

2011

Aarohi

Uttarakhand

Health programs

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Background – Kumaon region

Uttarakhand was carved out of the Himalayan and adjoining north-western districts of Uttar Pradesh on 9th November 2000 to become the 27th state of Republic of India. This mountainous state in northern India is divided into two administrative divisions – The Kumaon or Kumaun and the Garhwal region. Kumaon includes the districts of Almora, Bageshwar, Champawat, Nainital, Pithoragarh and Udham Singh Nagar. While Uttarakashi, Chamoli, Rudraprayag, Tehri Garhwal, Dehradun, Haridwar and Pauri come under Garhwal.



Source: Wikipedia

The Kumaon region is predominantly mountainous and farming is the main occupation. Poor infrastructural and logistical support makes travel in the region arduous and time consuming. Men migrate in great numbers in search of employment and many of them are part of the Kumaon regiment of the Indian Army. Due to this the resident adult population is mostly females. They take care of the households and the farms. Men return at the time of sowing but women take care of the rest at farms.

Women lead a hard life and it reflects on their poor health status. Since farming is mainly subsistence in nature, there is shortage of income and access to nutritious food. This reflects in the state's high malnutrition rates among women and children.

Cultural practices such as sending women to the cowshed during menstruation, severe dietary restrictions during pregnancy and lactation, not giving colostrum to new born babies, unhygienic practices during childbirth and many other such practices have all led to deterioration of the health of the women and children. However the scenario is definitely better where there is better dissemination of appropriate health information.

From the service delivery perspective, poor access to public health facilities (timely availability of clinicians at the facilities, poor logistics support, cost and time invested in reaching a facility) also contribute to the poor health conditions. The private sector is dotted by traditional medicine practitioners. In spite of women forming the majority of the adult population, participation of women in promoting their health is limited. Anemia and Leucorrhoea¹ are common ailments afflicting the population in the state.

Beginning

Satoli village

The people of Satoli village lead a difficult life and draw sustenance from agriculture and horticulture. Life for the villagers revolves addressing the basic needs of everyday rural living i.e. Collection of fuel wood, fodder, bedding for animals and travelling long distances to collect water. Returns from agricultural produce are not enough to sustain the needs of an ordinary family. Food produced on the land is barely adequate to support an average family for three to four months of the year. To meet their everyday needs, families depend on wages from doing semi-skilled labor and remittances from family members, who have migrated to the plains or joined the Indian Army. When Aarohi started, some basic infrastructure existed in the form of schools, roads and electricity but many villages were still far from the road and had no electricity. The agricultural economy was depressed and dominated by middlemen. Frequent hailstorms and dry spells took a toll on crops every year. The public health system in the area was not very well established. The small sub-centre in the village did not have a doctor and was not functioning well. Immunization and maternal care services were poor.

Cultural practices of delivering a baby two decades ago. Some of them still exist in remote villages

- *Delivery was conducted in poorly ventilated cowsheds and the area was kept warm using clay stoves which caused the room to fill up with smoke*
- *Severe dietary restrictions during pregnancy and lactation leading to anemia*
- *TBA left soon after delivery without delivering the placenta, this led to high MMR*
- *Baby was not put to breast immediately post delivery*
- *Baby was not breastfed colostrum. This led to poor immunity levels*
- *Primary immunization of children was not practiced*
- *Prolonged labor was not referred for medical intervention*

¹ **Leukorrhoea** (US) or **leucorrhoea** (Commonwealth) is a medical term that denotes a symptomatic thick, whitish or yellowish vaginal discharge.

Aarohi was set up in the backdrop of this difficult rural life. Its objective was to diversify the rural economy, bring better health and education facilities to the area and initiate processes for better management of natural resources. The activities of Aarohi were based on the needs of the community. The need assessment was conducted through village meetings. Some of the common issues discussed were water and sanitation, education, forest resources, health and economic problems. People relied on either home remedies or private practitioners of traditional medicine for healthcare.

The Approach

Aarohi envisaged providing good quality of care to the community. In the absence of qualified doctors Aarohi successfully included local traditional practitioners² into their health project and also adopted some of their practices. Aarohi also started with their own health program and recruited their staff. The health program of Aarohi consists of curative, preventive and promotive work. When Aarohi started, the clinic working hours were limited to mornings and afternoons were dedicated to community visits. The hospital staff would talk to women, provide antenatal care, information on deliveries and sometimes even conduct deliveries. Over a period of time, as the work grew, the clinical work and the community health became two distinct identities.

Aarohi realized in the beginning that to improve the health of the community, women need to be educated about good health practices. In 1993, they formed women's self help groups and through them took health education to the rural households. Women were educated about some of the major

Aarohi's rural hospital embraced both modern and traditional practices from the beginning. Even to this day, some of the more effective home remedies are encouraged as these are cost effective and easily accessible to people

health concerns afflicting the populace like hygiene & sanitation, safe delivery, malnutrition, anemia and leucorrhoea in women, dental care and tuberculosis. In 1999 they also started mobile health clinics to ensure that curative services reach remote villages.

Unlike most organizations, Aarohi conducts periodic and structured evaluation of their work. Here regular evaluation is done both internally and by external experts to assess the quality and output of various interventions. These evaluations help the organization refine their approach and program needs.

Aarohi Arogya Kendra (Aarohi Health Centre)

What started as a small clinic in 1992 in Satoli is now a rural hospital that can house 20 patients– Aarohi Arogya Kendra. In 1998, a local villager donated land to set up the permanent facility.

Services at Arogya Aarohi Kendra

The Health Centre is staffed by a doctor, four nurses, an X-Ray and a lab technician. It has the basic infrastructure of an out-patient department, a pharmacy, a laboratory which can carry out routine tests, an X-ray and ultrasound machine, an operation theatre for major surgeries and three beds to provide inpatient care. The centre has the facility to accommodate more patients in a separate building located

² Traditional practitioners include health practitioners who are not formally trained and are practicing herbal, Ayurvedic and shamanistic healing.

in the same premises during surgical camps. AaroHi also provides ambulance services, which is a boon to the villagers with limited access to transport services in the mountainous terrain.

From the beginning, AaroHi was seen as the first stop for emergency services in the region. The center acts like a first referral unit for major emergencies. The patients are stabilized and then referred to the nearest possible health centre. AaroHi also provides emergency services at homes. The bulk of the emergency services include closed reduction of fractures (which does not include surgical intervention), incomplete abortion, organophosphorus poisoning, congestive cardiac failure, typhoid fever, complicated labor, trauma, abscesses etc.

There are a high number of women in the age group of 35 to 45 years with utero-vaginal prolapse for which surgical intervention is needed. Most would come only when their daily work is not compromised.

As far as possible the pharmacy at the hospital gives preference to generic drugs which are more affordable to the community. They are sourced from LOCOST³ and local wholesale dealers. The hospital also gives preferences to local herbal remedies as they are often effective in treating common diseases such as cough, cold, arthritis etc. Adoption of home remedies has helped the centre keep its costs low. It also helps the community adhere to the treatment.

In 2006 the operation theatre was added to the centre along with a ward and a dental facility. The operation theatre has facilities for specialized surgeries such as gall bladder removal, major abdominal surgery, gynecological procedures, reconstructive surgery etc. However in the absence of a permanent surgeon the operation theatre is run on a camp mode. The surgeons from the cities visit the centre on a predetermined date to conduct operations. The process has been streamlined and planning for camps starts three to six months in advance.

An average of about 20 camps is held annually. The first two years saw a good number of surgeries (88 surgeries per year) but in 2009 the numbers fell (44 surgeries per year). This can be attributed to the fact that a backlog of cataract surgeries was addressed in 2008.

Pricing of services

The consultation fee at AaroHi is inclusive of medicines and diagnostics. It's based on the market price and on an average amount to close to one US dollar. The local quacks in the region charge anywhere between a dollar and two. The revenue generated is enough to meet the hospital expense for medicines and consumables.

The surgical procedures cost fifty percent or sometimes even thirty percent lesser than the market price. Eminent surgeons of the country render their services at the camps. Despite the high quality of care and low cost, the hospital has not been able to provide enough surgical care because there is no regular surgeon at the hospital. People who can afford better health services head to hospitals in the neighboring districts with advanced techniques for treatment such as laparoscopy.

³ Not for profit organization based in Gujarat (Western India) which manufactures and supplies generic medicines to not for profit organizations at cost much lower than the market price

Aarohi treated above 30,000 patients between 1993 and 2010. (Exhibit 1)

Scaling

Aarohi has not envisaged a growth plan. It's relying on growth to take its own course. Scaling of the hospital would depend on the demand for services and possibility of appointing a regular doctor who is able to work with limited resources and provide varied services including surgical treatment. In the absence of in-house doctors and specialists in the region, the hospital is exploring possible alternatives like tele-medicine (consultation) and tele-radiology (radiological consultation).

Community Health Program

The community health program of Aarohi works on the premise that eighty percent of health problems found in rural areas can be prevented or managed by village health workers and traditional remedies. They were clear from the beginning that to improve women and children's health in the community, the women need to be educated about good health practices. This also meant recruiting women (health workers) from the community and training them for effective dissemination of information. In 1993, they formed women's groups in the community, trained them and through them took health education to rural households. Women were trained about some of the major health concerns afflicting the populace like hygiene & sanitation, safe delivery, malnutrition, anemia and leukorrhea in women, dental care and tuberculosis. In addition, traditional birth attendants ('Dais' as they are called in the Indian villages) were trained to reduce pregnancy related risks to mother and child. The training of TBAs provided preventive (antenatal care and post natal care), promotive (health education on nutrition, breastfeeding etc.) and curative (conducting normal deliveries).

Another important practice at Aarohi is to do periodic evaluation of their programs. Most often, a baseline survey is undertaken and the program is evaluated against this post implementation. In 1998, one such evaluation revealed that TBAs were not effectively transferring health related information to the women in the villages. It was then decided that the Aarohi team would accompany the TBAs during their visit to the villages and interact with various groups in the area such as the micro-credit groups and the adult awareness and literacy groups. Eighty such visits were conducted. These evaluations helped Aarohi understand and collect measurable impact of their work.

Currently Aarohi's health interventions reach out to thirty villages with a total population of around 11500. The team at Aarohi move from village to village to spread health awareness and put in place mechanisms through which the villagers can access health services. Aarohi is planning to expand its programs to cover the men and the adolescents in the community. (Exhibit 2)



Figure 1: Health Workers with Arogya Project

Health Education

Awareness programs or health education programs of Arohi are not only limited to disseminating information but also attempt to develop mechanisms that make a community adopt new ideas. Village meetings and mobile camps provide information on the community health needs. Constant attempt is made to meet and educate the various formal groups in the villages. During these meets, the Arohi team identifies community need, discusses appropriateness of the identified need and then plans an intervention program. As most of the health education is through unskilled workers, training becomes of utmost importance. Health workers are trained on specific health issue affecting that community and on the designed preventive interventions.

An important group of women then identified were the traditional birth attendants in the community. None of them had received any formal training and adopted many cultural practices that were dangerous to the mother and child. Most deliveries were carried out at home by these traditional birth attendants (TBA). Arohi in 1994 took the next step in its community participation approach by starting the training of TBAs. Arohi stepped in to train some of the more competent TBAs to reduce pregnancy related risks to mother and child due to unskilled practices. They began with three TBAs and trained them in safe delivery practices, first aid, primary health issues and women's health.

The training of TBAs was initially on a weekly basis. After two years, the sessions were conducted on a monthly basis. The content of training was developed by a senior midwife trainer from England. The book “Where there is no Doctor”⁴ was used as a reference for the training manual.

There was also cross learning from other organizations working in the area of maternal and child health. TBAs were sent to organizations like Child in Need Institute (CINI)⁵ and Sewa Rural⁶ for training. The cross training helped the TBAs appreciate and understand the health issues surrounding pregnancy and child birth. It also exposed them to work in a clinical environment.

Aarohi carried out baseline studies to assess the MCH situation in the region and constantly revised TBA trainings. For e.g. in 1996, a participatory survey conducted in five villages indicated that anemia amongst women (15 to 45 years) in the regions was thirty two percent and sixty seven percent women suffered from leucorrhoea. So the TBA training emphasized on educating women about the two identified health problems. The TBAs in the years that followed have become most effective in creating awareness and bring paradigm changes in the way women in Kumaon took care of their own and their children’s health. Today, Aarohi has trained 93 TBAs (1995 to 2011)

Apart from conducting training of TBAs and health workers, Aarohi also worked with specific groups of people in the community such as school children and microcredit groups.

Health education with children began in the year 1999 with the aim of reinforcing concepts of personal hygiene, environmental sanitation and basic health

knowledge. Approximately one thousand children from thirteen primary schools and five junior high school were part this program. The topics covered included understanding the functioning of human body, the concept of disease, its prevention and management and first aid. Activity-based learning, games and yoga were adopted for training. In the year 2008, Bal Swasthya Prachar Teams (BSPT or children’s groups to encourage and participate in environmental hygiene) were formed with forty boys and girls each. These teams are now able to conduct their own meetings and share information amidst peers. The teams undertake monthly activities such as village cleaning campaigns, they encourage villagers to construct garbage pits, and they organize and participate in cultural activities and conduct yoga classes.

Micro-credit groups (MCG) were another group targeted by Aarohi to create awareness about women’s health issues and other basic primary healthcare. The health team meets these groups on a periodic basis and keeps a track of all discussions held and issues addressed. An evaluation of ten such MCGs

One year evaluation of health education with children program initiated in 1999

An increase of 67% in number of children brushing their teeth once a day

21% of them drink boiled water

⁴ ***Where There Is No Doctor – David Werner***, is the most widely-used health care manual for health workers, clinicians, and others involved in primary health care delivery and health promotion programs around the world

⁵ CINI has over 35 years of experience in the issues affecting poor women, children and adolescents from some of the most disadvantaged areas of India. (www.cini-india.org)

⁶ SEWA Rural is a voluntary development organization involved in health & development activities in rural tribal area of South Gujarat at Jhagadia (Western India) since 1980. www.sewarural.org

(2000) has indicated that the interactions with these groups help raise their awareness levels about different problems within a year.

Evaluation of 10 MCG results:

- *An increase of 20 percent of women who have some information on AIDS*
- *An increase of 80 percent of women who understood the need for delivery of a child in a clean and well ventilated room*
- *An increase of 22% of women in initiating breastfeeding immediately to birth*
- *An increase of 15% in primary immunization of children.*

The *mode of awareness* creation depends on the target audience – women or children. For adults, the program is conducted through discussions and village meetings where a health worker disseminates information to a group of 15-20 women. For children a playful approach is opted. Puppet shows are a popular method of teaching. These shows were started way back in 1997. Over the course of time the shows have been refined with training from expert puppeteers. Other methods of communication are flip charts, street plays (for large gatherings), slide shows, group discussions and video films.

Arogya Program (2005)

The Arogya program (2005) was a unique experiment to create a model for community based health care system. It was done in collaboration with Kassar Trust, a local organization in the Kumaon region. The project was piloted in 25 villages with an approximate population of 10000. Ten villages were selected from the Nainital District and fifteen villages were from Bageshar and Chamoli districts.

Under the program, village level institutions called Grameen Swasthya Samitis – (GSS) were formed under the leadership of a village head called the *Gram Pradhan*. The communities chose their own village health worker (*Swasthya Karmis*) who were then trained to provide first aid to common medical problems like diarrhea, fever, cough and cold, wounds, burns and bites. They were also trained to conduct antenatal examination of pregnant women and distribute iron and folic acid tablets. They were given the onus to ensure that the mother gets immunization against tetanus from government Auxiliary Nurse Midwives (ANM's) and to make sure the women underwent safe delivery at home or were referred to appropriate hospitals in time.

Primary immunization of children by the government was also to be assured by the health workers and the village committees. While the health workers were the central point of care, the village committees were responsible for planning and implementation. Both were trained in managing basic health issues within their village.

As the Arogya Project is focused on maternal and child health, all health workers are women. The community chooses them based on the role they need to play. Aarohi is specific that they should be at least a high school graduate and should show keen interest in the work. Based on this criterion, the village community nominates one woman in an open village meeting. Aarohi's long presence in the

region and the good reputation it shares, the current trainers of health workers are actually people who have worked with the organization for over 10 years.

The health worker (Swasthya Karmi or SK) reports to the supervisors who are employees of Aarohi with health-related experience between 3 to 6 years. They facilitate the work of the SK and do not directly work with the community. Supervisors report to the assistant coordinator who in turn reports to the coordinator. Every supervisor manages 3 to 4 community health workers. The coverage is a combination of population and spread. Each SK is responsible for one village.

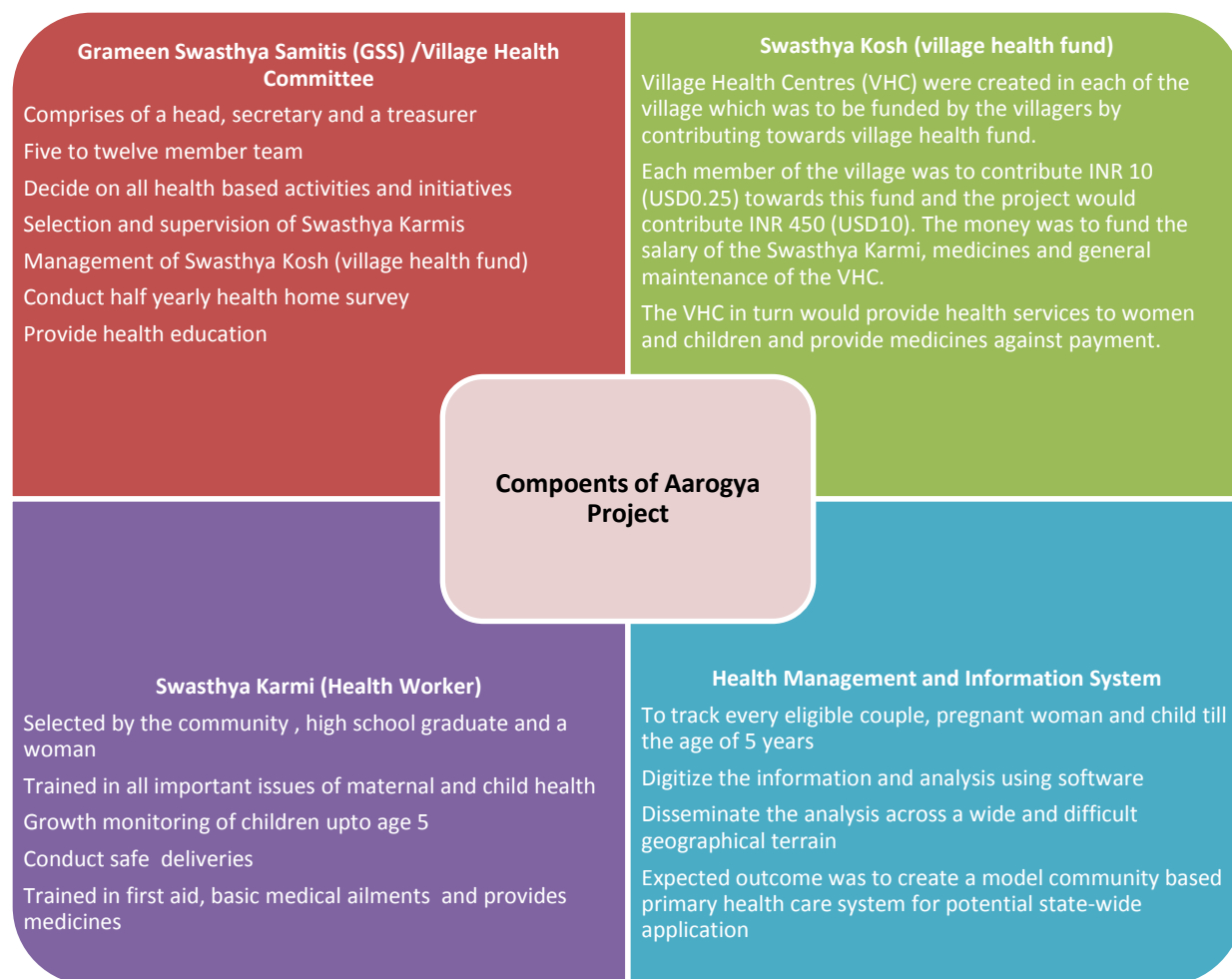


Figure 2: Components of Arogya Program (Phase 1)

The achievements in 10 villages directly under Aarohi during Phase 1 were (2005 to 2008)⁷:

- Complete primary immunization achieved for children between 12 to 23 months.
- No maternal deaths in the past four years.

⁷ Source: Evaluation done by a team from Tata Institute of Social Sciences led by Dr Ramila Bisht

- Awareness among women about antenatal checkups, immunization against tetanus, iron and folic acid tablets, safe delivery practices and breast-feeding practices was good.
- Safe delivery is practiced because there is a good risk perception among the community about the dangers of aseptic delivery. Besides, the I TBAs ensures that the family follows safe practices.
- Timely referral of complicated cases has been well achieved due to constant availability of trained TBA.
- Knowledge and awareness about personal, domestic and environmental hygiene are universal.
- Growth monitoring in children between 0-5 years is regularly conducted by the health workers.

Based on the outcomes of Aarogya during the first phase, the organization launched the second phase of the project in 2009 in Okhalkanda block with continued support from Sir Dorabji Tata Trust. Kassar Trust is no longer part of this phase. Meanwhile the project in the Ramgarh block is gradually being phased out.

	Ramgarh (2010)	Okhalkanda (2010)
Own Flush Toilet	93%	38%
Rate of antenatal check up	79%	62%
Home delivery	90%	90%
Delivered by trained TBA	85%	0%
Delivered by untrained TBA or other women		85%
Breast feeding within an hour of delivery	85%	65%
Respiratory illnesses treated by clinicians	81%	-
Respiratory illnesses treated by traditional practitioners	-	48%

Table 1: The impact of Aarohi's work in Ramgarh block (2010) as against the Okhalkanda block where no intervention has taken place

Mobile Health Camps

Mobile health camps are a combination of the curative and community health programs. The purpose of the mobile health camps is to reach out to remote villages which take a day of travel by road and another day's trek to reach. These villages have extremely limited access to health care and many cultural beliefs negatively impact health of the populace. The first mobile camp was initiated in 1999. A health team comprising of doctors and paramedical staff visit the villages, provide curative services and initiate preventive services. Aarohi

Number of camps (1999 to 2010)	76
People screened	3002

makes scheduled visits to these villages when required or every six months. These camps also provide an insight into community needs for possible future intervention.

Financial Model

Aarohi is registered as a not for profit Society and depends on various kinds of financial aid to fund its programs – health and education. The livelihood project⁸ generates enough revenue to cover its own expenses.

The health and education programs are funded by grant. Aarohi levies a small fee from patients and students as community contribution. The small fee is not sufficient to run the organization or its projects. The quality and modern methods adopted are expensive for the community and yet needed. So the Aarohi team constantly works to ensure a steady flow of funds to the programs.

Aarohi is trying to achieve a good balance between funding from grants, individual contributions and the surplus earned from the livelihood program. Aarohi has created a corpus from the revenue generated through its various programs and from individual donations.

In the last decade (2000 to 2010), the health expenditure amounts to 17 percent on an average of the total expenditure.

The organization has managed to keep its cost low by partnering with like-minded organizations and working with volunteers.

For the future a possible source of revenue could be training and capacity building exercises for other organization's working in the rural regions. Training of

government health workers and program monitoring of projects by other agencies could also be carried out to earn revenue. This is currently being done on request.

Organization Structure

Aarohi has a well-defined organizational structure with good representation of people from across the country and within the region.

The Managing Committee is the supreme administrative unit of Aarohi and is represented by members from within and outside the region. The Executive head is the Secretary of the organization and the Treasurer is a local associate. Dr Sushil Sharma is currently the Chairman. This committee is responsible for the laying and monitoring the guiding principles of the organization. The auditors are selected by the Managing Committee.

Besides the Managing Committee, Aarohi has a General Body with various categories of members. The General Body has a large representation from the local community. At the annual meeting, the Managing Committee updates the General Body about the work done in the last year. The General Body elects the Managing Committee once every 5 years.

⁸ Aarohi's livelihood projects consist of retail of herbs, natural cosmetic products and other agricultural produce

Every village has a village development committee and this group also forms a part of the institutional member at Aarohi. But now there are plethora of government-sponsored committees such as water and sanitation etc. This group was supposed to have played a role in developing the programs of Aarohi but they are not as active as would be desirable. At the same time, member village committees provide critical feedback during village meetings.

Aarohi wants to run itself like an organization rather than a one man institution. Keeping with this vision, they are developing young cadres to take the role of middle level managers. The vision is to balance the energy and creativity of youngsters with the experience of older people in the organization.

Conclusion

Dr Sushil Sharma - "Eventually the work in health will be more community based. Full time presence of doctor would not be mandatory as long as sufficient doctors come to Aarohi on a rotational basis. What will be required is good management by a good manager. Aarohi does not have a strict plan of growth. The vision was to create a more equitable society and any activity that helps to achieve the vision could be taken up. Growth will depend on the person who leads and who will paint on the canvas. Our job now is to develop a beautiful canvas."

The key takeaway's from Aarohi are its effective program management systems and regular feedback mechanism that help the organization constantly improve its intervention strategies to achieve better project outcomes. By employing local people and by working through health workers, the organization has managed to earn greater acceptability within the communities it works in. Unlike many other organizations, Aarohi is gearing up to become an institution so that it does not become a "one man show". Like Dr Sushil says, *"The process of change needs to be expedited now. One cannot wait for a generation to see a visible result in the community."*

"It is important to let go and make space for change" Dr Sushil Sharma's opinion on handing over the reins of the organization to someone else.

Exhibits

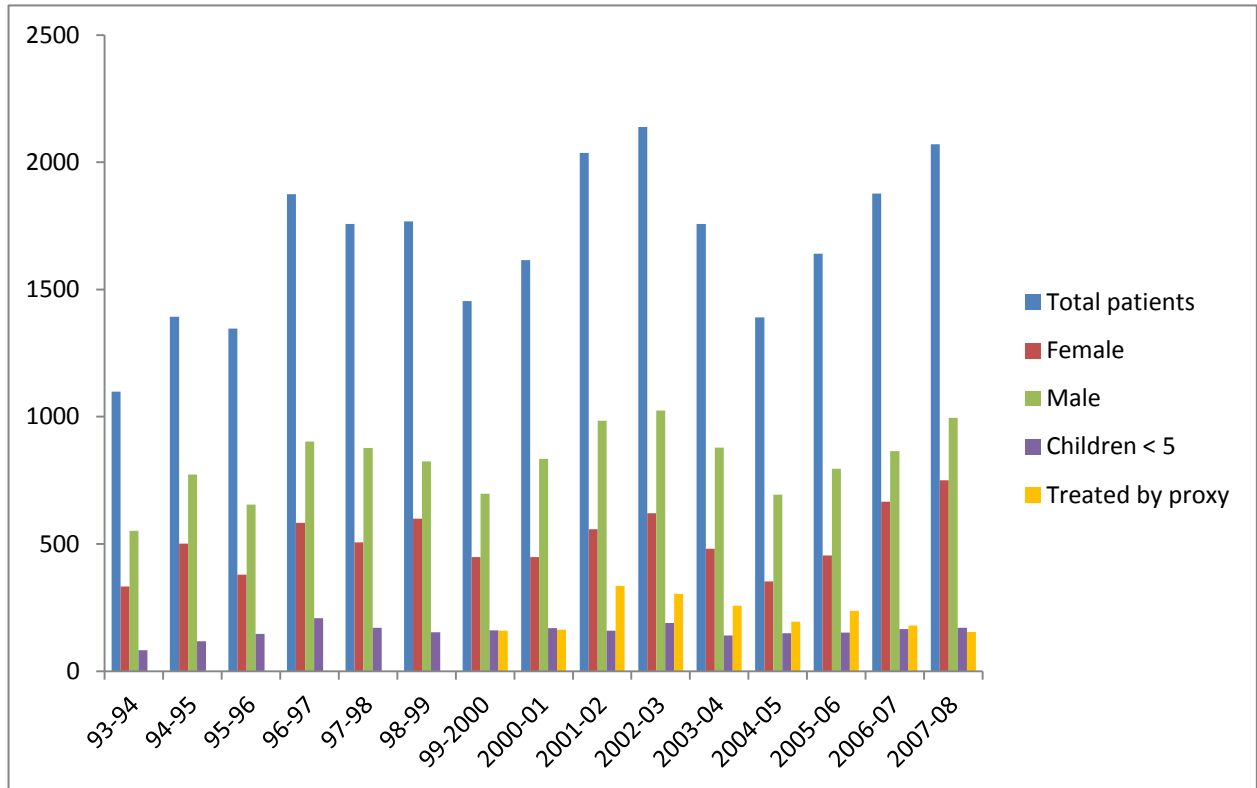


Exhibit 1: Annual patient statistics (1993 to 2007)

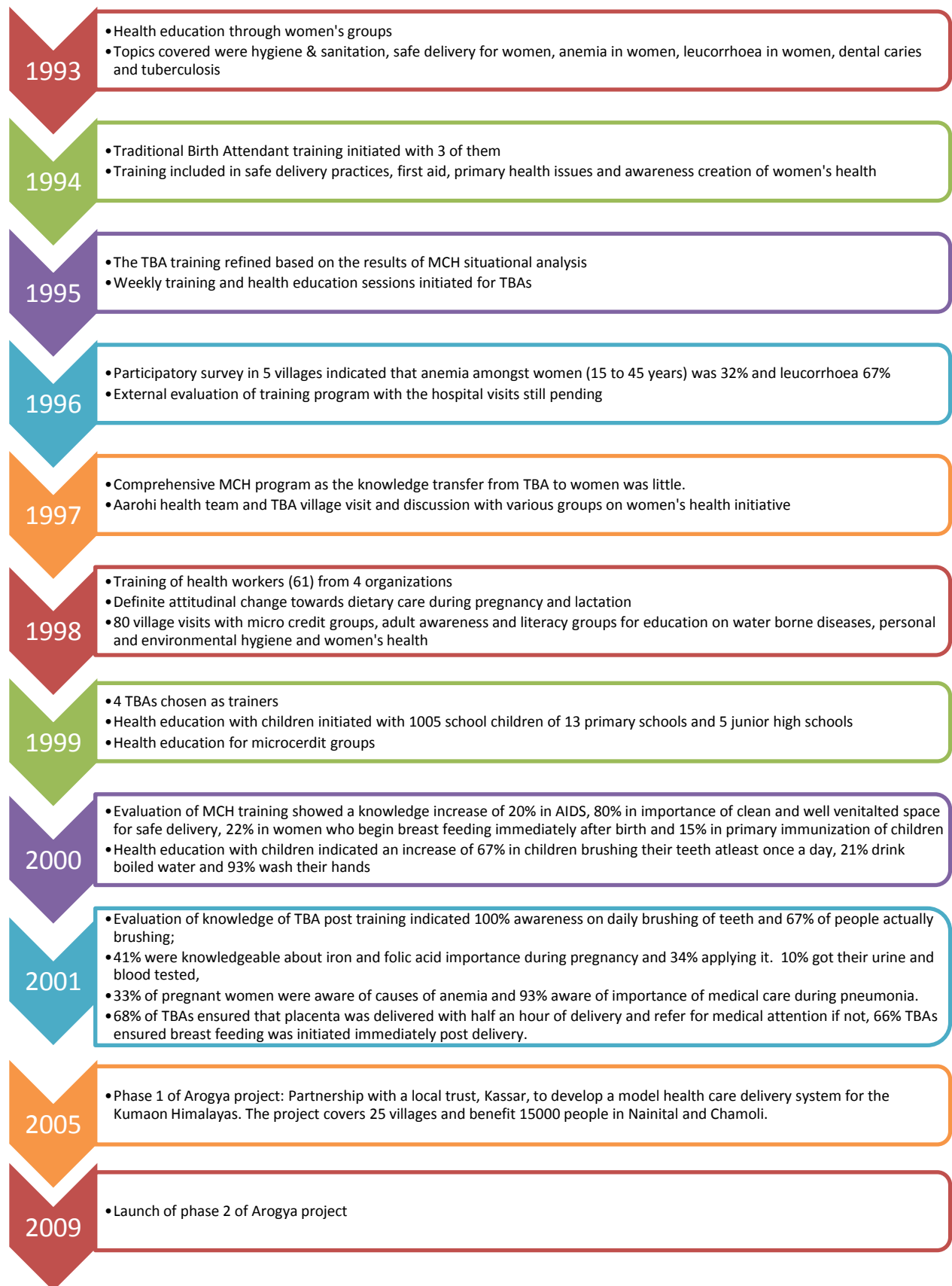


Exhibit 2: Timeline of Community Health Activities

Disclaimer

The case study has been compiled after primary and secondary research on the organization and has been published after due approval from the organization. The case has been compiled after field visit(s) to the organization in May 2011. The author of the case or ACCESS Health International are not obliged or responsible for incorporating any changes occurred in the organization after receiving the due permission from the organization to publish the case. The case study has been developed with a specific focus to highlight some key practices/interventions of the organization and does not cover the organization in its entirety.

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