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ANDHRA PRADESH

**NAANDI FOUNDATION
SCHOOL HEALTH PROGRAMME**



CASE STUDY

2006

SUBREGIONAL OFFICE FOR SOUTH ASIA, NEW DELHI

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FOREWORD

Ranking 127th out of 177 countries, India stands low in UNDP Human Development Index and still confronts a huge and widespread poverty problem. Although there has been a persistent decline in the overall poverty ratio over the last two decades, more than 370 million people are still estimated to live on less than 1 US Dollar a day, with rural areas holding most of the poor. As the biggest democracy in the world, India is still striving to extend basic human rights, including social protection, to all its citizens. Having the largest informal sector in the world, it is estimated today that some 300 million workers and their families are still deprived of any social protection benefit, which accounts as regards access to quality healthcare services to close to a billion people.

While facing this unprecedented level of social exclusion phenomenon, there is growing evidence that India has also taken the lead in fostering and implementing innovative strategies and mechanisms aiming the extension of social protection to all. The Government of India as well as various state governments has demonstrated a wider awareness and stronger commitment to respond to the social protection needs of the presently excluded groups. Trade unions, while increasingly extending their outreach to informal economy workers have also put social protection at the front of their social demands. The corporate sector is now expressing a strong interest in the extension of social protection as a part of the corporate social responsibility principle, while numerous civil society organizations are supporting community-based micro-insurance schemes that now proliferate all across India.

The diversity and scope of these initiatives in a country as big as India already represent a unique experience. This uniqueness is further enhanced since, while trying to bridge the social protection gap, India has also experimented with various ways allowing the excluded groups to benefit from some redistribution mechanisms that contribute under the national responsibility principle to the achievement of the over-arching goals of social justice and human-rights promotion.

This wide array of new experiences contributes in a big way to ILO's Global Campaign for Social Security for All. The ILO, with the assistance of the STEP (Strategies and Tools against social Exclusion and Poverty) programme therefore launched in the year 2003 a series of studies to identify and document the various types of initiatives and to recognize the best experiences that could be replicated in India and other countries for further extension of social protection.

In 2003, the ILO/STEP programme conducted a very first national inventory of micro-insurance schemes operating in India, which is presently being updated. This exercise was followed by various case studies which put a stronger emphasis on health, since health protection is the first priority for workers in the informal economy. This priority is also in line with ILO's interventions, medical care being regarded as the primary branch of social security since health is a concern to all groups and categories of workers.

For ILO and its development partners, health micro-insurance has an important role in local and, eventually, national development. It can promote the participation of communities in ways that go well beyond their financial contribution. It can serve to enable communities to become more aware of their health situation and to organize collective action accordingly, including activities to increase prevention, education and promotion. Moreover, by enabling members to

interact with providers as a group rather than as individual consumers, health micro-insurance can increase the voice of the population vis-à-vis the providers of services. In a development context, this characteristic is instrumental in bringing about the more important long-term effects of quality services. Furthermore, in a country such as India, where there is now a critical mass of community-based schemes and where these have started to organize into networks, it is already apparent that health micro-insurance has increased the voice of the poor and is beginning to influence the policy and legal context that governs social protection.

However, much more advocacy is still required to facilitate this process in order to achieve a more significant impact on the lives of the many poor. Since there could be no advocacy without evidence, the ILO has been increasingly engaged in the development of evidence-based knowledge on health micro-insurance and other demand-side health financing mechanisms. In parallel with new case studies being carried out, the ILO has also developed a multi-partnership approach that allows for the regular flow of additional relevant information that can then be processed into broader studies or into narrower information papers focusing each on a specific aspect of the health protection experiences.

Recognizing that the setting up of efficient and sustainable health protection schemes that may be organized in many different ways is much more challenging than some other protection mechanism, the ILO recently developed a new model of case study that fosters the development and application of more technical knowledge. These new case studies have the main following characteristics:

- ❑ They highlight the key features of the scheme in terms of operational mechanisms, performance indicators, evolution profile and development plans
- ❑ They provide, while looking at the evolution and situation of the scheme, an in-depth analysis of all data available
- ❑ They include the various support documents that may be deemed necessary to facilitate a possible replication of the scheme

The present document provides an example of this new knowledge development approach applied to health protection case studies.

CONTENTS

Executive Summary	1
Introduction	3
I. Background	
1 National Policies and Programmes	7
2 Andhra Pradesh Situation Account	8
II. Naandi's Answer Strategy	
1 The Education Programme	11
2 The Need for a Comprehensive Health Scheme	13
III. The School Health Programme	
1 Embarking in a Unique Strategy	19
2 Implementation Framework	22
3 From Strategy to Action	23
4 Organization and Functioning	25
5 Financing	30
IV. Performance Analysis	
1 Services	35
2 Costs	37
3 Subsidies	39
V. Impact Assessment	
1 Improvement in the Quality of Life	43
2 Knowledge and Health Behaviour	43
3 Scale Up	44
VI. Conclusions and Recommendations	
1 Conclusions	47
2 Recommendations	49
Annexures	
Annexure 1 Main Health Problems Affecting Children (State Health Programme)	53
Annexure 2 Source of Treatment for Children Prior to the Mela	54
Annexure 3 Information of Ministry of Education Officials	55
Annexure 4 Memorandum of Understanding - NICE Foundation	56
Annexure 5 Memorandum of Understanding - Shalini Hospital	59
Annexure 6 Memorandum of Understanding - Care Hospital	61
Annexure 7 Health Camp Information Report	63

Annexure 8	Information Leaflet	64
Annexure 9	Membership Card	65
Annexure 10	Hospital Referral Slip	66
Annexure 11	Student Details Form	67
Annexure 12	School OP Clinic Record Book	68
Annexure 13	Example of Morbidities Being Treated at the Base Hospital	69
Annexure 14	Giving a Future to a Young Girl: Anusha's Story	70
Annexure 15	Brief on Promoters	72
Annexure 16	Physicians / Specialists Supporting the Programme	73

LIST OF TABLES

1	Health Camps' Institutional Support	20
2	Distribution of OP Clinics	23
3	Partnerships Developed with Associated Hospitals	24
4	Distribution of Secondary Healthcare Services	28
5	Most Common Chronic Diseases Observed among Children	35
6	Most Common Acute Diseases Observed among Children	35
7	School Health Admission in Base Hospital: February 2005 – May 2006	36
8	Type of Surgeries Performed: February 2005 – May 2006	37
9	Monthly Costs – Out Patient Care	37
10	Monthly Costs – In Patient Care	38
11	Monthly Costs – Specialty Care	38
12	Cost per Child per Month	38
13	Main Features of the Scheme as Compared with UHS	48

LIST OF FIGURES

1	Benefits Provided by the Scheme	22
2	Service Delivery Planning at OP Clinics Level	26
3	Operation Chart	29
4	Distribution of responsibilities	31
5	In Patient Services utilization Profile	36

LIST OF BOXES

1	Most Common Diseases Affecting Children	8
2	Target Population Profile	12
3	Support to Services Provided by OP Clinics	26

LIST OF ABBREVIATIONS

AP	Andhra Pradesh
APSHP	Andhra Pradesh School Health Programme
CAH	Child and Adolescent Health
DEO	District Education Officer
DFID	Department for International Development
ECL	Ensuring Children Learn
ERG	Education research Group
GBPS	Government Boys Primary Schools
GGPS	Government Girls Primary Schools
GHS	Government High Schools
GPS	Government Primary Schools
GUPS	Government Upper Primary Schools
HIV/AIDS	Humane Immune Virus/ Acquired Immune Deficiency Syndrome
ICU	Intensive Care Unit
IP	In Patient
MOU	Memorandum of Understanding
NICE	Neonatal Intensive Care & Emergencies
NSS	National Sample Survey
ODA	British Overseas Development Agency
OP	Out Patient
ORS	Oral Rehydration Salt
SHP	School Health Programme
SSA	Sarva Shiksha Abhiyan
STEP	Strategies and Tools against social Exclusion and Poverty
TB	Tuberculosis
UHS	Universal Health Insurance Scheme
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
WHO	World Health Organization

Districts of Andhra Pradesh



EXECUTIVE SUMMARY

The School Health Programme is a unique and replicable model for delivery of essential healthcare services to underprivileged children in the country. Using the government school system as a means to reach to this section of the population, Naandi Foundation provides 60,000 government school children in Hyderabad with quality health services right within their school, at zero cost to the family.

- ❑ It has been recognized worldwide that an effective school health programme has a significant bearing on the academic achievement and overall development of students, and in turn the effective operation of schools. However, the limited interventions, data and research on morbidity patterns in children of 6-14 years, proves the lack of any coordinated efforts to this end
- ❑ Naandi Foundation has pioneered in 2005 a comprehensive health programme for 60,000 children studying in 289 schools in the city of Hyderabad
- ❑ The programme was piloted with the objective of studying the common disease patterns in this age group and arriving at a minimal cost at which comprehensive medical and preventive health services can be provided to the children
- ❑ Naandi's school health programme operates through a school based OP clinic which has been set up in nodal government schools, and has a Paediatrician visiting every alternate day during school hours for examining the children and providing medicines
- ❑ Clinics have been set up in strategically selected locations such that children from the neighbouring schools can easily access during school hours. Also distribution of clinics is proportionate to the number of children that it serves
- ❑ A dedicated base hospital with round the clock in patient department and toll free number connectivity has been set up to respond to the in patient care needs of these children. Diagnosis, investigations, medicines, surgeries, hospital stay and food for the patient and guardian - are all provided here at zero cost to the child
- ❑ While the base hospital takes care of most of the conditions, specialty cases such as neurology, gastroenterology, cardiac, eye, etc. are referred to tertiary care hospitals in the city
- ❑ What makes this programme really unique is the kind of partnerships that have been forged to provide high quality multi-specialty care to the underprivileged children at a very minimal cost. Private and trust hospitals and individual medical professionals have been inspired to come together as philanthropists to provide their expert services to children at subsidized or zero costs
- ❑ The result of this has been a unique health security net for poor children of Hyderabad that provides diagnosis, out-patient care, in-patient care, investigations, specialty consultations, surgeries and medicines all covered at the cost of Rs. 10 per child per month
- ❑ No other private or other insurance scheme has been able to match this programme in terms of cost or coverage. The programme is able to provide care from common cold to cardiac surgery, of a quality at par with that accessed the more privileged society

- ❑ Unlike other insurance schemes, the school health programme does not disqualify any child with any disease, including HIV/AIDS, and covers pre-existing illnesses as well. The only condition to be fulfilled is to enrol in a government school and attend regularly
- ❑ Apart from promoting schooling among these sections of society it also ensures a healthier student, and a more productive adult in years to come
- ❑ This scheme also has the scope for re-vitalizing government facilities as centres for quality health services, and urge local private/corporate firms to contribute to the programme
- ❑ Immediate outcomes of this pilot have been the interest expressed by several other state governments in the country to run school health programmes for their children, with a willingness to share half of the costs
- ❑ The scheme is already being replicated in Udaipur district of the state of Rajasthan wherein a wing of a maternity hospital has been dedicated to this programme, and will become a functional referral centre offering quality health services to government schoolchildren
- ❑ Naandi is exploring a multi-district partnership with the state government of Andhra Pradesh to implement this programme in urban, rural and tribal settings and thereby prove the viability of this strategy in any part of the country
- ❑ The Hyderabad model is unique owing to its proximity to Naandi headquarters. Naandi enjoys significant credibility among the local medical fraternity and thus has inspired philanthropy among many local doctors and hospitals. Establishing the school health programme in any other location - urban, rural or tribal will escalate the cost per child to some extent, where such high subsidies may not be available, and cost of specialty care will need to be included in the overall costs

I. INTRODUCTION

“An effective school health programme can be one of the most cost effective investments a nation can make to simultaneously improve education and health” - WHO Director General, April 2000

Education has been declared a human right, the denial of which can lead to “loss of potential and productivity” for an individual. But nearly 1 billion people or a sixth of world’s population, are illiterate. Moreover, UNICEF State of World’s Children 1999 report points out that 130 million children in the world are still denied this right - almost two thirds of them are girls. More basic than education is the need to be literate. Illiteracy afflicts the lives of children in coping with the challenges of society as adults. It impairs their ability to lead a financially stable and socially fulfilling life in terms of access to everyday opportunities to learn, grow and progress.

However, education does not function in isolation. There is worldwide consensus on the importance of education in relation to health and general well being of a child. The UNICEF report emphasizes “the unmistakable correlation between education and mortality rates”¹. The benefits of schooling are proved through a better social status, income, knowledge and skills, although there are not demonstrated immediately due to the time gap between commencement and completion of schooling. A healthy, happy schoolchild, on the other hand, can be an immediate and visible demonstration. Thus, health could be used very effectively as a tool to promote schooling. The reverse has also been proved especially in developing countries where fertility rates have been found to decline with rise in literacy, thus establishing that access to education can in turn improve health.

Even though access to health services has long been declared as a right of the child by several countries across the world, this has yet not been translated into positive action. As declared by the Office of the Human Commissioner for Human Rights, all State Parties made the convention that each child will enjoy the “highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. State Parties shall strive to ensure that no child is deprived of his or her right to such health care services².

Moreover, they also convened to “recognize for every child the right to benefit from social security, including social insurance”³ and shall take the necessary measures to achieve the full realization of this right in accordance with their national laws. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for maintenance of the child. However, in most countries any positive action in this direction has been patchy, if at all.

¹ A 10 percentage point increase in girls’ primary enrolment can be expected to decrease infant mortality by 4.1 deaths per 1,000, and a similar rise in girls’ secondary enrolment by another 5.6 deaths per 1,000. The State of World’s Children Report 1999; Education for All – Making the Right a Reality. Chapter 1, pg 7.

² Preamble to the Convention on the Rights of the Child – Article 24

³ Preamble to the Convention on the Rights of the Child – Article 26

World Health Organization has envisaged a unique role for schools to promote health. With more children than ever receiving a formal education, schools are an efficient way to reach school-age youth and their families in an organized way, and to ensure the individual growth essential for national development⁴. A report compiled by World Health Organization lists the “diseases of concern among young people” as the prime cause of mortality: intestinal parasites, malaria, schistosomiasis, tuberculosis, etc. Apart from these, it also mentions “conditions and lifestyles affecting health”: Injuries, depression and suicide, tobacco and substance use, excessive alcohol drinking, nutrition, fertility, unhealthy sexuality etc. These are more likely to occur in the age group 11 - 19 years.

⁴ Birdthistle I, 1999, « Improving health through schools : National and International Strategies », World Health Organization, Introduction, Pg 5

I. BACKGROUND

1. National Policies and Programmes

All over the world, various initiatives have been underway by the Ministries of Health and Education and non-governmental organizations to improve health through schools. The case of India is particularly pertinent in this regard. As early as 1960, the Government of India formed a School Health Committee to assess the standards of health and nutrition of school children and suggest ways to assess these standards. Since then, many state governments have provided funds for school health and school meal programmes. Despite these measures, school health services in India remain inadequate owing to shortage of resources and insufficient facilities.

The responsibility for school health in India is shared by various agencies. Among these, the prominent ones are: The Ministry of Health and Family Welfare, Ministry of Human Resource development, National Council of Educational Research and Training, Central Board of Secondary Education, State Health Education Bureau etc. This lack of ownership of the responsibility by any single body or department has led to a complete neglect of the programme, not only in terms of attention, but also human and financial resources.

A review of the national health programs being implemented in India will reveal there are schemes/programmes with dedicated resources and implementation guidelines, keeping in mind specific age groups - reproductive and child health program for young couples, pregnant women and mothers and their babies; Integrated Child Development Scheme for children under five years; sexual health and life skills programmes for adolescents; post menopausal women and senior age group as well. What has been missed is the school-going child. Some individual states have overcome this by conducting periodic school screenings and providing a voucher to the child for referral care at public hospitals. However, without proper follow up of children needing immediate care and with the deplorable condition of state run hospitals, simply screening the children does not improve their condition in any way.

That there is a dire need for initiatives and investment in school health is reflected in the National Health Policy 2002. Recognizing that education and health have a fundamental relationship that determines a child's performance at school in terms of attendance, academics and acquisition of knowledge, the policy envisages giving priority to school health programmes which aim at preventive-health education, providing regular health check-ups, and promotion of health-seeking behaviour among children. The policy also states that school health programmes can gainfully adopt specially designed modules in order to disseminate information relating to 'health' and 'family life'. This would improve the level of awareness, not only of the extended family, but the future generation as well.

The Policy also mentions, "a social health insurance scheme with government funding and service delivery through private sector may be an appropriate solution. However, the administrative and financial implications of such an initiative are still unknown". This emanates from the lack of statistics and data or reliable baseline information on the health problems of the five plus age group.

There has been a gap in identifying and addressing the health problems of children who survive the early childhood health challenges and reach the age group of 5 and beyond. *Child and Adolescent Health and Development* Unit (CAH) of the World Health Organisation has recently begun to review and analyse the data related to child health and illnesses in the age group of 5 to 9 years. They will include not only morbidity and mortality indicators but also

health and social issues that may affect health and development, and which need to be addressed with a public health response.

Box 1. Most Common Diseases Affecting Children

According to the Child & Adolescent Health and Development (WHO), children's health is affected by a variety of illnesses, the more common ones being: growth and nutrition; conditions resulting from pollution; parasites; blood disorders; infectious diseases; cardiac and respiratory diseases; accidents and injuries; skin diseases; sensory diseases; neurological diseases; congenital conditions; substance abuse; oral health; and mental health.

The need to address poor health of children has never been more urgent. In the face of debilitating diseases such as HIV/AIDS, it is important that the children of today are strong in health status and are conscious of their own well-being. Access to education, nutrition and health are imperative in order to ensure that the children of today become a healthy and productive workforce tomorrow.

2. The Situation in Andhra Pradesh

Andhra Pradesh, the fifth largest state in India (both in area and population), constitutes about 7.3% of India's population. There are 7,564,000 children enrolled at the states 52,769 primary schools in the state. In spite of the rapid development in information technology and other sectors in the capital city of Hyderabad, 40% of its population (over 3 million) remains illiterate and resides in slums located in extremely unhygienic surroundings⁵

A case in point here is the Andhra Pradesh School Health Project. Launched in 1992, the APSHP was a result of collaboration between the Government of Andhra Pradesh and the British Overseas Development Agency (ODA) for 7 million school children living in the state. The implementation of the project was to be integrated with that of another ODA programme, the Andhra Pradesh Primary Education Project. The project aimed to improve screening and referral of children by health workers for a wide range of health problems. It also aimed to provide schools with first aid kits and to enable health workers to train teachers in health education and first aid. However, the project had to be terminated due to factors like un-organized screening and referral of children in schools, inefficiency of teachers as health workers in using first aid kits and faulty needs assessment of children by planners. Apart from these, no pilot studies were conducted to establish the viability of the programme. Also, the programme design being complex required unhindered coordination of various agencies, which did not happen. A valuable lesson on proper programme planning, piloting and monitoring can be learnt from this project.

The screenings conducted by the Andhra Pradesh School Health Program provides data on common diseases found among children from 3 districts of the state, namely, Guntur, Kurnool and Nalgonda. The estimated incidence of these conditions has also been provided (see Annexures 1 and 2).

⁵ www.education.nic.in/janshala/andhra.pdf

II. NAANDI'S ANSWER STRATEGY

1. The Education Programme

Naandi⁶ Foundation is an autonomous, not-for-profit trust dedicated to changing lives of the under-served populations in India through public-private partnerships. Set up in 1998, Naandi's mission is create innovative alliances between state governments, corporates and civil society so that together innovative strategies to eradicate poverty are created and implemented to improve the quality of life of marginalised communities - farmers, tribals and children.

Under the banner of Child Rights, Naandi, in partnership with the state government of Andhra Pradesh, has been providing quality education and nutrition to the states' school children. Naandi began its quality education initiative, the "Ensuring Children Learn" programme in the city of Hyderabad with only ten government schools in the year 2002.

This first effort was multiplied by members of civil society and corporate institutions such as Dr. Reddy's Laboratories, Microsoft, Visaka Industries, Member Companies of ANCHAM Hyderabad and AP State Transport Corporation, who came up to champion the cause of quality education in government schools. Not only did these organizations contribute financially but their employees also participated in school events on a regular basis, sharing their problems, giving a voice to their needs and thereby encouraging teachers and children.

The focus of intervention in this pilot programme was on creating the right learning environment in schools by making sure basic facilities are in place, by encouraging innovative teaching, promoting extra curricular activities and nurturing creativity among children. Components of "Ensuring Children Learn" were strategized along the lines of the Sarva Shiksha Abhiyan (SSA) and operate within the state's education structure. Naandi's in house Education Research Group (ERG), consisting of experienced educationists, designed the programme to meet various educational challenges and guarantee literacy, numeric and comprehension skills in the elementary school child, through teacher training, academic support to the child, in giving drab government schools a complete makeover, involving the community and parents⁷.

The schools were given the much-needed uplift in no time, creating a furore in the arena of public education, catching the attention of the state, which then came forward with a formal partnership with Naandi Foundation to upscale this pilot programme. The partnership agreement with the government of Andhra Pradesh allowed Naandi to work in 289 government schools in the city of Hyderabad, in 5 continuous Mandals (blocks), covering 60,000 children from classes I to VII (age 6 to 14 years). 70% of the necessary funds were allocated by the State while the remaining 30% was derived from a diverse mix of contributions from individuals, corporates and bilateral institutions, as described below.

Supporting Naandi in this initiative was the Department for International Development, the social wing of the government of United Kingdom. Through a series of dialogues and presentation on the proposed programme objectives, the DFID entered into a one-year partnership with Naandi for this pilot programme, providing financial and technical support for the period 2004-2005.

The extended education program named "Ensuring Children Learn" (ECL) included:

⁶ 'Naandi' – a Sanskrit word meaning 'a new beginning'

⁷ Naandi Foundation, Annual report 2003 - 2004

- ❑ Direct academic support to the child to achieve grade specific competencies
- ❑ Support to teachers, in terms of teaching learning material and innovative methods of teaching
- ❑ Community level activities to involve parents in their child's learning process
- ❑ Material and academic support to girls enabling them to continue schooling

Box 2. Target Population Profile

- ❑ Project Location: Old City Area, Hyderabad District, State of Andhra Pradesh
- ❑ Administrative Sub-divisions Covered: 5 Mandals (Asifnagar, Bangladuba, Golconda, Bahadurpura and Shaikpet)
- ❑ Number of Slums in the 5 Mandals: 160 approximately
- ❑ Number of Children Covered: 60,000
- ❑ Children Covered by the Scheme as of % of Total Children Studying in Government Schools: 28%
- ❑ Girl Children as a Total Children Covered by the Scheme: 57%
- ❑ Number of Government Schools Covered by the Scheme: 289
- ❑ Schools Covered by the Scheme as a % of Total Government Schools: 30%
- ❑ Urdu Medium Schools as a Percentage of Schools Covered by the Scheme: 63%

All 289 government schools selected for the program are located in the old part of Hyderabad city popularly referred to as 'old city'. Selected in consultation with the government, these schools are located in 5 'Mandals' that are known to be very poor and congested. These schools cater largely to children of urban slum dwellers who live in extremely unhygienic surroundings putting children at high risk.

The five selected Mandals- are largely Muslim-dominated areas with 63% Urdu medium schools. The Muslim community in Andhra Pradesh (AP) fares poorly in terms of socio-economic indicators. A recent study conducted by the Commissionerate of Minorities Welfare reveals that 65 percent of working Muslims in AP earned less than Rs 11,000 a year and were either self-employed or working in workshops, or as artisans. It also showed that the literacy rate among Muslims was only 18 per cent as against 44 per cent among other communities as per the 1991 census. Muslim women were worse off at four per cent literacy.

The profile of students covered under the programme includes vast numbers (over 57%) of under-privileged girl children. It is indeed noteworthy that the number of girls attending government schools in Hyderabad exceeds the number of boys, a vivid testimony to existing gender differences in parental investment. Interactions with the community reveal that if they have some funds, parents send their boys to private schools.

Prior to starting the education programme, an analysis of the poor quality of elementary education in the city and state revealed the following:

- ❑ Low levels of learning and achievement: A significant proportion of children in the city's government schools go through elementary classes learning little. Recent research studies reveal that 50% of children in school in the 3rd standard level cannot write or comprehend what they read

- ❑ Alarming dropout rates: While 81.4% of children between 6-14 years in Hyderabad are reportedly enrolled in school, the dropout rates are as high as 40% between classes 1-7.
- ❑ Poor parental/community involvement: 53% of school dropouts stated that it was their parents who decided that they should discontinue their education. Parents' attitude has been conclusively linked to poor learning outcomes displayed by children who have been attending schools for several years and have yet, learnt very little.

In addition to the education programme, a nutritious mid day meal is also being provided to all the children in the city (130,000 in total) each day for the last 3 years. The meals are cooked most hygienically in a central kitchen, conform to the nutrition and calorie requirements for a child, and are supplied to the schools during the school hours. For many children, this is only meal of the day. Thus, with the Mid Day Meal that Naandi was already supplying in all government schools of the city, each child was provided with the right nutrition and an improved learning environment within the school.

With quality education and nutrition being ensured to children in government schools, Naandi planned to provide yet another basic necessity of life that these children had been deprived of - the right to good health.

2. The Need for a Comprehensive Health Scheme

During the course of the ECL program, the education team at Naandi observed frequent absenteeism and a generic low-energy index among children. This was due to general ill health and lack of efficient treatment for the children who primarily came from lower socio-economic backgrounds. Of the 60,000 children enrolled in the education programme, a majority lived in high-risk environments that increased their susceptibility to malnutrition, worm infestations, skin ailments, dental problems and congenial deformities in some cases. Some persistent conditions led to growth retardation, treatment for which went beyond their reach. Through observations at the government schools in which quality education is in process, Naandi Foundation identified some fundamental obstacles to a child enjoying the basic right of good health:

- ❑ A generic prevalence of ill health among the children, making them more susceptible to disease
- ❑ Timely medical care neglected in the household the children come from. As a result, most illnesses are diagnosed late, if ever
- ❑ The cost of treatment becomes prohibitive for poverty-ridden families
- ❑ The existing health insurance schemes are not completely customized to meet the preventive, promotive and curative needs of government school-going children.

Even when they came to school, the inattentiveness of the children and poor comprehension was palpable, not just by teachers but any visitor to the school. Seeking medical care was also not in the hands of these children. Given the economic condition of the families, the child's illnesses were mostly ignored, being a non-earning member of the family. The situation was far worse in the case of a girl child. Very often late diagnosis would lead to further complications, and hence increased cost of care.

Despite these established facts, there is no state health programme designed specifically for the age group 6-14 years. This age group is neglected to the extent of there being no indicators (national or international) for measuring their health status.

In addition the school environment was also found conducive to ill health:

- ❑ 33% of students did not have access to toilets
- ❑ 56% of students have no access to drinking water
- ❑ 65% of students have no access to electricity

Resource scarcity and poorly maintained facilities negatively affected the health of children, apart from instilling motivation levels among students, teachers and parents to even attend school.

The general ill health of school children undermined the efficacy of Naandi's education initiatives to a great extent. It became imperative then, to ensure that health needs of children were attended to, before they could be regular at school. Furthermore, the failure of the state sponsored school health program had left nothing for these children to turn to when in need of health care. Experience and empirical data convinced Naandi that the age group of 6-14 years warrants special attention to their health and nutritional status combined with access to education and skill development to ensure a healthy and productive work force for the country.

While providing a new face to the government school buildings, close attention was paid to ensure that children had access to safe drinking water and clean toilets in school. Whether it was restoring the existing toilet facilities or building complete new toilets, Naandi ensured that these basic needs were fulfilled. Not only did this impact the attendance in school, but also brought a huge number of girls back into school and ensured that they stayed for the entire day.

Responding to an urgent need expressed by most of the schoolteachers, Naandi provided all schools with a First Aid Kit. These boxes were tailor made according to the requirements of the school, to be useful for minor injuries, fever, vomiting or diarrhoea. They contained items commonly needed for children, such as bandages, an antiseptic, cotton wool, scissors, dressing pads, ORS sachets, etc. The box also had a nail cutter, which the teacher used while talking about self-hygiene to the children. Medicines (except Paracetamol 125 mg) have been deliberately excluded to prevent teachers/children from giving/taking prescription drugs, without prior advice from a medical practitioner.

Emergencies or accidents, no matter how minor and simple, require a deft hand to handle them correctly. Learning first-aid is a civic responsibility of each citizen, and so, along with a first-aid box, the teachers must also have the knowledge of basic first aid to be better equipped to handle minor injuries/incidents in school. For this purpose, Naandi invited St. John's Ambulance Association to conduct a 5-hour demonstration programme on first-aid for its Mandal coordinators. The facilitator provided theoretical inputs, and also made practical demonstrations with the help of a dummy. Naandi's Mandal coordinators (field staff) then shared this information with the schoolteachers during their visits.

School health clubs have been formed in the government schools, comprising of older children (class IV onwards). Club members hold the responsibility of maintaining the surroundings and keeping the school environment clean. The end result expected from this was that children would translate this learning in school to their homes and communities.

Having addressed the preventive and promotive aspects of health, it became imperative to introduce curative services to make the programme a holistic one. This was also an urgent need expressed by many teachers in school, since a huge number of children suffered from

acute and chronic conditions, while being too poor to access medical care. Uneducated and unaware parents would often visit a quack for a quick remedy, resulting in further complications, and finally have no resources to take the child to a government hospital. With a view to provide a comprehensive health coverage for underprivileged children in government schools, Naandi decided to design a new health protection programme that could only be accessed by children enrolled in government schools. This would also be a very effective tool to promote schooling and also ensure that the most needy and deserving child benefit from it.

III. NAANDI'S SCHOOL HEALTH SCHEME

1. Embarking in a Unique Strategy

Spearheaded by Naandi's Chief Executive Officer, Mr. Manoj Kumar, and a renowned Paediatrician, Dr. Padmanabh Reddy⁸, a series of consultative meetings were held with several health care providers and health financing agencies around the state and country, to arrive at a scheme that would offer a blanket health cover to children (6 to 14 years old) that would underwrite health care expenditures from common cold to cardiac surgery.

This programme was also going to redefine "school health" - as all earlier definitions of school health included only promotive and preventive healthcare. This section from the National Health Policy - 2002 illustrates the definition of school health:

"... Envisages giving priority to school health programmes which aim at preventive-health education, providing regular health check-ups, and promotion of health-seeking behaviour among children. The school health programmes can gainfully adopt specially designed modules in order to disseminate information relating to "health" and "family life". This is expected to be the most cost-effective intervention as it improves the level of awareness, not only of the extended family, but the future generation as well"

The School Health model was developed in house with a team of experts including economists, neonatologists, business leaders and social workers. The model was floated in discussions with insurance agencies, community based organizations and medical professionals before it took its final shape at the end of October 2004.

The process involved interactions with various agencies at multiple levels. Reaching out to all of them was a challenge. Before the programme could be implemented even as a pilot scheme, it was essential to co-ordinate with actors at the internal, administrative and community level to facilitate a systematic administration of quality healthcare services. From the very inception phase, Naandi recognized the necessity and adopted this broad multi-partnership approach.

Learning from the state-led school health programme that had to be discontinued, it was important to have thorough information to start with. This baseline would help to conclude on:

- ❑ A database of all children - with their personal profiles and medical history
- ❑ Common illnesses affecting this age group and in particular, in this section of population of the city of Hyderabad
- ❑ Frequency (or sheer number of children affected by each disease)
- ❑ Range of services that would be required - each of primary, secondary and tertiary level care, which would eventually decide the requirement of various specialty doctors
- ❑ Cost - this was the most essential question that needed to be answered, before the scheme was launched. Arriving at a nominal cost for providing a cover for all children in this age group could pave the way for a national policy that ensured the health of every child in school

Health camps in nodal government schools were one way of obtaining this information. Each camp needed to capture the personal details of the child, his/her photograph and their medical history in certain key areas. The planning began weeks in advance involving several departments

⁸ Annexure 14 – Note on Manoj Kumar and Dr. Padmanabh Reddy

from within Naandi - education team, school health team, IT/Systems department, Civil Society Cell, Commercial and Administration.

At the school administrative level, permissions were sought from the District Education Officer (DEO)⁹ to spread the word about school health camps. Separate sanctions were needed from the school authorities. Through dialogue and persuasion, the head masters/mistresses were convinced of the absolute necessity of a school health programme and their cooperation during the camps. Usually resistant to change, government school authorities tend to be suspicious of an initiative of this magnitude. Hence, getting their buy-in was crucial for a programme that was literally housed within the school.

At the community level, Naandi reached out to parents of the targeted children through meetings organized by School Education Committees. This involved undoing rigid mindsets and preconceived notions associated with schooling. Coming from lower socio-economic sections of society, these parents perceived school education to be of little use, perhaps as opposed to doing real time work. They also had misgivings about free health care as their earlier experience with government programme benefits had left much to be desired. Making parents understand the idea of promoting schooling through providing for health was a significant accomplishment in the pre-implementation process.

Support from Civil Society members was also enlisted for manpower support during the health camps. Software employees who had been associated with Naandi's education programme came forward to assist in designing the application for the data base that would store the information of thousands of children. Other volunteers in the health camps were college students, housewives, community youth, retired government teachers, etc.

Rigorous networking and liaison was undertaken to bring in doctors, specialists and health organizations that would volunteer their time and render service during camps. Working under a tight budget it became imperative to request for support from doctors. Reputed organizations such as the following extended their full support and time for these children:

Table 1. Health Camps Institutional Support

S. No	Institution	Support Rendered
1.	LV Prasad Eye Institute	2 Eye Technicians in every camp
2.	FMS Dental Hospital / Sai Dental College	2 Dentists per camp
3.	Shalini Hospital	4-6 Paediatricians per camp
4.	Andhra Pradesh Oral Health Association	Colgate toothpaste and toothbrush for each child in the camp.

The health camps required micro planning and skilful coordination with a target of 1,000 children to be covered on each camp day. The logistical aspects of these camps was one of the most challenging parts of the entire programme, and was also the component that contained the most room for errors in planning. Since all 289 government schools did not have the space or the infrastructure to hold a daylong camp, schools needed to be clustered into small groups and one among them would become the nodal school. The camp was to be held in this nodal school, and the children from cluster schools were to come to this nodal school on the camp day - either on foot, or in the vehicle that was organized for them.

⁹ Naandi obtained the DEO's signatures on a letter to get the go-ahead to start the campaign. In this regard, a brief orientation programme was conducted for MRPs, DRPs, DIOs and DyEOs on 27 October, 2004. See Annexure 3.

Choosing these nodal schools for each camp was a very challenging task, with so many parameters to be met. The Mandal coordinators (field workers), programme officers of Naandi, and the consultant paediatrician visited several schools and held lengthy discussions to finally arrive at the choice of school. The criteria for selection was a school with adequate infrastructure to hold a large number of children at one point of time, that could be easily accessed by the neighbouring schools and where the teachers and principal were willing to extend their cooperation. Thus, several school clusters and camp dates were finalized on day with no holidays or examinations, or religious festivals/customs, to check low attendance in the camp.

The flow of the camps was as follows:

- ❑ Classrooms in the nodal school were temporarily set up as mini-clinics - 6 contiguous rooms were set as follows: registration counter, height/weight room, paediatrician room, dentist's room, eye check and finally a counter free Colgate toothbrush and paste for each child
- ❑ A day prior to the camp, teachers were provided with student slips¹⁰. The teachers filled out the personal details of each child, such as date of birth, parent name, address, identification marks, etc.
- ❑ On the day of camp, each child carried his or her student slip to the registration counter. Here, desktop computers were set up each with a digital camera fixed on it. A photograph of the child was taken and a unique number was generated for each child. This number was written off out on a medical screening form¹¹ and the form was handed over to the child. This form carried various sections to be filled out by each doctor
- ❑ The child entered the next door where his/her height, weight, and mid-arm circumference were recorded and put down on the form
- ❑ The child then moves to the paediatric counter, where he/she underwent a general and systemic examination
- ❑ At the dentist counter, an overall check of cavities, oral hygiene-plaque/scales, and malformations - was done and recorded
- ❑ Next the student's eyesight is checked with a distance test and a torch light exam.

At each stage, volunteers helped and guided the children into sequenced counters. Maintaining the flow of children through the camp was necessary to ensure that all children were covered at the end of the day (9 A.M to 2 P.M) - approximately 1000 children per camp.

Each child submitted their filled out screening forms to a volunteer at the end of the sequence of examinations and was handed a Colgate toothbrush and paste. This added feature was to attract more and more children to the camp.

The health camps were finally completed in the month of February 2005, with all the vacations, public holidays and examinations in between. At the end of each day of camp, the data of each child was entered into the system.

What resulted at the end of 5 months of rigorous work was a huge wealth of information of all children - the medical details of each child along with their personal information. The data also provided the disease profile of these children, revealing that dental problems (35-40%), worm infestations (20-30%) and malnutrition (10-15%) among children were undetected and untreated, among many other conditions such as cardiac diseases, respiratory tract infections, vision

¹⁰ See Annexure 11

¹¹ See Annexure 7

defects, etc. This information was used to make an estimate of the disease load and approximate percentage of children requiring out patient and in patient care services. Also, how often these services would be needed, which finally led to the cost of providing these health services.

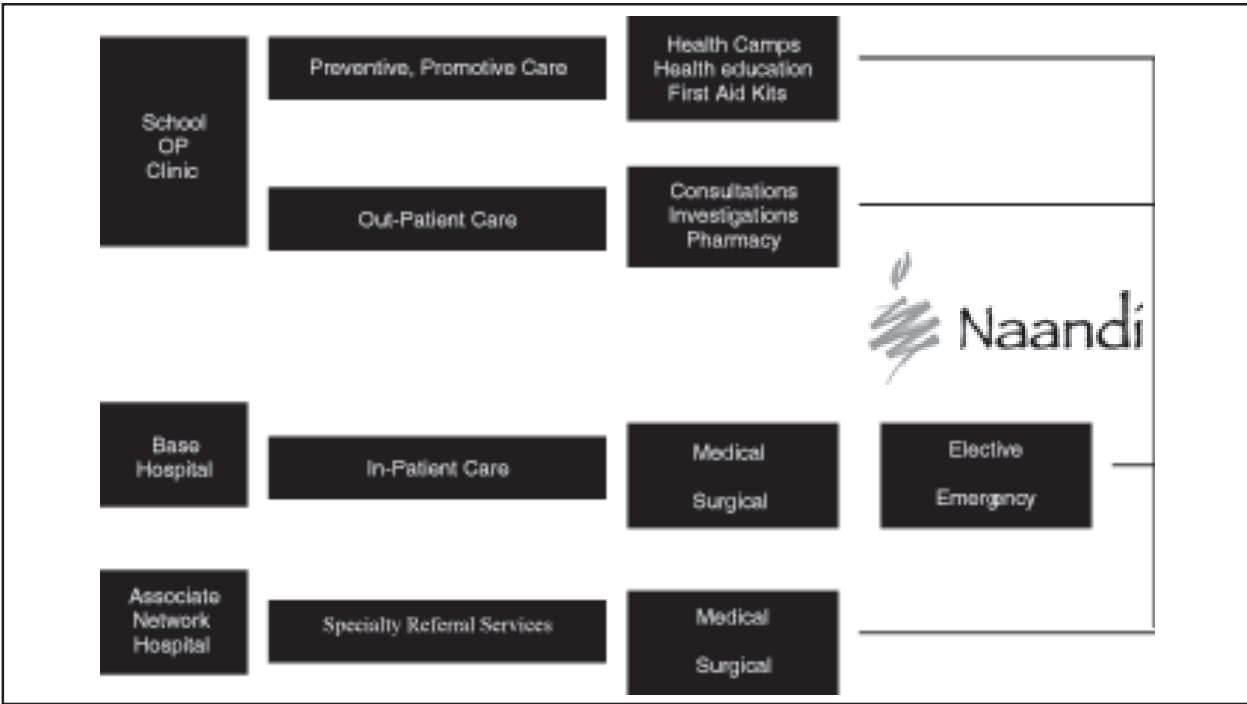
2. Implementation Framework

The inferences that were drawn from the health camps were that children needed the services of a paediatrician, everyday, in order to treat acute and chronic diseases and also for early detection of any signs and symptoms of other debilitating diseases that would otherwise become prohibitive to treat. They also required specialty services like cardiology, gastroenterology, neurology, etc.

What emerged out of brainstorming sessions was the need for 2 categories of services for these children - a) access to a doctor at their doorsteps, and b) hospital based services. These were to be provided in the following way:

- ❑ School-based out patient clinics - these were to be set up in nodal schools that could be easily accessed by 10-12 neighbouring schools. A paediatrician would visit the clinic on every alternate day during school hours, examine children and provide medicines
- ❑ A base hospital for children requiring further investigation, day care, hospitalization, surgeries, etc.
- ❑ The base hospital needed to have a 24/7 out patient department for emergencies, and access on Sundays when the school clinics would be closed
- ❑ The hospital needed to be accessible by phone as well; hence a toll free number was required
- ❑ In addition, specialty care tie-ups were required for a small percentage of these children who required surgeries such as orthopaedic, cardiac, etc.

Figure 1. Benefits Provided by the Scheme



3. From Strategy to Action

1. Photo ID Cards for Children

At the onset of the programme, drawing the information from the data base created with the health camps, each child was handed an ID card, carrying his/her photograph, some essential personal information, school information, a unique ID number and the toll free number. This card¹² was issued to enable the students to access out patient clinics at either their school or a neighbouring school and receive in-patient care at the base hospital. The card served as a foolproof identification system to ensure that the services were accessed only by these 60,000 government schoolchildren who most deserve it

2. Setting up Out Patient Clinics

Nodal school selection was based on the following criteria:

- ❑ Each clinic was to be set up for 2,500 schoolchildren
- ❑ This had to be housed within a government school, using an empty classroom or space or part of the staff room, such that regular classrooms were not disturbed
- ❑ The school needed to be located such that it could be easily accessed by 10-12 neighbouring government schools in the locality, within a radius of 3-4 km.
- ❑ Cooperation from the head of the school and the teachers was also essential for the smooth running of the clinic

After several rounds of survey of these 289 schools, and constant dialogue with teachers and district school authorities, 24 schools were selected. The routes to be followed by the doctors from the base hospital to the schools were then chalked out. Using the GIS mapping of the school, the car routes were finalized. A team of 6 doctors were to visit 12 clinics each day - 6 clinics (one each) in the morning for 2 hours (9 - 11 AM) and then another clinic in the afternoon (11 - 1 PM). This schedule was to be repeated the next day for the remaining 12 clinics - thus each clinic was served every alternate day.

The clinic locations were selected depending on the concentration of schools in each Mandal - for example, Asifnagar Mandal with 63 schools has 7 clinics, whereas Shaikpet Mandal with 24 schools has only one. Also, children could access any clinic in their locality, even if the clinic in their school (or neighbouring nodal school) was not functional on that day. Alternatively, the children could access the 24-hour OPD at the base hospital at any time.

Table 2. Distribution of OP Clinics

S. No	Mandal	No. of OP Clinics
1.	Asifnagar	7
2.	Bandlaguda	6
3.	Bahadurpura	6
4.	Golconda	3
5.	Shaikpet	1
	Total	24

In most schools, it was either an empty classroom or storeroom that was converted to a clinic. Some basic furniture was placed in the room - an examination table for the patient, a stool, a table and some chairs for the patient/parents. Each clinic had the overall schedule of all clinics

¹² See Annexure 9

with their locations and timings. This information was personally shared with the teachers as well for them to understand the working of the system and refer the children to the right place.

3. Setting up School Health Wing at the Base Hospital

As discussed in the strategy above, a base hospital was required to cater to the primary medical care needs of children. Several hospitals both charitable and private were approached to partner in this programme. Many required a lease agreement for at least 6 years and a down payment to the tune of few crores even before the start of the programme. Since this was a pilot programme, the requirement was a hospital facility for about one year only, and one that would not require significant investment for equipment or construction. In addition, quality of care needed to be assured within a reasonable cost.

The outcome was finally a tie-up with Srishti Associates for in patient care, and NICE Foundation for managing out patient care and the specialty tie-ups¹³. Experienced medical partners were required to provide the necessary clinical services, with Naandi ensuring all community linkages and the working relationship with the state government.

The facility provided by Srishti Associates was a wing of their Maternal and Child Hospital, where only minor civil works were required for a paediatric unit, along with all the equipment. The administrative set up of Srishti Associates was used for servicing the school health programme, and this further reduced the cost of the whole programme and also ensuring high quality of services.

4. Establishing Specialty Linkages

The programme has been launched in collaboration with NICE Foundation led by Dr. Padmanabh Reddy as its CEO, and tie-ups with major medical institutes in Hyderabad. These include hospitals such as Care Hospital, LV Prasad Eye Institute and Asian Institute of Gastroenterology. Most of these specialty linkages rely on a formal understanding (MOU) between NICE foundation and the partner organization for delivering low cost care to these underprivileged children¹⁴. A synopsis of the types of partnerships is given below:

Table 3. Partnerships Developed with Associated Hospitals

S.No	Institution	Type of Support	Type of Partnership
1	Care Hospital (for multi-specialty care e.g. cardiac, plastic, neurological surgeries, etc.)	Consultations and in-patient care at concessional rates	Signed MOU
2	LV Prasad Eye Institute	Consultation at their Vision Centres, spectacles, eye drops, etc.	Signed MOU
3	Dr. Ramaiyya's Urology, Nephrology Service	Diagnostics, drugs and disposables at concessional rates	Formal Understanding
4	Asian Institute of Gastroenterology	Diagnostics, drugs and disposables at concessional rates	Formal Understanding
5	FMS Dental Hospital	Diagnostics, drugs and disposables at concessional rates	Formal Understanding

¹³ Both MOUs presented in Annexures

¹⁴ Examples of the MOUs signed with CARE Hospital and LV Prasad Eye Hospital have been annexed

Individual medical professionals also agreed to provide free consultancy and treatments to underprivileged students either at the base hospital or their private facilities. Urging the doctors to contribute to a social cause by offering low cost care led to a significant reduction in the actual costs of investigations, hospital stay, surgeries and consultancy fee of the professionals. Thus, the cost per child was proportionately much less.

5. Community Level Meetings

Beginning with the schools authorities, who would be an important source of information for parents on school health, detailed information about the clinics and their location and timings were shared with them. The teachers in turn informed the parents as and when they came to the school.

Short discussions were held at busy locations/commercial locations in each community or “Basti”. Places like the local teashops, or grocery shops which would have a large number of people in and around them, were selected to disseminate information about the school health programme services for children during late evening hours. All schools and OP clinics have a chart showing the location of all other clinics and their timings for ease of access. The clinics remain open even during the vacations. This information was handed over to each child in every school in the form of a pamphlet that they could carry home. The information on clinics location, timings, 24-hour hospital services and free toll helpline services was explained in 2 languages - Urdu and Telugu.

During the summer vacations, the field staff at Naandi devised a very innovative means of spreading information about the school level activities that Naandi was engaging in, more as an enrolment drive to get more children into school in the next academic session. A short 30-40 minute skit was presented in key community locations, during late evening hours. In true spirit of public-private partnership, the skit involved members of Naandi, schoolteachers and Mandal representatives as actors. Enveloped in a scene from a typical slum household in the city, the messages that it carried spelt out the 3 main Naandi activities in government schools - quality education through material and academic support, nutrition through the mid day meal and access to complete healthcare services through the school health programme. These skits were held in 37 different locations across all the 5 Mandals where Naandi is working, for 6 months from May to November 2005.

4. Organization and Functioning

1. Out Patient Clinics

The school health programme required meticulous planning of all resources - financial, material and human. Out of the 24 clinics set up, 12 clinics run on Mondays, Wednesdays and Fridays. The other 12 clinics run on the alternate days - Tuesdays, Thursdays and Saturdays. On any given day, 6 clinics run between 9am and 11am and another 6 clinics run from 11am to 1pm. The same routine is repeated the next day with the other 12 clinics.

Thus, a team of 6 Paediatricians (salaried under school health programme) manage all 24 clinics. As is indicated in the table, 6 clinics run at a time at different locations. The doctors leave from the base hospital at about 8 am in the morning and travel in 3 different vehicles to the clinics (2 doctors in each vehicle). They are dropped one by one to the morning clinics, which they attend from 9 am to 11 am, and then travel to the next clinic in their vehicle to attend the next clinic from 11am to 1pm. The same routine is repeated the next day covering the other 12 clinics.

Figure 2. Service Delivery Planning at OP Clinics Level

MONDAY - WEDNESDAY - FRIDAY				TUESDAY - THURSDAY - SATURDAY			
Sl. No.	Time	Name of the OP Centre	Name of the Mandal	Sl. No.	Time	Name of the OP Centre	Name of the Mandal
1	9 AM - 11 AM	GBPS Edi Bazar	Bandlaguda I	1	9 AM - 11 AM	GPS Sultan Shahi	Bandlaguda I
2		GPS Panchamukhi Hanuman	Bandlaguda I	2		GBPS Chandrayangutta	Bandlaguda I
3		GPS Bazar E Ghansy	Bahadurpura I	3		GPS Sabzi Mandi – 2	Asif Nagar I
4		GUPS Dareeche Bawaheer	Bahadurpura II	4		GPS Dhoolpet	Asif Nagar II
5		GPS Tolichowki	Golconda	5		GPS Dhanalakshmi Pura	Golconda
6		GPS Round Table	Shaikpet	6		GPS Langar House	Golconda

Sl. No.	Time	Name of the OP Centre	Name of the Mandal	Sl. No.	Time	Name of the OP Centre	Name of the Mandal
1	11 AM - 1 PM	GPS Falaknuma	Bandlaguda II	1	11 AM - 1 PM	GPS Bi Bi Ka Chashma I	Bahadurpura II
2		GHS Vattepally	Bahadurpura II	2		GPS T.D. Singh	Bandlaguda II
3		GHS Jahanuma	Bahadurpura II	3		GHS Umda Bazar	Bahadurpura II
4		GGPS Mustaidpura	Asif Nagar II	4		GHS Kali Kaman	Bahadurpura II
5		GPS Vijayanagar Colony	Asif Nagar I	5		GPS Kulsumpura	Asif Nagar I
6		GHS Ist Lancer (Boys)	Asif Nagar I	6		GPS Deval Jam Singh	Asif Nagar I

Each clinic also has a helper assigned to the doctor. This helper/clinic caretaker has been selected from the local community - may be the parent of a student or may be an employee at the school, such as the gatekeeper of the school or the janitor. They are stationed at the clinic for those two hours and assist the doctor in dispensing the medicines, discipline the children who line up at the clinic, and are also responsible for maintenance of the clinic. For this work they are paid a small honorarium.

The advantage of making a local person in charge of the clinic is that they are familiar with students who live in the community and are able to ensure that each child access the clinic if they need to. Parents are also familiar with this local community member, and have the confidence to leave their sick child under his or her care for the doctor to examine, especially since both parents may be working to make ends meet.

The doctors carry medical equipment and some essential medicines with them to each clinic. These are listed below:

Box 3. Support to Services Provided by OP Clinics

Equipment/material: Weighing scales, height scale, blood pressure apparatus, stethoscope, cotton, gloves, facemask, spirit, ear buds and thermometer. Bandages and other dressing material and syringes, if required.

Medicines: Deworming tablets, topical ointments, supplements like iron, folic acid, vitamins; antipyretics, analgesics, antitubercular drugs, antibiotics, retroviral, antiepilepsy, antihistamines, expectorants, antispasmodics, antifungal, insulin, TT injection, etc.

The doctors are responsible for:

- ❑ Examining the children at the OP clinic, advise on the treatment and dispense the drugs to the guardian of the child or the schoolteacher
- ❑ Children in need of further investigation is carried out to the hospital in the vehicle itself along with a guardian, or they are asked to come to the hospital once the parent is available
- ❑ Similarly, children in emergency situations such as epileptic fits, or food poisoning (if it occurs during the clinic timings) are carried to the base hospital by the doctor in the vehicle
- ❑ Patients on long term treatment for some chronic conditions or the doctors also regulate TB, etc. If they de-default for even one day in taking medicines or coming to the clinic, the School Health Coordinators (see below) are alerted and the child is tracked down
- ❑ The doctors also maintain records of patients seen, type of ailment and medicines dispensed



2. School Health Coordinators

These are the grass root level workers who have been employed by Naandi specifically for the school health programme. The three coordinators hold the key responsibility of ensuring that the programme runs smoothly and they form a strong linkage between the school, the doctor and the hospital. Their responsibilities include;

- ❑ Managing the smooth running of the OP clinics they are in charge of (each one monitors 8 clinics)
- ❑ Liaison with the school authorities such as teachers and head of schools, to maintain the clinics
- ❑ Ensure that the children from surrounding schools access the clinics during school hours. For this, the school is encouraged to depute one teacher who collects all children requiring medical service and brings them all to the clinic. Sometimes, in the absence of any available teacher, the coordinators themselves bring the children to the clinic

- ❑ The school health coordinators are also to visit the community and counsel the parents of children who require surgery or hospitalization. At the start of the programme, parents needed to be convinced of the availability of these services, and made to believe that they would not be asked to pay. Being from extremely poor backgrounds, they found it hard to believe that their child could access quality health services at no cost to them. However, this is still a problem, given the cultural context, many a times fathers do not allow their children, especially daughters, to access any medical help
- ❑ Follow up home visits are also made to children who undergo surgery or long-term treatment to ensure that they attend school regularly

3. Base Hospital

On the clinical side, the school health wing at the base hospital is managed by a team of 3 doctors who work in shifts, along with a total of 12 nurses and sisters - 4 nurses in each shift. The doctors divide their work schedules between the Paediatric Intensive Care Unit and the School Health General Ward.

The doctors in rotation also maintain the night duty hours at the hospital to respond to any medical emergencies. Occasionally they are assisted by the OP doctors for night duty if required.

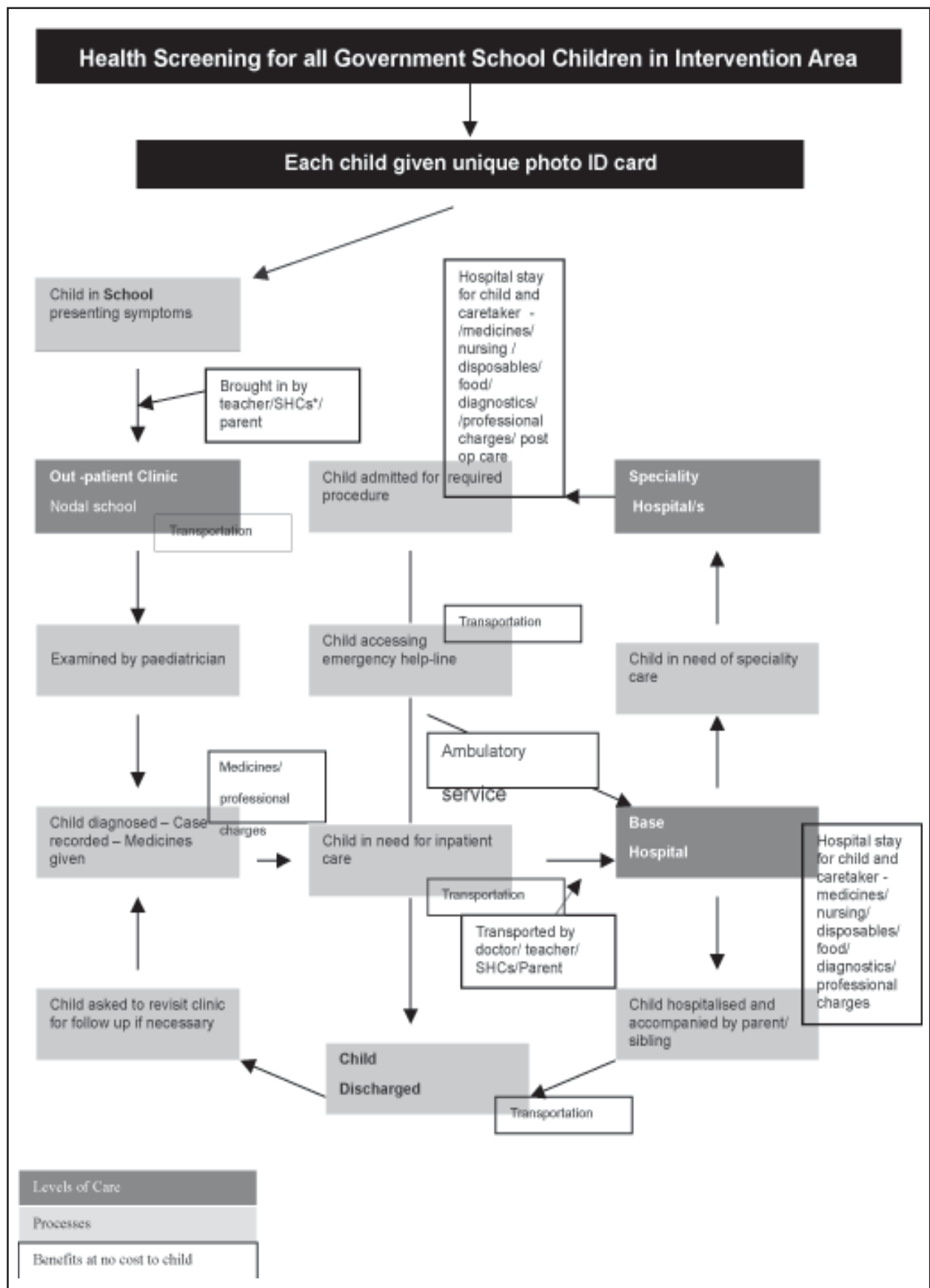
The requirement of speciality care and consultations are monitored by the base hospital. For children who need a specialty consultation or an investigation at a secondary or tertiary level institute, the hospital coordinates this with the designated hospitals that have been partnered with. The child is sent for the appointment along with a nurse and accompanying guardian and then brought back to the base hospital. Apart from cardiac surgery, the in-house doctors at the base hospital carry out most of the other surgeries. The details are given below.

Table 4. Distribution of Secondary Healthcare Services

S.No	Specialty	Hospital/Individual
1.	Cardiac surgery	CARE Hopspital
2.	Gastroenterology	Asian Institute of Gastroenterology
3.	Urethroscopy	Dr. Ramesh Ramaiyya (Pramila Hospital)
4.	Reankylosis	FMS Dental Hospital
5.	All others	Shalini Hospital (base hospital)



Figure 3. Operation Chart



5. Financing

The School Health Programme (SHP) began as an initiative that was funded by the Department for International Development (DFID) of the UK Government, as one of the components in the larger quality education program “Ensuring Children Learn” as a public private partnership with the government of Andhra Pradesh. This partnership agreement was for a period of one year from 2004 to 2005.

Subsequently corporate houses, individuals and civil society, are now supporting the programme in general, through the following fundraising options:

1. The Power of 10TM

This is an innovation devised by Naandi to enable individuals and corporates to change lives. This is a pay-roll deduction scheme where employees of corporate firms are invited to allow a direct deduction from their salaries of just Rs 10 or multiples of 10 every month.

It's the power and potential of the 10 rupees that motivated Naandi to innovate a novel way for individuals to “give back to society”. A voluntary contribution of only Rs 10 a month can make a whole world of difference. Being the cost of a chocolate bar or 2 cups of coffee, the sum of Rs 10 seems insignificant in isolation, but assumes substantial proportions when pooled in together.

Corporate establishments known for their values and ethics, which care about their social responsibilities, who believe in promoting the society they live in, are collectively contributing regular sums of money to Naandi. In many cases the parent company matches the contribution made by their employees with an equal amount and makes a consolidated donation to the programme, namely, Microsoft Corp., Portal Player, Computer Associates and Dr Reddy's Laboratories. Aptly named, the Power of ten elaborates on the potential of Rs 10 in ensuring a child's health. Donors are also able to ratify the use of their donations by visiting any of the OP clinics or the base hospital and interact with the children at any point of time. They are assured that their contribution provides free, quality healthcare to an underprivileged child.

Volunteering 10 hours a month:

The Power of 10 also enables individuals and companies to go beyond cash donations. It provides spaces for them to volunteer 10 hours of their time every month - helping with language tuitions to students, organizing exposure visits, math Olympiads, art camps, science fairs, or helping out at the OP clinics, making home visits, etc, The Power of 10 Tm movement already has over 14,000 individuals, corporate employees and individuals contributing to it. It continues to be not merely an asset base but also a source of pride and inspiration to Naandi, and a sign of its ability to mobilize civil society participation.

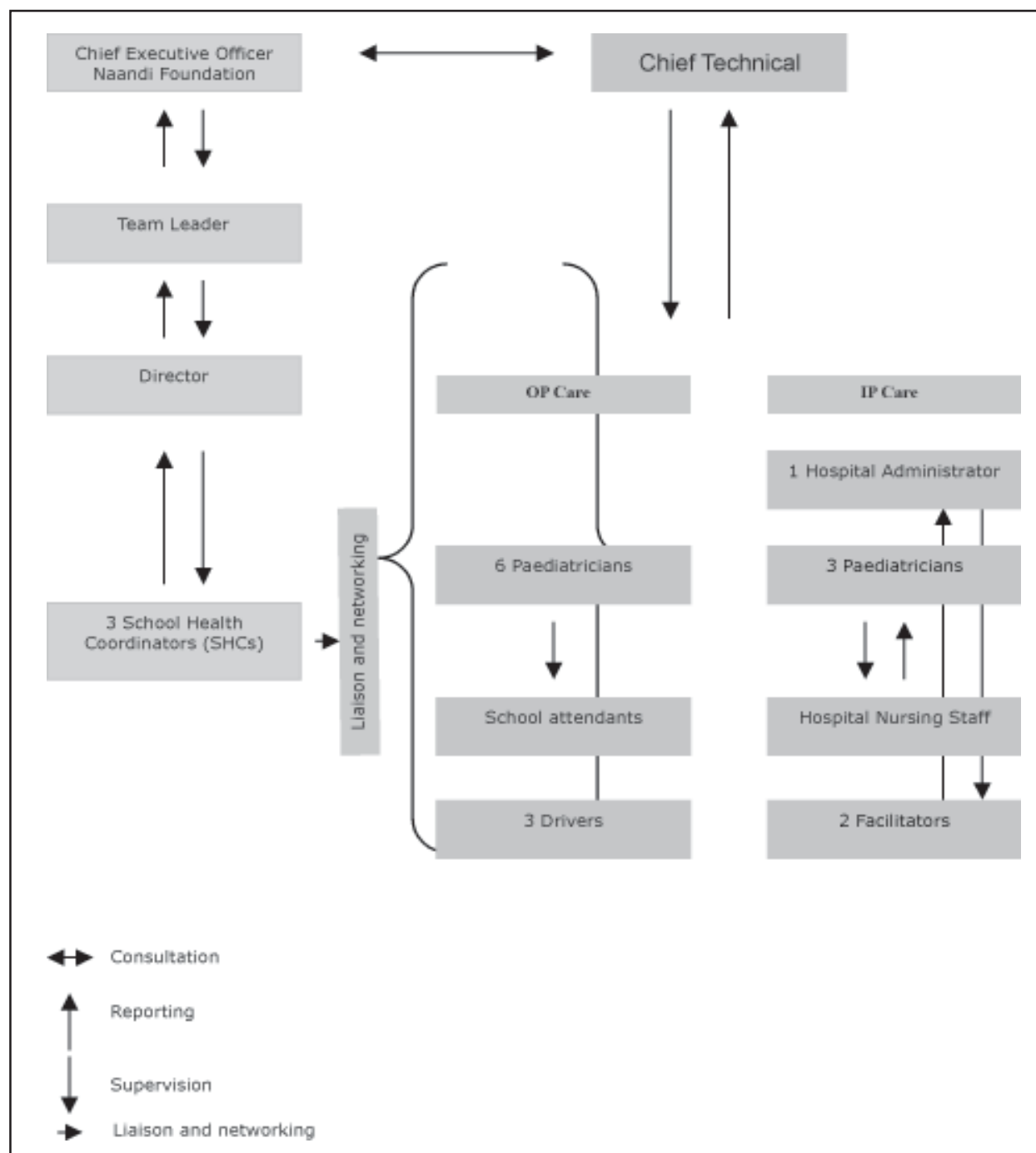
Hundreds of volunteers, be it housewives, pensioners, businessmen, young enthusiasts, and employees of corporates such as Careermosaic, Nagarjuna Group, Restile, I labs, DRL, Portal Player, General Electric, Microsoft, Orillion, SQL Star International, ABN Amro, HDFC and Planet Soft, among others are part of the Power of ten movement, and the numbers are still growing.

2. Foreign Individual Contributions

There is a constant effort to network with high net-worth individuals across the world that is keenly interested in contributing to causes in India. Donations for school health programmes have been received from a many non-resident Indians keen on ensuring the health of children back home.

There is also a move to establish offices in the USA to tap into the resources of the Indian community there, with tax benefits for them. The organisation is currently working towards obtaining the necessary certification towards that end.

Figure 4. Naandi's Distribution of Responsibilities



IV. PERFORMANCE ANALYSIS

1. Services

1.1 Beneficiaries

The health camps began in November 2004 and were completed in March 2005. The initial planning of camps was done keeping in mind the enrolment figures provided by the Government of Andhra Pradesh, which stood at 60,000 children from classes I to VII in the 289 schools. However, at the end of March 2005, the total number of children that attended the health camps was only 33,000. To cover up the children who did not attend due to sickness or simply being absent, and also the new enrolments in class I, another round of camps were held in the new academic session in June 2005, and another 19,000 children were added bringing up the total number to 52,000. Over the next few months, a few more new children who attended the OP clinics directly, without attending any camps, were added on the database - making the total number up to 60,000 children.

1.2 Out Patient Services

Out of a catchment of 2500 children for each clinic the average attendance each day ranges from 1 to 2% for each clinic i.e. 20-25 patients access everyday which may go up to 50 children during the monsoons. Between March 2005 and March 2006 more than 90,000 children have been examined at the OP clinics.

The common diseases found among these children are shown below.

Table 5. Most Common Chronic Diseases Observed among Children

S. No	Diseases	Symptoms
1	Skin	Infections, deficiency, manifestations like scurvy
2	Vitamin deficiency	Rickets, night blindness, B complex deficiency
3	Worm infestations	History of passing worms, poor health and hygiene
4	Anaemia	Pallor, failure to thrive
5	Chronic tonsillitis	Tender cervical nodes, sore throat, etc.
6	Orthopaedic problems	Fractures and malunion, non unions
7	Congenital defects	Cleft lip and palate, orthopaedic defects
8	Eye related diseases	Congenital eye defects such as cataracts, squints. Acquired eye diseases such as infections and refractive errors
9	Dental diseases	Flourosis, carries, malocclusions
10	Hearing defects and chronic ear infections	Recurrent middle ear infections and hearing impairment
11	Speech defects	Stammering, phonation problems

Table 6. Most Common Acute Diseases Observed among Children

S. No	Diseases	Symptoms
1	Infections	Viral infections like measles, mumps, chicken pox, HIV/ AIDS, diarrhoea, etc. Bacterial infections such as typhoid, gastroenteritis, dysentery, tuberculosis, etc.
2	Accidents	Road traffic accidents, burns, falls, poisonings, snake bites and animal bites

1.3 Admissions in the Base Hospital

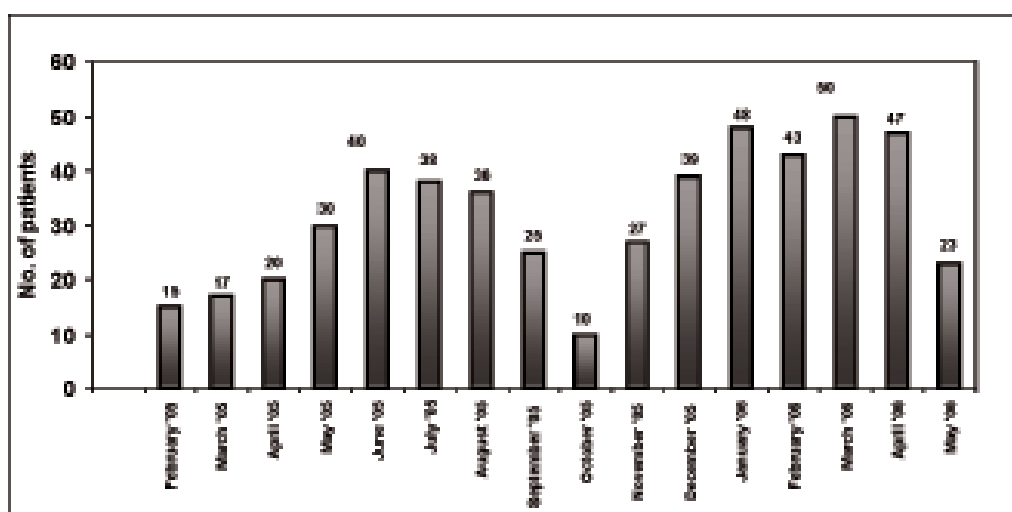
The following table provides the information related to admissions to the base hospital over a 16 month period from the inception of the programme.

Table NO 7. School Health Admissions in Base Hospital: February 2005 - May 2006

S.No	Month	No of Patients	No of Days in Hospital	Average Stay
1	Feb-05	15	55	3.6
2	Mar-05	17	80	4.7
3	Apr-05	20	115	5.7
4	May-05	30	158	5.3
5	Jun-05	40	225	5.6
6	Jul-05	38	316	8.3
7	Aug-05	36	261	7.2
8	Sep-05	25	175	7
9	Oct-05	10	88	8.8
10	Nov-05	27	200	7.4
11	Dec-05	39	287	7.3
12	Jan-06	47	352	7.5
	Sub -Total 1	344	2,312	6.7
1	Feb-06	43	278	6.5
2	Mar-06	50	287	5.7
3	Apr-06	47	326	6.9
4	May-06	23	171	7.4
	Sub -Total 2	163	1,062	6.5
	Total (16 months)	507	3,374	6.6
	Average NO days		210	

The following figure provides a better illustration of the in-patient care utilization profile, with may be seen as slightly increasing over time.

Figure 5. In Patient Services Utilization Profile



1.4 Surgeries Performed

Over the same period, the programme has covered a total of 113 surgical interventions, with most of these falling into the following five main categories.

Table 8. Type of Surgeries Performed: Febr. 2005 - May 2006

Type of Surgery	No of Children
Tonsillitis and ENT	38
Cardiac	19
Orthopaedic	17
Eye	17
Plastic surgery	10
Hernia	4
Acute Appendicitis	2
Nasal Polyp	1
Neurological	1
Urethroscopy	1
Gastro	1
Biopsy	1
Dental	1
Total	113

2. Costs

1. Cost of Out Patient Care

As described in the following table, the average monthly cost of out patient care comes to a total of Rs. 218,000

Table 9. Monthly Costs - Out Patient Care

S.No	Service	Unit Cost	Unit Description	No of Units	T. Cost INR
1	Doctor's salary – 6 doctors, 1 on standby	17,000	Per doctor	7	119,000
2	OP clinic attendant	250	Per attendant	24	6,000
3	Drugs*	50,000	Lumpsum		50,000
4	Vehicle – Fuel	4,580	40 Km per day	3	13,740
5	Vehicle – Maintenance	1,000	Per vehicle	3	3,000
6	Drivers' salary	4,000	Per Driver	3	12,000
7	Administrative staff – includes pharmacist, ayah	10,000	Lumpsum		12,000
8	Toll free number charges	4,500	Per month	1	4,500
	Total				218,240

* Drugs – Obtained from the main stockist in the city, with 15% discount

2. Cost of In Patient Care at Base Hospital

As described in the following table, the average monthly cost of in patient care comes to a total of Rs. 220,000

Table 10. Monthly Costs - In Patient Care

S.No	Service	Unit Cost	Unit Description	No of Units	T. Cost INR
1	Bed charges	150	Per hospital day	210	31,500
2	Nursing charges	150	Per Hospital day	210	31,500
3	Investigations	150	Per Hospital day	210	31,500
4	Drugs	200	Per hospital day	210	42,000
5	Gases and disposables	100	Per hospital day	210	21,000
6	Diet – for patient and guardian	100	Per hospital day	210	21,000
7	Professional charges	200	Per hospital day	210	42,000
	Total	1,050			220,500

2. Cost of Specialty Care

Table 11. Monthly Costs - Specialty Care

S.No	Service	Unit Cost	Unit Description	No of Units	T. Cost INR
1.	Includes professional fees, diagnostics, surgeries, drugs and disposables				150,000
	Total				150,000

Based on the information available at that point of time, the average monthly cost of specialty care has been estimated at Rs. 150,000.

4. Total Cost per Child Covered under the Scheme

Based on the above calculations, the overall cost for the provision of all health care services covered under the programme comes to a total of Rs. 9.8 per child per month.

This cost does not reflect however, some additional administrative costs which in the case of the Hyderabad intervention, could be borne by Naandi Foundation through the direct involvement of its staff.

Table 12. Cost per Child per Month

Cost Element	Total Amount in INR
Out Patient Care	218,240
In Patient Care	220,500
Specialty Care	150,000
Total Costs	588,740
NO of Children	60,000
Cost Per Child per Month	9.81

Cost per child per month equals rupees nine and eighty-one paise

3. Subsidies

The unit cost of Rs 9.81 per child per month has been possible only because of the large number of subsidies that have been obtained for this programme in Hyderabad. The partnerships forged with the specialty institutions have significantly reduced the costs for investigations and surgeries. Experienced and renowned specialists such as cardio thoracic surgeons, orthopaedic surgeons, neurologists, etc. of the city, have come forth on an individual level to contribute their services (surgeries, diagnostics, medicines) at no cost to the government school children and thereby reduced the unit cost significantly. With each orthopaedic surgery costing up to Rs 25,000, the benefits that these children gain from their philanthropy is phenomenal.

Even the demographical characteristics of the city of Hyderabad have had a positive influence in the day-to-day operations of the programme. Most of the government schools are in close proximity to each other and hence have led to reduce transportation costs, greater frequency of service delivery at OP clinics and a wider coverage.

While the fundamental strategy of the school health programme conceived by Naandi remains unaltered irrespective of the geographical setting in which it is implemented, the unit cost is subject to the extent of subsidies that favour the programme. In Naandi's experience, the unit cost shown holds good for metropolitan cities of the country where cross subsidies can be tapped and cost effective private partnerships can be established. Also, being cities, the density of population is greater and hence access to the schools is not expensive.

However, for areas with low density such as district headquarters, municipal towns and rural areas the model has to be customised and worked out. Here the extent of cross subsidy is less, the density affects the recurring costs such as transportation. The remoteness of the area results in extra miles to be travelled to reach even a local doctor.

Naandi has replicated the school health programme in the state of Rajasthan in Udaipur that combines both urban and rural areas. Based on estimates, the unit cost had to be increased to 50 paise per child per day (Rs 15 per child per month) to service 40,000 government schoolchildren.

Naandi has also been able to conclude that the school health programme in its current design can be implemented within 50 paise per child per day for a catchment of 40,000 children to be reached within a radius of 25 km.

The midday meal that is provided by the government costs Rs 2.50 per day. Naandi hopes to influence government policy to include comprehensive healthcare, for only paise per child per day - one-fifth the noon meal cost - as a fundamental right of a child, in addition to education and nutrition.

V. IMPACT ASSESSMENT

1. Improvement in the Quality of Life

The School Child Healthcare Programme serves 60,000 children in the age group of 6-14 years since November 2004. 60,000 children have been provided with access to a paediatrician, medicines within the school, and IP facilities (if required), everyday.

- ❑ An average of 350 - 500 of total children access the OP clinics everyday, availing the services of and experimented paediatrician and medicines, at no cost at all
- ❑ The National Sample Survey (52nd round) indicates that the average spending on health in urban poor households ranges from Rs 1,400 to Rs 2,000 a year for acute illnesses and about Rs 500 to Rs 800 for chronic illnesses. In addition, families also spend on travel, food, stay, etc on a visit to the doctor that adds to the overall expenses, including the loss of wages for that day. A significant proportion of this amount is spent on childhood illnesses, not counting the several illness episodes that remain untreated, as families cannot afford the expense. With the school health programme, this proportion in each household has been reduced to zero. Summing up this amount for all 60,000 households easily runs into a few crores that have been saved. Financial burden and indebtedness in marginalized families due to health expenditure on children, has thus been reduced to zero.
- ❑ Screening the children at health camps helped to create a disease profile of the children and also segregate the children that needed immediate attention in terms of surgery, hospitalization or long-term medication. These camps also helped to bring out certain hidden ailments in children, and allow timely intervention to prevent life long handicap. The programme has thus impacted the longevity of a significant number of children - those suffering from cardiac conditions and even undetected cases of hypothyroidism - and thus eliminated the chance of them becoming a burden on society.

2. Knowledge and Health Behaviour

The indirect positive impact of the programme has also been on the general attendance and enrolment of children in these 300 schools. Not only are sick children coming to school, owing to the prompt diagnoses and investigations, children are being cured faster and hence maintaining regularity in attendance. By relieving them of sickness and also preventing any in the future, the programme has allowed children to learn better in class, promoted all-round growth, and achieve Naandi's goal of providing poor government schoolchildren with complete healthcare coverage at zero cost to the family.

While regularity in school attendance was evident soon after the project began, impact on enrolment of new children into school became apparent in the new academic session. With the roll out of this scheme and availability of free quality health care within the school, parents were eager that their children benefit from it. The only condition being that they must enrol the child in a government school, increasingly children from neighbouring private schools are enrolling into government schools. Image of the government school took a full turn into an institution that fulfils the basic needs of children - education, nutrition and health - and positive feedback from parents about the school resulted in a ripple effect on the community, taking the enrolment in the new academic session in to all high time of last many years.

Good health in the 8 formative years of a child ensures that the family is not burdened by huge health expenditure and delivers an economically productive youth to the nation. Thus it is not just the child but his/her entire family that is being positively impacted with this innovation. While long-term effect of good healthcare on future generations will surface years later, the reduced morbidity and mortality among the present 60,000 children is already apparent.

An unexpected outcome has been observed in these 300 schools. With the clinic being situated within the government school, parents often accompany their sick children for a check up by the doctor, many of them entering their child's school for the first time! This has kindled the process of parent involvement in schooling. Unlike private schools, parents of government school children do not usually engage themselves in the child's learning process. School is just a place where children can be handed over while they earn their daily living. Now, at least in these 300 schools, the tide has changed, parents are entering school premises with ease, monitoring the mid day meal and tracking school performance. Thus, ensuring more accountability and commitment on part of the teachers. As an outcome, this was already apparent within a few months after the clinics were set up.

3. Scale Up

Impressed by this effective method of healthcare delivery to children, the government of Rajasthan invited Naandi to implement this program in the city of Udaipur. The state government partnered with Naandi is bearing 50% of the capital and recurring costs of the programme, to cover 40,000 government school children, with plans to expand to the entire state eventually.

The Government of Andhra Pradesh is keen that Naandi extend its wings to cover all schools in various locations of the state - a mix of urban, rural and tribal districts - reaching out to 300,000 children. Building on this model of delivering free healthcare to children, the government of Andhra Pradesh is now devising a state-wide strategy for ensuring healthy school-going children.

The Government of Madhya Pradesh has invited Naandi Foundation to start the School Health Programme in 2 tribal districts of the state with a commitment of sharing half the costs.

A partnership with the Government of West Bengal is being finalized at the moment to cover all school children in the city of Kolkata- roughly 250,000 children, in a phased manner.

In partnership with Effective Intervention (an NGO based in London), University of Cardiff and London School of Economics, Naandi is undertaking an action research in school health, to measure its impact on school attendance, enrolment and learning levels of children. Another facet that will yield important learning is the study of the changes in health-seeking behaviour in case of children's health, as well as health expenditure patterns of poor families, which are included in this research. With this study at least 20,000 more children from government schools will be added to the programme.

VI. CONCLUSIONS AND RECOMMENDATIONS

1. Conclusions

Naandi's school health programme is the only social security net for disadvantaged children in the entire country that provides a comprehensive benefit package including diagnosis, out patient care, in-patient care, surgeries, medicines, etc. all covered at a very minimal cost per child per day under the scheme

Developed completely in-house the school health programme was an experiment aimed at dispelling the helplessness of the poor in accessing healthcare, and its unfavourable impact on the child's future. Disillusioned by the dismal state of health services at government institutions, the poor are compelled to use private care, which in reality they cannot afford. Not surprisingly ill health has become a common cause of indebtedness among poor families. Thus diseases among children are largely neglected, owing to the large expenses the family will incur, especially on a non-earning member of the household. This is more so if the child is a girl.

This very innovative health protection programme has adopted the following main features:

- ❑ Comprehensive health profiles: From the outset, the programme organizes comprehensive health camps where each child covered under the scheme undergoes a thorough medical examination by a paediatrician, dental surgeon and community eye health worker, leading to creation of a data base of individual child health profile and overall disease burden.
- ❑ Foolproof identification system: To ensure that only the most deserving access health care services provided under the scheme, each child who underwent screening was provided with a photo ID card, with a unique identification number.
- ❑ School based out patient clinics: These are set up in 24 nodal government schools with each clinic being open on every alternative day during the school hours. Each clinic is linked with 10-12 government schools within a radius of 3-4 km. An experienced paediatrician diagnoses the children and dispenses medicines to the accompanying guardian free of cost.
- ❑ Dedicated base hospital for in-patient care: A base hospital with round the clock out-patient department (OPD) and toll free number connectivity has been set up. Diagnosis, investigations, medicines, surgeries, hospital stay and food for the patient and guardian - are all provided here at zero cost to the child's family.
- ❑ High quality multi-specialty care: To address medical problems needing high-end expertise, super speciality care is provided through a network of leading tertiary care institutes in the city.
- ❑ Extended healthcare services: While covering every possible disease that the child may present, the programme also promotes health and prevents illnesses through health education activities.
- ❑ Multi-partnership approach: The programme inspires professionals, specialty institutions, state government and private companies to be responsible for a poor child's good health and forge cost-effective partnerships.
- ❑ Stable financing commitments: The programme was highly successful in mobilizing and organizing a broad network of individuals and companies willing to provide a regular contribution to meet the running costs of the programme.

With the availability of free, quality health services for disadvantaged children under this programme, health expenditure and resulting indebtedness of families due to child illnesses are being reduced to zero. Comprehensive health services - preventive, promotive and curative - are being provided through an excellent system of out patient clinics in nodal schools, a first referral unit and linkages with tertiary level hospitals. The programme has brought together the government, the corporate sector and civil society members to contribute to the programme - financially or through service provision at zero cost.

The number of subsidies that the school health programme enjoys in Hyderabad is many, thus reducing the unit cost to Rs 10 per child per month. However, this programme can be run anywhere in the country for 40,000 children within a radius of 25 km, with an escalation in unit cost not beyond Rs 15 per child per month.

No other insurance programme - in terms of cost or coverage - has matched this scheme so far. All health insurance schemes operating in India still provide a very sketchy coverage of diseases, focusing on hospitalization costs only while applying harsh limitations on the various types of health services. They also generally exclude pre-existing illnesses while barring the entry to people living with HIV and groups at risk.

Among the existing health insurance schemes, the well known Universal Health Insurance Scheme (UHS), distributed by the four public sector insurance companies, charges an annual premium of Rs. 365 while targeting the Below Poverty Line Population. Even with its in-built subsidy component, this scheme cannot be compared to the benefits provided by Naandi's school health programme at an annual cost of Rs. 182.50 per child.

Table 13. Main features of the Scheme as Compared with UHS

	Naandi Programme	UHS
1. Risks covered	Health care	Health care, accidental death, loss of income
2. Scope of health coverage	OP care, investigations, hospitalization, surgical procedures, medicines...	Hospitalization
3. Level of health coverage	No limitation	Rs. 15,000 per episode
4. Caps on health services	No caps	<input type="checkbox"/> Room/board: Rs. 150 per day <input type="checkbox"/> Specialist fees: Up to Rs 4,500 <input type="checkbox"/> Medicines: Up to Rs. 4,500
5. Restrictions	No restriction	<input type="checkbox"/> Minimum period of 24H for hospitaliz. <input type="checkbox"/> Next illness after 60 days relapse
6. Exclusions	No exclusion	Pre-existing diseases, corrective, cosmetic and dental surgery, AIDS.....
7. Cost		
<input type="checkbox"/> Cost per person per year	182.50	365
<input type="checkbox"/> Subsidy element	182.50	200
<input type="checkbox"/> Net cost to insured	0	165

The programme is also innovative in that it serves the most deserving citizen of the country - the school-going child; delivered at one-fifth the mid day meal, and the only programme in the country that insures health of children, from common cold to cardiac surgery, including pre-existing illnesses, with no disqualification criteria except to be enrolled in a government school.

“Absenteeism has gone down to just about five percent from a serious forty percent in our school. Enrolment has also gone up to such an extent that we are having a problem accommodating them” School Principal, Manzar Ibrahim to City Express.

Naandi’s school health programme is yielding remarkable results in terms of attendance in school and overall impact on learning abilities of the child. The growing number of enquiries about the programme from other state governments such as Madhya Pradesh, West Bengal and Uttar Pradesh is another vivid testimony to that fact.

With an investment as little as 50 paise per child per day, the returns of the school child healthcare programme are phenomenal - complete healthcare for a child - ensuring retention of children in school - improved learning outcomes - an educated and healthy youth - and finally, an economically productive Indian. Thus, the returns to meagre 50 paise investment are zero financial burden due to ill health for marginalised families, with the assurance of a healthy nation.

2. Recommendations

1. Overcoming Gaps and Constraints

- ❑ There is a need to strengthen the community buy-in the programme. At present it is still largely the teachers and the Mandal coordinators who are responsible to get the children to the outpatient clinics. Ensuring that all the 60,000 families who are impacted are aware of the full benefits is still to be achieved. The schools surrounding the OP clinics are still not fully utilizing the available services. More detailed information needs to be given to them to create awareness about the programme and its services. Also, teachers and parents need to be mobilized to access the clinic, even if it means travelling a short distance on foot or public transport.
- ❑ There is a need to set up a strong information system in order to track the progress of the children under this programme and study and analyse trends.
- ❑ Children above 14 years of age are not being covered under the Hyderabad model. However, in the city of Udaipur all children from classes I to XII are benefiting under the scheme (age 6 to 18 years). The learning from this intervention needs to be studied and documented to analyse the range of services required for these children and the ultimate costs attached to these services. This information can be shared with other insurance companies or social insurance agencies in the country, and thereby assist them in designing a package of services, for an affordable price, for children in school-going age.

2. Enlisting State Government Long-Term Financial Support

Discussions are in progress with the state government of Andhra Pradesh for a long-term partnership that ensures the health of the state’s schoolchildren. The Department of Medical, Health and Family Welfare has shown keen interest in scaling up the programme. Not only in urban areas like Hyderabad city, but also explore a rural/tribal model for delivery of health services to the children thereby entering into a long-term agreement. With government financing the programme and Naandi ensuring delivery of quality health services, the school health programme is well on its way to being a true public-private partnership providing comprehensive health care to the schoolchildren.

ANNEXURES

ANNEXURE -1

Main Health Problems affecting Children (State health Programme)

Health Problems	Guntur	Kurnool	Nalgonda
Anaemia	2%	-	2%
Bronchitis	3%	3%	-
Dental	10%	18%	15%
ENT	16%	8%	15%
Epilepsy	-	5%	6%
Eye disease	10%	10%	6%
Heart problems	2%	2%	8%
Leprosy	2%	-	2%
MR	8%	8%	-
Night blindness	7%	3%	-
Tonsillitis	3%	3%	2%
Physically disabled	10%	11%	-
Polio	8%	8%	25%
Skin disease	5%	10%	10%
TB	2%	-	-
Other ailments	3%	10%	8%

Reference: TARU Leading Edge, Swasth Mela Evaluation – Final Report, E. 21

ANNEXURE -2

Source of Treatment for Children Prior to the Mela

Health Problems	Guntur	Kurnool	Nalgonda
District Government	3%	-	4%
District Private	8%	4%	4%
State Private	2%	13%	13%
Home remedy	2%	2%	-
Local government	3%	-	4%
Self medication	-	2%	-
State Ayurvedic	-	2%	-
State government	-	-	-
State missionary	2%	-	-
Taluq government (block level)	8%	2%	2%
Taluq private	23%	15%	2%
State specialist	3%	-	-
None	30%	48%	35%

Reference: TARU Leading Edge, Swasth Mela Evaluation – Final Report, E. 30

ANNEXURE - 3

Information of Ministry of Education Officials

Proceedings of the District Educational Officer & District Project Coordinator, Sarva Shiksha Abhiyan, Hyderabad

Proc.Rc.No.1395/B2/SSA/Hyd/2004

Dated: 25-10-2004

Sub: SSA, Hyderabad - Child Health Care Plan - Orientation to Dy.E.O., Dy.I.Os, MRPs and DRPs on 27-10-2004 at office of the SSA, Hyderabad - Reg.

Ref: Lr.No. N/SH/2004/009, Dated: 21-10-2004 from Venkata Ramana, Programme Manager, Naandi, Hyderabad

The Dy. Educational Officers and Dy. Inspector of Schools of Asifnagar, Golconda, Haikpet, Bahadurpura and Bandlaguda Mandals are informed that as part of promoting School Health, Naandi Foundation will organize a brief orientation programme for the MRPs, DRPs, Dy.IOs and Dy.Eos on 27-10-2004 from 10.30 AM to 1.00 PM on "Child Health Care Plan" which is planned to be launched on 14th November 2004 in collaboration with Government of A.P.

All the Dy. Educational Officers, Dy. Inspector of Schools and MRPs of above mandals are therefore requested to attend the said orientation programme at 11.00 AM on 27-10-2004 at the office of the Additional Project Coordinator, Sarva Shiksha Abhiyan, Block M-3, Beside Andhra Bank, Manoranjitham complex, Near Ajanta Gate, Exhibition Grounds, M.J. Road, Hyderabad District

District Educational Officer &
District Project Coordinator
Sarva Shiksha Abhiyan
Hyderabad District

ANNEXURE - 4

Memorandum of Understanding – NICE Foundation

MEMORANDUM OF UNDERTANDING BY AND BETWEEN NAANDI FOUNDATION AND NICE FOUNDATION

Whereas Naandi Foundation, commonly referred to as Naandi, a Public Charitable Trust registered under the Indian Trusts, 1982 was set up with the objective of bringing about people centred development process in the state of Andhra Pradesh.

Whereas Neonatal Intensive Care and Emergencies, commonly referred to as NICE Foundation is a unique not-for profit initiative set up with the primary objective of providing emergency medical care to the newborn to reduce neonatal mortality.

Whereas Srishti Associates is carrying on the activities of providing mother and child healthcare under the name and the style of “Shalini Hospital” situated in Barkatpura, Hyderabad.

Whereas Naandi, as part of its “Ensuring Children Learn” program in 300 government schools in 5 mandals of Hyderabad district, proposes to take up a comprehensive child healthcare plan in collaboration with Shalini Hospital and NICE Foundation.

Whereas Shalini Hospital shall provide In-patient (IP) Care and NICE foundation shall provide Out-patient (OP) Care at the schools and deliver speciality care through networking with speciality hospitals.

THIS MOU BY AND BETWEEN Naandi and NICE Foundation WITNESSETH AS FOLLOWS

1. Objective of the project: Provide preventive, promotive and curative healthcare to the under-privileged children studying in government schools at the elementary level (Classes I - VII) in order to enhance their performance and attendance in schools;
2. Tenure of the project: October 2004 to December 2005
3. Project Cost: Naandi shall pay NICE Foundation an amount of Rs. 500,000/- per month up to March 2005 and Rs. 300,000/- per month from April 2005 to December 2005;
4. Project deliverables: The following services will be provided under the Child Healthcare Plan by NICE Foundation:
 - I. Out-patient (OP) facility management
 - i. Every Alternate day 24 OP clinics will be functional with six Pediatricians attending to 2 OP clinics each in a day for 2-3 hours per clinic, OP shall function 6 days of the week;
 - ii. Pediatrician's responsibilities include examination of patients attending OP clinics, dispensing drugs, advising the patients or their guardians and referring patients to Shalini hospital or to speciality care hospitals for in-patient care;
 - iii. Providing supplementary drugs/tonics;

- iv. Basic health and hygiene education to all children;
 - v. Training school teachers on health education;
- II. In-patient (IP) facility
- i. Establish referral links with specialty hospitals for children requiring treatment and care of the nature of the specialty;
 - ii. Provision of all medical and surgical services (both minor and major) at specialty hospital;
 - iii. Provision of drugs, disposables and diagnostic services;
 - iv. Hospital stay for the patient and one attendant;
 - v. Present monthly reports on services delivered to government school children;
- III. NICE foundation shall take complete responsibility for all its acts and omissions in the discharge of its services and shall, in no case, take recourse to Naandi;
5. Naandi shall provide funding support to and facilitate the programme to achieve the desired outcomes and objectives and shall take Monitoring and Process Documentation of the project.
6. Release of Project Disbursements
- I. Naandi shall release project disbursements, in advance (before the beginning of each quarter) on the basis of a “fund request” from NICE Foundation on a quarterly basis;
 - II. The first disbursement shall be made on completion of pre-disbursement formalities and on the receipt of fund request for the first quarter;
7. Utilisation of Grant Funds
- I. Grant funds shall be utilized in accordance with the detailed budget specifications; A statement of expenditure shall be submitted within one month from the date of completion of each quarter; However, expenditures incurred at any point of time during the tenure of the project in excess of the budget provided for the relevant budget head may be ratified by Naandi subject to the overall project cost;
 - II. Grant funds released from time to time by Naandi shall be remitted into a separate account with a scheduled Commercial Bank and as such all transactions pertaining to the subject project shall be conducted through this account;
 - III. An audited utilization certificate issued by an external auditor shall be furnished annually by NICE Foundation to Naandi;
 - IV. Interest earned, if any, on the grant funds shall form part of grant funds released by Naandi and as such interest shall be utilized for the project activities only;
8. Activity and Financial Reporting
- I. NICE shall produce reports and other related information as and when required by Naandi and in the formats prescribed by Naandi;
 - II. NICE shall submit all accounts on quarterly basis;

- III. Naandi is entitled to take up Budgetary/Financial monitoring or internal auditing of accounts of the project either directly or through an auditor;
- IV. NICE hereby relinquish their intellectual property right and copyright on material produced or contributed by them;
- V. NICE shall prepare and maintain the reports and records and all the information obtained in the course of work under this contract shall be furnished to Naandi whenever necessary

For **Naandi Foundation**

For **NICE Foundation**

ANNEXURE - 5

Memorandum of Understanding – Shalini Hospital

MEMORANDUM OF UNDERTANDING BY AND BETWEEN NAANDI FOUNDATION AND SRISHTI ASSOCIATES

Whereas Naandi Foundation, commonly referred to as Naandi, a Public Charitable Trust registered under the Indian Trusts, 1982 was set up with the objective of bringing about people centred development process in the state of Andhra Pradesh.

Whereas Srishti Associates is carrying on the activity of providing “mother and child healthcare” under the name and style of “Shalini Hospital” situated in Barkatpura, Hyderabad.

Whereas Neonatal Intensive Care and Emergencies, commonly referred to as NICE Foundation is a unique not-for profit initiative set up with the primary objective of providing emergency medical care to the newborn to reduce neonatal mortality.

Whereas Naandi, as part of its “Ensuring Children Learn” program in 300 government schools in 5 mandals of Hyderabad district, proposes to take up a comprehensive child healthcare plan in collaboration with Shalini Hospital and NICE Foundation.

Whereas Shalini Hospital shall provide In-patient (IP) Care and NICE foundation shall provide Out-patient (OP) Care at the schools and deliver speciality care through networking with speciality hospitals.

THIS MOU BY AND BETWEEN Naandi and Shalini Hospital WITNESSETH AS FOLLOWS

1. Objective of the project: Provide IP Care to the underprivileged children studying in government schools at the elementary level (Class I - VII) covered under the School Child Healthcare Plan of Naandi and referred to for the purpose by Nice Foundation;
2. Tenure of the project: October 2004 to December 2005
3. Project Cost: Naandi shall pay Shalini Hospital an amount of Rs. 300,000/- per month up to March 2005 and Rs. 200,000/- per month from April 2005 to December 2005;
4. Project deliverables: The following services will be provided under the Child Healthcare Plan by Shalini Hospital:
 - I. 24 hour patient and emergency services;
 - II. Day care facilities for children requiring investigations;
 - III. Provision for hospital stay of patient with a parent/guardian, along with food for both;
 - IV. Allocation of 30 beds at the base hospital, to be used exclusively for school children covered under the plan;
 - V. Minor and major surgeries, when required;
 - VI. Provision of drugs and diagnostic services;
5. Srishti Associates shall take complete responsibility for all its acts and omissions in the discharge of its services and shall, in no case, recourse to Naandi;

6. Srishti Associates shall allow the representatives of Naani Foundation and NICE Foundation to visit Shalini Hospital and check the quality of services provided to the children;
7. Naandi shall provide funding support to and facilitate the programme and interventions to achieve the desired outcomes and objectives and shall take Monitoring and Process Documentation of the project.
8. Release of Project Disbursements
 - III. Naandi shall release project disbursements, in advance (before the beginning of each quarter) on the basis of a "fund request" from Shalini Hospital on a quarterly basis;
 - IV. The first disbursement shall be made on completion of pre-disbursement formalities and on the receipt of fund request for the first quarter;
9. Utilization of Grant Funds
 - I. Grant funds shall be utilized in accordance with the detailed budget specifications and mode given in the proposal; A statement of expenditure shall be submitted within one month from the date of completion of each quarter;
 - II. Grant funds released from time to time by Naandi shall be remitted in an account maintained with a Scheduled Commercial Bank and as such all transactions pertaining to the subject shall be conducted through this account;
 - III. An audited utilization certificate issued by an external auditor shall be furnished annually by Shalini Hospital to Naandi;
 - IV. Interest earned, if any, on the grant funds shall form part of grant funds released by Naandi and as such interest shall be utilized for the project activities only;
10. Activity and Financial Reporting
 - I. Shalini Hospital shall produce reports and other related information at regular intervals as required by Naandi and in the formats prescribed by Naandi;
 - II. Shalini Hospital shall submit accounts on quarterly basis in the formats prescribed by Naandi. Naandi is entitled to take up Budgetary/Financial monitoring or internal auditing of accounts of the project either directly or through an auditor;
 - III. Shalini Hospital hereby relinquish their intellectual property right and copyright on material produced or contributed by them, including reports and documentation produced under this contract. All such rights shall belong to Naandi who may freely transfer them to others entirely at its discretion;
 - IV. Shalini Hospital shall maintain proper reports and records and all the information obtained in the course of work under this contract shall be duly furnished to Naandi whenever necessary.

For **Naandi Foundation**

For **Srishti Associates**

ANNEXURE - 6

Memorandum of Understanding – CARE Hospital

**This Deed of Memorandum of Understanding is entered into
on this 1st day of June 2005**

Between

M/s. NICE FOUNDATION a Society registered under the Public Charitable Trust (vide Registration NO 1607, IV 32 of 2002) having its Registered Office at 4-1-1056, Bogulkunta, Hyderabad - 500 001 represented by its Chief Executive Officer, Dr. M. Padmanbh Reddy hereinafter referred to as "NICE FOUNDATION" which expression shall unless repugnant to the context mean and include all its administrators, managers, agents, successors, executors and assignees etc., of the First Part.

And

M/S. Quality Care India Limited, (CARE Hospital) a Company incorporated under the Companies Act, 1956 (vide Company Registration NO 01-14728) having its Registered Office at 6-3-248/2 Road NO 1, Banjara Hills, Hyderabad 500 034 represented by its Chairman and Managing Director, Dr. B. Soma Raju hereinafter referred to as "CARE HOSPITAL" which expression shall unless repugnant to the context mean and include all its administrators, managers, agents, successors, executors and assignees, etc. of the Second Part.

Whereas:

The Government of Andhra Pradesh in partial modification to its Lr. NO. 9037/K1/2005-1, dt 03.05.2005 informed the Naandi Foundation that it authorized the Foundation to refer cases of children suffering with Heart diseases to any authorized Hospital designated as referral hospitals for heart surgery / treatment under the child heart diseases programme (copy enclosed).

M/S. NICE FOUNDATION a Society registered under the Public Charitable Trust has an arrangement with Naandi Foundation which has the authority to deliver health care to the Government School going child and the schools registered under this plan will be extended necessary assistance to undergo the required medical treatment.

In its endeavour for this purpose it approached CARE HOSPITAL.

Whereas CARE HOSPITAL is a multi health care service provider and has hospital units at various locations is desirous of helping NICE Foundation in nits endeavour for achievement of the stated objectives on the following terms and conditions:

1. NICE Foundation will refer the children identified for speciality care.
2. CARE Hospital shall provide the services at a concessional tariff revised which is described more fully in Annexure - 1.
3. CARE Hospital shall raise a consolidated monthly bill for the services rendered to out patient and in patient referred by NICE Foundation shall settle the claim within one month from the date of submission by CARE Hospital.
4. NICE Foundation be assisted CARE Hospital to apply for various organizations for funds to meet the medical expenses of these needy children.

5. CARE Hospital helps the children with heart defects to apply to CARE Foundation for assistance since it is managing the Little Hearts Fund.
6. All disputes between the Parties arising out of the matters mentioned above in this Memorandum of Understanding and other matters which are incidental to the same shall be resolved through Arbitration as per the Arbitration and Conciliation Act, 1996 and its statutory modifications thereunder. The venue of Arbitration shall be Hyderabad and the language shall be English.

The original of the Memorandum of Understanding in duplicate on Stamp Papers of Rs. 100/- each and duly signed by the Parties are exchanged inter se.

IN WITNESS WHEREOF both the parties have signed this MOU on the day, month and year mentioned herein above.

For **NICE FOUNDATION**

For **QUALITY CARE INDIA LTD,**

WITNESSES:

Annexure 1.

Concessional Tariff Structure:

1. For Out Patient Evaluation:

i) Consultation	Free
ii) ECG	50% concession
iii) Echo	50% concession
iv) Labs	50% concession
v) Radiology	25% concession

2. For In-Patient Treatment:


A. Packages	As per subsidized general ward
B. Non Packages	
i) Bed charges	Subsidized general ward
ii) Consultation	Free
iii) Drugs and Disposables	Actuals
iv) Labs	40% concession
v) Radiology	25% concession
vi) OT Charges	25% concession
vii) ICCU Charges	50% concession
viii) Ventilator Charges	50% concession
ix) Professional Charges	0% to 100% concession at the discretion of the professional

ANNEXURE - 7. Health Camp Information Report

[illegible]

Complaints:	
Presenting VA	RE: LE:
Using Spectacles :	Yes / No
Eye Specialist Observation : Dr.	
Oral Hygiene Status :	
Plaque :	
Calculus :	
Stains :	
Dentition Status :	
<div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;"> 55 54 53 52 51 61 62 63 64 65 66 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> <div style="text-align: center;"> 18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28 48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> <div style="text-align: center;"> 85 83 82 81 71 72 73 74 75 76 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div> </div>	
Occlusion:	
Other Problem:	
Final Diagnosis and Treatment Plan	

ANNEXURE - 8. Information Leaflet (Telugu & Urdu)



వైద్య చికిత్సా కేంద్రము (OP Clinic)

ప్రియమైన విద్యార్థిని, విద్యార్థులు మరియు వారి తల్లి దండ్రుల సహాచారమునకై !!!

బంద్రగూడ, బహదూర్‌పూరా, ఆసిఫ్‌నగర్, గోల్కొండ మరియు షేక్‌పేట్ మండలములలో ఉన్న ప్రభుత్వ పాఠశాలల యందు 'నాంది ఫౌండేషన్' ఆధ్వర్యంలో విద్యపొందబడుచున్న వైద్య చికిత్సా కేంద్రములు (OP Clinic) 'వేసవి సెలవులలో' కూడా యథాతథముగా కొనసాగును. ఈ అవకాశమును ఉపయోగించుకొనగలరు.

అవసరమైనచో ఆరోగ్య సేవలను బంద్రగూడ నందు పొలిసి పిల్లల ఆసుపత్రి నందు కూడా అందించబడును.

అందుకు గాను ప్రతి-ఒక్కరూ విధిగా తమ ఫోటో ధృవీకరణ పత్రమును (Photo Identity Card) చూపి సేవలను పొందగలరు.

అత్యవసర వైద్య సహాయం కొరకు సంప్రదించవలసిన ఫోన్ నెం. **1600 425 4084**


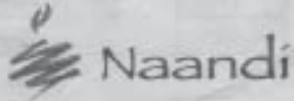
(OP Centre) آؤٹ پشٹ کلینک سنٹر

طلباء و طالبات اور سرپرستوں کو اطلاع دی جاتی ہے کہ چا تلڈ ہیلت سنٹر-گرمائی تعطیلات میں بھی کھلا رہے گا۔
ایسے طلباء و طالبات جو سرکاری مدارس، پبلک سکولز اور پرائیویٹ اسکولز میں تعلیم ہیں
اس سہولیت سے استفادہ کر سکتے ہیں

نا ندی فونڈیشن

اس کی جانب سے تمام بیماریوں کا علاج چا تلڈ ہیلت سنٹر میں کیا جائے گا
طلباء و طالبات کے علاج کے لئے "شالینی بچوں کا دوا خانہ" جو کہ برکت پورہ جی 2 پاؤ میں واقع ہے اس کی خدمات بھی میسر آئے گی
نوٹ: بچوں کے علاج کے لئے اسکول کا ہیلت شہتہی کارڈ ہونا ضروری ہے۔

فری میڈیکل ایمرجنسی نمبر: **1600 425 4084**

Out-Patient Clinic

For the information of Students and their Parents


Under the auspices of "Naandi Foundation", medical treatment centres (Out-Patient Clinics) are being organized, as usual, during summer vacations, in the government schools of Bandlaguda, Bahadurpura, Asifnagar, Golconda and Shaikpet mandalams. Make us of this opportunity.

If necessary, medical services can also be organized in the "Shalini Children's Hospital", Barkatpura

To avail to these services, every one has to show one's Photo Identity Card

For emergency medical services, contact Tel N0: **1600 425 4084**

ANNEXURE - 9. Membership Card

CHILD HEALTHCARE PLAN	
GPS KULSUMPURA ASIF NAGAR	Card No. 24-5-72-6
Class : 4	
Name : Marriyu Begum	
Parent : Ammad Makashin	
Address : 18-11-67/A/3 Barkas	
Identification Mark: A mole on the right hand	Date of Birth : 05-Jul-1994 Date of Issue : 8-Dec-2004

Emergency Number : 27568776
<ul style="list-style-type: none">• Always carry this card with you• Mention the Card No. when you call for Emergency help• Do not give the card to anyone• If you lose the card call the Emergency Number• The card is valid for 3 years or your finishing VII class whichever is earlier
<i>If found, return to:</i> Child Healthcare Center (Shalini Hospital) 3-4-140, Barkatpura, Hyderabad 500027 Email: healthcare@naandi.net Website: www.naandi.org

ANNEXURE - 10. Hospital Referral Slip



Shalini Hospital

3-4-140, Barkatpura Chaman, Hyderabad - 27.

Phone : 2756 8776, 2755 0763

Name _____

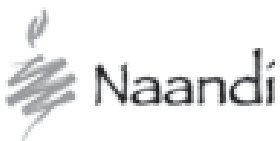
Age _____ Sex _____ Date _____

Ref. by Dr. _____



24 hours Pediatric Emergency Care

ANNEXURE - 11. Student Details Form

	
STUDENT DETAILS	
Child Id	: _____
School Name	: _____
Surname	: _____
Child Name	: _____
Parent Name	: _____
Class	: _____
Caste	: _____
Date of birth/Age	: _____
Religion	: _____
Gender	: _____
Identification marks	: 1. _____
	2. _____
Address	: _____

Phone (If any)	: _____

ANNEXURE - 12. School OP clinic - Record Book

[illegible]

ANNEXURE - 13.

Example of Morbidities being Treated at the Base Hospital

Month of June 2005

S. No	Type of case	Medicines Dispensed
1	Chronic Tonsillitis	5
2	CHD	7
3	LT CSON	5
4	Cervical Lymphoditis Tubercul. Infection	5
5	Tonsillitis	7
6	VSD	7
7	Accidentall Fall from Bicycle	2
8	Pain in Abdomen	5
9	Enteric Fever	10
10	Cervical Lymphodenopathy	4
11	Diabetes	5
12	Enteric and Malaria Fever	4
13	Fever	4
14	Tonsillitis	5
15	Tonsillitis	4
16	Tonsillitis	4
17	Tnsillitis	5
18	Observation	2
19	Congenital Heart Disease	11
20	Enteric Fever	5
21	Fever	6
22	Fever	6
23	Appendicitis	6
24	CHD & RTI	4
25	Chronic Tonsillitis	5
26	Cardiac Patient	9
27	Cardiac Patient	6
28	Fever Evaluation	3
29	Chronic Abdominal Pain	7
30	Cardiac Patient	3
31	Admitted in CARE Hospital	2
32	Lipoma	5
33	Bilateral Tonsillitis	5
34	Situs Inversis with Bronchitis	8
35	LTSCOM	5
36	Bilateral Tonsillitis	5
37	Bilateral Tonsillitis	3
38	Bilateral Tonsillitis	4
39	Ortho	22
40	Abdominal Pain	5
Total		225

ANNEXURE - 14.

Giving a Future to a Young Girl : Anusha's Story...

"Your daughter has a hole in her heart", the doctor told us the day after Anusha was born. We didn't know what it meant then, just feared that our daughter's life was at risk. The doctor consoled us saying a surgery would make it okay. But since I earned only Rs. 2,500 to 3,000 in a month as a tailor, there was no way we could afford the Rs 2 lakh surgery, even if we mortgaged everything we owned. Ever since, whenever we heard of a free health camp we would take Anusha there hoping for a miracle. We've gone to all the hospitals that have schemes to help white ration card holders. Anusha's name was put on many waiting lists for heart surgeries, I even got MLA's recommendation letter but nothing happened.

Breathlessness and fainting spells wre her life. She could barely attend classes; she'd go to school maybe eight or ten days in a month. If she walked a few steps she'd break out in a sweat and have to rest to get her breath back. There was a time when she went missing. We found her loitering in another lane looked dazed. She had fainted and couldn't remember where she was. As parents we felt terrible that we couldn't hep her. We decided to take her out of the private school and shift her to the government school nearby so she could be under our supervision. I think it was the best decision we ever made.

M. Krishna

Anusha's father, Kulsumpura, Hyderabad

This programme, more than anything else, will bring children back to schools, It is a great source of security and faith for the parents that the health of their child is in safe hands, and it's free. Word about the healthcare programme and the success of the surgeries has spread in the entire area. Fifty five children have enrolled in the school since the healthcare programme began six months back. I've been a principal for eight years in this school, I know the conditions the parents and children come from, this is the best support one could have given them. It has given life to Anusha and so many like her, and it continues to give good care to the children at the out-patient clinics that are run at various schools.

Bala Malleshwari

Headmistress, Government Primary School, Kulsumpura

"We couldn't believe Dr. Gopichand would be operating on our daughter". We saw him on TV one day. He is supposed to be one of the best doctors in the world. To have him operate on Anusha was a blessing, we could not have asked for more. He spoke with us very gently after the surgery. He said all would be well. Miracles happen. Naandi has made our miracle possible.

Vijaya

Anusha's mother, after the surgery

The School healthcare programme is the one actually playing the role of god for many families. What it has started is a long pending wish come true for many doctors. Supporting it is our way of giving back to society. Today Anusha is as normal as any other child. The hole in her heart, in her case meant blood was overflowing from one lower chamber of the heart (the one that pumps blood into the body) into the other (which send blood to the lungs) though a hole in the connecting wall. The lungs as a result were receiving more blood than they could

handle, and any minor effort made by Anusha - even talking for a long time - was pumping more into the lungs making her breathless. During the surgery we sealed the hole between the two chambers with a tissue from the pericardium. She will be just fine now.

Dr Gopichand Mannam

Chief of Cardio Thoracic Surgery, Care Hospital, Hyderabad

A contributor to the School Healthcare Programme



“I’m proud of the scar on my chest”. It’s making me a heroine, Lot of people visit me now from my school and the neighbouring schools. The hospital has given me a toy monkey to play with because they don’t want me to run about as yet. But the doctor said I’m going to get well soon and can join the skipping rope races with my friends. Earlier I used to watch them playing “round the world” (a game devised by the girls in the colony) with the skipping rope; soon I am going to go round the world too, with my skipping rope.

Anusha

Std III, Government Primary School, Kulsumpura

After her heart surgery

Rs 10 per child per month is all it takes to run this programme. A lot of logistical planning goes into making this possible. But once you have the people with the right spirit backing you, and are able to get the right infrastructure and tie-ups in place, you can give these deserving children, quality healthcare. At rs 10 per month we have shown it is possible. When Mr Montek Singh Ahluwalia (Deputy Chairman, Planning Commission) visited Hyderabad, he had remarked that this programme might be worth replicated across the country. If this can be taken to scale, I can guarantee it will cost less than Rs 10 per child per month - a mere fraction of what it costs for the midday meal.

Dr Padmanabh Reddy

CEO, NICE Foundation

Medical Partner for the School Healthcare Programme

ANNEXURE - 15. BRIEF ON PROMOTERS

- ❑ **Dr Padmanabh Reddy** - A Paediatrician by profession, Dr Reddy has 19 years of experience and passion for promoting children's health. Deriving from his long years of experience as a medical professional and researcher, Dr Reddy conceptualised the school health programme along with the CEO of Naandi Foundation. He has since then been deeply involved in translating the strategy into action on the field. With his dedicated team of Paediatricians, Dr Reddy has been delivering quality healthcare at all the clinics and base hospital for the last 15 months.

Inspired by his commitment to children's health and this unique model of service delivery, other medical specialists have been contributing to the programme by offering their services free of cost. Keeping the health needs poorest of the poor topmost in his mind, Dr Reddy is relentless in his pursuit of ways to bring the best quality healthcare to all the disadvantaged children of the country.

- ❑ **Mr Manoj Kumar** - As the Chief Executive Officer of Naandi Foundation, Mr. Kumar was instrumental in conceiving this model along with Dr Padmanabh Reddy. Putting to test his knowledge and prior experience in the banking sector and devising financial models, Mr Kumar put to test the design and viability of this scheme. Naandi's presence in 300 government schools of Hyderabad provided a platform for piloting this strategy. Having been successful and scaling up the model to various other locations the school health programme has drawn the attention of other state governments who have now invited Naandi to implement the same for their school children.

ANNEXURE - 16.

Physicians / Specialists Supporting the Programmea

Sl. No	Doctor's Name	Desianation	Hospital
	Cardiac		
1	Dr. K. Nageswara Rao Koneti	Paediatric Cardiologist	CARE Hospital
2	Dr. Kalyanasundaram	Cardiologist	CARE Hopsital
3	Dr. Gopichand Mannam	Chief of Cardiothoracic Surgery	CARE Hospital
	Neurology		
4	Dr. J.M.K. Murthy	Chief of Neurology	CARE Hospital
5	Dr. T.V. Ramakrishna Murthy	Consultant Neuro Surgeon	CARE Hospital
6	Dr. Syed Ameer Basha Paspala	Consultant Neuro Surgeon Gastroenterology	CARE Hospital
7	Dr. D. Nageswar Reddy	Chief Gastroenterologist	Asian Institute of Gastroenterology
8	Dr. G.V. Rao	Chief of GI & Minimally Invasive Gastroenterology	Asian Institute of Surgery
	Orthopaedic		
9	Dr. Radhakishan Rao	Paediatric Orthopaedic Surgeon	Consultant, Durushevar Children's Hospital
10	Dr. Deepak	Orthopaedic Surgeon	Consultant
	Dental		
11	Dr. P. Srinivas Reddy	Oral Maxiallo Facial Surgeon	FMS Dental Hospitals
	ENT		
12	Dr. Venkat Ram Reddv	Consultant Urologist Vice President Operations	Consultant
13	Dr. Ramesh Ramayya		Pramila Hospitals
14	Dr. Sanjay Chincholikar		Pramila Hospitals
	Eye		
15	Dr. Ravi Thomas	Director	LV Prasad Eye Institute Paediatrics
16	Dr. WSS Chandrasekaram	Surgeon, Consultant Paediatric Urologist	Shalini Children's Hospital
17	Dr. Madhumohan Reddy	Paediatric Surgeon	Shalini Children's Hospital
18	Dr. Prabhavati	Paediatric Anaesthetist	Shalini Children's Hospitals
19	Dr. Raju	Anaesthetist	Shalini Children's Hospitals
	Other Specialities		
20	Dr. V. Gowri	Professor & HOD, Dermatology, OMC	MNJ Cancer Hospital Mahavir Hospital & Research
21	Dr. M. Ramakrishna	Oncologist	
22	Dr. K.J.R. Murthy	Chest Physician	
23	Dr. B. Prabhakar Reddy	Specialist in Hearing & Speech Aids	Apollo Hospital Dr. Sayan's Rehabilitation Aid's
24	Dr. Mehul A. Shah	Nephrologist	
25	Dr. M.Y. Sayani	Chartered Physiotherapist	
26	Dr. Kishore L.T.	Chief of Radioloay & Imaaina	CARE Hospital
27	Dr. Y. Venkat Rao	Plastic, Hand & Cosmetic Surgeon	CARE Hospital
28	Dr. Bipin Kumar Sethi	Consultant Endocrinologist	CARE Hospital
29	Dr. Gouri	Child Psychologist	Shalini Children's Hospital
30	Dr. Nirmala	Physiotherapist	Shalini Children's Hospital

