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Sandesh

"The Message"
A Newsletter from IndUS of Fox Valley

From Editors' Desk

Dear Readers,

In debating the societal and economic ramifications of healthcare reform, it is easy to lose sight of the focus of healthcare itself: the individual. While healthcare policy triggers systemic changes eventually affecting those needing care, efforts at the grassroots level can deliver healthcare when and where they are most needed. Our February issue presents a variety of community-based models of healthcare delivery – private, non-profit, rural, and suburban. Though diverse in scope and objectives, all these efforts are united by a central theme: the promotion of health is a collective responsibility, and that we are all "involved in mankind" (John Donne 1572-1631).

Sandesh

An IndUS of Fox Valley

Publication

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Accessible and Affordable Healthcare Initiatives: Some Reflections from India

Manjusha Sridhar & Sridhar Srikantiah

The Beginnings

It was sometime early in the winter of 1979, when we started clinical terms at medical school, that we were taught the essentials of eliciting a medical history from real patients. The 1200-bed teaching hospital attached to our state-run medical school overflowed with 'clinical material' – patients. They filled up the allotted beds, and occupied the floors and verandahs. A few hundred medical and nursing students and residents and teachers kept track of them. Most of us students came from a growing 'middle class' and had rarely seen the inside of a ward of a public hospital like this before: when someone from our families fell ill, we went to a different kind of hospital – where we did not have to wait in interminable queues, where beds had clean sheets, where bathrooms were usable – all for a price that we believed we could afford.

Our grandparents and parents had used public hospitals (both of us were born in such hospitals) but that was in more difficult times. They in turn had taught us to live within our means. However, we were also protected from experience of living virtually without means. We learnt about that experience from our first patients, as we methodically gathered histories from them. Most were there because they could not afford private medical care, or because they were too sick and thus too risky for the private doctors to continue to treat them. All of them came a public hospital after they were convinced that nothing else would work.

At the large public, teaching hospital, even the basic services often did not function reliably: labs, radiography, antibiotics, and surgical supplies. But, it had something the private sector could never offer: the 24/7 attention of a large number of doctors from a range of disciplines, at very low cost (although opportunity costs and incidentals still counted, services were for free). By and large, all these characteristics still hold today. These hospitals had another unique, humane feature – they never turned anyone away. We were proud of this, and after we graduated out of the medical school, we attempted to replicate this in other settings.

SEWA-Rural: Affordable and Accessible Healthcare

We spent an intensely educational decade with SEWA-Rural, a voluntary organization located in a tribal sub-district of southern Gujarat. Thousands of people lived on the edge of a vast tribal hinterland of hundreds of square miles with scarcely any source of reliable health care. A highly motivated team had struck their roots to provide health care to the least privileged. The 100-bed general hospital provided subsidized outpatient and inpatient services for all. The subsidies were possible because of government grants and private donations. Those who could not afford to pay even this nominal amount were treated free of cost.

It was always difficult to identify patients who were genuinely deserving of fee waivers. Therefore, the policy was to err on the side of not denying care. Even so, this meant trying to make case-by-case

decisions to determine who could afford. Such decisions worked reasonably well, only because the person assigned the thankless task of assessing affordability was deeply knowledgeable of local people and their ways.

With some variations, this remains the operational model for most of the thousands of charity hospitals across the country. They are by and large cleaner, better managed, more popular and less crowded than public hospitals. Individually, these facilities are invaluable to the communities they serve; together, however, they cater to a small fraction of those who need care – the country being so vast.

We also learnt over these years that access is about much more than the ability to pay for services. The old and blind often remained blind because no one at home had any time for them. Women died at childbirth because the unqualified doctor who was called home to attend to her gave her an overdose of an injection to help hasten the delivery. Patients with tuberculosis traveled 300 km and crossed three major cities to come to our rural hospital for treatment because all TB centers in between were specialized centers which did not provide care for minor collateral ailments under one roof, as we did.

Charitable Trusts Try to Fill The Gap

Charitable initiatives represent a sustainable model insofar as altruism is sustainable. There are numerous examples in India that suggest that it can be sustained over many years. One such is the Bhansali Trust, a fascinating effort of a Jain family of diamond merchants hailing from North Gujarat. Bhansali Trust runs a large health program in their native district, including hospitals and outreach care, and supports a range of other social organizations across the state and country. In addition, they organize eye surgical camps at several locations to provide care to populations that have no real alternative.

The largest of these camps is held annually at Bodhgaya, Bihar. This gigantic operation, which has been organized for the past 27 years, starts with a five-month preparatory phase. The patients come from at least four surrounding districts inhabited by ten million people. The month-long surgical camp, conducts about 25000 cataract operations, almost all of them lens implants. These are conducted by a couple of dozen surgeons brought in from different parts of India. Another 8000 spillover patients are operated at a smaller camp at the same site a few months later. All services, including one-way transportation, overnight stay, food, surgery, and medicines are provided free of charge. Complication rates are similar to those in private hospitals. The camp has three-month follow-up phase to ensure sustainability of results. The value of these camps can be gauged from one piece of data: almost all eyes operated here over these years have had fully mature cataracts, and patients would probably have gone permanently blind if they had waited too much longer. The industry standard is to operate at the first sign of cataract. In rural Gujarat, for instance, it is difficult to find any patients at all with fully mature cataracts. It is worth pausing a moment to think of what this says about the state of health access in Bihar. The organizers of the camp have long

GE brings quality healthcare to Indian villages

The Indian arm of GE Healthcare, the healthcare business of General Electric Company, is promoting a unique public -private partnership (PPP) initiative to bring accessible and affordable rural healthcare across India. Under the three way PPP model, state governments provide space, GE donates equipment and a third private partner runs the health centers.

With this model, five diagnostic imaging centers have been set up in five medical colleges and hospitals in Gujarat, another is bringing the benefits of latest technologies to thousands in Jabalpur, Madhya Pradesh and yet another pilot project is underway in Uttar Pradesh.

The latest such PPP project with a difference was launched a couple of months ago to advance availability and use of critical medical technologies and support primary healthcare delivery in Banavaram in Tamil Nadu.

As part of its joint 'healthymagination' initiative, GE Healthcare and a group of its Asian American employees have adopted Banavaram's Primary Health Centre (PHC) in an effort to provide that community with better access to affordable healthcare.

Together, GE Healthcare and GE's company-wide Asian-Pacific American Forum (APAF) are contributing $100,000 (about Rs.4.5 million) for a two-year program that will include creating a medical-technology infrastructure at the clinic and training its employees in its use. At the end of the two-year program, all equipment will be donated to the PHC.

At Banavaram PHC, GE Healthcare will install the latest obstetric and other medical technologies to facilitate institutional deliveries of babies and provide advanced care to mothers, babies and the entire population.

The same model could be used to develop the existing infrastructure capabilities at more than 23,000 PHCs across India, which find it difficult to provide quality healthcare due to their stretched thin, Raja said calling private partnerships critical in increasing healthcare access to the masses.

GE Healthcare has also partnered with various state governments to extend healthcare access and together they are running a number of program in India and Bangladesh.

Partners include Manipal Hospital, Bangalore for cardiac screening in Tamil Nadu, Karnataka and Andhra Pradesh; Grameen Health for maternal and infant care in Bangladesh and NICE Foundation in Andhra Pradesh for maternal infant care and manpower training.

(*Reproduced from Health News, December* 9, 2009)

ceased to make efforts to raise the tens of millions of rupees needed to fund the camps – the camp is sufficiently well-known and funds pour in unasked; any deficit is met from the Bhansali family's personal resources.

Between them, public and charity institutions account for a substantial portion of in-patient care in India. The rest is accounted for private providers, who at best, are friendly and enterprising, and at worst, opportunistic. A common limiting feature of all three models is the high cost of drugs and consumables that is imposed even on the least affording patients, and doubtless contributes to the fact that serious illness in the family is the single most important cause of indebtedness among the poor.

The cost to patients is high not only because medicines are priced high, but also because many of these prescriptions are irrational and unnecessary.

A movement for rational drug use and pricing has been an important element of the larger movement for primary health care in India. One particular initiative is worth recounting here. In 1983, an organization called LOCOST arose from this movement, and now produces about 80 formulations of essential medicines of guaranteed quality at the lowest possible prices, for use by charitable institutions across the country. It has its own production unit near Vadodara, Gujarat, which adheres to all patent regulations, good manufacturing practices and quality control procedures. Many of the medicines are provided to non-profit institutions at a small fraction of the cost of equivalent popular market brands. LOCOST also actively promotes rational therapy. Its work in pharmaceutical policy advocacy has resulted in the elimination of several categories of harmful and irrational drugs from the Indian market, and has contributed significantly to the recent introduction of generic drugs in the market from high-end pharmaceutical companies.

A popular notion is that things could be turned around by bringing the private sector directly into health care. We know from long experience that private care providers understand access far better than does the public sector, and indeed thrive because they are accessible. But we also know that they often seriously compromise on the quality of care and will usually have nothing to do with patients who have limited earnings. We also know that the public health services are far less expensive, but suffer from insensitive and unimaginative planning and implementation. That makes them inaccessible to those who need them. What is needed to improve the accessibility is a combination: of the spirit of public service from the governmental and charitable institutions, and the rational, entrepreneurialism of the private sector. But we do not yet have many effective models to emulate.

An alternative approach is to improve the public sector through the democratization health care governance. The National Rural Health Mission, launched five years ago, is attempting to do this through massive investments in improving public health infrastructure and setting up a network of community structures to oversee the adequate utilization of these investments. These include a woman community volunteer called the Accredited Social Health Activist (ASHA), and community bodies to manage government health facilities so that they become more accessible and effective. The hope is that local ownership will provide the enterprise to make this happen, but it is yet too early to fully judge its success. □

Manjusha and Sridhar met at medical college in Vadodara, Gujarat. Manjusha completed her graduate degree in ophthalmology, while Sridhar studied pediatrics. During their long association with SEWA-Rural, Jhagadia, Manjusha set up and headed the ophthalmic wing of the hospital, trained paramedics in eye care and organized outreach eye care services. Sridhar explored a wide range of issues related to community health and hospital care. His work encompassed health issues affecting women and children, health, communicable diseases, emergency care, and rational therapeutics. Later, they moved to Rajpipla, deeper into the tribal belt, where Manjusha set up another small eye hospital under a local trust. She continues to provide surgical services there. Sridhar spent an a year at Emory University, Atlanta, GA, on a Hubert H Humphrey Fellowship in Public Health before joining ARCH, a nongovernmental organization to work on health and science education. For the past eight years, he has been providing technical support to several national heath programs that are engaged in child health and nutrition, and malaria control. They can be contacted at sridharmfc@yahoo.com

India: Healthcare Indicators at a glance

Population: 1.01 billion
Rural 741.66 million
Urban 285.35 million

Expenditure on health: 4.9% of GDP
Expenditure on health per capita: $109

Primary Care (in rural areas):
22,271 Primary Healthcare center
137,271 sub-centers
Hospitals: 15, 393
Public 4, 049
Private 11,344
Hospital beds: 875, 000

Doctors: 592,215
Nurses: 737,000
Medical Colleges: 170
New doctors every year: 18,000
Retail Pharmacy outlets: 350,000

(Source: WHO & ICRA report on Indian Healthcare)

The Fox Cities Community Health Center – A collaboration that changed our community

By Kristene Stacker & Sara Saxby

Already in 1997 at least 10,000 people in the Fox Cities had no health insurance or less insurance than they needed. At that time two other factors came into play: the closure of state-funded county voucher programs for medical care and local charity care programs had reached maximum capacity.

The major health care providers in this area found people with no or little health insurance delayed receiving care until they were desperate, and then used hospital emergency rooms as their primary source of care. This was expensive and did little to help with overall healthcare needs. For this reason, Outagamie County Department of Health and Human Services, United Way-Fox Cities, the Partnership Project, Goodwill NCW, the major HMO's and hospitals joined to create the Fox Cities Community Clinic.

Because of Goodwill's connections with the doctors involved in the Southern African Medical Project, it was solicited as a potential site for the new clinic. Goodwill offered to provide space and capital in the Menasha facility to build space to the Clinic's specifications and lease it back to the Clinic. Although the Clinic was a totally separate agency with a separate board of directors, the Clinic's two employees were employed by Goodwill and leased back to the clinic. This allowed the employees to have health, dental, and pension benefits without burdening the Clinic with those expenses. In addition Goodwill provided management and maintenance services to the Clinic.

By 2004 the Fox Cities Community Clinic was bursting at the seams. Its three exam rooms which handled 3,000 patient visits in 1997 were handling more than 12,000. The Clinic's board wrestled with three questions: Should it expand? Should it do so at Goodwill or consider an alternate location? How would it pay for *any* expansion? At this time one of Goodwill's programs also needed more space. And the existing space was right next to the Community Clinic.

The solution was Project Access, a $1.2 million public fundraising campaign to triple the size of the Clinic. The remodeling also expanded and relocated two Goodwill educational programs. Goodwill offered to lead the funding campaign and also create a condominium arrangement in which the Clinic would own its own clinic space.

Clinic remodeling began in April, 2004, and the new facility was completed in December. It included 12 examination rooms; consultation areas for patient privacy; more space for OB-GYN, mental health and dental care; an expanded pharmacy area; space for patient and student education and staff development; and a separate entrance.

At the same time the Clinic applied for and received the designation as a federally qualified health center, making it the Fox Cities Community Health Center (FCCHC).

The Fox Cities Community Health Center is one of 17 in Wisconsin and one of 1,100 in the United States. Community Health Centers – fulfilling one of the federal requirements for establishment – focus on serving patients with barriers to care, including poverty or low incomes, inadequate or no insurance, language or cultural differences, transportation, housing insecurity or even very poor health status. Community Health Centers are only established in areas after a federal review determines there are either too few physicians; or in the case of Fox Cities Community Health Center, underserved populations, such as ethnic or racial minorities, those living in poverty, or homeless.

Health Centers, alike in that they all must follow federal guidelines, form a national network of care sites. But, they remain independent non-profit businesses that adapt to and reflect the unique needs of each community. Some are remote and rural, others are bustling urban centers. They embrace the cultural, ethnic and social features of their patient populations.

One of the requirements to assure responsiveness to patients and the community is that 51% of the Health Center's governing board must be patients – or consumers – of the Health Center. The growing Hispanic immigrant population in the Fox Cities comprises about 25% of the patient base, and Hmong refugees have reached 2%, thus the FCCHC has speakers of those languages on staff to welcome and care for patients from these groups.

The rewards – and challenges – of caring for these segments of the population are similar for both free clinics and Community Health Centers. But, as a Community Health Center, its focus is to provide continuing care as a patient's medical home – a place where patients have a regular provider and high quality care, especially for those with who need to catch up on the routine care or have chronic conditions.

Services include: comprehensive primary

care, including women's health and obstetrics, well child visits and immunizations; sports, employment and general physicals, dietary counseling, behavioral health and an indigent drug program, as well specialty clinics in pediatrics, dermatology, orthopedics, physical therapy, urology, and podiatry. Meeting its mandate to provide not only high quality, but comprehensive primary

care, the Health Center recently added a dental clinic, with one dentist, hygienists, and technicians. In its first year on-site, FCCHC saw nearly 2,000 patients in the dental clinic. Dental patients are also medical patients, meaning they have one point for care and one integrated medical record that tracks care and recommendation for the "whole" patient.

Challenges, especially with the recession, have been growth in new patients every month! The Health Center received a federal grant to help patients who have no insurance and a state grant to support facilities and services, but neither grant can keep pace with the need. Wisconsin's Medicaid program, BadgerCare, has been effective in getting people into all the Wisconsin Health Centers, including the FCCHC. And, the high cost of insurance is driving people to seek care here for both the quality and reasonable costs.

Patients often come with not only the illness, but also personal challenges that prevent them from improving their health. Mental illness, addictions, family hardship and poverty all come to the Health Center with patients. For patients who have delayed care despite growing health care problems, primary care at the Health Center is just the first stop. Many patients need specialty care, and even though there is a willing community of providers in the Fox Valley, they are busy. The FCCHC patient care needs are more complex and require a higher level of care due to the delay in diagnosis and treatment or gaps in care.

Community Health Centers have gained recognition as a model for health care reform efforts because the mission to serve anyone who needs care in a medical home with a primary care focus works to cost-effectively improve health. This is a model that can work nearly anywhere in the world – the key is national policy and funding that establishes requirements that keep Health Centers focused on their mission (primary care for the underserved), emphasizes data-driven quality improvement and stresses understanding and caring for the unique community where a Health Center is located.

"With 45 years of history as outstanding examples of treatment and cost effectiveness, Health Centers have been the recipient of stimulus funding and have responsibilities written in both health reform proposals at the national level," states Kristene Stacker, R.N., the Center's executive director. "But," she adds, "Whatever the outcome of national legislation, we will continue to serve our mission of caring for the underserved and working with health and service providers to help people in our community."

The Fox Cities Community Health Center can be reached at 920-731-7445 or at its Web site: www.fcchc.org. □

Kristene S. Stacker is the Executive Director of Fox Cities Community Health Center. After graduating from Neenah High School she farmed with her husband until 1994 when she returned to UW Fox Valley as to pursue her nursing degree and graduated from UW-Oshkosh College of Nursing in 1999. She assumed a nursing position at Appleton Medical Center Emergency Services until her desire to work with the under-served brought her to Fox Cities Community Health Center in 2005.

Sara Saxby is a graduate of Menasha High School and the University of Wisconsin-Madison. After graduating from college in 1989, she worked for the Governor of Michigan for almost 11 years. In 2001 she and her family moved back to the Fox Valley. Sara has worked at Goodwill NCW since 2002 where she is considered the "Den Mother." Some of her responsibilities include coordination of the Goodwill NCW Board of Directors, working closely with the Goodwill Community Center campus partners, and assisting the President and CEO.

Quality, Accessible Health Care at a Profit

A Report by B. S. Sridhar

Large sections of Indian society have no access to even the most basic form of healthcare. Most healthcare facilities are located in the remote, expensive urban areas. Health insurance, especially for the poor, is non-existent. Most public hospitals and clinics provide sub-standard care. Public health expenditures amount to only 0.9% of the GDP, while private healthcare expenditures add up to 4.2%. Even after accounting for purchasing power parity, the per capita expenditure on healthcare in India is a meager $ 170. This compares with $7,421 per person spent in the United States, accounting for 16.2% of our GDP.

Quality, accessible healthcare at a profit! "You must be dreaming", you say. Faced with such Himalayan challenges, several visionaries and social entrepreneurs in India have invented revolutionary, mission-driven, effective, sound, profitable health care models. The MBAs at Harvard Business School and Wharton, and reporters of Wall Street Journal and Business week have swooned over these organizations. They are busy unraveling the secret of these transformational organizations. Allow us to introduce two such organizations. May be we too could borrow a lesson or two from their play book.

Aravind Eye Hospital

Aravind Eye Clinic, founded in 1976 by Dr. Govindappa Venkataswamy, a visionary physician, is the largest and most productive eye care facility in the world. Taking its compassionate services to the doorstep of rural India, it now treats over 1.7 million patients each year. Taking its compassionate services to the doorstep of rural India, it now treats over 1.7 million patients each year. Two-thirds of the patients

are treated free and the rest pay what they can afford! No wonder!

Headquartered in Madurai, Tamil Nadu, Aravind started with just 11 beds. Today, it consists of five hospitals and 3,590 beds. Doctors perform over 200,000 surgeries per year. In addition, Aravind is a teaching and research institution that trains ophthalmic professionals, and healthcare managers from around the world.

Aravind is more than an eye hospital. It is a social organization committed to the goal of elimination of needless blindness through comprehensive eye care services. The hallmarks of the Aravind model are quality care and productivity at prices that everyone can afford.

The modus operandi consists of holding screening "eye camps" in geographically vastly dispersed communities. These camps are funded and organized, and promoted by local business and community leaders. Aravind's teams evaluate, and then transport people back to the hospital for more advanced services.

Surgeons average 2000 surgeries per year, versus a national average of 220. Doctors are not paid based on the number of surgeries. The benefit of extensive training is a major selling point to attracting surgeons. The majority of the medical staff are recruited locally, and trained rigorously. Each year, over a hundred young women from local villages are trained. Employees at all levels are expected to embrace the vision.

Aravind also is a manufacturer of world-class ophthalmic products available at affordable costs. Because of the sheer volume, Aravind is able to not only offer free services to the others, but also fund all operations, and expansion. For a very informative video visit: http://www.youtube.com/watch?v=3cjnNPua7Ag

Dr. Devi Shetty is a doctor with a mission who believed that "*a country's poor needs to become healthy if the nation is to become wealthy*". In 2001, Dr. Shetty founded Narayana Hrudayalaya (NH), a cardiac hospital in Bangalore, India. Its primary mission is to deliver state-of-the-art cardiac care to poor people.

Two major constraints limit the access to quality, affordable healthcare in India: (a) Lack of transportation for patients to travel from rural areas to urban hospitals; and (b) Lack of financial resources or coverage such as Medicare or Medicaid.

NH has achieved its mission through a series of innovations that have revolutionized application of technology, care-giving processes, financial instruments and human resource policies. NH pioneered mobile outreach vans outfitted with cardiac equipment that did initial screening and diagnosis in rural areas. NH partnered with two research hubs to provide telemedicine so that patients in rural areas could have access to expertise to top-quality medical professionals via telephones and Internet. In addition, NH facilitated the poor to organize themselves as rural cooperatives that acted as insurance groups. Finally, it negotiated with insurance companies to offer low cost, affordable insurance coverage (Micro Health Insurance). Not only did poor benefit, the insurance companies have profited due to sheer volume new customers!

Between 2001 and May 2007, NH has performed over 23,000 surgeries and 34,000 catheterization procedures. The hospital subsidized poor patients to the tune of US$2.5 million that benefited close to half of all the patients that came to NH for treatment because they could not afford to pay their full cost. NH has become the world's largest pediatric cardiac care facility in the world, with over 40% of its cases involving children, and they come from as many as 73 countries from around the globe. The success of NH can gauged by the fact that with just 5000 beds it accounts for more than 12% of all cardiac surgeries and procedures in India and almost 40% of these are provided at highly discounted rate or free.

With a gross profit of 20%, the financial performance of NH compares well with 16% profit turned by the biggest corporate hospital. Due to accelerated pace of growth both in in-patient and out-patient segments, NH plans to add 25,000 beds by the year 2015. Thanks to its reputation for high quality care and its commitment to social mission NH attracts over $1 million per month in donations.

Dr. Shetty has scaled the NH model to eight states of India and has replicated the operational and business model in diverse specialties such as ophthalmology, nephrology, oncology, and neurosciences. Finding qualified, inspired people will remain a challenge for pioneers like Dr. Shetty. For more information about NH, please visit: *www.**narayana**hospitals.com*

U.S.-Sponsored Health Program brings Affordable Healthcare to Uttar Pradesh

In August of 2007, the United States government and the Government of Uttar Pradesh launched a healthcare program under which 700 hospitals in the state will provide uniform quality health services at less than half the market cost. Sponsored by the U.S. Agency for International Development (USAID), the "Merrygold Health Network" program will provide quality health care, including family planning, outpatient services and pediatric care, as well as immunizations.

The program addresses the reproductive and child health needs in Uttar Pradesh, where maternal mortality is the highest in the country and infant mortality the third highest. The program aims at facilitating more than 80,000 safe child deliveries in the next three years.

Under the Merrygold Health Network program, healthcare services will be available at less than 50 percent of the market cost.

Arogya Parivar Program - A Rural Health Initiative

In 2006, Novartis' Consumer Health and Sandoz divisions launched an initiative in India to address the neglected health needs of rural populations. The Arogya Parivar (healthy family) program started with pilot sites in the states of Uttar Pradesh and Maharashtra. It combines healthcare education with access to affordable medicines through local pharmacies. The initiative aims to build a sustainable business that improves access to healthcare among the underserved millions in rural India by providing locally available and affordable health solutions. This "social business" approach represents a mix of corporate citizenship and creative entrepreneurship.

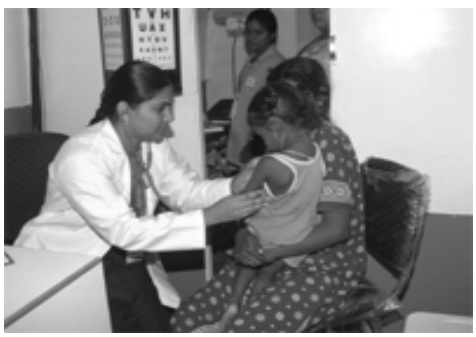
In the pilot phase, products focused on tuberculosis, other respiratory infections, coughs, colds, allergies, skin and genital infections, malnutrition in mothers and children, diabetes, intestinal worms and digestive problems - all important health challenges in these communities.
The intent is to collaborate with third parties to broaden the product portfolio to include medicines for additional therapeutic areas and items such as anti-malarial bed-nets. To be included, products need to be easy-to-use, relevant and have instructions in local languages. Packages are reduced in size so that weekly individual treatment costs are kept below USD 1.25.

Because transport and communication in rural India are difficult, a decentralized model was adopted, organizing the 200 health advisors and supervisors in autonomous "cells". They are not Novartis employees, but are trained to ethical standards set by Novartis. The initial phase of Arogya Parivar will address 120 of India's more than 600 districts, selected using criteria ranging from population and purchasing power to transportation infrastructure and density of private doctors. By the end of 2008, Arogya Parivar had increased the number of cells to cover a population of around 25 million villagers in seven states. Arogya Parivar health advisors speak to villagers about diseases and help them recognize symptoms. Periodic health camps bring in doctors to do examinations and make referrals to a treating doctor. A single health camp can attract from 200 to 2,000 people.

Smile on Wheels

A Report by Badri Varma

Smile Foundation is a national level development organization reaching out to more than 1 Lakh underprivileged children through various education and health care projects across 21 states of India. It launched the programme as part of its endeavour to introduce healthcare awareness and contemporary healthcare services seeking behaviour among the rural masses and the underprivileged. The programs are run in collaboration with local institutions and organizational specialized doctors, nurses, medical staff, equipments and medicines to the identified villages / slums in a systematic manner. Smile on Wheels vans cover the rural or slum areas in the vicinity where either no governmental health care facilities exist or the same is not sufficient for the population. Each unit is covering the vicinity of up to 25 kms from its centre and visiting 2-3 villages a day on a regular basis.



Health Services Provided

The services provided are OPD, Ante-natal/post-natal services, identification of difficult pregnancy and referral for institutional care, Immunization - Mother & children, Minor surgery, BP examination, X-ray, ECG, First Aid, Distribution of Iron Folic tablets, Vit-A Prophylaxis, Treatment of mal-nutrient cases, etc.

Working Model:

Smile on Wheels operates by taking well-equipped medical van along with

The mobile hospitals offer preventive, primitive and curative medical expertise to the needy children and women in remote rural areas and urban slums. In deserving and life-saving cases, it functions like a referral clinic and ambulance.

Each van is stationed in an urban centre usually with a static hospital, which acts like a referral medical centre. The team also carry out awareness activities on health and hygiene in order to achieve health seeking behaviour

Phase – I: Launched in June 19, 2006

Chief Minister of the Govt. of NCT of Delhi, Mrs. Sheila Dikshit flagged off the five mobile hospitals under Smile on Wheels from the Delhi Secretariat.

Five vans under the first phase of Smile

on Wheels has been reaching out to 1.5 lakh beneficiaries in a population area of 7.5 lakhs covering 249 identified villages across five Indian states. These are Orissa, Chhattisgarh, Uttarakhand, West Bengal and Maharashtra with Stations in Cuttack (Orissa), Bhilai (Chhattisgarh), Roorkee (Uttarakhand), Kolkata (West Bengal) and Talegaon (Maharashtra).

Phase – II: Launched in May 2008

Two more mobile hospital projects under Smile on Wheels programme are operational for the slum population of Delhi and Chennai from June 2008.

The mobile hospitals in phase – II are one and half time bigger than the hospitals as in Phase – I and are completely air conditioned. These are also equipped with dark rooms, advanced X-Ray machines and a few additional facilities.

Here are some examples of the work undertaken by Smile Foundation in different states in India.

Location	Area of Operation	Target Population	Implementing Partner
Chennai	6 slums	75,000 approx	Lifeline Group
Hyderabad	24 slums	75,000 approx	Operation Blessing
Ahmadabad	15-20 km radius	1.2 lakh	MARAG
Lucknow	6 villages	50,000	St. Mary's Polyclinic

Sevadham Trust and Smile Foundation launched Smile on Wheels program for Maharashtra on 8th of July 2006. Rural and tribal population around Talegaon is the beneficiaries under Smile on Wheels. Sevadham has been working in the fields of healthcare, education and socio-economic development for the rural and tribal populace particularly in the district of Pune for 25 years now.

Future Outlook

Smile Foundation aims to run a fleet of 30 fully equipped mobile medical vans under Smile on Wheels programme reaching out to around 35-40 lakh beneficiaries in coming five years.

Smile Foundation has been recognised with GE Healthcare–Modern Medicare Excellence Award as "NGO of the Year" for innovative contribution towards healthcare services for the poor and needy

For more details on Smile on Wheels Program Please write to:

Manju Singh
Sr. Manager (Programs)
spl_proj@smilefoundationindia.org

News ...

Fundraising for the Children of Haiti

IndUS is very happy to report that our fundraising effort to benefit the children of Haiti has been very successful, thanks to the generosity of the Fox Valley community. We are within the striking distance from $10,000, and are confident that we will reach that target. You will recall that IndUS started the process with a matching grant of $2,500 from its Investing in Children Fund. We gratefully acknowledge the generosity of children, adults and local organizations that have contributed. In particular, we would like to specially recognize:

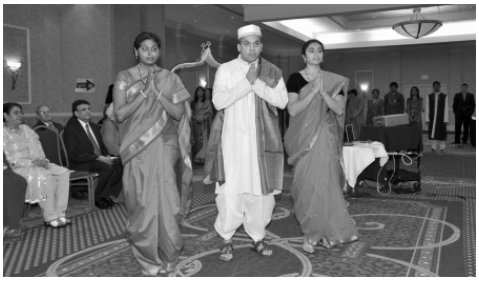
Les & Dar Stumpf Family Fund Grant: (Through the Community Foundation of the Fox Valley Region): $2,500

Hindu Temple of Northeast Wisconsin: $1,200
India Association NEW: $872
Bel Brands USA & employee: $700
Individual contributions : $2,180

We are in discussion with area organizations to leverage our funds to contribute toward the long-term welfare of children of Haiti in a sustainable manner. Please await details.

IndUS-2009 Annual Event

Just like the past years, this year IndUS-2009 Annual Banquet was also a sold out event. This year's theme was *The Glorious Tradition of Indian Textiles and Jewelry*. The program started at 5:00 PM with a reception, exhibition and socialization. The exhibition was a great attraction; it reflected the rich history of Indian textiles and jewelry which goes back to Indus Valley civilization. Live fashion show demonstrated of traditional clothing



of different regions, as well as the magnificent craft work of jewelry from

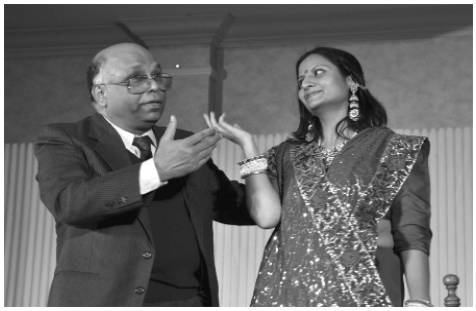
India. The exhibition items were displayed in three different rooms everyone enjoyed reading the description of those displays. Not only were there were treats for the eyes, but there were also a variety of appetizers to enjoy and satisfy the taste buds.

Following the reception at 6:30 the guests were guided to the dining hall.

This year IndUS had decided to recognize the guests and the volunteers for their support and hard work, who are the back bone of the organization. We are blessed to have more than 150 volunteers who participate and take lead roles in organizing the events and programs of IndUS. They give their time, share their ideas and bring lots of enthusiasm in organizing the events. We selected two people to represent the guests and two to represent the volunteers from the volunteer list and honored them by asking to light the lamp for the inauguration of the event.

The variety of authentic Indian cuisines, full of exotic flavors and the colors were another highlight of the evening. The food represented the diversity of the country through variety of spices, ingredients and the flavors of different regions. The unique as well as different taste and color of each dish represented the rich culture of different regions of India. After the mouth watering flavor of spices, the Sona Mango Cheese cake was really the icing on the cake. It was a soothing and comforting experience.

To top the evening, this year again there was a play *Manihar* (Diamond Necklace) performed by the very talented artists from our own valley. It was a stage adaptation of a short story, *The Lost Jewel* by Nobel Laureate, Rabindranath Tagore. The story was narrated by a semi-architect and a



historian who goes to learn yoga and local archeology and ends up trying to solve the mystery of the disappearance of the Mani Malika, the women who had lust and obsession for the jewelry and clothes. The play was funny, mysterious and a great success for IndUS 2009.

IndUS banquets have been a cultural experience for the people who have been attending the event for last several years and look forward to next year's event. Over the years the IndUS family has grown, with new people becoming members. Our members and guests are the strength of IndUS.

Let's Share

IndUS of Fox Valley recently revived its Let's Share program. "Let's Share" program was initially instilled with a goal of providing a forum to come together, share, learn, discuss various topics. While we do believe that such activity happens all the time at parties and get together, IndUS wanted to provide a semi-structured, and yet an informal, friendly setting for personal growth and networking. Most of us would agree that there is tremendous amount of expertise and wisdom within the local community who have excelled in diverse fields. We have very accomplished professionals in the field of medicine, science and technology, management, entrepreneurship, art, music, and so on. Using Let's Share as one of the avenues, IndUS tries to bring together like minded people who want to share and learn from each other. The format involves inviting a guest speaker or two who are experts on the chosen topic and they share their expertise with other members.

Till date we have had four sessions and they have been a great success. We meet on the first Sunday of every month with a new topic and a new speaker(s). The speakers present their thoughts which are followed by a Q & A session. Our first four sessions have been at Harmony Café, Appleton. We intend to cover wide range of topics like, health, career, finance, personal development, management, business oriented, parenting etc. in this forum.

On Sunday, November 1, 2009, Mr. Prateek Mehrotra & Mr. Rob Riedl of Sumnicht & Associates LLC, Appleton talked on the topic "*Invest Like Harvard and Yale In A Recovering Economy"*. The speakers presented various investment options that are currently available to an investor. Sumnicht & Associates LLC also gave out a wine bottle to one of the member of the audience – Sanjay Wahal for the best question during the Q & A session. You spot a winning idea, if you have capital on hand?

On Sunday, December 6, 2009, Mr. Paul Jones of University of Wisconsin-Oshkosh & Dr. Shyam Parekh of Kimberly-Clark Corporation shared their thoughts and experience about "*Venture Capital What is it? What it is not?"* They addressed some key questions as to how should one attract venture capital, if they have a winning idea? Also how do you spot a winning idea, if you have capital on hand?

On Sunday, February 7, 2010, Mr. Bob

Pedersen CEO, Goodwill Industries & Mr. D.P. Kar ADIRE Trust, Green Bay talked about "What is Social Entrepreneurship? Why is it Important?" Mr. Pederson talked about true social

entrepreneurship and gave some very good examples. Goodwill's role and the efforts they have undertaken were shared with the audience. He also presented his thoughts about next generation of social responsibility, and what it would be like. Mr. Kar through his presentation portrayed the efforts that ADIRE has undertaken in Jaba village, Orissa India and the difference it has made in the lives of the local population. ADIRE have undertaken health, education, energy and production related projects. The discussion generated so much interest that several people among the audience expressed the desire to learn more about the social entrepreneurship and use these skills to start some programs in India using Mr. Pedersen's ideas.

Some of the upcoming Topics are:

Live S.M.A.R.T.E.R - Dr. Al Lippart.
Date: March 7, 2010 at Harmony Café, Appleton.
Parenting in a Multi-Cultural Environment
Conquering Your Career: Should You? Would You? Could You?
Challenges and Rewards of Running your Own Business.

Greenville Elementary Diversity Fair

On February 10th IndUS participated at the Greenville Elementary Diversity fair, which focused on folk dances. Pushpa Arava and Viju Rao performed an Indian folk dance and also gave a presentation

on India. The kids enjoyed it very much and were enthusiastic in knowing more about India.

Volunteer Recognition Dinner

Over 90 people, volunteers and their families, attended annual Volunteer Recognition Dinner at UW – Fox valley on February 13, 2010. It was a kick-off to the celebration of the tenth year of formation of IndUS of Fox Valley. At this dinner, each year our volunteers select a theme for the next annual banquet, a showcase event held in autumn for the past twelve years. This year they voted for the theme: *India and the Movies*. The evening was a joyous occasion marked with fun and games followed by a sumptuous dinner. Anupma and Sanjay Wahal were the MC's and kudos to them for the superb job they did.

Presentation on India at Gardens of Fox Cities

On February 18, 2010, Sandhya Sridhar and Kamlesh Varma joined De Delum, retired librarian from Menasha Library at a fund-raiser soup dinner for Gardens of Fox Cities to make a presentation on India. Keeping with the theme, the guests were served Chicken Coconut Curry Soup. The audience was immensely interested in the topic as evidenced from a wonderful discussion of cultural differences, religions, cuisine, arranged marriages, caste system, architecture and lot more. In response to a request, there was even a spontaneous demonstration of how to drape a saree on a volunteer from the audience. This fund-raiser was one in the series organized by Gardens of Fox Cities.

If you liked the theme and the articles appeared in this issue, we would love to hear from you. You could send your feedback to Badri Varma at bvarma@uwc.edu.

If you have any suggestions for theme of future issues of Sandesh, please send them to us.

Up-coming Events

IndUS General Body Meeting

The Annual General Body Meeting of IndUS will be held on **Sunday, March 14, 2010 at 2:00 p.m**. at Fox Cities Rotary Multicultural Center, Appleton. In addition to reports of activities and financial state, there will be elections for the vacancies on the Board and the Executive committee. IndUS has reviewed the ad hoc structure of the executive committee adopted two years ago. After a review of the efficacy of the structure a constitutional amendment to the structure of leadership is being proposed. A nominating committee has been formed and it is chaired by Mr. Tim Higgins, the outgoing Chair of the IndUS Board. A detailed agenda will be announced very shortly.

Fun With Cultures: A day camp for children

Mark your calendars for an upcoming day camp for 6-14 year old children to be held at Goodwill Community Center in Menasha 9 am- 4pm, on Saturday, April 24, 2010. Children will participate in interactive workshops to develop appreciation of cultures around the world. Presenters from various cultures will share artifacts, dress-up clothes, flags, toys, dances, music, crafts, sample snacks, stories, games, customs, currency and slides or video clips. In the past we had presenters from Hmong, Japan, Korea, India, Pakistan, Lebanon, Nigeria, Sierra Leon, Switzerland, Guatemala, Columbia, to name a few. After experiencing exposure to various cultures, children work on team projects and plan a presentation of their own. The day will end with a reception for the parents highlighted by these presentations and awarding certificates for participation. In the years past, children have shown remarkable creativity and team spirit. Please contact us if you would like to register your child and/or volunteer for whole or part of the day.

IndUS Celebrates Tenth Anniversary

The idea of IndUS germinated in Fall of 1999 when a few key people in the community envisioned an organization that would dedicate itself to building friendship and goodwill between the people of India and the United States. The idea initially manifested itself in the form of two annual events, IndUS-99 and IndUS-2000, both held under the auspice of then Fox Valley India Association.

A need was felt to establish an independent entity that can better focus on its aspirations and expand its range of activities. IndUS was officially formed as an independent nonprofit organization on March 2, 2001 at Community Room at Neenah Police Station. An interim board and executive committee were formed. IndUS was registered and recognized as nonprofit organization under Section (c) (3) of the IRS Code in December 2002. A strategic planning session was held on June 3, 2003 when the current mission statement, together with its social, educational, cultural and charitable goals, were adopted.

The tenth anniversary is being celebrated with several marquee events. Some events already planned include:

CineFest India-II will feature four award -winning movies from India. The event is being planned in collaboration with Lawrence International. The four movies in Bengali, Hindi, Kannada and Malayalam, with English subtitles, will screened on April 3, 4, 10 & 11, 2010 at Warch Campus Center, Lawrence University, Appleton.

A literary conference featuring several published authors from South Asia will be held on September 10 and 11, 2010 at University of Wisconsin-Fox Valley. The event will feature panel discussions, workshops on writing poetry, and memoirs, a poetry slam featuring poems from various regional languages of India (with English translation).

Please await our announcement for details and more events to celebrate our birthday!

THEME FOR INDUS-2010
India and The Movies

At the Annual Volunteer Recognition Dinner on Saturday, February 13, 2010, IndUS volunteers selected the theme for this year's Annual IndUS banquet. The theme for IndUS-2010 is: *India & The Movies*.

IndUS-2010 will be held on **Saturday, November 20, 2010 at Radisson Paper Valley Hotel, Appleton**. The event will feature an exhibition, a banquet and a cultural program. Please mark your calendars.

A Steering Committee will be formed very shortly and we invite you to get involved in the planning and implementation of this marquee event.

For more information contact:
indusfoxvalley@yahoo.com

IndUS of Fox Valley
&
Lawrence International

Present

CineFest India-II

The Best of Contemporary Indian Cinema

April 3, 4, 10, 11, 2010
Show Times - 1:00 PM

at

Warch Campus Center Cinema
Lawrence University, Appleton

Tickets: $5

IndUS Of Fox Valley
3600 N. Shawnee Ave.
Appleton WI 5491*4*

IndUS of Fox Valley
Presents

Fun With Cultures:
A Day Camp for Children
(6-14 years old)

Saturday, April 24, 2010.
9 AM- 4 PM

Goodwill Community Center
Menasha

For further information contact:

Sridevi Buddi (920.968.9880
sridevibuddi@yahoo.com)

Shakti Shukla (920.730.4014,
shaktishukla@gmail.com)