REACHING THE POOR WITH HEALTH SERVICES

2007

India

Community-Based Women's Trade Union Brings Health Care to the Poor

The Self-Employed Women's Association (SEWA), a trade union, was founded in 1972 in Ahmedabad, Gujarat State, India, to empower poor women who earn a living outside the formal sector through their own labor or small business. These women don't earn a regular salary and have no welfare benefits like those employed in the organized sector.

SEWA had two main goals; (a) to help these women achieve full employment which would offer security for work, income, food and social protection, and (b) to make them individually and collectively self-reliant, economically independent and capable to make their own decisions. In addition to banking and credit services (SEWA Bank), and insurance (Vimco SEWA), SEWA became actively involved in public health services in the early 1970s, to provide its members and non-members with some form of preventive and primary health care. It aimed to serve the very poor, particularly those living in areas not otherwise served by government or non-government organizations (NGOs). SEWA had to overcome many challenges to provide the needed health service to those very poor.

Health Care in Gujarat

In India, as elsewhere, the poor die earlier, are more prone to illness, and have less access to health care than the better off. Reaching this poor, largely illiterate, and geographically dispersed population, especially residents of remote rural areas, poses many challenges. Foremost among them are identifying and overcoming difficulties the poor face in obtaining health care.

India's public sector is vast but underfunded and not nearly large enough to meet current health needs. The private sector is growing quickly, but it is unregulated. Lacking standards of care, it has many unqualified practitioners who likely provide too many inappropriate treatments. Patients pay out of pocket for much of their care, both public and private.

In Gujarat, relative to all-India, the private for-profit health care sector is thriving. The problems with publicly and privately provided care are the same in Gujarat as elsewhere in India. Most people, in both urban and rural Gujarat, use the private sector for outpatient and inpatient services. According to the 1995–96 National Sample Survey Organization (NSSO) survey, nearly 82 percent of outpatient treatments among rural residents were obtained from private providers, as were 76 percent in urban areas. The private sector accounted for 71 percent of hospitalizations in urban Gujarat and 67.4 percent in rural Gujarat. Among the areas included in this study, the public health care system is strong only in Ahmedabad City, where four large government hospitals provide outpatient and inpatient care.

Distance and lack of financial resources are major barriers to health care seekers among the poor in Gujarat. Health care (particularly curative, expensive, inpatient care) is widely available in urban centers. But for village dwellers far from an urban center, the closest source of health care may be hours away. Twelve percent of rural women have to travel at least 5 km to reach the nearest health facility. Based on the 1995–96 NSSO Survey, the wealthiest quintile of rural Gujaratis (measured by yearly household expenditure) was 4.6 times as likely to have been hospitalized over a one year period than the poorest quintile. In urban areas, the ratio was 2.9.

SEWA Health Services

SEWA first became actively involved in the public health field in the early 1970s through health education and provision of

maternity benefits. In the early 1980s, SEWA negotiated with the Indian government to help distribute maternity care to poor women. A focus of SEWA Health has always been to build capacity among local women, especially traditional midwives *(dais)*, so that they become barefoot doctors in their communities. Today, SEWA's health-related activities are many and diverse. They include: primary health care delivered through 60 stationary health centers and mobile health camps; health education and training; capacity building among local SEWA leaders and dais; provision of high-quality low-cost drugs through drug shops; occupational and mental health activities; and production and marketing of traditional medicines. Reaching the Poor deals with the three activities summarized in table 1.

The Reproductive Health Mobile Camps

In response to demand from people in remote and under-serviced areas, SEWA Health began organizing reproductive health (RH) mobile camps for women in 1999. RH mobile camps are carried out mainly in the slum areas of Ahmedabad City and in the villages of three districts and are funded largely by the United Nations Population Fund (UNFPA) and the Government of India. More than 35 camps are carried out per month, and the mean attendance per camp is 30 women, for a total of more than 12,500 patients per annum. Health care at the camps is provided by empanelled physicians and 50 barefoot doctors and managers. The camps are repeated in each area, on average, once per year.

Table 1. The Three SEWA Health Services Covered by Reaching the Poor

Variable	Reproductive health mobile camps	Tuberculosis detection and treatment	Women's education sessions
Start-up date	1999	1999	1999
Target population	Women, reproductive age	Men and women, all ages	Women, reproductive age
Geographic coverage	Mainly Ahmedabad, Kheda, and Patan Districts	North and East Zones of Ahmedabad City (population 375,000)	Mainly Ahmedabad, Kheda, and Patan Districts (but also the other districts where SEWA Union has members)
Services	Education and training; examination and diagnostic tests (cervical examinations and Pap smears; treatment, referral; follow-up	Diagnosis; treatment; medicines	Education: SEWA orientation; first aid; general disease and HIV/AIDS; immunization and child care; airborne and waterborne diseases and tuberculosis; sexual and reproductive health
Annual utilization rate	12,500 women	575 patients under treatment at the DOTS center; 23 served by barefoot DOTS workers	6,000 women
Cost to user	Rs 5 consultation fee; medicines sold at wholesale price (about one-third market price)	Services free; indirect costs only	Rs 5 SEWA Union membership fee
External donor	UNFPA and Indian government	WHO, Indian government, and Ahmedabad Municipal Corporation	Indian government, UNFPA and Ford Foundation
Human resources	6 part-time physicians 50 barefoot doctors and managers	5 stationary centers (each with 2 to 3 staff) and 11 grassroots DOTS providers	35 grassroots workers and full-time staff

DOTS Directly observed treatment, short course; UNFPA United Nations Population Fund.

Source: Table 9.1, Gwatkin, Wagstaff, and Yazbeck (2005).

Activities at the RH mobile camps include health education and training, examination and diagnostic tests (including cervical examination and Pap smears), treatment, referral and follow-up. Camps are usually held during the afternoon, and their duration is three to four hours. Those attending the camps are asked to pay a 5 Rupees (US$0.11) contribution, and one-third of the total cost of medicines provided (although even these fees may be waived for those who are very poor.)

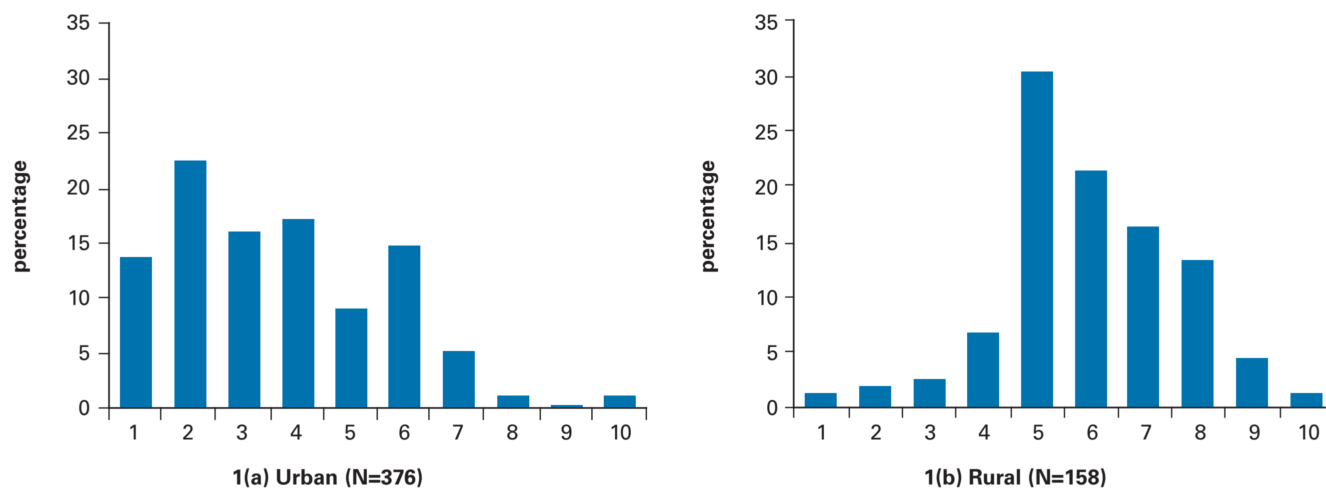
Increasingly in rural areas, SEWA Health is conducting these camps in collaboration with the Government of Gujarat, with camps held right at government primary health centers (PHCs), which are usually located in or near small villages. These camps differ from the standard "area" camps (described above) insofar as medicines are given for free, the range of medicines available are restricted to those on the government's formulary, and health care is provided by public doctors and nurses. Free transportation is provided by SEWA to women living in neighboring villages.

Reaching the Poor

376 urban and 158 rural women were surveyed to assess the socio-economic status (SES) of the women using the RH mobile camps, as they attended randomly selected camps. They were compared to the general urban and rural populations of Gujarat, using recent, representative surveys. It was found that the RH mobile camps are very effective at reaching poor women in Ahmedabad City. A comparison based on a composite SES index showed urban camp users to be significantly poorer than the population of Ahmedabad. Camp users (and their families) were, for example, significantly less likely to possess a motorcycle or scooter (12 percent vs. 43 percent), were more likely to rely on public (vs. private or shared) toilets (22 percent vs. 9 percent), and were less likely to use natural gas as a source of cooking fuel (35 percent vs. 66 percent). Figure 1(a) illustrates the distribution of urban camp users by deciles of the SES index score–the leftward skew of this graph indicates that camp users were more likely to be from poorer segments of the general population. The percentage of camp users falling below the 30th decile of the SES score—which roughly approximates the poverty line in India—was 52 percent (Figure 1).

In rural areas, the camps were less effective in reaching poor women. Rural women did not differ significantly from the general, rural population in terms of their SES index score. Figure 1(b) indicates that the majority of rural camp users are from less poor deciles of the population. Only 5.7 percent of users fell below the 30th percentile–suggesting that SEWA Health's rural RH mobile camps do not effectively target the very poorest.

Figure 1. **Frequency distribution of SEWA reproductive health mobile camp users, urban and rural, by deciles of the SES index score**



Source: M. Kent Ranson, Palak Joshi, Mittal Shah, and Yasmin Shaikh: "India: Assessing the Reach of Three SEWA Health Services among the Poor," in *Reaching the Poor,* Gwatkin, Wagstaff, and Yazbeck Editors, World Bank, Washington, 2005

What Worked and Why

For the most part, the urban services seemed to be effectively targeting the poor. Reasons for this success are likely to include:

- SEWA personnel treat people with respect and warmth and give them detailed information;
- Services (especially RH mobile camps and women's education sessions) are offered "right at people's doorsteps", i.e. SEWA Health takes the services to the poor, rather than trying to bring the poor to the services;
- The services are delivered by women and by (or at least in part by) the poor themselves;
- The services are generally combined with efforts to educate and mobilize the community; for example, preceding the RH mobile camps, SEWA Health workers go door-to-door, educating people about the service, and educating people on how to use it;
- Services are free or low cost and medicines are much cheaper at SEWA facilities than in private shops;
- SEWA is an entity that people know and trust.

In-depth interviews with SEWA Health grassroots workers suggest that there are two main barriers that prevent poor rural women from using the RH mobile camps. First, for some, the 5 rupee registration fee prevents some from attending the camps. Second, the camps may be difficult for women to attend, as they often coincide with hours of work.

There are likely to be other, broader reasons underlying the difficulties in delivering services to the rural poor. Studies in other SEWA departments have documented similar discrepancies in the equity of utilization of rural versus urban services. For example, the poorest rural members of SEWA's insurance scheme (Vimo SEWA) have lower rates of claims than the less poor. Reasons for this differential include:

- Problems of geographic access, both to inpatient facilities and to Vimo SEWA's grassroots workers;
- Weaker "links" between members and local Vimo SEWA representatives in rural areas (i.e. the contact between members and the organization is less frequent, and less intensive, in rural areas);
- Weaker capacities among Vimo SEWA grassroots workers in rural areas.

SEWA Health has taken steps to improve the accessibility of the rural RH mobile camps. SEWA Health waives the registration fee and the medicines fee for those who appear to be particularly poor–typically a few women presenting to each camp. Perhaps these exemptions could be granted more liberally, and in a manner more objective, for example, by providing exemption to all those who possess a below poverty line (BPL) card.

It must also be remembered that failure of a service to reach the poorest of the rural poor does not necessarily mean that the service has failed in "reaching the poor." Even those households that fall in the higher deciles of the SES index in rural areas should be considered "less poor" rather than "wealthy." Compared to their urban counterparts, these rural households have less in the way of cash reserves, material wealth, and thus economic security.

In conclusion, the findings of this study suggest that delivery of services through a broad-based, development-oriented union can facilitate equitable delivery of health care services. Government and donors can help to ensure that established NGOs, with an interest in providing health services, have the capacity and the resources to do so.

This brief is intended to summarize good practices in Health, Nutrition, and Population. It was adapted from M. Kent Ranson, Palak Joshi, Mittal Shah, and Yasmin Shaikh, "India: Assessing the Reach of Three SEWA Health Services among the Poor," chapter 9 in *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why,"* Davidson R. Gwatkin, Adam Wagstaff, and Abdo S. Yazbeck, eds. (Washington, DC: World Bank, 2005). The views expressed in this note do not necessarily reflect those of the World Bank.