Institute for Rural Health Studies

Hyderabad

The Institute for Rural Health Studies (IRHS) was established in 1981 by Dr Patricia Bidinger (Pat) and Mrs. Bhavani Nag in Hyderabad to do research on the nature and cause of rural health problems. Their initial research examined the agricultural and socio-economic determinants of health and nutrition in rural Indian villagers. The research covered inputs including income, expenditure, harvest data, labor force participation as well as health and nutrition parameters. During interaction with the villagers it became evident to Dr. Pat and Bhavani that access to healthcare was minimal.

A woman came to them one day saying, “Amma, we don’t mind answering all your questions about how many hours we work in the fields or showing you how much we eat or letting you examine our bodies, but Amma, why don’t you do something useful? The baby is sick.”

This was the turning point in their careers and they began to provide healthcare. Today, IRHS is known more for its healthcare provision and helping rural people to access healthcare than research. It provides both curative and preventive healthcare as well as helping villagers access secondary and tertiary level facilities.

This report briefly explains how IRHS has managed to provide seamless access to healthcare for thousands of people throughout the state of Andhra Pradesh through both rural clinics and its related Hyderabad-based programs in the city’s bus-station connecting to a network of patient counselors in government hospitals.

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How it all began

When the Institute for Rural Health Studies (IRHS) started its work, “Health for All in the Year 2000” was a very popular slogan but how it translated into action was ill-understood. Rural health needs were not well understood and yet at that time more than 80 percent of the population lived in rural areas. Little interdisciplinary research existed. IRHS was established to do research on the agricultural and socio-economic determinants of health and nutrition with the view of helping improve rural health. The organization carried out several interesting interdisciplinary studies. Soon it became apparent that the need for healthcare was unmet. Villagers requested Dr. Pat and Bhavani to do something about the situation. Thus, their first efforts to provide health care began in Dokur village of Mahbubnagar district in February, 1982. It consisted of a table and two chairs for Pat and Bhavani outside a cowshed where they lived with the majority of patients exhibiting signs of tuberculosis, leprosy and respiratory tract infections.

What was the situation like then?

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1 Capital of South Indian state, Andhra Pradesh
3 Second largest district in Andhra Pradesh in terms of area
The village where the first rural clinic is situated was plagued by the age old problems of ineffective public healthcare facilities. Primary care in the rural areas was found only in market towns or in remote areas ill-served by public transport. Some of the common problems were:

- Poor infrastructure and, more often than not, the primary health centers were found in market towns.
- Most often, vaccinations would either be contaminated due to poor cold chain storage or never reach the villages.
- The problems faced by villagers were unknown to both medical doctors and government officials. Few realized that health was not merely a clinical problem in the villages.
- The quality of care was substandard with trained doctors preferring to settle in the cities or district capitals. Most of the providers in the rural areas were quacks. Invariably, a simple condition would worsen for the lack of appropriate and timely care. All treatment was injection-driven.

“There was fear in accessing care in the cities or even district capitals as the surroundings were unfamiliar and people were frightened.

In order to address the unmet needs, the organization started a small village clinic comprising consultation and basic laboratory investigations for detection of tuberculosis, malaria, anemia and other routine conditions. These clinics were run five day a week and manned by two paramedics trained by Dr Pat and other volunteer doctors from the UK. The first proper clinic was constructed in 1987 from a hut funded by Oxfam (UK)⁴. There was no electricity and laboratory equipment was basic: monocular microscope, hand cranked centrifuge and simple staining methods. When patients arrived who needed onward referral, staff responded by setting up a referral system to the District Hospital and/or Hyderabad, the state capital.

What is the IRHS healthcare delivery system all about?

In Dr Pat’s own words: “…that someone from a remote village can be guided through the torturous route of the Indian healthcare system to access vital tertiary health care at no cost to him/her except lost wages and/or one way bus fare if over 18 years of age”.

The village clinics have evolved with more structured in-house management and a permanent modern building in Dokur village. The Kotakadra village⁵ clinic operates once a week from a small two-room hut from which lab tests, gynecology exams and the pharmacy are done. Consultations are held within the roomy village temple premises.

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⁴ Oxfam is an international confederation of 15 organizations working in 98 countries worldwide to find lasting solutions to poverty and injustice.
⁵ Another village in Mahbubnagar district
The components of the IRHS healthcare system are:

- Village clinics in a remote rural area of a chronically drought-prone district
- Travelers’ Aid for the Sick - an office in the central bus station in Hyderabad
- Patient Counselors located in both the bus station office and in tertiary care level public hospitals.

At the village level

Village Clinics

The Dokur village clinic is a permanent building designed and constructed by IRHS in two stages. A reception area, patient waiting area, two consultation rooms, an examination room, laboratory and pharmacy room make up the clinic. In Kotakadra the same services are provided. The equipment and staff are transported each week in a large van from Dokur.

The clinics are manned by local people (paramedics and village health workers) who are trained by IRHS and occasional volunteer doctors from the UK. The clinic charges a fee of INR 2 (0.04 USD)\(^6\) for consultation and diagnostics. The medicines dispensed are high-quality, generic and inexpensive. For people who cannot even pay this small amount (primarily the elderly and disabled), the services are free. All children are free, irrespective of their economic status. The clinics are now visited on average by over 600 patients every month or more than 7000 in a year. The conditions seen vary from simple colds and coughs to malignant tumors and severe neurological conditions. Patients from the surrounding villages and even neighboring districts visit the clinics.

Paramedics are the foundation of the clinics. They are recruited from the community and trained by IRHS. IRHS tries to ensure that medical volunteers are present part of each year to further educate the paramedics. Medical volunteers do not treat patients rather teach the paramedics newer treatment protocols, improve examination techniques and reinforce ‘best practices’. Volunteer nurses help streamline the clinic functioning and ensure that hygiene standards are upheld. On home visits nurses monitor staff to ensure adherence to protocols.

These paramedics are “the doctors”. They are trained to document in detail the history of the condition, relate it to the socio-economic status of the patient and then provide treatment. They are responsible for referring serious cases to Hyderabad for appointments in tertiary facilities. Some patients are referred directly to the Mahbubnagar district hospital. The first preference of referral is always a public hospital. If the patient’s condition is too complex for a state hospital, corporate hospitals are used. Many of them offer free services to IRS patents.

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\(^6\) Conversion 1 USD= 50 INR
In order to decide on financial aid a patient referral form captures the clinical history, family history as well as the socio-economic status of the family including outstanding debts. Paramedics are also responsible for community health work which is done in teams – paramedics and health workers.

Health workers, trained by paramedics and volunteer doctors and nurses, have important responsibilities both in the clinics and in the communities. In the community they are the institute’s major force for preventive care. They track every pregnant woman and provide antenatal care including checking fetal heart beat and position. They monitor the growth of children between birth and three years of age using a growth chart. The reverse side has a check list for developmental milestones. Full breast feeding is encouraged with introduction of solid food at six months of age and when families are extremely poor the health worker provides supplementary feeding in the form of Poshana – a mixed food for babies above six months of age. Iron and folic acid are provided to both pregnant women as well as teenage girls who will soon marry. They facilitate the government’s immunization program by encouraging timely vaccination and creating awareness through the public loudspeaker. They also conduct home visits to patients who cannot come to the clinic and provide education on health and nutrition to school children in their schools and during Friday evenings when they serve tea and biscuits.

In the clinic, height, weight and blood pressure are measured by health workers. Apart from the clinical work, they also maintain patient records, conduct laboratory tests, run the pharmacy and assist the paramedics as and when needed. Inventories are maintained for medicine and supplies and all money collected is recorded by category of income: clinic consultations, general medicine or chronic patients’ medicine fees. This is sent to Hyderabad each week to be recorded and inventories filled.

All too frequently villagers seek care when their condition is advanced and little can be done. They recount that there is no one whom they
can approach. The clinics’ preventive activities have addressed this problem within the immediate catchment area. However, in distant areas, this is more difficult and patients present with advanced disease. The paramedics of the clinic not only identify patients requiring tertiary care but also explain in detail about the condition and the importance of treating it. This is an important aspect in creating awareness. The paramedics are assisted by the clinic health workers who also emphasize preventive care and reassure patients going for tertiary care to Hyderabad. All clinic staff tell their patients to promote the clinics in their villages.

The work of the IRHS clinic does not end with writing a referral. They go a step further and actually make an appointment to see the appropriate doctor through a phone call to office staff in Hyderabad in partnership with the patient. In addition, the travel and stay is also financed to those who cannot afford the cost. Most adult patients pay only one way bus fare to Hyderabad while all those 18 years and below are free. Travelers Aid for the Sick staff in the bus station office greet and process the patients upon arrival. They insure the patient is guided to the correct bus which will take them to the appropriate hospital where their patient counselor is waiting.

**On reaching Hyderabad**

*Travelers Aid for the Sick Project*

The Travelers Aid for Sick office is located in Mahatma Gandhi Bus Station (MGBS) in Hyderabad. Buses from all over the state come to this station. The Andhra Pradesh State Transport Corporation (APSRTC) has provided a room for IRHS within the station premises. The centre not only serves the patients coming from villages for treatment but also acts as a center for education and first aid. The center originated when IRHS staff realized that sick villagers were picked up by touts on the bus platforms – sometimes with disastrous results, e.g., Nagaraju. Children were maimed by unethical doctors used by touts and sometimes lost their lives. Villagers were easy to misguide as they were extremely naive. It was felt that the whole purpose was lost if timely and appropriate treatment was not made accessible. This centre fulfilled that purpose.

Villagers reach this office either through the IRHS clinics or through word of mouth. Patients have come from all over the state simply by word of mouth. In the village clinics themselves patients, are told where to find the office and look for the many signs on the bus station walls directing patients to the office. Patients from the clinics are in possession of a counseling form in Telugu along with the telephone number of the office and their counselor to be. Meanwhile, head office staff make the appropriate appointment and note it in an appointment book. Each Saturday, the coming week’s appointments are photocopied and distributed to all staff. When clinic patients arrive at the bus station, the counselor cross checks the information on the counseling form with the appointment book. The patient is given instructions on which bus to take to his hospital. The Travelers’ Aid for the Sick saw more than 4000 patients last year at a total cost (including all surgery and medical care) of about INR 600000 ($14,000).
The staff at the travelers’ aid office also scans the platforms in search of potential patients from villages in Andhra Pradesh, as well as abandoned children, destitute women and injured travelers.

**Story that inspired Travelers’ Aid for the sick project**

*It was the plight of a young child who moved me to start this programme. I was in a remote village when a young boy of two (Nagaraju) was brought to me by his mother. She explained that the boy had been born without an anus and that her husband and his sister took child to the district hospital for help, but that they had told them to go to Hyderabad. They were frightened and came back to the village. Then they decided that he would die and went to Hyderabad very, very reluctantly.*

*In the bus terminal they met a ‘kindly’ person who told them they looked worried and asked if he could help. He said he knew a hospital where the doctor just ‘loved’ poor, rural people and that he would charge them only a little. He took them to a private nursing home where someone opened the anus in a crude manner. (The correct treatment is to leave the anus as is and put a colostomy or tube connecting directly to the gut.) He then said that the hospital needed what was the equivalent of a year’s wages from the father. He returned to the village and borrowed money from everyone and even sold his little plot of land and his hut. When he realized that he could never pay off the debts, he never returned to the village. When I saw Nagaraju, now aged 2 years, his anus was a mass of scar tissue and fecal material was coming out of his penis and he was nearly dead. I took the boy and went back to Hyderabad with the abandoned mother and child. A pediatric surgeon had to operate three times to save the little boy’s life. I vowed to start our programme to combat the touts who were ruining the lives of innocent village people.*

*Recently, I was standing outside the Mahbubnagar District Hospital when I saw a woman run across the open area next to the hospital. She threw herself into my arms and said, ‘Remember me, I am Nagaraju’s mother. He is now 10 years old.’ What more inspiration can one ask for?*

They direct them to the appropriate public hospitals or call Child Line. The center also provides information to all on basic health issues, stocks condoms and basic medications. Measuring blood pressure and blood glucose, counseling on HIV/AIDS, reproductive health and lifestyle management are all part of the daily routine.

**At the hospital**

A government order (GO) issued to IRHS permits patient counselors to work in all government hospitals. It also allocates to them office space in each hospital to use for record keeping and counseling. Once the patient reaches the hospital, the counselor welcomes each patient and verifies the records she holds with the government issued identity card issued to the family. Each counselor ensures an appropriate consultation with a vetted doctor. The counselors are present during the consultation and note down the doctor’s advice in writing on a predesigned form. The generic names for the drugs prescribed and any tests ordered are also noted. All the information provided to the patient is repeated again to the patient and his questions answered. If the patient is not admitted depending on the requirement, patient is either provided with drugs or counseling or both. The total patients referred last year were more than a thousand. This is fewer than previous years due to the introduction of Arogyasri\(^7\) – government funded health finance scheme for tertiary care in

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\(^7\) Arogyasri is a state funded health insurance for below poverty line citizens in Andhra Pradesh, India for treatment of diseases involving hospitalization and surgery/therapy through an identified network of health care providers
2007. This decline in numbers relates to the nature of the program whereby even small hospitals (especially maternity hospitals) were given the rights to be paid for surgery on poor patients. Hospital administrators saw an opportunity to ‘scout’ for poor patients seeing local doctors or RMPs in rural areas. For a fee, sometimes up to INR 5000 (USD) per case, the local doctor would send a poor patient to a hospital in Hyderabad. Recently, the government has withdrawn privileges from many of the smaller and more unscrupulous hospitals and numbers are now picking up again.

“A man approached us while we were counseling one of our own patients in a cancer hospital. He wanted us to look at his wife’s records and explained that the doctors only looked at the records and never at his wife. We looked at the records and explained that she had a small tumor that had been removed from her neck and that she would probably be all right. He was so delighted you would have thought we had sprinkled fairy dust on him. That’s how we realized the importance on

Counseling

The counselors are trained to be empathetic. In some cases, particularly those involving bad news, the patients are brought back to the head office and the situation is explained to them in privacy and in a way they understand.

After outpatient department closes, counselors proceed to hospital wards where they counsel ward patients about their conditions, the importance of good diet and hygiene. They answer any questions patients or their relatives may have. If they cannot answer the question they will seek the doctor in charge in an attempt to answer that question.

The patient counselors have been trained both in aspects of medicine and psychology. Indian medical doctors and psychologists take weekly classes. They always involve issues in light of the Indian culture.

Head office

The head office at Hyderabad while not directly involved in healthcare is equally important to the whole system. With such disparate working locations, it is necessary to monitor all aspects of the

Drug Provision

If the condition requires medication for a longer duration or is chronic in nature, the medicines are provided every four weeks in the clinics. Each patient is put on a chronic patient’s list (e.g., cardiac) and his medicine is bagged separately and sent to the clinic on a regular basis. All counselors ensure that their patients are provided with the correct medication at all times. The prescriptions are filled by a registered pharmacist (Bachelor’s in Pharmacy) who also maintains all the IRHS medicine purchase using a sophisticated computer program designed to help IRHS remain a cost effective organization.

work and ensure careful and ethical documentation of patient records and supplies. Procurement of medicine at the lowest possible cost and the highest quality is important and to this end IRHS has a sophisticated drug tracking system thanks to a volunteer from McKinsey and Company. Most medicine comes from a nonprofit drug trust, plus two wholesalers. The IRHS, thus spends less than
INR 200,000 ($4500) per year. IRHS is protocol driven. Each and every task has been well documented and subjected to scrutiny by staff, board members and outside experts.

“Weekly meetings with a medically qualified board member ensure administration remains at high level.” To do this, each office staff maintains a list of routine as well as periodic tasks to be done. This “to-do form” was also devised by the same volunteer from McKinsey and Company.

The director is responsible for all funding, working with the board members, human resource management and liaising with local authorities. She is also the clinic’s first line of medical information for patient appointment. She maintains the list of acceptable doctors.

Selection of doctors and hospitals

IRHS has developed its own system of vetting the hospitals and doctors who are crucial to its work. From their three decades of experience, they have extensive information on hospital facilities and capabilities of doctors. The first choice is to send a patient to a government hospital in an effort to teach rural villagers that they can be cured of their diseases without going into debt. Where government hospitals are deficient in services or unable to carry out a necessary operation the IRHS turns to private hospitals.

IRHS is able to use some private hospitals for two reasons -

- The hospital itself has chosen to recognize IRHS and accord it free services
- Aarogyashri has enabled IRHS to access facilities in private hospital provided quality of care meets the high standards of IRHS

Cervical Cancer Control Project

In the district hospital (public) in Mahbubnagar, IRHS runs the state’s only cervical cancer control program located in its own outpatient department. Cervical cancer is the leading cause of death in Indian women, yet the government attempts little to control it. Auxiliary nurse midwives (ANMs) were trained by a specialist doctor at the Institute of Oncology (MNJ Cancer Hospital8). The same doctor has volunteered her services as an advisor since 2001 when the WHO offered IRHS a grant to begin the program after hearing of the pioneering work on cervical cancer carried out by them in the mid-90s.

Using a sophisticated system developed by the WHO, each patient’s cervix is examined using the

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9 MNJ Institute of Oncology is an autonomous and nonprofit Institution under the Government of Andhra Pradesh devoted to improving cancer treatment, prevention, education and research
visual inspection method using both acetic acid and Lugol’s iodine (VIA & VILI). The cervix is examined with a colposcope, a microscope made especially for cervical examinations. A positive reading warrants a biopsy which is taken by an ANM and sent to Apollo Hospital for pathological analysis. The results are conveyed to the patients after two weeks. The INR 150 (3 USD) cost per biopsy is borne by the IRHS. Biopsies positive for a precancerous lesion or CIN, as it is known, are indicative of the need for cryotherapy or freezing of the lesion. The patient is recalled to the hospital where one of the ANMs performs the cryotherapy. This means that the woman will not go on to develop cervical cancer. Part of the team of ANMs goes to a different rural village each week with the same program. Using borrowed space (a school, government building or community hall), women are called for screening. The protocol is identical to that in the hospital (consent form, blood pressure check, counseling, etc.) with one exception. The ANM stops after performing a biopsy in women with positive lesions. If a biopsied lesion is ultimately positive, the villager is recalled to the hospital for cryotherapy.

When the ANMs identify a woman with cervical cancer, they are immediately referred to the patient counselor posted the state’s only public hospital specializing in cancer diagnosis and treatment. Again, the referral system is seamless.

Since 2001 anywhere from 1500 to 6000 patients have been screened each year. There have been no adverse patient events and only one case of severe bleeding which was stopped by the ANMs themselves. One of the world’s leading experts on the technique (from WHO) vetted the ANMs and was impressed by their skill. IRHS cervical cancer screening is the only such program in India completely run by ANMs.

**How is IRHS financed?**

IRHS depends on donations from individuals and two supporting trusts: the Indian Rural Health Trust in the UK (a registered charity) and the Rural Health Studies Trust in the US (a 501(c)(3) organization. The clinic fees charged for consultations and medicine are modest as the medicine is sold at cost and users pay only INR 2 per visit. There are no revenue generation activities at the IRHS. All other programs of the IRHS (Cervical Cancer Control project in the hospital and villages, the Travelers’ Aid for the Sick bus station services and the Patient Counsellor program) are free. The Institute’s recurring expenses for fiscal year 2010-11 were approximately INR 3,000,000 (60000 USD). Patient aid was nearly INR 600000 excluding medicine at INR 200000 (4000 USD). Breaking down the expense by program is difficult as supplies go to all programs. Access to funds is one of the main challenges of the Institute. Without accessing more funds, the ability to serve patients will be diminished as the cost of transport, food and salaries continue to rise sharply.

**What are the replicable components?**

**Paramedics**

Training local people as paramedics and health workers to serve their own rural areas is a cost effective and sustainable way to offer medical help in areas where there are few viable sources of medical care, i.e., most of rural India. Using urban-based office staff for ‘ready reference’ (which includes a panel of specialists who will answer the questions quickly), the clinic staff are able to offer rural patients the added bonus of backup for unusual situations. India has fewer viable Primary Health Centers. Doctors come less frequently or even rarely, the father away they are from the
district headquarters (this has been the experience of IRHS as well as another Indian organization in a coastal district of Andhra Pradesh). A PHC doctor will show up only once in 10 days if he is more than 20 km from the district headquarters. The IRHS offers competent general medical services as well as excellent gynecological care, something few PHCs can match. Both diagnostic tests and medicine are in abundant supply in contrast to most PHCs. Medicine is given in adequate amounts, e.g. a month’s supply of antihypertensives. The staff is punctual and responsive and maintain good records. This included registers for diabetes and hypertension as well as lists for chronic patients with epilepsy, rheumatoid arthritis and cardiac conditions. Again, with less cost, they offer more to rural patients.

Thus, a paramedic/health worker run primary care facility centre with onward referral to tertiary care is a viable alternative to the present situation in India. The cost of running two clinics with all its staff, medicine and lab facilities is less than what the government would pay a single doctor: INR 38000 each month or less than USD 900 per month.

Training

Training is essential if one is using local, untrained, people to run a health center. The majority of training has been oral, backed by written notes made by a series of volunteer doctors and nurses. Today, bi-weekly lectures on aspects of medicine are given by one of the two paramedics to the junior staff. If a volunteer with medical training is there, he may also take one of the classes. Informal teaching is also done during evening clinics when there are fewer patients.

The paramedics are constantly encouraged to keep themselves updated by reading various medical textbooks and treatment protocols. It also helps that the training does not aim towards them becoming full- fledged doctors and is limited to primary care such as that would be given by a doctor with a first medical degree.

The clinic can be compared to the one in medical colleges where treatment and training go hand in hand. Also the doctors on their board are always available in case of emergencies and training needs. This support system is what boosts the confidence of the paramedics.

They are trained to refer to patients appropriately. They do not handle anything that is beyond their expertise. Using the clinic mobile phone means that paramedics can call with questions or, if confident (which is most of the time) simply call with a referral to make an appointment. Basic training would take two years.

Monitoring and Accountability

IRHS emphasizes documentation as the key to sustainability. Documentation brings in accountability which is lacking in the Indian public health system. Dr Pat herself documents patient details when visiting the clinics which reinforce its importance. The training is not abused by the paramedics because of the monitoring and accountability systems in place. Every action is documented and sent for audits to the head office in Hyderabad. Any gaps are discussed and addressed together as a team. Any non compliance of protocols – clinical and non-clinical is not taken lightly by the organization and people are made aware of such a situation. For example, a driver was found to be tampering with fuel bills. He was immediately terminated. Everyone understands they are accountable. At the same time they also know that there is a support system to fall back upon and it
is just a call away. This kind of system is totally lacking in the public sector. A doctor at a primary health centre or a nurse at a sub-centre level does not know who to talk to when a problem is encountered. This brings hesitation in decision making which may have disastrous consequences for the patient. In PHCs, patients are often just ‘bumped’ to the next level. For a rural patient with a small income, this can be a strong deterrent. Accountability combined with a constructive support system is vital.

Supervision

Most supervision involves phone calls. Every morning staff calls the person in charge of their unit. (Dr Pat speaks with clinic staff and bus station staff. The pharmacist/financial person is responsible for speaking to all cervical cancer staff while head of the patient counselor program speaks to each of her staff members.). Random checks are done by asking to speak a person suddenly or asking questions possible to answer only if they are physically present. This kind of stringent system is required for remote supervision. For a larger scale operation a similar system could be implemented by using computer or phone technology.

Referral System

The referral system of IRHS bridges the rural urban divide - something the Indian public health system was designed to do but has not accomplished. The seamless IRHS model is efficient due to the presence of stringent monitoring and accountability. The people participating are accountable for their work, monitored and work together as a team. Apart from the medical training given to counselors, psychological training is emphasized - both on a continuous basis. The public system has proved to be deficient in both training and accountability. An alternative solution could be public-private partnership. The private organization could take over the existing system using the extensive and tested documentation. The monitoring and accountability should remain with the private organization. On the other hand, the public contribution would be in the form of infrastructure and human resources.

Affordable

Given the nature of the system one would assume the care provided would be expensive. But IRHS strives hard to keep the cost down. Using generic medicines, appropriate technology and stringent monitoring measures, the cost of care is minimized. They would rather treat a child than invest in capital assets which would not necessarily increase the productivity or improve care. Today IRHS is in the process of developing a management information system whereby referrals would be uploaded instantly and patient records could be computerized for storage, greater accuracy and easy transferability.

Conclusion

The IRHS trained local rural people as paramedics, health workers, cervical cancer control nurses and patient counselors. Training and supervision have been continuous. The Institute's work offers an alternative model to the existing primary health care system in India. It also provides a model to bridge the rural-urban divide for patients needing to access tertiary care. In the view of the recent debate on the introduction of a program to create a bachelor’s in rural health, this model is worth evaluating.
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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