



This issue, which was supposed to come out in September, has been delayed to cover two special events that took place in September 2018. The historic decennial celebration of Public Health Resource Society was held in Raipur, Chhattisgarh, on 21st September, 2018. The celebration highlighted the work of Public Health Resource Network to mainstream public health concerns in health delivery systems and the challenges faced, particularly by the most marginalized tribal populations of the country in living their lives with health and dignity.

The National Health Assembly, held once again at Raipur on 22nd and 23rd September, 2018, was organized by the Jan Swasthya Abhiyan as the forerunner to the People's Health Assembly to be held in Bangladesh in December 2018. The Assembly aimed at evaluating and critically analyzing current processes and policies that impact health and healthcare at National, regional and local levels. The six themes covered defending health systems, public private partnerships/Insurance/schemes, gender and health, access to medicines and social exclusion and social determinants of health. The Assembly concluded with the presentation of a People's Health Manifesto.

In a welcome move, NITI Aayog's

## STAFF NEWS

October 2018 is seeing some changes in the staffing of PHRN.

Dr. Ganapathy Murugan, Executive Director of PHRN, is on a year-long sabbatical and Dr. Vandana Prasad will be officiating as Acting Executive Director.

guidelines on nutrition management of children with severe acute malnutrition upheld the rights of young children to freshly cooked meals using locally available ingredients and to Take Home Rations made again from locally available ingredients. These guidelines validate the stand taken by civil society as opposed to the proposal by the Minister WCD, who recommended commercially produced fortified foods for distribution in anganwadis. This puts an end to over a year-long controversy between public health practitioners and the Minister.

25th September was the day the Supreme Court of India gave its final decision on Aadhaar. Holding that Aadhaar was constitutionally valid and did not violate anyone's privacy, 4 of the 5 judges delinked Aadhaar from several services, but maintained it for welfare schemes, PAN and filing IT returns. However, they also ordered that lack of Aadhaar could not deny children any benefits. The lone dissenting judge held Aadhaar to be unconstitutional and also held that by linking it to welfare schemes, PAN and income tax, it virtually ended up covering all aspects of human existence. This dissent leaves the door open for further challenges to the Supreme Court decision.

Dr. Muneer has moved to Fortify Health and will be located in Mumbai.

Sayan has moved to Coalition for Food and Nutrition Security; he will be based in Guwahati.

Dr. Osama Ummer has moved to OPM in a research position.

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## DECENNIAL CELEBRATIONS OF PHRS

*Kandala Singh and Ghazala Afrin*

Public Health Resource Society (PHRS) has entered the tenth year of its operations this year. The day-long decennial celebration was held at Aashirvad Bhawan, Raipur, Chhattisgarh on Friday, 21st September 2018 and was attended by 160 participants including resource persons. 'Health of the Tribal Communities in India' was the core theme of the celebration, which ended with a cultural performance.

Dr. Suranjeen Pallipamula Prasad, President of PHRN, and Ms. Sulakshana Nandi chaired the session on experience sharing by network members, team members, past students, and community members. Prof Rajib Dasgupta presented Morbidity Patterns among Tribal Populations in India. Ms. Anju Khewar presented on the Experience of the Mitandin Programme in Tribal Population, while Dr. Abhay Bang presented the Tribal Health in India Report. Prof. T. Sundararaman dwelt on PHRN's contribution in Shaping the Public Understanding and Discourse on Health and Healthcare and Dr. Kamlesh Jain released the Health Policy Primers.

The celebrations began with songs led by different members of the audience, from around the country and different movements.

The day was partly spent discussing PHRN's work and its contribution to public health discourse. Dr Ganapathy spoke about PHRN's journey, outlining PHRN's core strategies and approach to work. Dr. Vandana Prasad, National Convenor and now acting Executive Director, then introduced the four state conveners of PHRN: Ms. Sulakshana Nandi in Chhattisgarh, Dr. Suranjeen Prasad in Jharkhand, Dr. Madan Pradan and Mr. Haldhar Mahto in Orissa, Mr. Rafay Ejaz Hussain in Bihar. Several network members and well-wishers of PHRN who were present shared their experiences. For example, women volunteers from the community - change vectors from different blocks in



*Dr. Suranjeen Pallipamula Prasad, President PHRS, addressing the audience*



*Dr. Vandana Prasad, National Convenor, PHRS,*



*Dr. Ganapathy Murugan, Executive Director*



*Dr. Sulakshana Nandi with BPO and mentors*



*Dr. Xaxa and Sarojini*



*Presenting the souvenir*



*Release of Health Primers*

*Dr. Vandana Prasad with the Health Primers*

Orissa, West Bengal and Jharkhand – shared that they have learnt a lot about a range of issues: malaria, pneumonia, the importance of tri-colored food, etc., thanks to the training they have received from PHRN. Devika Singh from Mobile Crèches spoke about the long association between PHRN and Mobile Crèches, and said that both organizations share similar values. She emphasized the importance of crèches as a means not only to improve child health, but as a necessary step to empower women. Prof. Sundararaman spoke about PHRN's contribution to public health discourse. He opined that

by interrogating dominant discourse from a pro-people, academically rigorous and evidence-based platform and building the capacities of public health practitioners to do the same, PHRN has had an important role to play in shaping discourse.

A large part of the discussion focused on tribal health. Professor Xaxa spoke about inequities in tribal health from a historical and politico-economical perspective. Dr. Abhay Bang shared the key findings of the recently released Tribal Health in India Report with the audience, while Ms. Anju Khewar

shared learnings from the mitanin programme and its role in tribal health in Chhattisgarh.

Dr. Kamlesh Jain from Pandit Jawarharlal Nehru College, Raipur was then invited to release five public health policy primers prepared by PHRN and its partners. Dr. Vandana Prasad shared that the illustrations have been done by Indranil and Mr. Bashir. The primers were put up for sale at the stall outside the venue for a nominal cost. Everyone was then invited for the cultural evening, which was full of lots of songs and dance!

## FROM THE SECRETARIAT

Kandala Singh, Programme Manager of the PRIDE Project in New Delhi, attended a six-week summer school on "International Community Health" run by the University of Oslo (23rd June - 3rd August). As part of a class of diverse students from 21 different countries, she attended lectures on many of the themes that PHRN works on: TB, malaria, adolescent, reproductive and sexual health, child health and Nutrition, among others.

The staff at the secretariat were busy over the past three months finalising the programme for the decennial celebrations of PHRS. Suggestions



were invited from all PHRN members to strengthen the day-long programme

and ensure that PHRN's various areas of work were adequately covered.

## NEWS FROM ODISHA

### Nutrition through kitchen gardens

*Swati Das and Shahnawaz*

Nutrition through green vegetables has always been recommended by nutritionists, and if that green vegetable is fresh, coming directly from the backyard to the kitchen, it is Sone Pe Suhaga. At the Khajuri crèche in Bissamcuttack, Rayagada, such an initiative has been taken up with the cultivation of a kitchen garden.

Crèche workers Amrita Wadaka and Jamuna Kadraka, along with members of the crèche committee, decided to use the space available at the back of the crèche to grow vegetables for use in the crèche kitchen. Saplings and seeds of different vegetables were contributed by the women of the community. Some left-over money was used to fence the space. Within a couple of months, the kitchen garden was ready with Bhendi (Bhindi), Janhi (Torai/ Gourd), Kalara (Bitter gourd), Kumuda (Pumpkin). There is now a regular supply of fresh green vegetables to the crèche kitchen and Amrita and Jamuna enjoying feeding them to the children at the crèche. This kitchen garden has become



an inspiration for other crèches and with the monsoon in full swing at Rayagada, adds to the beauty of the place in more ways than one!

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### Update from PI (Porborish Initiative) Crèches

*Swati Das and Shahnawaz*

There has been significant action in the last three months under the programme “Mainstreaming of Crèches to

Reduce Malnutrition in Odisha” – a collaborative effort of PHRN and APPI (Azim Premji Philanthropic Initiatives) supported by Government of Odisha.

During this period, we welcomed new members to the district teams of Rayagada, Kalahandi, Nabrangpur and Koraput. These newly recruited members, along with the old team members underwent training in July at the ‘IT-Zone Training Centre’, located in picturesque Siriguda. Rajesh Sriwastwa came down from Ranchi to speak to the



teams on the PHRN perspective and approach to working with communities. Teams benefited greatly listening to the previous experiences of running the AAM crèches. Satya Patnaik added to the discussion reminiscing about how the network came to be formed and previous work carried out.

Following the training, teams have shown great enthusiasm, working hard even in the face of unfavorable weather conditions to achieve the target of 150 crèches by the end of January 2019. In this period, the number of crèches increased from 30 to 70 in three districts, with Malkangiri with 10 crèches joining Rayagada and Kalahandi where creches are currently running. Till September 2018, these two districts had opened 30 creches each. Rayagada and Kalahandi, have almost reached their saturation of 30 creches each and 10 crèches have opened so far in Malkangiri with the process continuing. In Koraput and Nabrangpur, 15 creches sites each have been identified in both the districts and will soon get operationalized. Newly selected creche workers from all the districts underwent a three-day training programme, at their respective districts and showed great motivation to start working.

As we engage more with the community, we see a many-fold increase in support from them. It is heartening to see their enthusiasm and participation in the crèche openings and thereafter. Women from the community take it upon themselves to sweep and clean the creche the previous evening and prepare for its opening. The menfolk helping to repair a broken door or fixing the window so that it is safe for the little children coming to the creche. It is common to see the ground being swept cleaned and plastered with a mix of cow dung and water. Beautiful floral motifs either in rice powder or different colored powders adorn the doorstep, with torana, decorations made from mango leaves strung together, hanging from the door frame. Clearly, it's a festival for which the village has come together!! A festival that would



hopefully see the end of malnutrition amongst its children.

This has strengthened our belief regarding the requirement of crèches in these remote villages. And also, that a community will come together to work towards the betterment of its children given some support.





## NEWS FROM CHHATTISGARH

### PRIDE programme in Narharpur block, Kanker district

Deepak Kumar

PRIDE project under the aegis of PRADAN in Narharpur block of Kanker district is moving forward in a positive direction at community level. Since March the project has come a long way and has received wide attention from community as well as from frontline health workers in the village.

In Narharpur block, a total 90 potential CVs were identified by our mentors from 3 clusters - Surahi, Umradha and Sarona. At present in the block, the training of 58 CVS from all three clusters has been completed in two batches. In the first batch, 36 CVs and in the second batch, 22 CVs got the training from master trainers on PB 1, which has 6 micromodules covering gender, food security, farming and food production from a nutrition lens, maternal health, care during pregnancy and after delivery, family planning, etc.

After training, many CVs shared that they learnt many new things. For example from the Daal Chawal game, they understood that the determination of sex is dependent on men, not on women but presently in their village

During PLA meeting on Gender (MM-1) in Tikrapara Village, one woman started crying. She shared that she has suffered from similar stigma in her life. If she would have attended this training before then she would not have faced such stigma and depression. She has 5 girl children and she was blamed by her family members for giving only girl child. Her two children are dead now due to lack of knowledge and awareness.

women are blamed for giving birth to a girl child which is not fair.

Apart from this, mentors from their respective areas are also interacting and building rapport with AWWs, Mitanins, ANMs and Panchayat functionaries as well as other village institutions such as village organizations (VOs), CLF, etc., to support their PLA meeting in the village with SHG members.

During our 2nd Batch of training one CV told in her local language

“भैया तुम मन ला का का अनिमि वनिमी बोलत हो और बतात हो, देख न मोर भी वैसे ही होत है, बार बार चक्कर आत है और बोतल पर बोतल चढ़ रहे और सुई भी लग रहे”.

The third training is proposed in October 2018.

*Impacting health and nutrition status of women and children through PLA meeting in villages*

By September, we completed rolling out of MM1 and MM2 in the block, in PB1 training PLA modules which covers “Gender and Food Security” and “Understanding Food & Nutrition”. In addition, we also started rolling out of MM3 which covers topic “Food security: our farms, our food”. This PLA meeting was attended by adolescents, pregnant and lactating women, frontline workers, SHG and non-SHG women

and men. However, the participation of men in PLA meeting have been very little so far.



*2nd Batch of CV Training in Umradha Cluster*



Rohini Jain of village Singarwahi, AWC No. 02

I received an iron kadahi from my department two months back. When I cooked, I found that the colour of cooked food had become black. I threw away the food and stopped cooking in the kadahi. At that time I did not know the benefit of cooking in iron kadahi. After that it was lying unutilized in the centre. When Pradyuman (mentor from PHRN) visited our centre 6 days ago and found that I am not cooking in it, he told me the benefits of cooking in an iron kadahi. Since then, I started cooking in it. Although the colour becomes black, children are enjoying the cooked food. Now they ask for food twice. If he would not have told me the benefits of cooking in an iron kadahi, I would not have used it and it would still be lying



*CV explaining picture card during PLA meeting in Thema Village*



*PLA meeting in Charbhatti Village on MM2*



Out of total 58 trained CVs on PB-1, 10 to 12 CVs have become capable enough to conduct meetings on their own or with little support from the mentors.

In Module MM-1, gender-based discrimination, violence against women, division of work amongst men and women in the village was the focus point of discussion amongst SHG members while in MM-2 not buying Kurkure, chips and cooking in iron kadahi, and Tiranga Bhojan have received wider attention. The PLA meeting in villages is promoting communities to take action on scientific practices around their health and wellbeing at various levels, especially at individual, and community/institution level. For e.g.,

- Many women started talking to their husband regarding changing division of work in their home.
- Many CVs as well as other SHG members understood the ill-effects of junk food, Kurkure and chips on their children, and they stopped buying and giving those foods to their children. Most of them have started feeling that it should be banned from the village.
- During the PLA meeting, iron deficiency disorders among women and the importance and benefits of cooking in iron kadahi was explained. Some CVs have brought this utensil from the market and have started cooking in it. They are also promoting it to other women.
- At institution level, some AWCs have started cooking in iron kadahi; this was not being done before as AWCs were not aware of its importance and benefits.

Some VOs have planned to purchase iron kadahi in bulk and to distribute them to all SHG members. Since it is not available in the local market easily, they have ordered shopkeeper to make them available in local market.

## Other activities

*Deepika Joshi*

### ***Fifth Global Symposium on Health Systems Research in Liverpool in October 2018***

PHRN's entry 'Nutritional Status and its determinants amongst the Sabar community was selected in photovoice exhibition in Fifth Global Symposium on Health Systems Research held in Liverpool in October 2018.

### ***Poster selection in fifth HSR symposium, 2018***

Sulakshana Nandi presented the poster 'Analysing formulation and performance of Public Private Partnerships in health: Evidence from four case studies in India' at the Symposium. The study is authored by Sulakshana Nandi, Vandana Prasad, Deepika Joshi, Indira Chakravarty, Ganapathy Murugan, Pallavi Gupta, Chandan Kumar, Shahnawaz Khan, Md Allam Ashraf.

### ***Oral Presentation in fifth HSG symposium, 2018***

Sulakshana Nandi made an Oral presentation in the symposium on the theme 'Is private sector the answer to achieving effective coverage and financial protection under publicly funded health insurance?: Evidence from Chhattisgarh, India' authored by Sulakshana Nandi et al

### ***World Conference on Bioethics - Health for All in an Unequal World: Obligations of Global Bioethics***

The 14th World Congress of Bioethics with the theme Health for All in an Unequal World: Obligations of Global Bioethics will be held in Bangalore from Dec 5-7. Following entries by PHRN were selected.

1. Abstract selected for poster titled "Restriction to Contraception Services a Violation of Human Rights of Baiga community" selected in the Congress. It is



authored by Deepika Joshi, Sulakshana Nandi, Preeti Gurung, Ganapathy Murugan and Chandrakant Yadav.

2. The abstract titled 'Geographical inequity in availability of hospital services under the state funded health insurance scheme in a central Indian state' has been selected for Oral presentation. It is authored by Sulakshana Nandi et al.
3. PHRN members are co-authors in the abstract selected and titled 'Understanding health inequities in tribal communities: Reflections on some Ethical Issues'.

### ***Media Articles on privatization***

Sulakshana Nandi and Deepika Joshi wrote a two part series on the ongoing privatization of health services in Chhattisgarh in the news website Scroll. The link can be found below-

1. <https://scroll.in/pulse/891907/chhattisgarh-is-outsourcing-diagnostic-services-to-the-private-sector-despite-having-adequate-staff>
2. <https://scroll.in/pulse/891906/chhattisgarh-plan-to-build-6-hospitals-under-public-private-model-shows-disregard-for-past>



Public Health  
Resource Network

# Analysing formulation & performance of Public Private Partnerships in health: Evidence from four case studies in India



Jan Swasthya  
Abhiyan

Public Health Resource Network and Jan Swasthya Abhiyan (PHM India)

## Background

In India, central and state governments have entered into Public Private Partnerships (PPPs) for healthcare. Current evidence points to their mixed performance. Objective of this formative research was to study the formulation, implementation & performance of four PPPs in three states– Outsourcing of (1) Radiology services in Bihar; (2) Human Resource and (3) Rural Mobile Medical Units (MMU) in Chhattisgarh and (4) Hemodialysis services in Delhi.

## Methods

- Qualitative study, using the multiple case study method
- 28 individual and four group interviews with health officials and staff
- 36 individual and nine group interviews with community
- Programme data, media reports and grey literature were reviewed
- Cases first analysed individually and then together, on emerging themes.
- Public Health Resource Society Institutional Ethics Committee gave Ethical Clearance.
- Informed consent was taken verbally
- Names of respondents, and some designations kept confidential
- Methodology got revised as per need and availability of data
- Biggest challenge was in accessing data and information from government

## Results & Discussion

### Prior Situation

- Situation leading up to the PPPs highlights critical gaps in health system functioning
- However, weakness in the health system was a consequence of the government's own policies and functioning

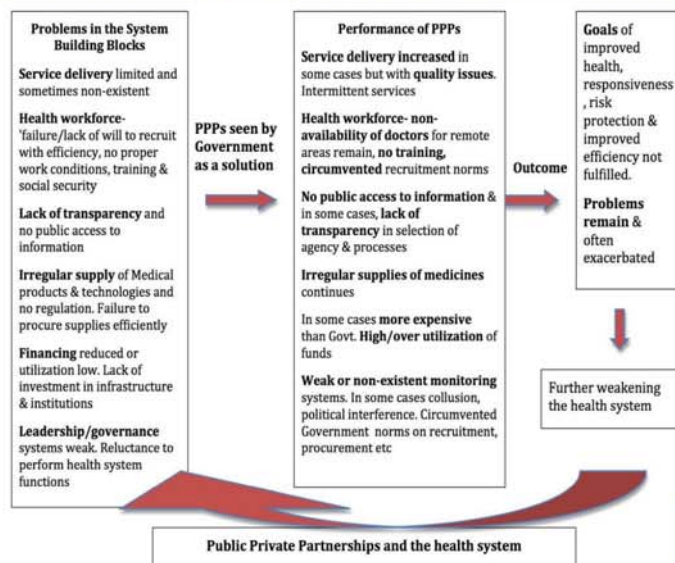
### Initiation of the PPPs

- PPPs were introduced as a solution and to substitute government health services
- But mostly without adequate situation analysis
- Significant role played by NRHM in pushing for PPPs

### Implementation

- All PPPs when implemented had quality issues and most did not adhere to the contract
  - A number of previous issues/problems remained the same
  - Seen as a way to circumvent government norms like caste reservation
  - Costs to the government and people
  - Termination or closure of some PPPs
  - PPPs filled the identified gap to an extent
  - But they addressed selective gaps, while the core and larger health system issues remained unaddressed
- ### Monitoring and accountability
- No systems for monitoring, grievance redressal or evaluation
  - No capacity building or orientation to the staff of private entities on principles of public provision
  - Non-transparency and lack of information regarding PPPs in public domain

## Conceptual framework on the impact of PPPs on the government health system



## Learnings for further research

- Need to scrutinise rationale & intention behind PPPs along with implementation & performance
- Need to study using a health systems framework- how is it affecting the whole system? is it weakening or strengthening it?



## Conclusion

The PPPs filled a gap in health system functioning for some time and in some cases provided services that were absent till then. However there were serious issues regarding their quality and performance. The study raises concerns on the long-term implications of PPPs on the government health system and their sustainability.

Sulakhana Nandi, Vandana Prasad, Deepika Joshi, Indira Chakravarty, Ganapathy Murugan, Pallavi Gupta, Chandan Kumar, Shahnawaz Khan, Md Allam Ashraf  
Funding: Oxfam India Contact: chhattisgarh@phrindia.org

failures

### Resource Gap Analysis as part of JSA – PBI campaign

As part of the JSA-PBI campaign in on

strengthening of Public Provisioning of health care in six states, a resource gap study was undertaken for health facilities in Korba district to understand the gaps in Human Resource, medicines

and other supplies for the optimum functioning of a facility and the requisite budgetary provisions for it.



## NEWS FROM JHARKHAND

### Poshan Mah (Nutrition Month)

Shampa Roy

Poshan Mah was celebrated in September in convergence with Department of Women and Child and Social Security in 5 blocks of 5 districts of Jharkhand. As part of the FAAM and PRIDE projects, the Jharkhand team of PHRS was integrally involved in the celebrations in schools, VOs and AWCs across the districts of Godda, West Singhbhum, Ramgarh, Gumla and Khunti. SHG members and adolescents, VO members, ward members, panchayat samiti members, as well as the mukhiyas participated in these events. The celebration was initiated by a team comprising of the local anganwadi workers, ANMs, sahiyas, nodal teachers, change vectors and mentors from the project, who were further supported by the CDPO, BDO and BEO at the block level. The Director of the Department of Women and Child and Social Security also encouraged the team.



Godhbharai at Chapidih in Raidih



Convergence meeting at block level - Sonua



*Eat helthy food discussion in Sonuna*



*Poshan discussed at village level*



*Poshan rally at Patratu, Gola*



*Discussions with adolescents at Hari High School, Torpa*



*Poshan Mah discussions at Kemte AWC*



*Poshan Mah discussions at Khirakhar, Nawalgarh*

**पोषक मेला. रत्नावांघ के ग्राम संगठन प्रदान व पीएचआरएन ने आयोजित किया कार्यक्रम महिलाओं ने जाना पौष्टिक भोजन का महत्व**



Convergence with ICDS Poshan Mah



Poshan Mah discussion at Pogra AWC - a PHRN and PRADHAN invitatie

With a core focus on nutrition, many events such as rallies, VO discussions, 'godhbharai' celebrations, 'annaprasan' celebrations, school discussions, etc., were conducted to attract attention to relevant issues. Women and adolescents gained a platform to discuss issues of food and nutrition, teen rangon ka thali, importance of iron and folic acid supplementation, hygiene and sanitation, infant and young child feeding, anaemia prevention, antenatal and postnatal care, and needs during adolescence. Furthermore, the different nutrition-related schemes and programmes of the government were also highlighted to create awareness. More specifically, ICDS services including village health and nutrition day, growth monitoring at AWC, growth chart preparation, counselling for adolescent girls, as well as pregnant and lactating women, antenatal checkups and immunization were given special attention in the platforms.

This celebration was an opportunity for service providers, communities and change vectors to join hands and work

together for the cause of better nutrition and encouraged healthy behaviour for improving the quality of life of the community, especially for women and children.

**Bringing positive change - case studies**

*Annesa Sarkar*  
*Anima Mahato*

Anima Mahato is a 32-year old woman living in village Mohukudar in Jhalda Dorda GP, Jhalda 1 Block with her husband, one son and one daughter. She is a farmer.

Her first child was a girl, and after 5 years her second child, a boy, was born.

She was completely ignorant about the family planning methods. When she learnt about them, she consulted her husband and shared everything she learnt from the Meeting Cycle 6. Her husband was not interested in using condom. Anima then consulted ANM and finally, she decided to use Copper-T.

Her decision was successful. She shared, "I am not facing any problem using this Copper-T. If I had known in detail about this, I should have done it much earlier. I have talked and discussed with my SHG members. Three of the women of my village have decided to use Copper-T."



### ***Pralapi Mahato***

Pralapi Mahato is a 28-year old woman living in village Putidih, Ilu Jargo GP, Jhalda 1 Block with her husband, mother-in-law and father-in-law.

She attended Meeting Cycle 5, where she learnt about consumption of tri-coloured food and use of iron vessel for fighting against anaemia. But she took the information very lightly and did not follow it.

Then she found that her haemoglobin count was only 9gm in the Haemoglobin Test Camp. She got frightened and related the symptoms of being anaemic.

The same day, she discussed the matter with her family, and requested her husband to buy an iron kadahi as soon as possible, which he did the very next day. Since then, she started cooking vegetables in that kadahi for herself and her family.

She stated, “In spite of knowing the importance of consuming tri-coloured food, and importance of cooking in Lohe Ka Kadahi, I ignored the message. But when I got my report and talked with ASHA didi about it, I became afraid for myself as well as for my family members. It is now more than 5 months that I am cooking in Lohe Ka Kadai. Surprisingly I can say I don't feel that much weakness as I used to feel earlier.”

Now, she has decided to test her haemoglobin and is expecting a better result.

### ***Gajulabala Mahato***

Gajulabala Mahato is a 38-year old woman living in village Karadoba, Mathari Khamar GP, Jhalda 1 Block,



with her husband, 2 sons and 1 daughter. Gajulabala is a farmer and her husband is a daily labourer.

Earlier, Gajulabala did not look after her health at all. Though her day-to-day work was hectic, she didn't consume tri-coloured food on regular basis. Cooking in an iron vessel was beyond her imagination.



After attending Meeting Cycles, she started a kitchen garden and cultivated 10 types of vegetables- tomato, chilli, okra/ladies finger (bhindi), lablab bean (Sim), basella (Poi sag), bottle gourd (Louki), sponge gourd (Nenuya), bitter gourd (Karela), cowpea (Boti), kang kong (kolmi sag) in 1 decimal area. She also started cooking the vegetables in Lohe Ka Kadahi on a regular basis.

She explained, “After attending Meeting Cycle 5, I got to know that the reason for my weakness, tiredness, dizziness, back pain may be anaemia. Now I don't need to buy vegetables from market as I get them from my kitchen garden. I cook them in the Lohe ka Kadahi. My family and I eat sour food after lunch.”

### ***Sonubala Mahato***

Sonubala Mahato is a 27-year old woman farmer in village Karadoba, Matari Khamar GP, Jhalda 1 Block. She lives with her husband, one daughter and one son.

Sonubala attends all the Meeting Cycles and grasps the main messages of each



had diarrhoea. Since more than 1 year, my family and I are practising handwash, and today I can say, the issue of stomach aches or diarrhoea has almost been solved in my home.”

**Ichag village**

Ichag is a village at Jhalda 1 Block, where Meeting Cycle 1 to 4 was not practised. But since August, 2018 PBN2 was initiated at the village.

Ichag 1 Upasangha was inactive for 1



women bought the iron vessels and started using it cook tri-coloured food. Currently, a total 98 women have started cooking in Iron vessels. The rest plan to buy the vessel within one week.

Once all the population buys the



iron vessels, the Upasangha has decided to initiate kitchen gardens within one month.

**Lohe ka kadahi abhiyaan**

Lohe Ka Kadahi Abhiyan signifies the journey of women towards fighting against anaemia by cooking vegetables

year. After practicing Meeting Cycle 5, the participants became interested in the Picture Cards and its stories. The stories were not only limited within the Upsangha level, but has spread very quickly at Samiti level and in the community too.

in iron vessels. This initiative also promotes tri-coloured food.

A recent haemoglobin test camp

*Lohe ka Kadahi Abhiyan at Boro Puhara village*

Meeting Cycle. Besides practising kitchen garden, cooking in iron vessels and consuming tri-coloured food, she is the first person to start proper handwashing.

Every time, before cooking or before eating, she washes her hands. She has also taught her children and checks whether they are practising handwashing or not.

She shared, “Earlier my children often

Upasangha conducted a Haemoglobin Test Camp on 12th September, 2018, with the support of BMOH, and found that 84% women under that Upasangha were suffering from anaemia.

At their own initiative they called a mass meeting with the report, and decided to buy iron cooking vessels to fight against anaemia.

Within one week of the camp, 73





*Lohe ka Kadahi Abhiyan at Boro Puhara village*

organised by village organisation (VO), identified 465 women out of 521 were anaemic. After the women got the report about their own or their children's haemoglobin test results. Three Upasanghas took the initiative and started the Lohe Ka Kadahi Abhiyan at community level. A total of 614 iron kadahis have been brought and are in regular use in 91 hamlets. Observing

these 614 women buying and using the iron vessels for cooking vegetables and fighting against anaemia, other women of the community got interested and plan to buy them within a week after discussing with their SHGs. Three villages - Ranidih, Ichag 1 and Boro Puhara - aim to make the Abhiyan 100% successful by starting cooking in iron vessels in each and every house.



*Lohe ka Kadahi Abhiyan at Ranidih village*

Apart from fighting against anaemia and promotion of tri-coloured food, this campaign is also helping the women to be united at group level and buy the kadahi collectively, for which each

woman is getting Rs. 20 discount.

This abhiyaan is ongoing and will continue till all the women (of our working areas) have started cooking vegetables in the vessel and are consuming tri-coloured food on a regular basis.



### THIRD NATIONAL HEALTH ASSEMBLY

*Press release issued by JSA*

*Kamaney wala khayega, lootney wala jayega, naya zamana ayega* (a time will come when the working people will earn, oppressors will suffer, and a new era will emerge) .... This was the call of over 2000 health rights activists from 24 States, declaring at the same time that the time to make health and health care a fundamental right is now.

The Third National Health Assembly was being organised by Jan Swasthya Abhiyan (JSA) at Ravindra Manch in Raipur, Chhattisgarh on 22-23rd September, 2018. The objective of the Assembly was to evaluate and critically analyse current processes and policies that impact health and healthcare at National, regional and local levels. The two-day programme had plenaries and sub-plenaries planned around six themes - defending health systems, public private partnerships/

Insurance/schemes, gender and health, access to medicines and social exclusion and social determinants of health. The Assembly concluded with the presentation of a People's Health Manifesto.

The inaugural plenary session was on Defending Public Health Systems: Emerging Challenges. Dr. Amit Sengupta, Global coordinator of People's Health Movement stated that health is first and foremost a fundamental human right. Demystifying the hype created by the Union Government around the National Health Protection Mission as being the panacea of all that ails our health sector, he asserted that health is not just an economic, but also a political and social issue. Dr. Sengupta highlighted that it is imperative for different movements to come together and wage a collective fight for better health.

Speaking against privatisation of





health services, Sulakshana Nandi, co-ordinator, JSA-Chhattisgarh, said that for most of the marginalized, vulnerable and weaker communities residing in the remote areas, government facilities are the only refuge. She pointed out that public health systems are being weakened by diverting public funds towards subsidies to the private sector, mainly through public private partnerships (PPPs) and insurance schemes. Guided by the primary motive of profit maximisation, the private sector is not interested in providing health services to the poor and the vulnerable.

“People in small places, do not have small problems. The private sector does not enter the difficult terrain where complexities of public health issues are graver.”, asserted Dr. Raman Kataria, founder-member, Jan Swasthya Sahayog, an organisation of health professionals running a low cost health facility in Bilaspur, Chhattisgarh. He said that in addition to problems of human resource shortage, there is a lack of social sensitivity among young doctors. It emanates from the fact that our medical education lacks a social perspective, he said.

Sarojini N, national co-convenor, JSA, recounted large-scale deaths of children in Gorakhpur last year as a manifestation of the dilapidated condition of health services in India. She highlighted that the recent incidents of removing egg from the mid-day meals, not including non-vegetarian food in pregnant women’s diet, rising prices of food grains, cow vigilantism have to be looked at as issues contributing to the public health crisis. To revisit the debate on Health for All, she said that “All” in this context should explicitly include Muslims, Adivasis, Dalits, sexual minorities and others.

Malini Bhattacharya, general secretary, All India Democratic Women’s Association, stated that today the government is moving away from promises made under the Alma Ata Declaration of Health for All. She said

that decentralisation of healthcare was first implemented during the 1970s when community health workers were introduced in the health system, ICDS was initiated, and sub centres were linked to PHCs. After the launch of National Rural Health Mission in 2004-05, health indicators saw an improvement. But now from more than a decade, all the indicators have been stagnated and the outlook of the government has become regressive.

The session ended with performance of a play by Mitanins, frontline health workers from Chhattisgarh. It depicted the nexus between the government and the private health sector, conniving together to overcharge patients. The play showed how a simple case of jaundice which does not usually require either hospitalisation or expensive medicines, cost the patient’s family Rs 55,000. A complicated issue was explained simply through this cultural performance.

*Gaon chodabnahi, jungle chodabnahi, mayemaatic hodabnahi, ladayi chhodabnahi* (we will not leave our village, we will not leave our jungle, land and soil, we will not leave our struggle), was one of the songs sung by the indigenous people at the National Health Assembly, echoing the struggles of the tribal and indigenous communities to unite and fight for forest, land, river, environment and village where they have been residing peacefully for decades.

The theme of the third plenary session was about social processes and conditions influencing people’s health.

K B Obalesh, State Convener of Safai Karamchari Kavalu Samiti, Karnataka shared the issues and challenges faced by the manual scavengers in India. Highlighting adverse impacts of discrimination, he said that due to untouchability practiced by the doctors and paramedical staff, health care needs of manual scavengers remain largely unaddressed. In the absence of affordable and accessible health care facilities, people are forced to opt for

self-medication.

Referring to the recent deaths of 11 Sanitation workers in a week in Delhi, he stated that “these are government sponsored killings”. He further elaborated that Swachh Bharat Abhiyan (SBA) has failed to capture the needs of manual scavenging and sanitation workers. The household toilets constructed under SBA are not mechanised and require manual cleaning which is to be carried out by manual scavengers.

Speaking on the issue of inaccessible health services among religious minorities, Dr. Shakeel Ur Rahman said that Muslim women face triple burden of poverty, gender discrimination and religious discrimination. He elaborated that when a pregnant Muslim woman goes for institutional delivery in a government hospital, she is subjected to verbal abuse by the medical worker and is blamed to have given birth to many children. This attitude discourages such women from availing public health facilities. He said that decentralised data from sub centres in Bihar shows that while the population of Muslims is 15%, only 3% of health facilities are present in those areas. Shakeel asserted that identity of a patient has a crucial bearing on health services availed by that person and it is time to recognise that.

Legal expert Usha Ramanathan talked about dangers of AADHAR and UIDAI. She said that by linking AADHAR to health services, government is collecting digital footprints of the Indian population which can then be used by private companies to make business. She asserted that “fundamental rights are being jeopardized in the name of promoting economy of the nation.”

“Before independence, tribals had right over the forest and use to take care of forests, but post-independence, the forests were taken over by government and government planted Eucalyptus trees which depletes the nutrients and moisture reserves of the soil.” stated Gangaram Paikra, an eminent adivasi

*Some glimpses of action at the Third NHA*

*\*Taken from JSA's website <https://phmindia.org>*



activist from Sarguja, Chhattisgarh. He said that food habits of tribals are being altered, impacting their nutrient intake adversely. A situation is being created where they are turning into vegetarians, but traditional food items like local millets are extinct from the market. Promotions of hybrid seeds for high yields have diverted the agricultural practices and indigenous plantations are under threat.

Rinchin said “In the name of development, pollution has been poisoning our health and lives. The ponds and rivers are polluted with mine water and the same water is being consumed for drinking by communities in Raigarh district of Chhattisgarh.” Raigarh is among the foremost mining districts of the State.

Talking about environmental as well as health damage, she said that coal ash, which is banned from being disposed off in open, is being dumped in forest areas,

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## **Abandon the AB-PMJAY scheme based on the discredited insurance model**

*Press release by JSA*

The recent announcement regarding the launch of the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) scheme has raised expectations that the scheme will somehow address the extremely urgent needs regarding healthcare in the country. Expectations have also been raised because of the labeling of the scheme as the ‘largest health protection scheme in the world’ and the promise that beneficiaries will receive Rs.5 lakhs as cost of hospitalisation.

The Jan Swasthya Abhiyan wishes to point out that the mere assertion that the AB-PMJAY is the largest health protection scheme in the world, does not make it so – in fact it is entirely misleading. The Government’s own National Health Mission has an outlay of around Rs.35,000 crores, many times more than the Rs.2,000 crores allocated

covering trees in their entirety. It enters environment of residential areas of the tribals. The coal ash has been found to have heavy metals, carcinogens and other poisonous metals which affect people’s health adversely. She said that all these activities are happening in full knowledge of the government.

Rajani Soren from Human Rights Law Network spoke on the legal struggles being fought by people in Chhattisgarh.

The second day also saw speaking discussing, debating and declaiming about different issues on health and healthcare at 5 sub-plenaries and several workshop sessions.

The Assembly came to an end with the entire gathering lending their voice to the song ‘We the People’ sung by Charul and Vinay. Before that the Assembly endorsed a Health Manifesto, to be issued to all political parties in the run up to the state and national elections.

for the scheme in the 2018-19 budget.

The Jan Swasthya Abhiyan is deeply concerned about the haste with which the scheme has been conceived and announced without regard for the negative experience with existing insurance schemes, such as the RSBY. The AB-PMJAY is based on the discredited ‘insurance model’ despite massive evidence against the effectiveness of such insurance-based schemes involving major participation of the private sector in service delivery. There are also serious doubts regarding the viability of the programme given that this year’s budget provides only a token allocation for the scheme.

The AB-PMJAY, like its predecessor the RSBY scheme and several state level schemes, is to provide insurance cover for hospital-based care. The enhancement of cover to Rs.5 lakhs has been continuously stressed while publicising the scheme. However, past experience shows that an overwhelming majority of claims under insurance schemes are actually in the region of

10,000 to 50,000 rupees. Thus the raising of the limit to 5 lakhs will not translate into a windfall for patients, as we are being led to believe.

Public funded insurance schemes like the RSBY have failed to make even a small dent as regards access to healthcare services. Data about the RSBY shows that only a fraction of projected beneficiaries were actually enrolled. The even more important concern has been about the quality of services provided and clear evidence that the scheme was being milked by unscrupulous private providers to profiteer, often by doing unnecessary procedures and ignoring real needs. Horrendous reports of misuse involving the conduct of unnecessary hysterectomy (uterus removal) operations in women as young as 23 years old have emerged from different parts of the country. It needs to be underlined that the scheme is being rolled while both the Central and State Governments have shown no interest in implementing robust mechanisms for regulation of private medical facilities. The Clinical establishments Act, passed by Parliament several years ago, is yet to be implemented meaningfully in any part of the country. At the same time reports surface regularly of incidents of gross negligence, malpractice and overcharging in private facilities in different parts of the country. A majority of facilities empanelled under the RSBY scheme were private (4,291 out of 7,226) and the same trend can be expected to continue in the new scheme. The Niti Ayog claims that the AB-PMJAY will be 17 times bigger than the RSBY scheme but the moot question is: how can we expect the same government to effectively run a much larger scheme when it failed entirely in case of the RSBY scheme and several state level schemes. The direction of the AB-PMJAY would thus be of, as earlier in the case of public funded insurance schemes, indiscriminately using public resources to strengthen an unregulated, and in several instances corrupt and negligent, private health care providers.

There are also serious doubts regarding the real intent behind the hasty announcement of the scheme at a juncture when several state level elections and the national elections are just a few months away. The scheme has been announced without an adequate provision for its funding in the 2018-19 budget. By the finance ministry's own admission an annual outlay of Rs.12,000 crores will be required to fund the programme, while independent estimates put the figure much higher – at around Rs.50,000 crores. What has however been allocated in the 2018-19 budget is a pittance in contrast – just Rs.2,000 crores. This raises the suspicion that the announcement regarding the scheme has more to do with attempts to score a political point rather than a real intent in addressing urgent healthcare needs of the Indian people.

Further the scheme will only cover hospital based care, while data shows that the bulk of expenditure that patients incur is on conditions when they are not admitted to hospitals – such as patients receiving care for TB, cancers, etc. An associated announcement has been of the plan to strengthen 1.5 lakh primary level centres, now to be named “Health and Wellness Centres”. In itself this is

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## NUTRITION NEWS

### Controversy over hot-cooked meals and locally prepared THR for children under 5 resolved

NITI Aayog, following the intervention of the PMO, has finally settled the controversy between the Ministry of Women and Child Development and the Minister of Women and Child Development regarding provisioning of meals and THR in anganwadis. As part of the country's first-ever guidelines on the nutritional management of children with severe acute malnutrition (SAM), NITI Aayog has accepted the recommendations of the National Technical Board of Nutrition, which has authorized feeding SAM children with freshly cooked food prepared

welcome as it would strengthen public services. However the 2018-19 budget has allocated a meager Rs.1,200 crores for this purpose, which would possibly suffice to meet just 5% of the need. We are again concerned about the intent of this announcement – whether a mere ploy to garner electoral benefits or a real attempt at strengthening public services.

The Jan Swasthya Abhiyan urges the government not to view decisions regarding healthcare as opportunities for ensuring electoral success. We note that successive budgets – especially over the last 4 years - have contributed to the serious underfunding of the National Health Mission, tasked essentially with strengthening public services. We demand that the government abandon plans for the AB-PMJAY. The projected annual outlay of Rs.12,000-50,000 crores, as per different estimates, would be much better utilized by investment in expansion of public facilities and creation of permanent public assets. Feeds by publicity agencies of the government, to news agencies, about a few hundred people who are benefiting from the new scheme are not a substitute for meeting the healthcare needs of crores of people across the country.

from locally available cereals, pulses and vegetables, and distributed by anganwadis, as recommended by the Ministry officials. In contrast, the Minister had wanted to introduce commercially prepared meals and THR in anganwadis as part of the community management of undernutrition.

The guidelines also outline the role of anganwadi workers and auxiliary nurse midwives (ANMs) in identifying severely wasted children, and enrolling the remaining children into “community based management”, which includes provision of nutrition, continuous monitoring of growth, administration of antibiotics and micro-nutrients as well as counselling sessions and imparting of nutrition and health education.

The morning snacks and hot-cooked

meals, which are served at anganwadis to children between the age of three to six years, should be “prepared freshly and served at the centralised kitchen/anganwadi centres. Locally available cereals, pulses, green leafy vegetables and tubers, vitamin C rich fruits, as well as fresh milk and 3-4 eggs every week” have also been prescribed. It is also suggested that local self-help groups, mothers or village committees be engaged for the preparation of these meals.

Similarly, the take home ration, which is given to children between the ages of six months and three years, has to be prepared from “locally available and culturally appropriate food ingredients”. Use of extra oil/ ghee in these food items is also suggested in order to ensure these are “energy dense”.

The government has also revised the method to be used to measure wasting and advised calculating weight based on the height of children instead of the mid-upper arm circumference. However, some experts feel that the use of MUAC has a place in the identification of SAM children.

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### **Demands made in the Right to Food Campaign Statement on Starvation Deaths**

*28 September, 2018*

As immediate measure, the Right to Food Campaign demands the following:

1. Universalise PDS: End quota system and expand the National Food Security Act to ensure universal rations from the Public Distribution System (PDS) to all families
2. Prevent Aadhaar Exclusions: Ensure that no family is excluded for want of Aadhaar to avail of their social security entitlements especially rations, pensions and NREGA – delink Aadhaar from all social welfare schemes
3. Provide Community Kitchens: Provide free hot, cooked nutritious midday meals for pregnant women, lactating mothers, homeless persons

and the elderly in anganwadi centres or schools. Also extend school midday meals during vacations and start free community kitchens in all urban areas.

4. Improve School and Anganwadi Meals: Eggs, fruits and milk for children everyday through the mid-day meal scheme and ICDS

5. Provide Special Nutrition and Pensions: Provide all the 75 identified particularly vulnerable tribal groups (PVTGs) nationwide and the highly impoverished Musahar dalit community in Bihar, Jharkhand and Uttar Pradesh, which have had the most deaths, with a special free nutritional package similar to that provided to Rajasthan's

Sahariyas along with monthly social pensions

6. Pay Compensatory Allowance: As mandated in the food law, provide all excluded families with compensatory food security allowance, with retrospective effect of at least one year

7. Amendment of the NFSA: To make subsidised pulses and edible oil legal guarantees under the PDS and mandatory inclusion of eggs in midday meals and Anganwadis.

8. Implement and Operationalise Grievance Redress and accountability provisions in the National Food Security Act.

## MATERNITY ENTITLEMENTS

Maternity Entitlements – Non negotiable and Overlapping Health Right for Women and Children

The National Foundation of India organised a Workshop on *Maternity Entitlements - Non-negotiable and Overlapping Health Right for Women and Children* on 22nd September 2018, as part of the side events at the Third NHA. The workshop aimed at examining the status of ME at the policy domain, gaps in the law, and understanding its implications on women's and children's health and nutrition.

Dr. Dipa Sinha, Convenor, RTF, informed the audience about the campaign by RTF, JSA, and the Working Group for Children under Six to ensure ME. She traced the history of ME in India, noting that while the NFSA committed at least Rs. 6000 to all women who gave birth for the first two children, the current government has reduced the amount to Rs. 5000, and limited it to the first child. She stressed the need for convergence between MOHFW and MWCD.

Sejal Dand from Anandi, Gujarat, pointed out that the current Maternity Benefits Act benefitted only 4% of the women who worked in the organised sector. She underlined the

need for maternity to be recognised as work, as it involves care of the future generation, ME to be unconditional and based on minimum wages, and the need to prevent discrimination due to pregnancy and childbirth.

Dr. K.S. Velayutham from FORCES, Tamil Nadu, explained that the Dr. Muthulakshmi Reddy Maternity Benefit Scheme of Tamil Nadu, which is held up worldwide as model scheme, has, through its effective implementation, helped reduce Tamil Nadu's IMR to 17 per 1000 live births and MMR to 52 per 100000 live births. The scheme has achieved almost 100% institutional delivery and 94.4% women register within the first trimester of pregnancy.

Unlike the PMMVY, where ME is managed by MWCD through ICDS, the Dr. Muthulakshmi Reddy Scheme is operated by the Dept. of Health and Family Welfare through PHCs. PMMVY compensates a total of Rs. 5000 in three instalments, while in Tamil Nadu, the compensation is Rs. 18,000 given over five instalments and two kind benefits. The state scheme is for the first two deliveries, while PMMVY is limited to the first child.

FORCES Tamil Nadu is now conducting advocacy to increase the period of maternity benefits to nine months.

Dr. Rajat Das spoke about the initiatives in West Bengal. He shared the positive interventions in the state, noting that 95% of births are conducted in institutions, IMR is 25 per 1000 live births and 90% of the children are immunised. The state has initiated the amended Referral Transport Scheme (Nischay Yan Prakaalpa), where ambulance drivers receive incentives to provide free services for pregnant women and sick newborn, including a second referral and drop-back facility. However, the difficult geographical terrain like hills, tea gardens or forest areas makes it difficult of women in these areas to access entitlements.

From other parts of the country, activists and programme personnel reported that the problems women faced when trying to access ME included

- Low awareness of scheme among both women and service providers;
- delay in payment, with some women in Chhattisgarh not having received even the first instalment after two years of childbirth;
- corruption;
- lack of forms, documents, including Aadhaar;
- difficulty in opening bank accounts, especially for those with changed surnames and who are living in interior villages and habitations;
- exclusions of single mothers and widows;
- exclusions of PVTGs, who have high fertility, because ME is available only for the first child;

The workshop participants noted further that there is no grievance redressal mechanism. They further agreed that release of payment should be a priority. Future campaigning will include the demand that registration for PMMVY should be done by the Health Ministry and the accountability to lie with the State and not the beneficiary. The registration must lead to automatic release of timely payment of not less than Rs.6000 as notified under Section 4A of National Food Security Act. Any delay should have penalty for non-

action. Jan Swasthya Abhiyan demands immediate release of all payments due since April 2017 by December 2018.

Given the abysmal situation of maternal health where women fail to gain the required weight during pregnancy, the campaign demands universal maternity entitlement linked to minimum wages

## AADHAAR JUDGEMENT

On 25th September 2018, the Supreme Court passed its judgement on the various petitions regarding AADHAAR. Of the 5-judge bench, 4 judges held AADHAAR to be constitutionally valid and that it did not violate the privacy of individuals. In addition, the Court took the following stands:

1. AADHAAR linking is mandatory for PAN, filing Income Tax Returns and accessing welfare schemes. However such linking is not mandatory for mobile connections, bank accounts, school admissions, examinations conducted by CBSE, UGC and NET and digital wallets.
2. Private entities cannot ask for AADHAAR details.
3. Children cannot be denied benefits under welfare schemes for lack of AADHAAR.
4. Aadhaar details of a person cannot be disclosed in the name of national security.
5. Section 47 invalidated – Individuals can now file cases in a Court related to Aadhaar.

The lone dissenting judge, Justice D.Y. Chandrachud, differed quite strongly, on several key points in the judgement. Besides holding Aadhaar to be unconstitutional as it was passed as a Money Bill, he held that "the purported safeguards in the Aadhaar architecture are inadequate to protect the integrity of personal data, the right of informational self-determination and, above all, rights attributable to the privacy-dignity-autonomy trilogy."

Justice Chandrachud's dissent paves the way for challenging the Supreme Court's decision of 25th September.

for nine months (three months before and three months after delivery) as maternity benefits

Maternity entitlements are essential for all women irrespective of age, and number of children. Hence conditionalities under PMMVY should be removed with immediate effect.

## NEW READINGS

*Global Health Governance and Commercialisation in India – Actors, Institutions and the Dialectics of Global and local.* Edited by Anuj Kapilashrami and Rama V. Baru. Global health governance has been the subject of wide scholarship, more recently brought to the fore by priorities for global health defined by the Sustainable Development Agenda. The health landscape itself has changed dramatically in the last two decades, shaped by cross-border flows of capital, ideas, technology intermediated through the complex interaction between global, national and local actors and institutions.

This book analyses the complex terrain of global health governance and local responses to new global forms of integration and fragmentation in India. It unpacks local manifestation and translation of global health architecture and regimes and how these processes influence public health policy and practice; as well as to what extent rules and flows are complied with, resisted and transformed at national and sub-national levels. It speaks to this interface between the global, national and local focusing on processes, dilemmas, conflicts and trade-offs that such engagement presents for national health policies and health systems, .

Filling an important gap in global health governance scholarship in India, the book is a useful contribution to the fields of global health policy, international health and development, health systems, health inequalities, public health, public administration, development studies, social work, nursing, management studies and mainstream social science disciplines that engage with globalisation and health.

## PUBLIC HEALTH RESOURCE NETWORK (PHRN)

Public Health Resource Network (PHRN) is a growing network of individuals and organizations with the perspective of strengthening technical and management capacities to take action towards the common goal of 'Health for All'. Its main objective is to contribute and strengthen all efforts directed towards the goal of 'Health for All' through promotion of public health, social justice and human rights related to the provision and distribution of health services, especially for those who are generally left underserved. PHRN is currently working directly in the states of Bihar, Chhattisgarh, Jharkhand and Odisha and has contributed to the on-going work of strengthening public health systems in other states through its partnerships with other institutions.

Whereas PHRN is a voluntary network of many hundred concerned public health practitioners who are willing to intervene towards 'Health for All' by creating capacities and engaging with the public health system, Public Health Resource Society (PHRS) is the core group that has initiated the network. PHRS is a national level organization that is registered in Delhi under Societies Registration Act 1860 (Act XXI). It comprises of a small group of members and full timers that provides leadership to the network as well as functions as its secretariat.

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