td>
</tr>
<tr>
<td>17. Knowledge of HIV related prevention practices</td>
<td>By 2005 at least 90% of young men and women, aged 15-24 years, should have access to IEC to reduce their vulnerability to HIV infection</td>
<td>?</td>
<td>C H G M P</td>
<td></td>
</tr>
</tbody>
</table>
Session 4: Health Sector Reform: Context, nature and scope

Objectives:
By the end of this session, participants will:

- Be able to list health system functions and characteristics
- Have explored factors that led to health sector reform globally and in India
- Have an understanding of the variations in nature and scope of HSR across different countries and regions
- Develop tools for analysing the implications of HSR for sexual and reproductive health services

Session Duration: 4 hours and 30 minutes

Session Plan

There are four activities in this session

Activity 1: 30 minutes
The session starts with an introduction to health systems through a discussion, a very brief presentation just on objectives and functions and the relationship between the two. Distribute Handout-1 and Handout-2 and explain a framework for classifying health systems in order to understand the nature of problems faced and the type of reform needed.

Activity 2: 90 minutes
Participants watch a film on India’s health system challenges. The film is about one hour.

Ask participants to identify major challenges facing the Indian health sector, according to the film, have a detailed discussion.

Activity 3: 60 minutes
Presentation on global and Indian context of reforms and framework for assessing its implications; especially implications for SRHR (30 minutes)

Allow time for detailed discussion (30 minutes).

Activity 4: 90 minutes
Presentation of a case study of health sector reform experience in Kerala by a resource person with first-hand experience of the reform process in the state.

3 The film is “Health Matters”, a documentary by Shikha Jhingan, shikhaj@vsnl.com, shikha.jhingan@gmail.com
Session 4. Handout 1

Definition, function and characteristics of health systems

A health ‘system’ refers to the people, institutions and resources, arranged together to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health (World Health Report, 2000).

Health systems fulfill three main functions:
- resource generation (taxes, public insurance, private insurance, user fees, pre-payment, donor funds);
- arranging for the provision of services (management of human resources, drugs and equipments, facilities, knowledge); and
- stewardship of health services (leadership, decision-making, regulation).

Characteristics of health systems: the WHO typology
In the early 1980s the World Health Organization (WHO) proposed a typology of national health systems based on the national economic level and the extent of state responsibility for the provision and organisation of health services. This typology is a useful starting point for classifying national health systems. According to this typology, national health systems can be classified into one of nine categories – by high, medium and low levels of gross domestic product (GDP), and by high, medium and low level of state responsibility for the provision and organisation of health services.

A high level of state responsibility, for example, goes hand in hand with a largely publicly financed health system. In contrast, a low level of state responsibility for health usually goes hand in hand with a predominantly privately financed health system.

Adapting this framework
The level of health resources in a country is better captured by the level of total health expenditure in US dollars than the level of economic development (as used in the WHO typology). We therefore use per capita total health expenditure in US dollars as our measure of health resources. The World Health Report 2004 indicates that in 2001 per capita health expenditure ranged from US$ 4,887 per capita in the United States of America to US$ 1 in Liberia. We classify countries into three categories as follows:
- low per capita total health expenditure: US$ 45 or less in 2001;
- middle per capita total health expenditure: US$ 46-US$ 2,421 in 2001; and

Categorising the level of state responsibility for health care
State responsibility for the provision and organisation of health services can be inferred by analysing data on public expenditure’s share of total health expenditure. These data are again available in the World Health Report. Data for 2001 indicate that the share ranges from 13% in the case of Cambodia to 96% in the case of Niue. We use the following three categories for classifying countries:
- low: less than 33%;
- medium: 34-67%; and
- high: more than 67%.
### Session 4. Handout 2

**Matrix for classifying health systems**

<table>
<thead>
<tr>
<th>Level of state responsibility for health (share of government in total health expenditure)</th>
<th>Level of health resources (Per capita health expenditure in US $)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
</tr>
<tr>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
</tr>
</tbody>
</table>
Session 5: Financing reforms

Objectives
By the end of this session, participants will

- Understand the term financing and the different mechanisms of financing
- Have a framework for evaluating different financing mechanisms for sexual and reproductive health services
- Get an in-depth understanding of the functioning of community-financing schemes and their prospects and limitations

Session duration: 4 hours 30 minutes

Session plan

This session has three major activities. The first part is an introduction to health financing and aspects of health financing reforms (90 minutes). The second part is about health insurance, and is an input session by a resource person (90 minutes). The third part is a simulation game on Community-Based Health Insurance.

Activity 1: 90 minutes

Responses are sought from participants on what they understand by financing of health care; clarification given about differences between ‘budget’ and ‘financing’; and that there is no health care that is “free”, someone has to pay for it. (5 minutes)

This is followed by a power–point presentation specifically on financing mechanisms. During discussion of each financing mechanism, draw responses from participants based on Chapter 2 in the Rights and Reforms book, which is an essential reading for this session. (25 minutes)

At the end, students have to look at national accounts statistics from the Rights and Reforms book and write down how the health sectors of South (India, Bangladesh, Nepal, Sri Lanka, Pakistan, Maldives) and South East Asian countries (Myanmar, Thailand, Indonesia, Cambodia, South Korea, Malaysia) are financed. (About 15 minutes)

\[4\] The first part of this power point presentation is presented at this point, and the second part as summary and conclusion at the end of this session.
Participants have been assigned to read one set of papers the previous evening: general paper on financing + paper on user fees; papers on financing reproductive health services; papers on insurance; papers on CBHI.

Give participants about 5 minutes to look through their papers again. Now distribute Handout -1 on criteria for evaluating financing reforms, and have a discussion evaluating each mechanism of financing (45 minutes).

**Activity 2: 90 minutes**

This is a presentation by a resource person on issues concerning Health Insurance for the poor proposed by the Government of India, and an alternative Universal Coverage Scheme proposed by him.

**Activity 3: 90 minutes**

This consists of a simulation game on community financing and a concluding summary by the facilitator.

The game is played as follows:

1. Participants are ideally divided into 3 groups (or multiples of these). There are three different community profiles: Community A has 100% on or below poverty line. Community B has 15% poor, 45% middle and 40% upper income group. Community C has 100% in the upper income bracket.
2. Each group gets a description of the game and a work sheet.
3. The game is played as follows: At the start of the game, each community gets people to pay a subscription/season for a community health financing scheme. The proportion of subscribers and amount they are willing to pay varies by community profile. This amount is written in the worksheet.
4. The first season is assumed to a good harvest.
5. Now, three health needs cards, including one serious epidemic, one common health problem like fever, scabies, coughs, diarrhoea etc. and one MCH card is picked by the different groups from a central pile. These cards mention the health needs and also cost of treatment. Proportion falling ill, or in need of MCH services varies by income group, and each group gets instructions about this in their respective worksheets.
6. The group now has to make calculations about how many people have a health need and how much money has to be taken out of the community health fund, and arrive at an end of the season fund balance.

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5 This game has been developed by TK Sundari Ravindran and is still evolving. This is not the final version. Those using the game are requested to cite the source.
7. Season 2 now starts; die is thrown and we get a good or bad season. The collection of second round of subscription depends on the kind of season, with more poor and middle groups defaulting if this is the second consecutive bad season. Add the fund collected to the previous balance.

8. Now 3 health needs cards are picked again. The proportion of people in the community who fall ill varies also according to whether it is a good season or bad (in addition to variations by income level). Calculations of demands on the health fund are made, and balance arrived at.

9. The game stops after the fund position of each group has been written on the white board/flip chart.

10. A detailed debriefing of each group, followed by discussions on the difficulties and prospects of such community financing schemes.

Materials needed: A die to throw and find the season; 6 sets of health cards (2 low, 2 high and 2 mixed economic groups) x 2 seasons, i.e. 12 sets of cards.

Each set of health cards has 3 conditions: Common illness; communicable disease and MCH. It mentions what is wrong and what it costs per person.

The cards are as follows:

<table>
<thead>
<tr>
<th>Seasons</th>
<th>MCH</th>
<th>Communicable diseases</th>
<th>Common illnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Season 1</strong></td>
<td>Normal delivery in local health facility (60 LCUs)</td>
<td>Chicken Pox (30 LCUs)</td>
<td>Fever (15 LCUs)</td>
</tr>
<tr>
<td></td>
<td>Contraception (5 LCUs)</td>
<td>Measles (30 LCUs)</td>
<td>Worm infestation (25 LCUs)</td>
</tr>
<tr>
<td></td>
<td>Antenatal care in a normal pregnancy (5 LCUs)</td>
<td>Dengue fever (80 LCUs)</td>
<td>Genital fungal infection (30 LCUs)</td>
</tr>
<tr>
<td></td>
<td>C-section following complications (500 LCUs)</td>
<td>10 % of poor households have a TB patient (200 LCUs/head)</td>
<td>Conjunctivitis (15 LCUs)</td>
</tr>
<tr>
<td></td>
<td>Septic abortion (500 LCUs)</td>
<td>Malaria (50 LCUs)</td>
<td>Scabies (15 LCUs)</td>
</tr>
<tr>
<td></td>
<td>Childhood diarrhea (15 LCUs)</td>
<td>Two households have HIV seropositive members (LCU 1500/head)</td>
<td>Throat infection (30 LCUs)</td>
</tr>
<tr>
<td><strong>Season 2</strong></td>
<td>Ultrasound scan and care for high risk pregnancy</td>
<td>Typhoid (80 LCUs)</td>
<td>Urinary tract infections (50 LCUs)</td>
</tr>
<tr>
<td>(280 LCUs)</td>
<td>Measles (30 LCUs)</td>
<td>Scabies (15 LCUs)</td>
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<td>------------</td>
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<td></td>
</tr>
<tr>
<td>Normal delivery in local health facility (60 LCUs)</td>
<td>Infant suffering from pneumonia (150 LCUs)</td>
<td>Viral hepatitis (150 LCUs)</td>
<td></td>
</tr>
<tr>
<td>Septic abortion (500 LCUs)</td>
<td>Immunisation of infant (5 LCUs)</td>
<td>C-section following complications (1500 LCUs)</td>
<td></td>
</tr>
<tr>
<td>Septic abortion (500 LCUs)</td>
<td>Immunisation of infant (5 LCUs)</td>
<td>C-section following complications (1500 LCUs)</td>
<td></td>
</tr>
<tr>
<td>Cholera (100 LCUs)</td>
<td>Chicken pox (30 LCUs)</td>
<td>Worm infestation (25 LCUs)</td>
<td></td>
</tr>
<tr>
<td>Two households have HIV seropositive members (LCU 1500/head)</td>
<td>Throat infection (30 LCUs)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Conclude with a summary of health financing reforms (presentation).
Session 5. Handout 1

Rating financing mechanisms

Rate health financing mechanisms given below by their contribution to gender, and socio-economic equity, ability to raise resources for health care and scope for improving quality of health care services on a scale of 0 (no contribution likely) to 10 (very high level of contribution). After filling in the matrix, give reasons for your rating in the space provided below and overleaf.

<table>
<thead>
<tr>
<th></th>
<th>Gender equity</th>
<th>Economic and social equity</th>
<th>Raising resources for health care</th>
<th>Quality of health care service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>User fees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-payment (community financing- a form of prepayment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session 5 Handout 2

Implementing a Community financing Scheme

This is a simulation game on the working of a community financing scheme.6

You belong to a rural hamlet of 100 households who depend on farming for their livelihood. Because of increasing costs of health care borne by members of your community, the leadership, with advice from the health department and some NGOs, has recently decided to set up a community health fund.

Subscription to the community health fund is voluntary. Subscription has to be paid per household once in four months, after each harvest. Subscribing households are entitled to have cost of treatment covered for all its household members.

Subscription (Premium) rates have been set on a sliding scale according to income levels:

- Agricultural labourers' households  
  10 LCUs (local currency units) per season
- Middle and small farmers' households  
  15 LCUs per season
- Large farmers' households  
  20 LCUs per season

1. Read the community profile of your community
2. Add up the total subscription amount available to your community health fund at the beginning of this season. Write this in the worksheet given to your group. (We assume that the first season follows a good harvest).
3. Now pick three ‘health needs’ cards. Each card describes one health need and how much it costs to have health care for this.
4. Calculate on your worksheet how much money has to be taken out of the Community Health Funds for this season. Deduct this from the total subscription received, and you have the balance at the end of season 1.
5. Season 2 now starts. A die is thrown by a member of any one of the groups. It is a good harvest for all communities if the throw is 2 or 4; a bad harvest if the throw is 1, 3 or 5; if the throw is 6, the die has to be thrown again.
6. Subscription for season 2 has to be collected. A bad harvest could mean some households are unwilling to pay this season's subscription (refer to your community profile).
7. Now, three health needs cards are picked again. A bad harvest means more people will be sick, and a good harvest means less people would be

---

6 Game developed by TK Sundari Ravindran, still in formative stages. Feedback for improvement most welcome.
sick. Routine health needs such as immunisation will be the same for good or bad harvest.

8. Calculate on your worksheet how much money has to be taken out of the Community Health Funds for this season. Deduct this from the total subscription received, and you have the balance at the end of season 2.

9. Repeat steps 5-8 for season 3. The game stops with calculation of balance at the end of season 3.
Session 5 Handout 2 a

Community profile
Your hamlet of 100 households consists only of subsistence farmers and agricultural wage labourers, all of whom may be classified as poor. Twenty households are living in total destitution and cannot afford to pay for any health fund even in a good season.

If good season, number of subscribers is 80; if bad season, number of subscribers falls to 40.

Season no. 1

Total Fund available:
No. of subscribers______ $\times$ Subscription per household ____ = _____ Total (1)

<table>
<thead>
<tr>
<th>Health need</th>
<th>No. of persons needing care</th>
<th>Cost/person</th>
<th>Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good harvest</td>
<td>Bad harvest</td>
<td></td>
</tr>
<tr>
<td>Epidemic</td>
<td>80</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>MCH</td>
<td>25 for routine and 5 for serious</td>
<td>25 for routine and 8 for serious</td>
<td></td>
</tr>
<tr>
<td>Common illnesses</td>
<td>60</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>(2)</td>
</tr>
</tbody>
</table>

Amount given out in season 1 __________ (from 2 above)

Balance at the end
Of season 1 __________ (3) [deduct (2) from (1)]
### Season no. 2

No. of subscribers _____ x Subscription per household _____ = _____ Total (4)

**Total Fund available:** \((3)+(4) = \) ________ (5)

<table>
<thead>
<tr>
<th>Health need</th>
<th>No. of persons needing care</th>
<th>Cost/person</th>
<th>Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good harvest</td>
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</tr>
<tr>
<td>Epidemic</td>
<td>80</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>MCH</td>
<td>25 for routine and 5 for serious</td>
<td>25 for routine and 8 for serious</td>
<td></td>
</tr>
<tr>
<td>Common illnesses</td>
<td>60</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Amount given out in season 2** ________ (from 6 above)

**Balance at the end Of season 2** ________ (7) [deduct (6) from (5)]
Community profile
Your hamlet of 100 households consists of 15 poor agricultural labourers’ households, 45 households of middle farmers (middle income) and 40 households of large farmers (high income).

If good season, number of subscribers is 97; if bad season, number of subscribers falls to 78 (only 40% of the poor, 80% of middle income and 90% of high income groups continue).

Season no. 1

Total Fund available:
No. of subscribers_____ x Subscription per household ____ = _____ Total
(1)

<table>
<thead>
<tr>
<th>Health need</th>
<th>No. of persons needing care</th>
<th>Cost /person</th>
<th>Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good harvest</td>
<td>Bad harvest</td>
<td></td>
</tr>
<tr>
<td>Epidemic</td>
<td>55</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>MCH</td>
<td>15 for routine and 3 for serious</td>
<td>15 for routine and 5 for serious</td>
<td></td>
</tr>
<tr>
<td>Common illnesses</td>
<td>35</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>(2)</td>
</tr>
</tbody>
</table>

Amount given out in season 1 = (from 2 above)

Balance at the end Of season 1 = (3) [deduct (2) from (1)]
Season no. 2

No. of subscribers _____ × Subscription per household ____ = _____ Total (4)

Total Fund available: (3)+(4)= ____________ (5)

<table>
<thead>
<tr>
<th>Health need</th>
<th>No. of persons needing care</th>
<th>Cost /person</th>
<th>Total cost</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
<tr>
<td>Epidemic</td>
<td>45</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>MCH</td>
<td>15 for routine and 3 for serious</td>
<td>15 for routine and 5 for serious</td>
<td></td>
</tr>
<tr>
<td>Common illnesses</td>
<td>25</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>(6)</td>
</tr>
</tbody>
</table>

Amount given out in season 2 __________ (from 6 above)

Balance at the end Of season 2 __________ (7) [deduct (6) from (5)]
Session 5 Handout 2 c

Community profile
Your hamlet of 100 households consists only of middle and large farmers, all of whom may be classified as rich.

If good season, number of subscribers is 100; if bad season, number of subscribers falls to 90.

Season no. 1

Total Fund available:
No. of subscribers_______ x Subscription per household _____ = _____ Total

(1)

<table>
<thead>
<tr>
<th>Health need</th>
<th>No. of persons needing care</th>
<th>Cost /person</th>
<th>Total cost</th>
</tr>
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<tr>
<td></td>
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</tr>
<tr>
<td>Common illnesses</td>
<td>25</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>(2)</td>
</tr>
</tbody>
</table>

Amount given out in season 1 __________ (from 2 above)

Balance at the end Of season 1 __________ (3) [deduct (2) from (1)]
**Season no. 2**

No. of subscribers _______ x Subscription per household _____ = _____ Total

(4)

**Total Fund available:** (3)+(4)= ____________ (5)

<table>
<thead>
<tr>
<th>Health need</th>
<th>No. of persons needing care</th>
<th>Cost/person</th>
<th>Total cost</th>
</tr>
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<tr>
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</tr>
<tr>
<td>Common illnesses</td>
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<td>40</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>(6)</strong></td>
</tr>
</tbody>
</table>

**Amount given out in season 2** __________ (from 6 above)

**Balance at the end Of season 2** __________ (7) [deduct (6) from (5)]
Community Based Health Insurance Initiatives In India

In India, more than 90% of the general population and almost all poor are not covered under any health insurance schemes and spend a large proportion of their household income on treatment. It has been found that out-of-pocket expenditures for health care can be ‘catastrophic’ in the sense of leading to or aggravating poverty by crowding-out other essential consumption items such as food, housing and clothing.

Community financing through pre-payment mechanisms – where the individuals or families put aside money in regular intervals in a health fund which finances (in part or whole) their medical expenses in case of illness - is being recognized as an important option to reduce catastrophic illness expenditure for people in rural areas and informal sector.

In India community financing experiments are limited and these programmes are usually run by NGO’s or non–profit organizations. Health care providers implement only 12 per cent of the schemes. Currently, there are about 52 CBHI/Micro Insurance in India, initiated and administered by NGOs. Of these, 25 schemes came up during the last four years alone. Around 5 to 6 million poor individuals are covered for various health risks through such schemes. In many schemes, the community is also involved in various activities such as creating awareness, collecting premiums, processing claims and reimbursements, and the management of the scheme (deciding the benefit package, the premiums, etc).

Characteristics
CBHI organizations rely on financing from various sources, including government, donor agencies, community and self generated sources. Most insurance schemes (66 per cent) are linked with microfinance services provided by specialised institutions (16 schemes) or non-specialised organisations (15 schemes).
They target primarily workers and families of informal sector and rural population. This ranges from tribal populations (ACCORD, Karuna Trust, and RAHA), dalits (Navsarjan Trust), farmers (MGIMS, Yeshasvini, Buldhana, and VHS), women from self help groups (BAIF, DHAN) and poor self-employed women (SEWA). The size of the target population ranges from a few thousands to 25 lakh (Yeshasvini trust).

Structures and features
Community Based Health Insurance in India can be categorized into three types based on their structure and features.
- Type I (Provider model)—the provider of health care plays the dual role of providing care and running the insurance programme (e.g. ACCORD, VHS). Here the NGO hospital provides health insurance for the target population.

- Type II (Insurer Model)—where a voluntary organization/NGO is the insurer, while purchasing care from independent providers (e.g. Tribhuvandas Foundation, DHAN Foundation). In this model the NGO takes the role of the insurer, collects money and purchases healthcare for its members.

- Type III—(Intermediary design)—The NGO plays the role of the agent purchasing care from providers and insurance companies (TPA, e.g. SEWA, Karuna Trust, BAIF). In this model, NGO collects the premium, but passes it onto a formal insurance company. This company then takes the risk of running the insurance.

### CHARACTERISTICS OF THREE TYPES OF CBHI MODELS IN INDIA

<table>
<thead>
<tr>
<th></th>
<th>Provider Model</th>
<th>Insurer model</th>
<th>Intermediary model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs a community based</td>
<td>Not necessary</td>
<td>Necessary</td>
<td>Is beneficial if one wants to negotiate an effective package with the insurance company.</td>
</tr>
<tr>
<td>organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community awareness</td>
<td></td>
<td>Necessary</td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td>Depends on the benefit package, usually lower than the other models</td>
<td>Depends on the benefit package.</td>
<td>Depends on the products available. Can be negotiated.</td>
</tr>
<tr>
<td>Benefit package</td>
<td>A very comprehensive package. Usually includes outreach activities, OP and IP</td>
<td>Limited and depends on the cost of treatment and the numbers insured.</td>
<td>A standard package covering IP only. Certain aspects, e.g. the maximum limit and exclusions can be negotiated.</td>
</tr>
<tr>
<td>Fund management</td>
<td>Usually institutionalized and easy</td>
<td>Members have to be trained and supervised initially</td>
<td>Collection of premium needs to be supervised. Financial risk is with the company.</td>
</tr>
<tr>
<td>Providers</td>
<td>The NGO hospital. A single provider usually.</td>
<td>Multiple private providers. Usually no control over them. Tendency for moral hazard is high, especially in the intermediary model.</td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>Simple and shared between the institution and the community.</td>
<td>Complicated and the sole responsibility of the community</td>
<td>Simple and shared between the NGO and the company.</td>
</tr>
<tr>
<td>Enrolment into the scheme</td>
<td>Tends to be higher as compared to the other two models</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization of services</td>
<td>Higher as the package is more comprehensive.</td>
<td></td>
<td>Lowest among the three models.</td>
</tr>
<tr>
<td>Risk management</td>
<td>Is the lowest among the three models</td>
<td>Being flexible, they can introduce measures to control risk</td>
<td>Is already built into the model. But more can be done.</td>
</tr>
</tbody>
</table>
### Provider Model | Insurer model | Intermediary model
--- | --- | ---
Cost recovery | The least among the three models | Usually meets moderate costs. However, the scheme is vulnerable as the risk pooling is small. | Is financially sustainable as the risk sharing is large. Administrative costs are subsidized by the NGO and the community.
Protection against catastrophic health expenditure | The most efficient, especially in those schemes where there is no upper limit | Depends on the upper limit. The higher the upper limit, the greater the protection. | 


**Premiums:**
Apart from the structure, pre-payment schemes/community based health insurance schemes in India differ in terms of amount of premium collected, coverage, benefit package and management of funds. Most of the programmes cover rural poor and the premiums range from Rs.20 to 120 per person per year. The premium is usually paid as a cash contribution once a year during a definite collection period.

**Benefit packages:**
The benefit package of majority of schemes includes ambulatory care and inpatient care but some schemes limit it only to ambulatory care. Most schemes had important exclusions like pre-existing illnesses, self-inflicted injuries, chronic ailments, TB, HIV; etc. Most of the schemes reimbursed only the direct costs of treatment and not costs incurred for transport, loss of wages etc. CBHI schemes also provide supplementary benefits such as life insurance, insurance against personal accident and/or asset insurance etc.

**Fund management**
Fund management in the majority of schemes is done by the community members, or by the voluntary organization thereby keeping transaction costs low. This is done by efficient monitoring of supply of health care, influencing health behavior through health education and designing tailor-made schemes to community needs.

**Examples of some notable CBHI schemes**
The Yeshaswani scheme is an insurance scheme for farmers, designed and implemented by the cooperative department of the Government of Karnataka since 2002. The scheme provides financial risk protection against 1600 types of surgeries offered in 90 accredited hospitals at prefixed rates. The premium is modest, at Rs 120. Outpatient treatment is free and any diagnostic service resulting in surgery carries a discount of 50%.

The prepayment scheme initiated by Tribovandas Foundation provides coverage to members of one fifth of households of more than 300 villages at a premium of
Rs. 10. The benefit package includes free primary care subsidized drugs and 50% subsidy on hospital care.

SEWA, which operates in Ahmedabad, provides hospitalization cover up to Rs 2000 per person to SEWA union members and their husbands. The premium ranges form Rs.22.50 for individual and Rs.45 for couples.

The CBHI scheme initiated by Karuna trust in Karnataka covers hospitalization expenses up to Rs 25000 per person per and it also covers loss of wages. The premium per person is Rs 30 per year and is fully subsidized for the SC/ST population.

The central government has implemented Universal Health Insurance Scheme (UHIS) in 2003. This scheme has been implemented as a community-based insurance scheme by NGOs through four public sector national insurance companies. This scheme provides financial risk protection up to Rs 30,000 per annum towards medical care in hospitals, one time compensation of Rs 25,000 in case of accident and a grant of Rs 750 for loss of wages @ Rs 50 per day for 15 days. The annual premium for this scheme is Rs 365 for one person ; Rs 547.5 for a family of five; and Rs 730 for a family of seven. Originally, BPL families were eligible for a premium subsidy of Rs 100 per annum.

The UHIS was revised in 2004 and the scope of coverage is now restricted to BPL families. The subsidy has been increased to Rs 200 against the Rs 365 premium paid for individual coverage; Rs 300 for the Rs 547.5 premium for a family of five and Rs 400 for those paying a premium of Rs 730 for covering a family of seven persons.

At present several new initiatives are coming up at the central and state level which aims at providing comprehensive community based health insurance through public-private partnerships. The insurance regulatory and development authority (IRDA) has recently passed the Micro-Insurance Regulations 2005 that aim to promote rural insurance.

The IRDA has allowed insurers to (a) issue policies with cover ranging from Rs 5,000 to a maximum of Rs 50,000 for general and life insurance, and (b) appoint self-help groups, micro-finance institutions and other NGOs to act as micro-insurance agents for the distribution of micro-insurance products under this new regulation.
### MAJOR COMMUNITY HEALTH INSURANCE SCHEMES IN INDIA

<table>
<thead>
<tr>
<th>Name and location</th>
<th>Population covered of the scheme (target population in 2003)</th>
<th>Premium collected (per cent target population covered in 2003)</th>
<th>Benefit package</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCORD Gudalur Nilgiris, Tamil Nadu</td>
<td>Tribes living in Gudalur taluk and who are members of AMS union(n=13,000)</td>
<td>Rs 25 per person per year (36%)</td>
<td>Hospitalization cover up to Rs 1500 per person per year</td>
</tr>
<tr>
<td>BAIERali Kanchan Pune, Maharashtra</td>
<td>Women members (between 18 and 58 years) of the micro savings scheme in 22 villages (n=1500)</td>
<td>Rs 105 per person per year (58%)</td>
<td>Hospitalization cover up to Rs 5000 per person per year</td>
</tr>
<tr>
<td>BUCCS Buldhana, Maharashtra</td>
<td>Members of the Buldhana Urban Cooperative and Credit society(n=17500)</td>
<td>NA</td>
<td>Hospitalization cover up to Rs 5000 per person per year</td>
</tr>
<tr>
<td>DHAN Foundation Kadamalai taluk, Theni</td>
<td>Women members of the micro finance scheme and living in mayiladumparai block (n= 19049)</td>
<td>Rs 100 per person per year (40%)</td>
<td>Hospitalization cover up to Rs 10000 per person per year</td>
</tr>
<tr>
<td>Karuna Trust T NarsipurBlock, Mysore</td>
<td>BPL families in T Narsipur Block (n = 278,156)</td>
<td>Rs 30 per person per year. Fully subsidized for the SC/ST population (31%)</td>
<td>Hospitalization cover up to Rs 25000 per person per year. Includes ambulance services and loss of wages.</td>
</tr>
<tr>
<td>Raigarh Ambikapur Health Association (RAHA)</td>
<td>Poor people living in the catchment of the 92 rural health centers and hostel students. (n = 92,000 individuals)</td>
<td>Rs 20 per person (58%)</td>
<td>Primary and secondary health care</td>
</tr>
<tr>
<td>MGIMSHospitalWardha,Maharashtra</td>
<td>The small farmers and landless labourers living in the 40 villages around Kasturba Hospital (n= 30,000)</td>
<td>Rs 48 per family of four (in cash or kind) (90%)</td>
<td>Hospitalization cover up to Rs 1500 per person per year</td>
</tr>
<tr>
<td>SEWA Ahmedabad, Gujarat</td>
<td>SEWA Union women members (urban and rural), and their husbands living in 11 Districts of Gujarat (n = 1,067,348)</td>
<td>Rs 22.50 per person or Rs 45 for a couple (10%)</td>
<td>Hospitalization cover up to Rs 2000 per person per year</td>
</tr>
<tr>
<td>SHADE Kolencherry,Kerala</td>
<td>Members of the SHGs operating in Ernakulam district (n = 9000)</td>
<td>The UHIS scheme (Rs 548 for a family of 5) (20%)</td>
<td>Hospitalization cover for family up to a maximum limit of Rs 30,000 per family per year</td>
</tr>
<tr>
<td>Student's Health Home, West Bengal</td>
<td>Full-time student in West Bengal State from Class 5 to University level (n= 104,247)</td>
<td>Rs 4 per student per year (23%)</td>
<td>Primary and secondary health care</td>
</tr>
<tr>
<td>Voluntary Health Services, Chennai, Tamil Nadu</td>
<td>Total population of the catchment area of 14 mini-health centers (n= 104,247)</td>
<td>Rs 250 per family of five (12%)</td>
<td>Hospital cover</td>
</tr>
<tr>
<td>Jan Arogya Feb 2003</td>
<td>5 to 70 years of age (Children between 3 months and 5 years can be covered provided one or both parents are insured)</td>
<td>&lt;46 years Rs. 70 per person 46 to 55 years Rs. 100 56 to 65 years Rs. 120 66-70 years Rs. 140 Dependant children (5-25 yrs) Rs. 50</td>
<td>Hospital benefits upto a max of Rs 5000 per patient per year.</td>
</tr>
</tbody>
</table>
A systematic review of experiences of various community financing arrangements reveals that community-based health insurance schemes have made positive contribution in terms of financial protection, resource mobilization, prevention of social exclusion, and in health care provision.

The main strengths of the CBHIs schemes are that they have been able to reach out to the weaker sections and provide some form of health security, increase access to health care, protect the households from catastrophic health expenditures and consequent impoverishment or indebtedness. However in most schemes the exclusion of poorest of poor is visible and also less cross subsidization.

Due to small amounts of revenues pooled CBHI schemes provide basic primary and secondary care, and not catastrophic illnesses, which is the principal cause of impoverishment.

Moreover, community-based schemes also tend to become too small to bargain or negotiate better terms of services from providers. Further scaling up and expansion of coverage of these schemes is a challenging task as majority of schemes depends crucially on external funding and donor assistance.
Session 6. Priority setting

Objectives
By the end of the session participants will
- Gain a basic understanding of “priority setting” as a technical concept
- Gain an understanding of the WDR-93 approach to priority setting and implications for SRH services
- Appreciate alternative approaches to priority setting

Session duration: 90 minutes

Session plan
The session consists of two activities.

Activity 1: 30 minutes
The session begins with a brief presentation on priority-setting, mainly to introduce concepts and definitions, with a focus on changes in priority-setting methods implemented as part of health sector reform in many countries.

Activity 2: 60 minutes
This is a simulation exercise aimed at acquainting participants with some basic issues/problems with priority-setting based on cost-effectiveness and limiting the role of the state to financing public goods in health, and those with catastrophic costs.

Participants are divided into three groups, representing three country teams: India, Nepal and Malaysia. Each group is asked to decide what SRH services will go into the essential services package of their country.

For this, they are given: estimate of the per-capita public expenditure on SRH for their country, based on WHO data on health expenditure and assuming that no more than 50-60% of the public health expenditure is likely to be spent on SRH. They are also given cost-estimates for various SRH services based on some recent figures. They are given about 20 minutes for this. (Handout 1)

Now distribute Handout 2 which has the priority-setting criteria used for deciding which services should go into an essential services package financed publicly.

Each group now faces members of another group (who assume the role of a ‘consultant’ group. For each service that the country’s policy-makers have included in the Essential services package, the ‘consultant’ group queries using the questions in the criteria (ie. Is this a public good? Does this have significant externalities? Etc.) and permits or does not permit the service to be included.
The facilitator then debriefs the groups and summarises the learnings.

Some of the main points to be highlighted are:

- Using these priority-setting criteria limits the services that go into the essential services package to a bare minimum, and includes only the ‘traditional’ SRH services: e.g. antenatal care, immunisation, family planning, STI/HIV awareness and education.
- There is a fundamental disjuncture between the vision for comprehensive SRH services as set out in ICPD and what will be available if these priority-setting criteria are applied. Even delivery care will not usually be included, especially where public spending per capita on health is very limited.
- When one examines what is actually available as SRH services in many countries, it becomes clear why only a narrow range is available: this is most probably the result of selecting the “best-buys” using WDR-93 method of priority-setting rather than on population’s needs.
Session 6. Handout 1

Each of your groups has been assigned a country’s name. Spend about 20 minutes working in your groups, to come up with a list of sexual and reproductive health services that you would suggest are included in the Essential Services package for your country group. The services selected should fall within the cost limits prescribed, and you should be able to justify why you selected a particular service and not another.

<table>
<thead>
<tr>
<th></th>
<th>India</th>
<th>Malaysia</th>
<th>Nepal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita public expenditure on health</td>
<td>24</td>
<td>143</td>
<td>12</td>
</tr>
<tr>
<td>In PPP US$ (2001)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated per capita public expenditure on sexual and reproductive health</td>
<td>10</td>
<td>60</td>
<td>5</td>
</tr>
<tr>
<td>In PPP US$ (2001)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Per capita cost of sexual and reproductive health services (estimates from various studies in developing countries)**

- Prenatal and delivery care: 5.8
- Postnatal care: 2.5
- Family planning: 2.0
- Treatment of STIs (syndromic management): 1.2
- AIDS prevention: 2.7
- Emergency Obstetric care: 25.0
- HIV/AIDS- ARV treatment & care: 40.0
- Cervical cancer screening: 10.0
- Breast cancer screening: 18.0
Session 6. Handout 2

Use the following framework to decide which of the services included in the Essential Services Package by different countries as part of the previous exercise should be retained in the package and be publicly funded.

Figure 4.3: Criteria for deciding what interventions governments should finance and provide

Yes

Public good? → No

Yes

Significant externalities? → No

Adequate demand? → Yes

Catastrophic cost? → No

Insurance appropriate? → Yes

Beneficiaries poor? → No

Cost effective? → No

Do not provide

Public? → Yes

Private?

Leave to regulated private market

Finance Publicly

Source: Musgrove et al. 1999 (22)
Session 7: Decentralisation

Objectives
By the end of the session the participants will
- Know the definition of decentralisation
- Have conceptual clarity on the forms, degrees and scope of decentralisation
- Be acquainted with the evidence on impact of decentralisation on health and SRH services

Session duration: 3 hours

Session Plan:
The session consists of four activities. The first is an interactive session by the facilitator introducing concepts and giving short exercises to ensure that these have been internalised. The second activity is a role play that helps participants appreciate the complex processes and interests that come into play with decentralisation and the implications these may have for sexual and reproductive health services. The third activity is an input by a resource person on decentralisation in health in Kerala as part of the larger process of political decentralisation. The fourth activity is an input session by the facilitator, summarising the major findings.

Activity 1: 45 minutes
The session begins with a brief presentation on the definition of decentralisation, different forms of decentralisation, different degrees and scope of decentralisation. Participants are given Handout 1 on different forms of decentralisation (15 minutes).

After the presentation, the facilitator reads out three scenarios on decentralisation (Handout 2). For each scenario, participants have to identify the form of decentralisation, and the degree and scope of decentralisation.

Break the participants into buzz groups, and ask these to discuss and present the implications of one scenario for integrating health services, accountability to poor and to women, for quality of health services and for issues of equity (Questions for buzz groups given in Handout 2).

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7 This power point presentation is to be presented in two parts: introducing concepts, as part of this activity, and summarising the implications of decentralisation for SRH services, as part of the conclusion.
Activity 2: 60 minutes
This is a role play. Six participants are to be briefed at the end of the previous day on their role. Role-players do not know about each others' roles and must be briefed not to discuss this with each other prior to enacting the role-play.

Role-players sit around a table and enact a meeting held to discuss decentralisation and SRH services. Handout 3, providing background information is distributed to all participants. Once the role play is over, the participants will be asked to diagnose the role play in large group and come out with recommendations on how to strengthen SRH service impact of devolution.

The following is a list of possible questions for the debriefing and large group discussion:

- Which of the actors in the role play is supportive of devolution, and who is against it? Why?
- Who is supportive of SRH service provisioning, and who is against it? Why?
- What is the effect of devolution on SRH services?
- What measures did the sexual and reproductive rights and health expert recommend for strengthening SRH services?
- What was the outcome of the lobbying by SRRH expert?
- If you were in the shoes of SRRH expert what else would you recommend the UNFPA representative and Indian government to strengthen SRH service impact of devolution?
- What would your recommendations be to NGOs to strengthen SRH service accountability of devolution?

Activity 3: 90 minutes
This is an input session by a resource person who has been involved in Kerala’s decentralisation process and specifically with decentralisation in health. He presents an analysis of opportunities and challenges posed by the decentralisation exercise in Kerala.

Activity 4: 30 minutes
The facilitator pulls all the activities together and summarises the major implications of decentralisation for SRH services (Presentation).

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8 Handout 3 also contains the roles of the six role-players. This is not to be distributed to participants but only to the person playing the specific role.
Session 7 Handout 1

Different forms of decentralisation

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deconcentration</td>
<td>Administrative responsibilities transferred to locally based office/s of central Ministry of Health</td>
</tr>
<tr>
<td>Delegation</td>
<td>Management responsibility transferred to a semi-autonomous entity such as a Health Board representing different interest groups. The aim is to free central government from day-to-day management functions</td>
</tr>
<tr>
<td>Devolution</td>
<td>Political and administrative authority for health is transferred to an independent statutory agency of local government such as a municipality or local council. Local levels are able to generate (some) revenue due to their statutory status</td>
</tr>
<tr>
<td>Privatisation</td>
<td>Contractual agreements are established between the public and private (for-profit or not-for-profit) sector for delivery of services. Government retains regulatory responsibility</td>
</tr>
</tbody>
</table>

Session 7 Handout 2

Read the following statements and identify the form of decentralization

The state of X in Amazania passed the X Local Government Act in 1993. The Act called for decentralization of significant service delivery functions, including health, to local governments.

The state of Y in Amazania, passed the X local Government Act in 1993. The Act called for decentralization of infrastructure development (roads, check dams, wells) to local governments, but not health services. Health was decentralized from state to district level of the Health Department.

The state of Z in Amazania followed a similar path to state Y. In addition it set up an autonomous body, and made procurement and distribution of drugs its responsibility.

Read the following statements and identify the scope and degree of decentralization

In state X of India 95% of its health facilities, 60% of its personnel (other than FP and HIV/AIDS) and 45% of its budget were transferred from the center to local governments. The nature of health services, other than FP and HIV/AIDS, and whether and how much is to be charged is also left to the local government. Drug procurement and distribution happens through the bureaucracy at state level.

In state Y of India, the District Health Officer under the new decentralized system has control over 75% of health personnel, 80% of its health facilities (other than specialized hospital), 75% of the district health budgets, and 100% of drug procurement and sale. A few national health services have to be compulsorily provided, while others it can decide upon. All services to be provided have to be provided free of charge.

In state Z, the pattern is slightly different. The District Health Officer has control over 50% of health personnel (public health-including MCH- under the officer control, family welfare and STI clinics vertically managed), 60% of district health budget, 60% of the health facilities (other than all district hospital). However drug procurement and sale is totally under the control of the drug procurement organization. All other things are same.
Session 7 Role Play
Devolution and implications for SRH services

Background:

The Timbaktu government passed a legislation devolving all social services to local governments in 1993. The government believed that devolved planning and monitoring would result in a better match between services and local needs, integration of different services, increased accountability to citizens and hence better quality of services. The government also hoped that devolution would increase local resources, which are much needed in this lower middle income country. As part of the devolution process 80% of the Ministry of Health’s facilities, 60% of its personnel, and 60% of its budget were transferred from the centre to local governments.

Recently the Resident Representative of the UNFPA met the internationally reputed Director of a Gender and Health Research Institute (also a founder of the national Sexual and Reproductive Rights and Health network). He was concerned about the country’s poor progress with regard to reproductive and child health (RCH) service implementation, in spite of the fact that the government had signed Programme of Action of the ICPD, 1994. According to him devolution had led to deterioration in the implementation of RCH programme. The Resident Representative asked the Director of the Institute to co-convene a meeting (with him) of different stakeholders associated with health/RCH services. The aim of the meeting is:

- To get stakeholders’ views on what action is needed to improve RCH services in the country within the context of devolution.
- To facilitate a consensus on what action is required to improve RCH service access, which can then be taken up by the Resident Representative with the Ministry of Health

Briefs for different actors

All

You should not read your brief during role play. Instead, you should internalise the brief overnight, and argue your case forcefully in your own words.
Director of family planning and MCH:

You are aware of the high rates of high maternal mortality rate in the country, and spread of STIs in the communities. The workers, providers and managers are no longer under your control and you feel a loss of power. You want to go back to centralization of health services. If this is not possible, provision of services in the area of contraception, MCH, sex education, should at-least be made compulsory in all Panchayati Raj Institutions (PRIs) and Nagar Palikas (NPs). You are aware that several PRIs and NPs had banned sex education in schools, as it was against local cultural norms. You also know that wide range of contraceptives, as recommended under RCH programme, was not provided as it was not prioritised by the elected representatives. You also feel that coordination between PRIs at village level and Zilla Parishad at district level had to be strengthened, for improving referral services with regard to emergency obstetric cases. Referral was adversely affected with devolution.

Right wing religious leaders

You do not want to come for this meeting where sex and sexuality are discussed openly, and where the chairperson is known to favour provision of sex education, abortion, and contraceptive services even to unmarried women (and men). This is completely against the tenets of your religious beliefs. You feel forced to attend the meeting because UN organisations provide funding for formal education through religious schools. You decide to attend for 15 minutes, make your case that cultural rights are more important than rights of adolescents to information on sexuality and contraceptive services, as well as rights of women to abortion services, and then leave the meeting

Doctors and workers association:

You want to go back to the centralized system where better supervision, drugs and referrals were available. The PRIs and NPs in poorer geographical areas were unable to pay full salaries as they did not collect much through taxes. But you do not want to state your preference for centralized system in front of the Director of local government, as he controls the payment of salaries. You want to suggest that they give incentives to doctors and workers placed in poorer provinces, and allow doctors to practice in private sector in the evening in addition to their public sector job.

Director of Local Government:

You are happy with devolution of health services and now exercise control over immense financial and human resources. You are aware that the Minister of Health has spoken to the Minister of Local Governance on the deterioration of RCH indicators. You do not understand why so much fuss is being made about this issue, when the nuts and bolts of devolution are still being worked out. You
do not want the government to make it compulsory to implement full range of RCH services as there will be backlash from PRIs and NPs in conservative areas and controlled by fundamentalist parties, and it is unaffordable in resource poor areas. Your Minister would much rather improve school buildings, health buildings and roads - which are more visible- and will help him come back into power.

Gender and Health Research Director (also founder of SRRH network)

You are a researcher cum activist of international repute. You want to use this platform to recommend several steps to ensure that RCH policy that you and other activists fought for at the national level is implemented on the ground:

- Women’s groups should be represented in health boards of local government at different levels, which oversee health programmes of local government units.
- There should be a 50% quota for women in PRIs/Zilla Praishad and NP units as members and leaders
- Provision of RCH services by PHCs and first referral should be made compulsory through a government order
- 50% of the local government budget should be for provision of RCH services
- A national RCH committee should be set up with representatives of the Directorate of Local Government, other relevant Departments, women’s rights groups and sensitive donors to oversee implementation of RCH policy

You hope to find an ally in the Director of FP and MCH, and push your agenda

Resident Representative:

You are an expatriate who has come to this country recently. The regional representative of the UNFPA has told you that the RCH service performance in the country of your posting is poor, and you need to work towards improving it. You know from previous postings that it is difficult for you as an expatriate to push RCH agendas without the support of women’s rights groups, hence you have approached a RCH network to work towards consensus building.

Adapted from:

Session 7. Notes for the facilitator

Given below are responses to the exercise given in Handout 2.

Recording sheet (to be put up on chart, without the answer in blue)

<table>
<thead>
<tr>
<th>Scope</th>
<th>State X (DHO)</th>
<th>State Y</th>
<th>State Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of health facilities</td>
<td>High</td>
<td>High</td>
<td>Moderate</td>
</tr>
<tr>
<td>Personnel</td>
<td>Moderate</td>
<td>High</td>
<td>Moderate</td>
</tr>
<tr>
<td>Resource allocation</td>
<td>Moderate</td>
<td>High</td>
<td>Moderate</td>
</tr>
<tr>
<td>Financing</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Prioritisation of health services</td>
<td>Moderate to high</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Drugs</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Possible implications</td>
<td>Can respond to local needs to some extent, on the other hand scope for prioritizing curative over preventive</td>
<td>DHO can respond to local needs to some extent Can ensure integration of health services at service point</td>
<td>Lack of integration between FP and public health services could affect population and women in particular Stigmatisation of people with STIs Referrals could get badly affected</td>
</tr>
<tr>
<td></td>
<td>Less scope for corruption</td>
<td>Referral to specialized hospital may get affected</td>
<td>If the DHO and Drug institute</td>
</tr>
<tr>
<td>The fact that only partial control over personnel could have adverse implications for supervision</td>
<td>poor and women may not have adequate resources if state is poor</td>
<td>head do not get along drug flow could get affected, if they get along well, drug procurement would be efficient</td>
<td></td>
</tr>
<tr>
<td>Not full control of budget can be constraining.</td>
<td></td>
<td>DHO could be demotivated because of lack of total control</td>
<td></td>
</tr>
<tr>
<td>Danger that elected people are not aware of health issues</td>
<td></td>
<td>Cannot respond to local situations and needs</td>
<td></td>
</tr>
<tr>
<td>Lack of integration of FP and HIV/AIDS with other services problematic</td>
<td></td>
<td>Little downward accountability to women and poor</td>
<td></td>
</tr>
<tr>
<td>Drugs may or may not reach on time</td>
<td></td>
<td>May not have adequate resources if state is poor</td>
<td></td>
</tr>
<tr>
<td>If user fees charged it could be problematic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May not have adequate resources if area/state is poor</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session 8. Public-private interactions (PPIs)

Objectives

By the end of the sessions participants will

- Understand the meaning of the term PPI and be acquainted with the different forms of PPI in SRH services in their states/country
- Have analysed the actual/potential impact of PPIs on equity, efficiency, quality and accountability of SRH services

Session Duration: 2 hrs 30 minutes

Session Plan:

The session consists of four activities.

Activity 1: 45 minutes

The session starts with an input defining public-private interactions and the range of possible roles for the public and private sectors within such interactions (Presentation). Distribute Handout 1 when discussing the range of possible roles for public and private actors within PPIs.

Activity 2: 45 minutes

Distribute Handout 2 to participants, consisting of arguments by proponents of PPIs. Go over each statement and ask participants to decide if they are

- Completely in agreement with the statement
- Partially agree
- Completely disagree with the statement

Within a set time limit for each statement, encourage debate and a consensus. This activity requires the facilitator to be very familiar with arguments for and against privatisation in general.

Activity 3: 30 minutes

Make a brief presentation on forms of PPIs in Sexual and Reproductive Health services.

Activity 4: 90 minutes

Distribute Handouts 3 and 4 to participants. Handout 3 contains descriptions of specific forms of PPIs and handout 4 has a table for analysing these. Divide
participants into groups. Each group has the task of analysing one type of PPI and entering their answers in the table in handout 4. (30-40 minutes).

Put up a flip chart with the table in Handout 4; elicit and enter responses of each of the groups, and discuss the implications.

**Summarise the main findings about implications of PPIs for SRH services**

*(presentation)*
### Session 8. Handout 1

**Examples of types of public-private interactions in health**

<table>
<thead>
<tr>
<th>FINANCING</th>
<th>PROVISION OF EDUCATIONAL SERVICES, CLINICAL AND NON-CLINICAL SERVICES, DRUGS AND SUPPLIES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public*</td>
<td>Public: Tax-funded or social-insurance funded provision of primary and hospital care</td>
<td>Private: Contracting out clinical services with for-profit and non-profit organizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public and private: Payment to public and private facilities for delivery of essential package of services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social marketing** of products and of behaviour change messages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social franchising** of provider networks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Manufacture of products and supplies by a for-profit firm with financing from government and/or international organizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Financing from bilateral donors for International NGOs to build capacity of public sector providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private management of public hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Loans to providers to set up and deliver priority services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deputation of government staff to non-profit private facilities</td>
</tr>
<tr>
<td>Private</td>
<td>User fees in public hospitals</td>
<td>Payment at point of service delivery at private hospitals and to private providers</td>
</tr>
<tr>
<td></td>
<td>Private financing and construction of public hospitals</td>
<td>Payment through private insurance for services by private providers or facilities</td>
</tr>
<tr>
<td></td>
<td>Private financing of capacity building for public-sector providers</td>
<td>Health management organizations and private insurance which are intermediaries for both private and public sector providers</td>
</tr>
<tr>
<td>FINANCING</td>
<td>PROVISION OF EDUCATIONAL SERVICES, CLINICAL AND NON-CLINICAL SERVICES, DRUGS AND SUPPLIES</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Public and private</td>
<td>‘Self-managed’ hospitals financed by services provided to beneficiaries of National Health Funds (public) or private insurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Donor and/or government subsidies for community financing schemes with services restricted to public sector facilities</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>Coalition of not-for-profit and corporate sector and local governments for public awareness e.g. related to HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>Public and private</td>
<td>National health funds covering the uninsured in a private insurance scheme with services provided in public or private facilities</td>
<td></td>
</tr>
</tbody>
</table>

* Includes governments and international donors ** These arrangements are discussed in detail in the next section

Session 8. Handout 2

Arguments by proponents of PPI

The major arguments used by advocates of PPIs for promoting them are as follows:

- Many developing countries already have a large private sector in health. It is the responsibility of governments to harness these resources to promote better health for all, and especially the poorest in the poor countries of the world.

- The public sector should limit its role to financing, and purchase health care from a number of providers who compete with each other.

- PPIs will improve health sector efficiency. Competition between the public and private sectors will ensure that resources are allocated more efficiently. Government public health interventions can be restricted to areas where there is market failure. Private for-profit institutions can provide effectively and efficiently in other areas to complement the social commitment of public sector institutions.

- The quality of health and related services will improve because the monopoly for provision of goods and services by the public sector will be replaced with competition between public and private sectors.

- PPIs will bring the benefit of the private sector’s expertise in reaching and motivating consumers. This can help achieve wider population coverage with health promotion messages, services and products.

- PPIs will contribute to health equity. Those able to pay will use private services while public resources are targeted to reach those who cannot pay.

Examples of some Public-Private Interactions in health and specifically SRH

Social Marketing
India has a long history of a condom social marketing programme sponsored by the government. Operative since 1968, this scheme includes three different qualities of condoms called Nirodh, procured from Indian condom manufacturers and supplied to marketing companies and NGOs called Social Marketing Organisations (SMOs). SMOs get a promotional incentive per condom sold. A similar social marketing programme for Oral contraceptive pills was launched in 1987. Since 1988, the government of India has also provided funding to specific commercial organisations and NGOs to implement social marketing ‘Area Projects’ in specific geographic locations (1).

In Uttar Pradesh, an extensive social marketing programme was started in 1997, designed and managed by the State Innovations in Family Planning Services Agency (SIFPSA), constituted jointly by USAID, the government of India and the government of Uttar Pradesh (2).

There is a large oral pill social marketing project, also funded by USAID, operating in eight Indian states: Madhya Pradesh, Bihar, Rajasthan, Jhrakhand, Uttaranchal, Uttar Pradesh, Chattisgarh and Delhi. The private sector partner for this project is the Indian owned Industrial Credit and Investment Corporation of India (ICICI) bank. Technical support is provided by Commercial Market Strategies (CMS), and PATH (Programme for Alternative Technology in Health), both US-based consultancy organisations. This social marketing programme called ‘friends of the pill’ (Goli ke humjoli) is based on extensive qualitative research among current and potential OC users, their spouses and key household decision-makers. The programme uses mass media advertisements, and celebrity endorsements to raise awareness about oral contraceptives and to address concerns related to side effects. Over 30,000 pharmacists and 22,000 traditional doctors have been trained on issues related to oral contraceptives, and briefing sessions have been held for medical associations and other civic groups. Information is disseminated by mail to over 27,500 doctors, and there have been over 300 newspaper and magazine articles on programme (3).

Population Services International (PSI), a US based social marketing firm, is another player in the social marketing field in India. A more recent addition of PSI products is the clean delivery kit which includes tetracycline eye drops to treat chlamydia, Vitamin A megadose capsules, soap, a plastic sheet, a new razor blade, clean cord ties, pair of gloves and pictorial illustration of correct use of the kit (4).
In the 1990s, condom social marketing programmes have been initiated also as part of the HIV/AIDS prevention strategy in many parts of the country. An innovative project in Chennai, Tamil Nadu, is a community-based social marketing project “aXess”. This project recruits and trains IEC and sales agents from among members of the community, exclusively or in addition to members of specific risk groups. These agents are financially rewarded not only for sales of condoms but also for recruiting other sales agents and educators, so that the network expands, creates a high demand for information and products and gets the community increasingly involved.

This project differs from other social marketing projects in that it relies exclusively on one-to-one dissemination of products and information, rather than use advertisement and mass media. The project's pilot phase was 1997-99, which is reported to have been successfully completed (5).

**Social franchising**
A small number of social franchising projects for the delivery of reproductive and sexual health services are also found in the country. Among the best known efforts in this respect is the JANANI programme operational in the poverty-stricken Northern state of Bihar (6). JANANI was set up by the US based NGO, DKT, in 1995. Financial support for DKT is from USAID.

Starting off as a conventional social marketing programme with subsidised products from the Government of India, JANANI has now established a social franchising programme for the provision of contraceptive services. The programme receives funding support from OECD. The franchising brand is 'Titli' or butterfly, and franchisees are Registered Medical Practitioners (RMPs), a group comparable to Vietnam's assistant doctors and China's Village doctors. The RMPs are provided with training in primary care for reproductive and sexual health. All RMPs are selected by the organisation, and are required to have literate wives (they are almost all men), who also receive training alongside their husbands. The women are trained to diagnose reproductive tract infections using WHO protocol for syndromic management. Strict quality control is maintained through supervision of the facilities at regular intervals.

This RMP network is linked to a franchise of MD and MBBS doctors in urban areas, called the 'Surya' network. Titli franchisees can refer patients to members of the Surya network, for IUD insertion, abortion and voluntary sterilisation, for which they receive a referral fee. There are six training centres located throughout Bihar, and operated as independent businesses, and provide free training to Surya members in IUD insertion and manual vacuum aspiration. As of November 2000, there were 140 Surya Clinics and 12,000 Titli Centres in Bihar (6).

Another social franchising scheme operates sexual health clinics for inter-city truckers. The funding is from DFID, and a pilot project is ongoing. The package
includes treatment for STIs based on syndromic approach which requires only one visit, condoms and educational materials. Five million truck drivers and their assistants are targeted. Sexual partners are also supposed to be included in the target group, though it is not clear how they will be reached. Doctors in private practice at or near truck halt points are being included, and the franchise may expand to include paramedics. Where necessary, doctors may be identified and helped to establish a practice. Franchisers are being sought from among pharmaceutical companies, trucking companies or NGOs with commercial expertise. This scheme appears to be financially sustainable – franchiser can cover the costs, give a margin to the franchisee and keep the package affordable (7).

**Contracting out primary care services**

In Tamil Nadu, the state government has involved private-for-profit organisations in construction, maintenance and provision of equipment in public hospitals and health centres. The government provides staff and drugs and manages the facilities. As many as 100 primary health centres (PHCs) in Tamil Nadu are to be maintained through various private companies and industrial houses (8). Karnataka proposed to engage NGOs to operate some of the government facilities in remote tribal and backward districts, in an attempt to enhance coverage (9). This has also been attempted in Maharashtra for several years even before the World Bank project (8).

**Private participation in public hospitals**

In India, Contracting out of non-clinical services in hospitals - e.g. laundry, cleaning services, drivers, dietary services - is a feature of state-level HSR projects in all the seven World Bank funded State Health Systems Development Projects (9-13). In 2002, in four of the states of these seven states there were at least 500 hospitals contracting non-clinical services ranging from ambulance services and maintenance of medical equipments to cleaning and laundry and catering services (14). In Uttar Pradesh, space in public hospitals was to be leased out to private diagnostic services (13). In Maharashtra, a joint venture company including the government and the private commercial sector has been launched to set up a super-specialty hospital (14).

Besides these, which are a part of the 'reform' packages, there have been public private partnerships initiated in these and other states through the independent initiatives state governments in the face of resource constraints. In Kerala and Rajasthan, hospital development committees have been set up to mobilise private resources in addition to charging fee for services (13,15).
References

Session 8. Handout 4

PPI analysis sheet

Read through the examples of PPIs in India given in Handout 2. Analyse each of these according to categories given in the table below. Record your findings in a separate chart.

<table>
<thead>
<tr>
<th>Name of PPI</th>
<th>Who is involved from the public sector? What do they do?</th>
<th>Who is involved from the private sector? What do they do?</th>
<th>What components of SRH services are being offered?</th>
<th>Which sections of the populations are covered by this service? Who gets left out?</th>
<th>Are some groups likely to have less/more access than others? Why?</th>
<th>What is the quality of service likely to be? Will this differ for different social groups?</th>
<th>Who participates in decision-making? Who is the service accountable to?</th>
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</table>
Session 9. Health Systems Accountability and Community Participation

Objectives

By the end of the session participants will

- Have an understanding of health accountability to community underpinning World Bank initiated HSRs and rights based groups.
- Be familiar with accountability mechanisms and the extent to which marginalised people/women hold accountable health policy makers, managers and providers within and outside HSRs in Asia
- Have examined the role of financial contribution by clients, community participation, and community health structures in strengthening health/SRH accountability
- Be able to outline what can be done to strengthen SRH service accountability further in the context of reforms and outside

Session duration: 3 hours

Session Plan

The session consists of four activities.

Activity 1: 15 minutes
Brainstorm participants on what they understand by accountability. Distribute Handout 1, and also put up in a power point presentation definitions and dimensions of accountability.

Activity 2: 60 minutes
Distribute Handout 2 on the two perspectives on accountability, and give participants some time to discuss in a buzz group (two-three neighbours) the answers to questions given. Allow 15-20 minutes for the discussion. In the large group, ask for responses to the questions, which one or more of the groups may answer. Put up a flip chart with the table format given in Handout 2, and write in the responses from different groups (25-30 minutes).

Consolidate these responses with the next few slides in the power point presentation describing and contrasting the varying concepts of accountability, within reforms and outside reforms (15 minutes).

Distribute Handouts 3 and 4

Activity 3: 90 minutes
Participants are divided into four groups. Each group is assigned two case studies on accountability, and has to examine the different dimensions of
accountability within these. (If time is short, then only one case study may be assigned). Group work should take no more than 30 minutes. Each group then reports back in the large group (10 minutes presentation each, and 5 minutes discussion).

**Activity 4: 15 minutes**
Bring all the main points together, and close with the last few slides from the power point presentation, which discuss factors that influence the impact of accountability strategies on SRH services.
Accountability

What is accountability?

Accountability refers to whether and how power holders at different levels engage with demands from other parties, respond to them, justify their decisions and actions, and are sanctioned for violation of policy and procedural decisions.

Different dimensions of accountability:

Health accountability experiences can be explored from different angles

- Who is accountable?
- To whom?
- With regard to what?
- When?
- How is accountability operationalised?
- What is the outcome of accountability processes?
Session 9. Handout 2

Different perspectives on health sector accountability

Accountability in World Development Report, 2004

According to the World Development Report, 2004 health accountability strategies need to be tailor-made to the kind of health service. The Report identifies four kinds of health services demanding four different accountability strategies.

- Transaction-intensive and individual-oriented clinical services (e.g. EmOC) accountability of which can be ensured through financial contributions by the client, third-party payments, co-production of services by clients, and monitoring of workers and services by organized clients.
- Population intensive health programmes (e.g. immunization) accountability of which can be ensured through strengthening poor people’s voices so that the required resources are allocated and through entering into result oriented contracts with public and private providers.
- Family oriented services that support self care (e.g. safe sex education) accountability of which can be strengthened through involving civil society and community groups in provisioning and monitoring.

Health Accountability: Rights based groups

Accountability of the health sector is to mainly citizens, through a process of deepening of democratic decision making with regard to health. This entails four roles for citizens:

- Citizens playing a watchdog role to ensure that health services are delivered by the public and private health sector as per health legislation and policy with no financial abuse,
- Citizens co-governing health care at local level through a process of devolution, and ensuring accessible, comprehensive and quality health services,
- Citizens influencing, protecting and demanding national level health legislation, policies, budget and public-expenditure in keeping with relevant international goals and targets, as well as Right to Health as elaborated in the general comments of the Committee for Economic, Social and Culture Rights, and
- Citizens influencing, protecting, and demanding policies and resource allocation by donors in keeping with international agreements

Murthy R.K, forthcoming, Accountability to Citizens on Gender and Health, paper prepared for Women and Gender Equity Knowledge Network, WHO commission on Social Determinants of Health


Questions for buzz group discussion:

1. Is there any difference between thinking on health accountability between the WDR, 2004 and the rights based group? While responding examining, what the two paragraphs have to say on:
   - Who is accountable?
   - To whom?
   - With regard to what?
   - When?
   - How accountability is to be operationalised?

2. If yes what are the differences?

<table>
<thead>
<tr>
<th></th>
<th>WDR, 2004</th>
<th>Rights based approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is accountable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To whom</td>
<td></td>
<td></td>
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<tr>
<td>With regard to what</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How accountability is to be operationalised</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Which is more likely to have a favourable impact on health policy, legislation, budgets, service delivery? Why?
**Session 9. Handout 3**

**Health Accountability from lower to higher levels**

<table>
<thead>
<tr>
<th>Accountability of whom</th>
<th>Lower order of accountability</th>
<th>Middle order of accountability</th>
<th>Higher order of accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health workers</td>
<td>Health workers, doctors, middle level managers</td>
<td>Health personnel at all levels, including policy makers (also donors and private sector)</td>
<td></td>
</tr>
<tr>
<td>Accountability to whom</td>
<td>Higher ups</td>
<td>Higher ups and colleagues</td>
<td>Citizens - marginalised groups</td>
</tr>
<tr>
<td>Accountability with respect to what</td>
<td>Input Managerial</td>
<td>Inputs, Outputs Expense Managerial</td>
<td>Impact and social relevance, and other variables Political</td>
</tr>
<tr>
<td>When accountable</td>
<td>Post implementation</td>
<td>Post implementation</td>
<td>Design and post implementation Non implementation</td>
</tr>
<tr>
<td>Purpose of accountability</td>
<td>To detect any error</td>
<td>To detect any error</td>
<td>To prevent any error, as well as detect</td>
</tr>
<tr>
<td>How accountability is operationalised</td>
<td>Bureaucratic rules and procedures Demanded spaces</td>
<td>Self regulation</td>
<td>Pressures from below-demanded Legal accountability</td>
</tr>
</tbody>
</table>

Session 9. Handout 4

Strategies for strengthening community health accountability:

Within reforms

• Involving community representatives and health groups in planning health sector reform projects, health sector wide approaches, poverty reduction strategy papers.
• Involving community representatives and health groups in community level and hospital level health structures (health committees, health boards, hospital boards etc.)
• Strengthening professional councils and their ability to press for accountability
• Promoting community health financing for strengthening health accountability
• Introducing health accountability tools like maternal mortality audit, provider report cards, patient rights charters,

Outside reforms

• Using progressive legislation on right of citizens to participation, public interest litigation, and right to information for promoting health accountability.
• Using international human rights instruments, agreements reached in gender/health specific conventions, MDGs and other targets for pressing for health accountability,
• Demanding gender sensitive health legislation, policies, programmes and budgets for furthering health accountability
• Monitoring implementation of progressive health legislation, policies, budgets and programmes.

Session 9. Handout 5

Case studies on health sector accountability

Your group has been assigned one set of two case studies. Go through the case studies and answer the following questions within your group:

In the two case studies given to you,
1. Who is accountable?
2. To whom?
3. How is accountability operationalised- What are the tools and strategies?
4. If the example is from outside India, is it possible to transfer the experience to India? Why?
5. What is the outcome of the accountability process on health and SRH services? Why? What can be done?

Your group has about

One member of your group will present the answers to these questions in the large group.

Group 1
Community participation in the Health and Population Sector Strategy formulation, Bangladesh:

In 1996 a consortium of donors led by the World Bank, assisted the government to prepare a Health and Population Sector Strategy (HPSS). A 40-member task force on community and stakeholder participation was constituted to gather feedback on what should be the different components of the HPSS. The task force consisted of three stakeholders: primary stakeholders (clients, in particular women, children and poor), secondary stakeholders (public providers, Ministry of Health and Family Welfare officials, drug companies, donors health NGOs, and private sector doctors) and external stakeholders (outside the health sector like media, political parties and religious leaders). Gender experts were also involved. The stakeholders prioritized reproductive and child health (family planning, emergency and essential obstetric care, prevention and control of STD and HIV/AIDS), control of communicable diseases, limited curative care (for accidents and injuries), and behavioural change communication as part of the Essential Service Package (ESP). Researchers have critiqued the HPSS formulation process on several accounts. Some argue that the process is controlled by the World Bank. Rights based women’s organization were not invited for consultation, and had to demand that they be invited. Certain controversial and low priority women specific health services have been kept outside the ESP, though demanded by civil society actors and poor women. While the design of
the HPSS was to some extent participatory, the monitoring remained under the control of the government and donor officials.

*Arrows for Change*, Volume 9, No. 3, 2003

**Using international human rights instruments for holding providers to account** (Peru)

Marina is a 23 year old woman, who lives in Puno, a city in southern Peru. She makes a living through street vending. During one of her visits to the market she met with an accident, and went to a public hospital in the city for treatment on 15th January, 1996. A general practitioner in that hospital, using the pretext of a gynecological examination, raped her. This sexual assault produced vaginal bleeding and severe emotional suffering, leading her to consider suicide. She reported the violence to the police, who with great reluctance recorded her case. When the matter came up to the court, she was verbally humiliated by the perpetrator. The verdict based on an arbitrary evaluation of the evidence, declared the rapist innocent. The Latin American and Caribbean Committee for the Defense of Women’s Rights (CLADEM) and the US based Center for Reproductive Rights Law and Policy (CRLP) brought her case to the Inter American Human Rights Commission on April, 1998, charging the Peruvian state with violation of the CEDAW and the Inter-American Convention to Prevent, Sanction and Eradicate Violence Against Women. In March, 1999, the Commission granted a hearing attended by Marina. The Commission’s mediation resulted in an amicable solution amongst the parties. CLADEM and CRLP are now monitoring the implementation of the agreement.

While Marina’s case ended on a good note in terms of securing justice using human rights treaties, at times it may be one step forward and two step backwards. Between 1996 and 2000, several Peruvian women underwent forced sterilization as part of the public health policy on population control. One woman died at the operation table when she was undergoing sterilization. The Peruvian Ombudsman Center, with the help of human rights and women’s rights organisations, documented the case and submitted it to the Inter-American Human Rights Commission. The Commission held the government responsible for her death. What occurred in response, however, was restriction of contraceptive and abortion services by the government. In September, 2002, the Ombudsmen center filed another case stating that the new policy, like the earlier one, also discriminated against women. It is not clear whether the Ombudsmen center was successful in demanding a gender sensitive health policy.

**Source:**


Group 2:

Community based monitoring and evaluation of Poverty Action Fund:

The Uganda Debt Network (UDN) is a civil society organization monitoring the Poverty Action Fund (PAF) set up as part of the Poverty Reduction Strategy in 17 districts of Uganda. The PAF was to be used for five sectors, viz. health, primary education, agriculture extension, water and sanitation, and rural feeder road maintenance. In May 2000 the UDN established PAF Monitoring Committees in 17 districts of Uganda. However, this district level structure was found to be inadequate in mobilising communities to monitor the PAF. The UDN then decentralized the monitoring further through a Community Based Monitoring and Evaluation System (CBMES). The CBMES is a system of community monitoring at not only district level, but also sub-county (like Blocks), parish (between village and Block level) and village levels. The two main aims are to empower communities so that they are able to:

- Articulate development priorities, and take part in local development planning, monitoring and evaluation,
- Oversee that the local governments perform their functions as expected.

The CBMES was piloted, along with the Kamuli District PAF monitoring committee, in eight villages of two sub-counties. The initial CBMES planning meetings were held in public spaces accessible to all, with approximately 33% of the participants being women. Of these participants, 80 were selected for training, with women constituting nearly 40% of those selected. The participants in the training programme identified indicators for monitoring each of the five sectors. The indicators identified for monitoring health included: number of medical personnel, time of reporting and hospitality of medical personnel, availability of medicines, waiting time for services, distance of health center, availability of immunization services, number of beds and availability of syringes, gloves and cotton wool. The participants were trained in collecting data on indicators developed and record it in a ‘Report Card’, and interacting with government officials. The findings were fed back in both the selected sub counties to the chairperson, sub-county members, members of the press and local radio, government officials and members of the communities.

The following changes were reported in the health services due to the community based monitoring and evaluation process: removal of user fees leading to increase in utilisation (one county), improvement in stock of medicines and supplies (one county), establishment of immunisation outreach services (one
country) and increase in beds in general ward and labour ward (both counties). The improvement in water and sanitation services through the monitoring processes led to reduction in work load of women, and hence improved their health. However, some shortcomings of the health care services continued. The availability of beds and drugs, though improved, was far from adequate. In one county, treatment for HIV/AIDS continued to be not available. Long distance of health care services continued to pose a problem. Inadequate resources to cope with increase in demand after the improvements in goods, personnel and removal of user fees was a problem. Corruption continued to be a problem. Some of the constraints in implementation of CBMES included lack of adequate resources for travel and other expenditure incurred by monitors, the fact that some of the community members had conflicting interests (like being part of the school committee), and a few took bribes to hide facts.

Source:
Uganda Debt Network, 2002, The Community Based Monitoring and Evaluation system (CBMES) Pilot Test in Kamuli District, 11th to 13th April, 2002 UDN, Uganda

Using Public Interest Litigation for pressing for accountability on gender and health

In 1982 the Indian state recognized that a third party could directly petition the court whether through a letter or other means, and seek its intervention in a matter where another party's or the general public's fundamental rights are violated. This legal procedure is referred to as public interest litigation (PIL)

Some of the gender and health issues taken up through PIL in India include the rape of women by police or employers, enforcement of the ban on sex selective abortion, violence against sex workers, rape of women by police, promotion of harmful reproductive trials and contraception by the government through its public health programmes. Between 1980 and 2000, the use of PIL has led to the suspension of clinical trials of injectable contraceptives, and banning the use of Quinacrine for non surgical female sterilization.

Amongst the constraints in using PIL in India have been the paternalistic attitude of some members of the judiciary, difficulty in enforcing progressive judgments (due to reluctance on the part of the local police and, disappearance of the perpetrators or victims), and over dependence of victims on intermediary organizations to take up such cases. Further, not all advocacy groups in the country are familiar with using PIL to enforce accountability on gender and health issues. Neither are all health or women’s NGOs (other than health rights and women’s rights groups) familiar with using PIL for demanding accountability.
Provider report cards refer to any effort to compare providers within a specified geographical region on a routine basis, according to certain standards of quality performance. These report cards can be public (results made available to citizens) or private (results made available only to the provider), they can be voluntary or mandatory, and can be sponsored by professional associations, government, health plans, and civil society organisations. They may be conducted by government, private sector, or civil society actors. When provider cards are made public and mandatory they tend to promote accountability to citizens on health.

The Yellow Star Program in Uganda is one example from a developing country. It is sponsored by the government and donors. The Program evaluates health care facilities (public and private) on a quarterly basis using 35 indicators, spanning technical and interpersonal domains like standard of infrastructure, management systems, infection prevention, health education and interpersonal communication, clinical skills and client services. Ratings of a provider are made available to the public. A facility in which all providers have received a 100% score for two quarters receives a yellow star, which is then posted prominently outside. If performance falls, it is removed. The average score climbed from 47% in the first quarter to 65% in the second. Initially implemented in 12 of the 56 districts, plans are now afoot to expand to all the 56 districts of the country.

In India, in Bangalore public domain score cards on all local government services, carried out by the government using client inputs, are disseminated to media and community groups since 1993. It measures behaviour of staff, problem resolution rates, and client satisfaction with services. It created greater confidence amongst the public, and quality of public services improved in five years, though less than 50% of clients were fully satisfied with services.

While the Uganda and Bangalore report cards have not included sex/gender specific indicators for monitoring, Costa Rica has included the criteria of existence of a mechanism to analyse maternal death and delivery complication rate. Haiti has included availability of family planning supplies as one of the indicators. There are however concerns that providers may be constrained by availability of resources or civil service rules from addressing shortcomings. There are also concerns that performance will improve only on the variables measured, and not on those left out. The clout of the medical lobby may also come in the way of effective implementation.

Accreditation with the Malaysian Society for Hospital Accreditation (MSQH): The case of Seremban Hospital, Department of Obstetrics and Gynecology Department.

Seremban Hospital is located in Seremban, the capital of the state of Negeri Sembilan in Malaysian peninsula. The Hospital is publicly funded, and is also the training and referral hospital for the state. The Hospital has 800 beds, 20 clinical specialisations and a variety of support services. Services are provided free of cost to those who cannot afford to pay.

Seremban Hospital has experienced different kinds of quality assessments leading to different accreditations. In 1999 (and then again in 2001) the Hospital achieved a three year hospital accreditation through the MSQH which is the focus of this case study, with a particular thrust on its Department of Obstetrics & Gynecology. The team for Quality-check with MSQH comprised of participants from the public and private health sector. The quality standards and indicators used by the Obstetrics and Gynecological department were developed through the Ministry of Health, the State Department of Health and Seremban Hospital’s quality assurance committee. The tool which was used covered aspects such as client satisfaction, quality of service, effectiveness of and adherence to guidelines, extent of teamwork and competencies of staff. Each assessment process took three to four days (with the hospital prepared for three years), with the assessors interviewing clients and staff, as well as surveying the facilities. The wider community was informed of the independent quality assessment through non-government organisations, community leaders and publicity banners. Lessons from the quality assessments have led to the setting up of an early pregnancy assessment unit and day-care surgery to reduce admissions in the obstetrics and gynecology ward. They have helped shorten client-waiting times in the Department (through one staff providing multiple services) and encouraged clients’ husbands to be more involved in their wives’ care. The numbers of referral and repeat cases have reduced, leading to decongestion in wards. The complaints of patients are more speedily addressed than before, and the quality of interaction with staff has improved. The exact impact on maternal health outcomes, and other dimensions of women’s reproductive and sexual health is not clear. At the institutional level, a community fund raising campaign was initiated to meet infrastructure gaps that were highlighted through the study (e.g. medical equipments).

Accreditation has also enabled the Hospital to source funding more easily. Through participation in such processes, the hospital has developed skills to train
other hospitals in quality assessment. However, workers at lower levels complain of heavier workloads.

**Group 4:**

**Medical ethics and councils**

Along the lines of the Medical Council Act in United Kingdom, the Indian government enacted the Indian Medical Council Act, 1956. This Central Act has been amended several times subsequently, and different states have also enacted state level acts. As per the Central Act the doctors are bound by the Code of Medical Ethics, which states that “the prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration”. The Central Act includes several rules that pertain to reproductive-health and rights of women and men. Doctors, irrespective of their religion, have to comply with the Medical Termination of Pregnancy Act of 1971 and the Pre-natal Sex Determination Test Act of 1994 (under which they should not disclose the sex of the foetus). They have to obtain the consent of both the wife and husband before performing any operation that would affect sterility of either party. Doctors have to obtain consent of patients before performing any clinical trials. Adultery with patients is strictly prohibited. However, the code of ethics does not protect the reproductive rights of married women in the absence of consent from husbands, or adolescents. It is silent on the duties of doctors in providing services like artificial insemination, sterilisation and medical termination to single women who are outside the institution of marriage. Further the extent to which it has actually protected health and reproductive rights of clients has been minimal. As a result of lack of knowledge or lack of faith of clients in Medical Councils, few clients or their relatives choose to place their grievances before these, and rarely does a Council support the position of clients due to strong self protecting tendency amongst medical doctors. In Maharashtra, on an average only one case per year was placed before the Dental Council since 1990 and even fewer before the Council of Indian Medicine. The Council of Homeopathy received a slightly higher figure of five to six complaints per year. There are very few examples of disciplinary actions taken on the

Iyer, Adithi, the Tale of Medical Councils, Health for the Millions, Vol. 22 No. 4, July-Auguet, 1996

Jesani, A, Law, Ethics and Medical Councils, Evolution of their Relationships, Medical Ethics, Volume 3, No. 3 April to June, 1995

The Health watch groups and community groups in Bangladesh

In 1998 the Government of Bangladesh, as part of health sector reforms, initiated efforts to enhance community participation in the public health system. Two specific measures were introduced. The first was the setting up of village level clinics managed by Community Groups comprising of nine members viz. elected local government body, local influential residents representing various professions, representatives from landless groups and women, and local public health providers. The land was supposed to be donated by the village, the building, drugs and doctors were to be provided by the government, and the clinic's cleaning and maintenance was to be the responsibility of the community. The community group members were also to help in delivery of public health messages. The second measure was the setting up of Upazilla (sub division) and Union level (lower than sub division) Health Watch Groups (HWGs) comprising of representatives of local NGOs, communities, non-health professionals (lawyers, teachers and journalists), and non government doctors. The responsibility of setting up the HWGs was given to NGOs. Resources for functioning of the HWGs were initially allocated by the government.

The Community Groups and Community Clinics were over a period of time closed. The land that was given by the community (often by the relatives of the elected leader of Union Parishad) was located in one remote corner of village. The civil society members of the community groups were chosen by the elected leader, and comprised of mainly the elite. The landless and woman representatives chosen were indebted to the leader in many ways, and rarely raised questions. The well-off members of the village were not willing to contribute to maintenance. The Community Groups did not play any oversight role, and in fact some members did not even know that they were members.

A study of Health Watch Groups in nine upazillas revealed that where they were supported by rights based NGOs they performed reasonably well. By policy, public health providers including public doctors were kept out of the HWGs, as its official role was oversight. The rights based NGO had brought in leaders of landless groups and women’s group it had organized at the community level into the HWGs. Fifty percent of the members and leaders of HWGs were poor women. They had prior experience in demanding accountability. The capacity of landless and poor women was built on functioning of HWGs and interaction with professional members. The discussions were more participatory than community groups. However hierarchies between non health professionals and non government doctors and community members prevailed. On technical matters and budgets the former were more competent, while on agitation the latter were better experienced. They protested in front of the clinics when doctors were not present, drugs were not available, or a pregnant women was kept waiting. When members from active Health watch Group area came they were hence given better services. In the case of emergencies, including maternal health, HWG
members accompanied the patients, and arranged transportation. Overall, doctor attendance, treatment of clients, and waiting time reduced. On the negative side, some doctors secured transfer from the area. Drugs continued to be not available in some Upazilla and Union level health facilities. Some doctors ignored the HWGs as it had no legal mandate. The doctors observed that the HWG could only demand but not enforce accountability. The nurses were more responsive as they lived in the area. The new government which came into power however stopped funding of the HWGs, and only two of nine HWGs continued to function subsequently.

Session 10. Issues for policy advocacy in HSR and SRH

Objectives

By the end of the session participants will

- Come up with a list of priority issues for advocacy in HSR and SRH
- Know what advocacy is and the steps involved in planning for advocacy
- Be able to apply a framework for identifying factors that affect policy development and implementation in order to advocate strategically

Session Duration: 3 hrs

Session Plan:
This session is made up of three main activities.

Activity 1: 45 minutes
Start with a brief brainstorming on what participants understand by advocacy. Sum up participants’ contributions with a brief (2-3 slides) presentation on advocacy (15 minutes).

Divide participants into buzz groups. Each group has to go through their notes from the first day of the course and identify five major issues which they feel need to be addressed through policy advocacy (15 minutes).

Ask groups to report on issues they have identified, note these on a flip chart and consolidate (15 minutes).

Activity 2: 45 minutes
This is an interactive input session on steps involved in advocacy, and a framework for analysing the context in order to strategise appropriately (Presentation). Illustrate each slide with a number of examples, elicit examples of advocacy from participants and try to link these to the slides. Distribute Handouts 1 and 2, and go through these with participants.

Activity 3: 90 minutes
Distribute Handout 3 presenting the case study from South Africa about fighting for pap smears. Participants are divided into four groups, and the groups’ task is have to answer a set of questions analysing the advocacy process. The small group discussion should take about 30 minutes, report back by four groups about 40 minutes and 20 minutes for consolidation and summary by the facilitator.
Session 10. Handout 1

<table>
<thead>
<tr>
<th>Popular initiative</th>
<th>Consultative councils</th>
<th>Participatory formulation of rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hearings</td>
<td>Use of media</td>
<td>Civic lobby</td>
</tr>
<tr>
<td>Public interest court actions</td>
<td>Citizens’ monitoring</td>
<td>Raising public awareness</td>
</tr>
<tr>
<td>Participatory budget</td>
<td>Mobilisation</td>
<td>Building consensus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alliances and coalitions</td>
</tr>
</tbody>
</table>

Formal advocacy tools

Non-formal advocacy tools
Session 10. Handout 2

There are different kinds of tools that organisations may use to influence policy. The tools can be grouped in two categories:

- formal tools, which depend on the institutional and political architecture of each country
- informal tools, the feasibility of which will depend on the local political culture.

**Formal advocacy tools include:**

- popular initiatives
- public hearings
- public interest court actions
- participatory budgets
- consultative councils
- participatory formulation of rules.

**Informal advocacy tools include:**

- use of mass media
- civic lobby
- citizens’ monitoring
- raising public awareness
- mobilisation
- building consensus
- alliances and coalitions

**Formal advocacy tools**

These tools use participation mechanisms which are formally included in different rules (constitutional texts, laws, decrees, public institution regulations). If these mechanisms do not exist in a particular country, civil society organisations can use advocacy to demand that they be introduced.

**Popular initiatives**

Popular initiatives (‘iniciativa popular’) are a mechanism of semi-direct democracy that allows citizens to present legislative proposals. Constitutions usually state which topics can be covered by a popular initiative. Making a legislative proposal through a popular initiative usually requires that you collect the signatures of a minimum number of citizens whose names are on the electoral register. This proposal is then presented to the government in a prescribed way.

**Public hearing**

Public hearings are organised by the legislature (parliament) or bureaucracy to provide an opportunity for groups and individuals to publicly give their opinion about a particular topic or policy. The purpose is to promote communication between government and the community. The hearing is a consultation. There is no obligation on government to follow the recommendations made in a public hearing.

The types of participants who are allowed to participate in public hearings vary. For example, in some cases anyone who is directly or indirectly affected can speak or make a written submission. In other cases, only organisations can speak or make submissions. In some cases any individual or organisation can apply to participate. In other cases, government invites the people whose opinion it wants to hear.

**Public interest court actions**

A public interest court action aims to protect the collective interests of society or of groups of people. It does so through taking up a case which will set a precedent that can then be applied to cases affecting people in a similar situation.
The three main instruments for public interest court actions are:

- appeal on the grounds of unconstitutionality;
- administrative appeals; and
- amicus curiae (‘friend of the court’) actions

In the appeal on the grounds of unconstitutionality, the judge is asked to stop the action or omission that threatens a particular right.

In an administrative appeal, an executive office (national, provincial/state or municipal) is asked to stop a particular action or omission which threatens a right. The ways in which such an appeal can be presented are established in the administrative procedure rules in each jurisdiction (municipal, provincial/state or national).

An amicus curiae action is a submission made by a third party which is not directly involved in a judicial dispute, but has an interest in the final result of the litigation. For example, a civil society organisation can present evidence in a case which deals with an issue that it is concerned with.

Participatory budget
A participatory budget is a tool through which the government allows the participation of the community in various stages of the budget process. Participatory budgets are most common at the local level where there is a close relationship between government and ordinary people, and the size of the population is not too big. Porto Alegre is probably the most famous example of participatory budgeting.

Consultative councils
Consultative councils are sometimes called advisory or community councils. They are formal bodies set up by government to allow for interaction between itself, citizens and civil society organisations. In most cases there are guidelines to which types of organisations will be part of the council.

Participatory formulation of rules
Participatory formulation of rules occurs when the government publishes its proposals for regulations or other laws for comment by interested parties.

Informal advocacy tools
These tools can be used without government providing any formal channels for their use. Their use therefore depends mainly on the willingness, capacity and opportunity that people and civil society organisations have for using them.

Mass media
Mass media can be used both to influence decision makers and to raise public awareness. Civil society organisations thus need to understand how the mass media operates, learn to adapt their message for different audiences, and establish links with reporters.

Civic lobby
In politics, lobbying refers to efforts made to influence the ideas and actions of those with power to make decisions. The word ‘civic’ refers to efforts by civil society organisations, in contrast to those carried out by groups who defend the interests of business.

Citizens’ monitoring
The purpose of citizens’ monitoring is to increase the quality and transparency of government actions. Monitoring involves collecting information. Information can be obtained from providers and actual and potential beneficiaries. It can also often be found in documents. And it can be done through participatory observation. Monitoring can:
- establish a baseline at the time when a policy is first implemented
- establish standards or goals to be reached, and measure actual achievement against these goals
Raising public awareness
Raising public awareness involves making different community groups aware of issues. Possible public awareness activities include conferences and workshops, preparation and dissemination of reports about an issue, and public discussion forums.

Mobilisation
Mobilisation goes beyond raising of awareness into organising people to take action. Mass mobilisation tactics which can show the authorities that a large number of people support your cause include public demonstrations and protests. You can also mobilise people less publicly to participate in your organisation's activities.

Building consensus
This tool is used to assist people or groups who have different points of view on a problem to reach consensus so that they can work together. This is often done with the help of a third party who acts as a facilitator or mediator. The underlying premise is that if the different actors are concerned about the same topic, the facilitator may be able to help them find ways of working together. If it succeeds, the tool helps avoid polarisation and conflicts of interest.

Alliance and coalitions
The strength of a cause is much greater when a group of people and organisations with similar objectives come together to support it. Alliances range from the more flexible networks to more formalised coalitions. Some alliances are permanent while others are temporary. Some focus on a single topic while others cover a range of issues. In some cases the members of an alliance will not agree on all topics. They nevertheless come together to strengthen their advocacy for the issues on which they agree.

Session 10. Handout 3

Case study: Fighting for Pap smears in South Africa

You have been divided into groups. Read the case study given below and answer the following questions:

- What are some contextual factors that facilitated the advocacy campaign?
- Who were the actors at whom advocacy was targeted?
- Who were all the actors involved in the advocacy campaign?
- Which strategies were used in this advocacy campaign? Why do you think these were chosen?
- Which other strategies might have been used?

Cancer of the cervix is the biggest cancer killer of women in South Africa. One of the ways to reduce the number of these deaths is for women to have regular pap smear tests to screen (test) for this cancer, which can be cured if it is found in its early stages. However, most South African women do not have a pap smear, not even once in their lives.

The Women's Health Project (WHP) is an NGO that takes up women's health issues. WHP felt the lack of a policy on pap smears was inequitable. Death from this type of cancer is preventable. If there is no screening in the public sector, it is only people rich enough to attend private doctors who will be protected. WHP therefore decided to run a campaign around pap smears.

First WHP needed to identify the key stakeholders and find out what they thought about the issue. Then they had to work out a message to reach each of the stakeholders.

- **Women**: WHP's aim is to involve ordinary women in the policy process, so women were their first target. Many women were aware that women are dying from cancer of the cervix. But many were not aware that pap smears can help in detecting and preventing cancer. Even those women who had pap smears often felt abused by the hostile attitude of health workers.

- **Health system managers**: WHP was worried that health system managers would argue that pap smears are too expensive and that the expense cannot be justified. WHP did research into the costs of pap smears; into where facilities were available; and into what was done in other countries. WHP's research showed that frequent pap smears would be very expensive. However, experience elsewhere showed that pap smears are effective in preventing cancer even if they are done less often. The World Health Organization (WHO) suggests that only three smears in a life-time are necessary, at age 30, 40 and 50.

- **Private doctors and academics**: WHP published its research findings. It also organised a meeting that included influential private and public sector doctors, academics and other health service providers. At this meeting the stakeholders agreed that the WHO proposal was a good one. This strengthened WHP's position because it had the backing of important stakeholders.

In 1994, after many months of organising and speaking to women and policy-makers, WHP held a big Women's Health Conference. The conference brought together regional networks of women's groups, NGOs, academics and health workers. WHP used this conference to take its pap smear policy proposals forward. After the conference, the proposals were publicised in a book, in pamphlets in several languages, in press briefings, and in report-backs to organisations.
After the 1994 elections, some of the people who had participated in the conference went into management positions in the government Department (Ministry) of Health. After 1994, WHP also needed to get its ideas across to the new politicians. WHP presented the findings of its research, including the findings on costs, to the Parliamentary Select Committee on Health.

The WHP researchers now had a national reputation for their technical expertise. They were invited to serve on an intervention team around pap smears together with the National Cancer Association and academics at a leading hospital. The government established a National Cancer Control Advisory Committee, and put the issue of pap smears on its agenda. WHP was also invited onto this committee, and a WHP staff member was elected as chairperson.

By early 1997 a National Cancer Control strategy was being finalised for presentation to the Department of Health.

Session 11. Closing session

Objectives
By the end of the session, participants will

- Consolidate what they have learned in the course
- Evaluate course content and methodology

Session Duration: 2 hrs 30 minutes + 2 hours examination.

Session Plan:
This session is made up of four activities. The first is a consolidation exercise. In the second activity, participants give a written evaluation of the course. The third session consists of distribution of certificates, and leave-taking. The fourth part (2 hours) is an examination.

Activity 1: 90 minutes

Prior preparation:
Participants are to be given Handout 1 on the previous evening, to be completed in small groups as homework.

Put up a flip chart with the table in Handout 1. Elicit responses from each group and consolidate the scores given for each reform in terms of their contribution to increasing the range of services, the population coverage, equity and quality, and compute the average score. This gives an overview of how participants assess different dimensions of health sector reform at the end of the course (60 minutes).

Follow this up with a brief exercise in which each participant writes down one thing he/she can do to constructively engage with HSR and to ‘right’ them: make them serve equity goals and contribute to achieving the ICPD vision for sexual and reproductive health services. Get a quick round of responses and consolidate with a presentation on an ‘Agenda for Action’ (30 minutes).

Activity 2: 30 minutes
Distribute Handout 2, which is the evaluation form. Allow about 30 minutes for participants to write detailed responses.

Activity 3: 30 minutes
The certificates may be distributed (10 minutes), and some time may be spent in receiving/sharing by participants on the course content and processes. There may be a formal vote of thanks and leave-taking. If time permits, the course should end with a fun-game for leave-taking.
Activity 4: 2 hours
Distribute Handout 3, which is the examination question paper. Participants have two hours to complete the exam.
Session 11. Handout 1

Based on what you have learned in the course, assess the implications of each of the reforms for SRH services.

<table>
<thead>
<tr>
<th>Implications</th>
<th>Reforms</th>
<th>Increase in the range of services available? (e.g. RTIs/STIs, infertility services, cervical cancer care)</th>
<th>Initiation of services for populations not hitherto covered? (e.g. adolescents, men, menopausal women)</th>
<th>Improvement in the quality of care?</th>
<th>Increase in access to care for rural, low-income and other marginalised groups</th>
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<tr>
<td><strong>Financing:</strong></td>
<td>User fees</td>
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<td>CBHI</td>
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<td>Private Insurance</td>
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<td><strong>PPIs:</strong></td>
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<td>For-profit Contracting</td>
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<td>Outright provision of infrastructure and equipment</td>
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<td>Social marketing</td>
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<td>Social franchising</td>
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### Implications of Reforms

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<th>Implications</th>
<th>Increase in the range of services available? (e.g. RTIs/STIs, infertility services, cervical cancer care)</th>
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<th>Improvement in the quality of care?</th>
<th>Increase in access to care for rural, low-income and other marginalised groups</th>
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<td>Not-for-profit Contracting</td>
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<td>Priority-setting</td>
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<td>Decentralisation</td>
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Session 11. Handout 2

Final Evaluation

1. What were your expectations for the course?

2. Were these expectations met?
   a. Yes  b. No  c. Partially

   Feel free to comment

3. Are there any topics or themes that were not covered in the course that you wish had been included? If yes, please list them.

4. Which sessions of the course were most valuable for you?

5. Which sessions of the course were least valuable for you?
6. If we had to cut something out of the course, what would you suggest we leave out?

7. Did you feel the level of the course was appropriate for you?
   a. Just right            b. Too difficult            c. Too easy

   Please feel free to comment

8. Some courses make a personal impact and some don’t. Reflecting on this course, do you think there are ways in which it has impacted on you?

9. (If applicable) Were you satisfied with the logistical arrangements (Place to stay, food etc.?)

10. Please provide us with any additional comments or reactions to the course that you believe will make it better for others
Session 11. Handout 3

Examination question paper

1. What are some major challenges facing India’s health care delivery system (a sub-system of the health system) in achieving its objectives of improving the health of its people? (Short answer: up to 150 words) 10 marks

2. What are the major objectives of the new generation of health sector reform being implemented since the 1990s? Give details of which aspects of the health system they seek to alter and why. (Short answer: up to 150 words) 10 marks

3. What are the major mechanisms for financing a health system? Assess each mechanism for its
   a. Revenue generating ability
   b. Influence on efficiency
   c. Implications for equity
   (30 marks)

4. Read the descriptions of specific PPIs given below. Answer the following:
   a. Who is involved from the public sector and what is their role?
   b. Who is involved from the private sector and what is their role?
   c. What range of services are provided?
   d. Who will the services cover? Who may be excluded and why?
   e. What are the implications for quality of care?
   f. Who is involved in decision-making? Who are the services accountable to?

i. In collaboration with government and local private practitioners, Mahavir Trust Hospital, a non-profit specialty hospital, runs a public-private mix project in Hyderabad city. The project area has a population of 500,000. Slum-dwellers comprise about 75% of the population. The slum population is at higher risk of TB than the non-slum population. At the onset of the Mahavir project, the local private practitioners were contacted by the Medical Advisor of the hospital and informed them about DOTS. Private practitioners refer TB suspects to Mahavir Hospital. Diagnosis and initial treatment is done at the hospital. Subsequently, patients had the choice of receiving free drugs at any one of 26 neighbourhood DOTS clinics, or remaining with Mahavir.
Between 1995 and 2000, 332 private practitioners in the neighbourhood referred 2178 suspected TB patients to Mahavir Hospital for diagnosis. DOTS for 761 patients was done at the clinic of referring private practitioners, 609 patients chose DOTS clinics in some nursing homes with supervised treatment, 153 chose NGO clinics and 653 remained with Mahavir.

ii. In 1998, the Government of Maharashtra proposed the development of a 200-bed super specialty hospital with a large private sector financial participation, managed along corporate lines. The aim of this innovative scheme was to provide increased access to high quality specialist services. A range of super-specialty services of an international standard would be provided for private (paying) patients. Ten per cent of diagnostic and treatment services would be provided to identified disadvantaged groups. Corporate management would ensure that the government’s investment would be optimised and that the funding would be available for cross-subsidization of services to disadvantaged groups who would otherwise not have access to these services. A joint-venture company was incorporated in 2001.

5. What is the likely impact of devolution on the provision of preventive, promotive and curative health care services to all sections of the population? (Short answer, up to 250 words, 15 marks).
Annex 1 List of essential readings

All participants have been given a copy of Ravindran TKS and de Pinho H. (eds). *Health Sector Reform and Sexual and Reproductive Health*, Johannesburg, School of Public Health, University of Witwatersrand, 2005. All chapters of the book are part of the essential readings for the course.

**Session 2. Sexual and reproductive health and rights**
3. Setting the stage. (Chapter 1). In *Looking back, looking forward: A Profile of sexual and reproductive health in India*. Delhi, Population Council, 2004.
4. IPPF Charter on sexual and reproductive rights
5. UN. Universal Declaration on Human Rights

**Session 3. Provisioning SRH services**
7. Data from RCH-2 Program Implementation Plans Document Chapter 1 and from *Looking back, looking forward: A Profile of sexual and reproductive health in India*. Delhi, Population Council, 2004.

**Session 4. Health sector reform**

**Session 5. Financing reform**


16. International Labour Organization. Insurance products provided by insurance companies to the disadvantaged groups in India, 2005.pp


**Session 6. Priority setting**


**Session 7. Decentralisation**


23. Mahmud, S, Space for Participation in Health Systems in Rural Bangladesh, The Experience of Stakeholder Community Groups, in Cornwall A and V.S, Coelho (eds.), *Spaces for Change? The*


Session 8. Public-private interactions


Session 9. Health service accountability


33. Thomas, et al, 2006, Strengthening Citizen Voice and Accountability for Better Service Delivery- India case study, DFID, UK (Overview and Health section)


36. Ranjani K. Murthy. Service accountability and community participation in the context of health sector reforms in Asia:
Implications for sexual and reproductive health and rights. Rights and Reforms Project, Johannesburg, School of Public Health, University of Witwatersrand, 2005.

Session 10. Issues for policy advocacy in HSR and SRH