EHAC

# Meeting Record Notes

4th Quarterly Meeting of the Equitable Healthcare Access Consortium

Held on Friday & Saturday, 12th & 13th April 2019

at Indian Institute of Management Udaipur

Version 1 dated 17th April 2019


**Compiled by:**

Devendra Tayade

Prakash Satyavageeswaran

## Attendees

| Organization | Participants |
|---|---|
| Action Research and Training for Health (ARTH) | Dr. Sharad Iyengar<br>Dr. Peeyush |
| Aravind Eye Care Systems (AECS) | Dr. Devendra Tayade |
| Basic Health Care Services (BHS) | Dr. Pavitra Mohan<br>Dr. Sanjana Mohan<br>Ms. Manisha Dutta<br>Dr. Yogesh Sharma |
| DHAN Foundation | Mr. R. Rajapandian |
| Fernandez Hospital | Dr. Evita Fernandez<br>Dr. Tejaswini Basavarj |
| Indian Institute of Management - Udaipur (IIMU) | Prof. Janat Shah<br>Prof. Prakash Satyavageeswaran<br>Prof. Patrali Chakravarthy |
| Indian School of Business (ISB) - Hyderabad | Prof. D.V.R. Seshadri |
| L V Prasad Eye Institute (LVPEI) | Dr. G. Chandra Sekhar<br>Ms. Anshu Bhargava |
| PEOPLE TREE Hospitals | Dr. Chandrasekar C. |
| Sant Singaji Institute of Science and Management (SSISM) | Mr. Pranjal Dubey<br>Mr. Prashant Sharma<br>Mr. Mahesh Sabre<br>Mr. Radhesham Nagar |
| SMILES International Institute of Colo-Proctology | Dr. Parameshwara C.M. |
| Swami Vivekananda Youth Movement (SVYM) | Dr. G S Kumar<br>Dr. Suneetha Singh |
| Vikram Hospital | Dr. Rajesh B. Iyer |
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|---|---|
| Observers | Ms. Vidhya Srinivasan<br>Ms. Bindu Sukeshini<br>Ms. Sameera Banu<br>Dr. Harish Iyer<br>Mr. Jagdish Rattanani<br>Dr. Laxmi Jhala |

## Action Points

1. Sameera – Make a repository on democratized innovations
2. Sameera, Anshu and Arnaz – Structure the pilot capturing and ongoing updates mechanism through a form
3. Vidhya – Ensuring the communication strategy is consistent
4. Anshu – Present an outline for quality module
5. Patrali – Generate a happiness report on the ARTH and BHS field visit
6. Prashant, Dr. Pavitra, Dr. Kumar and Raja – Development of SOP for conducting field surveys
7. Dr. Yogesh – Options for networking & connecting with medical students
8. Dr. Harish – Put up a 2 to 3 page article on democratization of healthcare innovation
9. Teams for 4 focus areas - to work on action items as presented before next meeting

## Minutes

Day 1 – First half

DVR provided the introduction to the meeting, talking about the progress of the EHAC since its inception. DVR also introduced the various members of the consortium and their association with the consortium. EHAC was started a year ago with the thought of how equitable healthcare needs to go beyond eyecare. Going beyond healthcare, a common man also needs access to education and livelihood. The first meeting was hosted by LVEPI at Hyderabad, the second by DHAN Foundation at Madurai, and the third by People Tree Hospitals at Bangalore. DVR then provided an overview of the agenda for the present meeting. He identified the learning modules of EHAC as an important initiative. He also talked about the four thrust areas of the EHAC -

1. Quality care with Empathy
2. Educational Courses
3. Reaching out to the Medical student fraternity
4. Primary care for the poor

Prof. Janat welcomed the gathering. He stated that the purpose of management schools is to build a better society. Thus, what EHAC is trying to do is in line with what IIMU also envisions. The problems that EHAC is trying to solve is what can be called as 'Wicked Problems'. As management educators, we approach these problems from the perspective of supporting experimentation, theorizing and dissemination. EHAC is a startup and for a startup, a small group of committed people can achieve its mission. He shared his delight in hosting the 4$^{th}$ quarterly meeting as well as the first interaction with the medical students. As educators we are interested in developing students who balance value with their own livelihood.

Arnaz then provided a progress report. EHAC has now been registered as a Trust with address at the LVPEI KAR Campus in Hyderabad. She also shared the resolutions that were passed (Refer to Arnaz's presentation for details). She also made a call for the members to discuss sources of income for the consortium for its various activities. Arnaz provided an update on the discussions with the Grey Campus on the hosting of the courses. She then introduced the new logo for EHAC and thanked Vidhya for her support in coming up with this. She also thanked all the different volunteers who support the work of the EHAC. Finally, she also talked about the process of decision making through the core team.

Prakash then provided an update of the courses and, with Arnaz, walked through the Empathy course module by Rajashree and Deepa. He also described the courses and modules in order to provide a background for the afternoon discussions. Dr. GC commented that the course content must be peer reviewed before going live. DVR also talked about the need to ensure that there

are no copyright violations and that all citations and references are provided. He shared that there is a need to collectively decide on whether EHAC should be providing certificates.

DVR discussed the Vision, Core Value, and Mission of the EHAC in order to make the purpose of the organization clear to the new comers as well as the existing members. Dr. C agreed that the vision, values and mission is very important and proposed that every meeting should begin with a reading of the same. Dr. Harish raised the need to look at preventive and promotive care as part of the Mission of the EHAC. Dr. Pavitra responded that currently it is subsumed under primary care but suggested that this could be discussed in greater detail in the afternoon.

Mr. Prashanth and Mr. Mahesh presented the results of the diseases survey done by SSISM in and around Sandalpur, within a 70kms radius. The objective of the survey was to assess the health scenario in the area and based on the findings take some action as a part of EHAC . They provided the demographics and other details of patients (Refer to Prashanth's presentation for details). They showcased the nearest government hospitals and the time to reach these centres. They stated that a vast majority of the cases are simply referred to the hospitals in the city. Dr. Rajesh enquired further details about whether the people take medicines. Mr. Prashanth responded saying that most people need further counselling, and even after the counseling medicines are consumed sparingly because of the costs involved. Most people depend on babas, which is further aggravated by the live experience of people being simply referred to city hospitals as stated by Dr. Pavitra. Dr. GC stated that people not taking medicines regularly for chronic asymptomatic diseases is a global problem. The solution according to him is to have local community members providing the right advise and information. He discussed the example of vision guardians that LVPEI supports. The vision guardian model takes care of gender inequalities as well as local care within 50 kms radius. Dr. Evita enquired about where women go for deliveries. Mr. Prashanth responded that women were not very responsive. Dr. Kumar pointed out that the sample size can be increased. Mr. Prashanth requested for support from the doctors in the room to do methodologically rigorous work. Dr. GC also suggested that for some of the results that are staring us in our face, scientifically rigorous data is not necessary. Dr. Harish suggested that the core group can also consider low cost medicines as options for people not consuming medicines because of the cost implications. Dr. Rajapandian suggested that triangulation can also be done using secondary data from PHU's and Government hospitals in the area. He also responded to Dr. Harish on medicines stating that medicines can be procured free of cost from the government for non-communicable diseases. In addition, there are low cost generic medicines, Jan Oushadhi. Dr. Pavitra supported Dr. GC's view stating that the survey results clearly points to a lack of primary healthcare services. At the next stage, more specific information would be needed to take action.

DVR suggested that SSISM and Pranjal can take the lead to create a protocol on health surveys with support of Dr. Kumar, Dr. Pavitra, Rajapandian, under the mentoring of Dr. GC and Dr. Evita. This protocol can be placed on the EHAC website and can be accessed by anyone wanting to do health surveys.

*Tea Break*

Dr. Harish talked about his interest on understanding who makes decisions on what we should be researching on. The contribution of India in providing low cost medicines to the world were based on some decisions taken at some point of time. How do we learn from other countries who are far ahead of us on something? He talked about his experience on healthcare in Cuba and the fact that a poor country could have an astounding healthcare system. The key question is how do we make sure that we are not left behind. Democratizing healthcare is probably part of the solution. How do we involve the communities in this? How do we prioritize these questions? How do we address the information asymmetry between the scientists and common man? Scholars may know the theory and technical knowledge but the locals know what they need, what works and what doesn't. He shared his experience at Dhan Foundation, Madurai, where he saw people from the bottom of the pyramid involved in decision making, which made him think about democratizing decision making. We know from the earlier session that a person goes to the baba for information. Mr. Jagdish said we need to figure out how places like Cuba manage to provide high quality healthcare. Dr. Harish suggested that brain drain could be one challenge. Doctors are created in large numbers and they are seen as any other professionals. Cuba invites poor people from all over the world to come and study in their medical colleges. He also stated that one cannot avoid the politics in healthcare. Dr. C suggested strongly that we should take up Democratizing Innovation in Healthcare should be one of the themes that EHAC should take up.

Dr. GC distinguished between process innovation and technology innovation. We should be careful about systems we will ape. For example, the US system is not what we want to replicate.

Anshu reflects and adds that she thinks innovation and democratization should also be seated in education. Like letting the kids explore what they want and not forcing them to be in IITs or medical schools. What is right and what is wrong innovation? If we put this into education, then possibly there might be some change.

Dr. Rajesh talks about deworming program which villagers often think is not good for them. He feels that this program is definitely making an impact because earlier he used to see live worms and now he and his team see dead worms.

Dr Pavitra adds that Societies that are unjust can't see equitable system. He opined that we need to see in terms of what kind of society we are in as well. Democratizing cannot happen unless researchers are involved with the community. Eg. Adherence to TB treatment itself is a huge problem (though we know that certain med regime will cure TB). So there might be a chip which tracks if a patient is taking medicine or not but it may not help to understand what are the reasons behind him not taking the medicine.

DVR provided an overview of the Innovation Pyramid. He suggested that we should be focusing on Process innovation, Product Innovation and Business Model Innovation. He said that this is core to EHAC as a value add. This can also result in a knowledge management system. Dr. Pavitra said that there are many such repositories and we need to be careful that we are not duplicating these efforts. Dr. Harish said we need to fold in what the community thinks about these innovations. Dr. Devendra said that there has to be mix of community ownership. Bindu talked about the need for customization. DVR suggested that Dr. Harish and Rajapandian can take the lead in making a concept note and circulate it to the core group for consideration as a theme for the EHAC.

As part of live updates, Rajapandian provided the progress of the various pilots that DHAN is involved in.

1. with Kauvery hospital – 4 cardiac camps have been conducted - 1 in Hosur and 3 in Trichy. 640 members have been screened. 72 cases were referred for cancer, cardiac issues and NCD's
2. with LVPEI on vision screening - 10camps for vision screening have been conducted. 168 people were screened, 134 surgeries were referred, 58 surgeries were completed
3. with LVPEI on livelihood opportunities orientation - MOU has been shared, not got enough traction
4. with People Tree Hospital – 3 Mega Camps conducted in the areas of Eye Health and Gynaec problems in the locations of Kuddur, Pavagada & Kestur. They are working on having a subsidized cost for surgeries.
5. with SIICP on Colorectal Awareness - 30,000 awareness booklets have been distributed in 5 districts of Mysore that have been covered. 128 procedures have been performed at affordable rates of Rs. 10,000 (Actual cost is 1-1.8 lakhs).
6. with Sankalp to provide screening training to prevent mother to child Thalassemia has been scrapped.

7. with SAKSHAM to train community workers on disability and other areas has been scrapped.
8. with Fernandez Hospitals to train community workers on mid-wifery - this project is yet to start

Prashant provided updates about SSISM related pilots next. He talked about the successful pilot with Narayana Health, where a group of students did internship on path lab. DVR asked about the outcome of this training. Prashant responded that the students are now looking at employment opportunities in hospitals in Indore or surrounding areas. Further, some of the students were also interested in a Master's program on lab services offered by Narayana Health. Another project was with People Tree, which could not take off due to lack of hostel facility. The Dhatri mother's milk bank counsellor project has been placed on hold due to change in government and later the model code of conduct. Discussions for students training and placement with Fernandez Hospital for nursing assistant or other such roles has restarted. LVPEI also has offered two courses for the students of SSISM - ophthalmic nursing assistant and vision technician this will start sometime in 2019 . This is a funded program and girls will get a job after that.

Dr. Tejaswini provided updates on partnership between Fernandez Hospital and Saksham. 10 Volunteers have been identified and it will begin in the month of May . It will be 2 half day courses. Dhaatri Milk bank was established at Nilofur hospital- mother's milk is in store there. All New born babies are on mother's milk in ICU-outcomes in pre term babies have improved and survival rates have improved.

Dr. GC spoke about similar kind of innovation in eyecare area; that of grief counsellor. This has resulted in more tissue being available.

Dr. Parmesh provided updates on the DHAN Foundation pilots – Tumkur and Ramanagara regions are next on the agenda. 128 procedures were done in Mandya at very affordable rates. He also talked about the indigenization of the scope instrument with Aurolab to make it commercially available at affordable rates. Dr. Harish asked about the costs of procedures and Dr. Parmesh responded that they are able to provide a low cost, including cost of surgeons. The problem is more of uneven distribution of doctors.

Dr. Sanjana provided an update on their collaboration with Global Hospital Nursing School for sourcing nurses. It is a 6 month internship program. The nurses in making can come and intern with Amrit Clinics. This project is on hold for now

DVR brought the session to close and then initiated discussion on how to make the pilots more robust.

DVR stated the need to catalogue the successes of the pilots and place it on the EHAC website. He called for a volunteer to focused follow up on the pilots. Sameera agreed to work on this is a systematic manner and present it on the website in a uniform manner. He requested the pilot leads to provide the information to Sameera and Arnaz. Anshu also volunteered for this work.

*Lunch Break*

Day 1 – Second half

Arnaz invited Dr. Rajesh and Dr. C to moderate the session on Quality care with Empathy. Dr. Rajesh gave an introduction to the session by talking about the need for knowledge to ensure quality. He also talked about the need for standard protocols. Given the proliferation of information, there is probably a need to have specialization right from MBBS. To make sure that the whole thing works, there is a need to ensure that there are some minimum standards that are agreed and then are met. He gave an example of medicines under Jan Oushadhi program. Similarly, procurement even in the corporate needs to ensure quality. Greed, ethics and corruption are important factors in the quality question. Having a network of care providers can reduce the load on tertiary care. Continued education of PHC doctors is important, which can emanate from the EHAC member base. Dr. GC countered that one of the problems with the current system is that we have too much specialization. We need to focus on the patient rather than on the disease. Dr. Pavitra talked about research that shows where the system starts with a GP rather than a specialist, there is a 5 to 7 years increment in the lifespan. We may want to look at systems where we have more family physicians.

Dr. C talked about the experience of People Tree Hospitals (PTH) in trying to provide quality care – starting the PTH Foundation even before starting PTH. The surgeon does the surgery free of cost. He also talked about their patient adoption programme. In a similar manner, they have also gotten equipment and money from institutions such as Rotary club. Anshu suggested that we could identify parameters for quality care and then pool the performance of the member base to showcase the work and the best practices. Dr. GC asked what the difference would be between this and from NABH documentation. He suggested that Anshu can provide an outline and then the core group can review it. Dr. Harish raised a question on whether high quality is an excuse to kill competition. Dr. GC suggested that in most cases cost of drugs in not the problem.

DVR then took the lead on the Educational Courses. He provided more details on some of the courses. He elaborated that the course by Dr. Javadekar is on schemes provided by the government. Bindu said she will be working on the module on personal finance for healthcare. Dr. Devendra provides that the concept note on the module on equitable access to healthcare

is ready and has been detailed. They are now working on finding the content. DVR reiterated to all the teams working on modules that only textual and video content is needed and the software will be taken care of by Grey Campus.

Dr. GC focused on the questions of Fellowship and the MDP. The other questions will get better answered tomorrow based on today evening's experience. Dr. Pavitra shared his experience on running a Fellowship in primary healthcare. In medical school this is often neglected. They have brought together 6 organizations to create a Fellowship, which will be targeted at recent medical graduates who have not started residency. Dr. GC connected some of the dots from morning session, especially the gap between the graduates every year and the number of PG seats and suggested that there is scope for such a Fellowship. It needs to have a broader theme and should ensure a sustainable career. Dr. Sharad asked why we should not have non-doctors also as targets for this fellowship. Dr. GC agreed that this question has merit, but parked that to the side as the core theme is about engaging the medical fraternity.

Dr. GC said that there is also the contradiction between the intellectual satisfaction of specialized delivery of service and providing generic care to a large number of people. Dr. Yogesh asked about what were the objective of reaching out to medical students. Dr. GC responded that the students are not exposed to role models who are able to do well while doing good. Dr. C added that the students should know that there is scope for doing idealistic and ethical work. These need to be brought out to the medical students. Dr. Yogesh suggested that student leaders can be included into the next quarterly meeting. Through these student leaders we could reach out to thousands of students. DVR requested Dr. Yogesh to anchor these efforts. Dr. Evita asked what is the appropriate time to deliver the messages we want to give – just before graduation, around internship time, etc.? Dr. GC opined that this should be done during clinical rotation. DVR suggested that Dr. Yogesh can work with Grey Campus for extending reach. Dr. Harish asked what is the first point at which the idealism is lost. Dr. GC responded that it starts at college and continues on through the work. Other questions that came up were- are we open to other health professionals to be part of the courses? Dr. GC also said that the members should have their own staff go through these courses. Dr. Sharad said that for the vast majority of the students, working ethically in a corporate hospital is what they want to figure out. Dr. C suggested that from a practical point of view, we should target all medical students irrespective of their year. Bindu suggested that we need to open the exposure to non-doctors. She also suggested that we could have webinars to reach out to more people across geography. DVR clarified that EHAC is open to everyone and not just doctors. Dr. Sunitha said that for primary healthcare we need to have all four pillars involved (equitable, community involved, appropriate technology, and medicine). She also talked about her own experience from college about primary healthcare observer-ship (Community Orientation Programme). DVR said that we need to use social media more. DVR also suggested that there

can be a module on Entrepreneurship for Medical Professionals. This could potentially be led by Rajesh Pandit.

*Tea Break*

Dr. Pavithra and Dr. Sharad invite participants to share their experience from orientation visit of BHS and ARTH primary care centres.

Anshu spoke about the concept of Taruni sakhi being a great idea. Asha workers were not getting supply of drugs from govt, and they in turn were approaching Taruni sakhi to get that supply. Corporate hospitals were struggling to get GNMs and here system was run by them.

At ARTH one of the focus areas was on geriatric and mental care. The bond formed between workers and people was really good. There was the good practice of waste disposal and good documentation. So looking from quality angle, these things are possible in primary care too, it doesn't require extra cost. They have also come up with MIS concept they are measuring and monitoring lot of things. Delivering mothers come to clinics to deliver (emphasizing institutional delivery). They also had phulwari concept (Child care centre) where children are taken care and mothers work.

Some of the challenges Anshu articulated were -

Acceptance from the community and taking care of family, women working here were driving these things. They are the decision makers.

Continuous training versus attrition. How are you keeping them engaged?

Supply chain versus medicine dispensing. They are doing good? How are they able to do this?

Home care and technology- since they are taking care of geriatric care and mental health, getting some technology for them to monitor the same will help.

DVR said it was time to write a case study on primary healthcare.

Dr. Kumar mentioned that there is a huge divide between the way the Govt. and BHS/ARTH work. What did they think about that? And what were their plans to be sustainable?

Dr. Evita said tht everyone took pride in what they were doing. Atmosphere was cheerful and clean. But it is sad that the ARTH facility have been denied accreditation and had to close down (a facility) and people have to go to other place. We met ordinary women with tremendous courage. The model seems to be coming out of deep concern for people/ human lives. Who takes over from you is the question on my mind?

Dr. Sunitha shared that the team itself was the most remarkable thing. Their commitment to work for the community was extraordinary. The participation from the females in the community was appreciable. She felt that there was a gap in the loop of primary services. A substantial number of people still don't get the services. Again, how much of the technology applications are we using? Should we be addressing some of their social issues and empowerment?

Rajapandian acknowledged the good leadership skills that Dr. Pavitra and Dr. Sharad have, which is visible in the field. After gov;t support is reduced, no of cases have decreased they will need to look for alternatives. He said that he wants to understand the business plan of the two ventures. He also wanted to understand the policy implications of their work.

Dr. Harish mentioned that healthcare cadre at bottom of pyramid is mainly women and they are highly underpaid, so how does this work in the other world where we need to scale up. We need commitment but do we get that just on inner satisfaction? He wondered how do we square the contradiction between the aspirations of people and the fact that we are working primarily with volunteers in the field.

Bindu appreciated the passion and commitment of the two organizations. She asked how can the volunteers be more made more loyal.

Dr. Sharad said that referral was not a problem. They referred just 6% and cesareans are 50% of that i.e 3:% which is still very low.

Dr. Pavitra said that anything (a venture) that grows rapidly is cancer.

Regarding their funding model- he mentioned that they were running on grants. Cost of delivery at their organization was Rs 600. The moment they plan to take it to Rs. 1000, people say don't do it. How do they run a model without funds if people are not able to pay?

In response to the question on the business model and the funding, they stated that grant based work is the only possibility among grinding poverty. The assumption that costs will be lower was not also borne out, as things cost more. What does sustainability really mean? It does not really say that the patient has to pay for the services. Dr. Sharad said that research innovation grants cover many of the costs.

Pranjal suggested that we could do the equivalent of TED Talks for medical professionals by our members. It would be a great forum. DVR requested Dr. GC to include this point in the discussion on the topic next day.

Dr. Devendra led the wrap up for Day 1. Dr. Evita said Enriching. Other responses were Awesome, Enriching, Stimulating, Hot. Devendra said the core thing for him was alignment. He recapped that we started the day with DVR's session and Prof. Shah's introduction. Arnaz's

progress report let us know where we have reached. He then appreciated the study by SSISM and requested all members to support them to go further. He then talked about the question raised by Dr. Harish about democratization of innovation in healthcare. He highlighted that during the discussion on pilots, the story of Dr. Paramesh led him to look at the need for the members to support each other. The afternoon sessions, as precursor to tomorrow's discussions, were enriching. We need to focus on the already committed courses. In the session by Dr. GC, there were many good suggestions. Finally, in the discussions on field visits, the alignment came out.

*End of Day 1 sessions*

Day 2 – First half

Arnaz started off the meeting by setting the agenda for the day. She then invited DVR to anchor the discussion on new pilots. DVR suggested that for future student interactions, the video recordings done yesterday can be edited and used as it is not possible for all the senior members to be present for all interactions.

DVR led the discussion on new pilots. He also called for improving the template on capturing the pilots basic information, and another for monthly progress report. Dr. Pavitra also suggested that we could have a monthly call and share the minutes (standardized) to Arnaz.

List of New Pilots:

1. Fernandez Hospital and BHS - Dr. Evita suggested a pilot on how Fernandez Hospital can be a referral-Secondary(Level 2) hospital for AMRIT clinics
2. Fernandez Hospitaland SSISM - Training modules - short term courses for SSISM girl students to build their skill sets
3. Fernandez Hospital and ARTH – Midwifery training
4. Fernandez Hospital and DHAN Foundation – health in Telangana – to be further defined
5. BHS, SSISM and Patrali - There is need to train nurses on Management skills (delegation, team work, planning of work (short term)). Patrali has agreed to support in creating a network of people.
6. Training Departments of organizations(SSISM, DHAN, Aravind, BHS, ARTH, SVYM - Dr. Kumar will lead this pilot) on Management of health services -Bilingual training with technology focus - skill india certification to be explored, learning by doing -Explore long term certification

7. ARTH and Fernandez Hospital - Training module on clinical skills in focused areas - led by Dr. Sharad and Dr. Evita.
8. ARTH, DVR & Patrali - Dr. Sharad called for support on better understanding and addressing Human – Animal Conflict. DVR suggested two names and volunteered to work with Dr. Sharad on this. He said he will take the lead. Patrali also volunteered to work with the team on this.
9. BHS and LVPEI for NABH accreditation of AMRIT clinics.

Some of the other discussions during the session involved Dr. Devendra discussing the support of Skill India for certification of training programs. He also talked about a Coursera like platform called AuroSiksha.

*The members then broke up into four teams for group work on the four themes.*

*Tea break*

*Group presentations by the four teams*

Dr. Evita led the discussions on the location and dates for the next meeting. The same was decided as ISB, Hyderabad for the 23rd and 24th of August 2019.

## Press Coverage

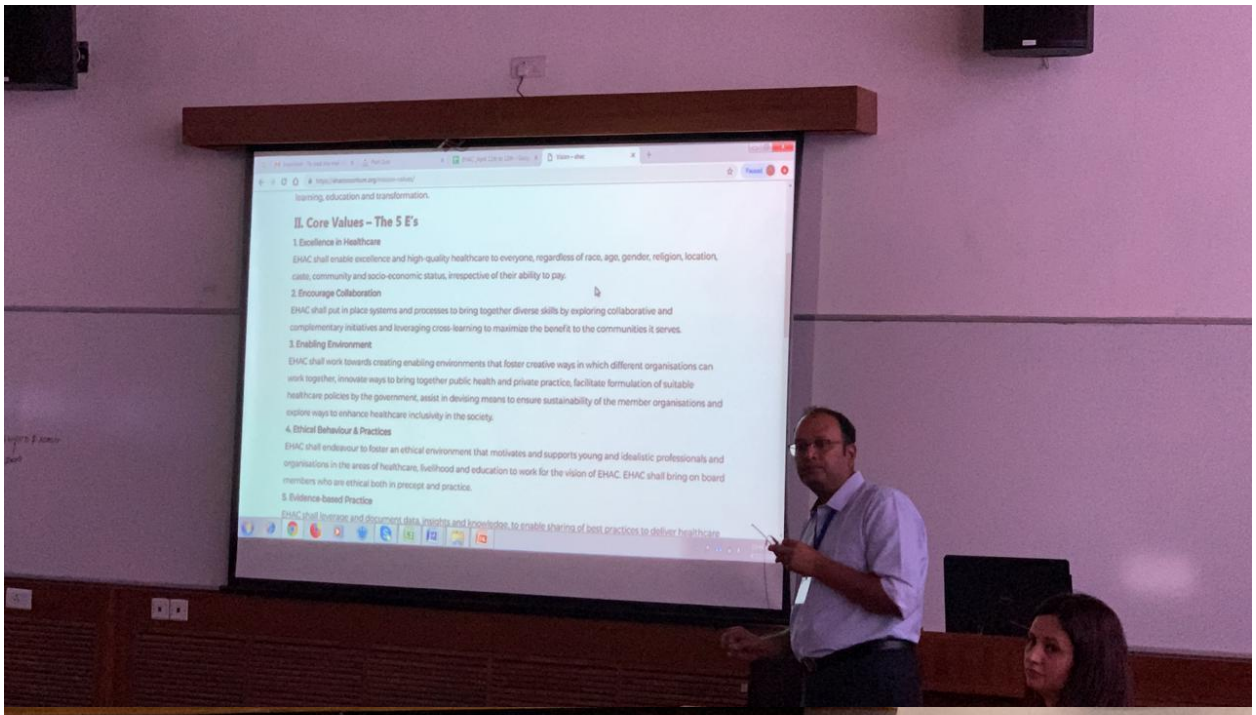
https://udaipurtimes.com/thought-leaders-descend-in-udaipur-for-equitable-healthcare-access-consortium-meeting/

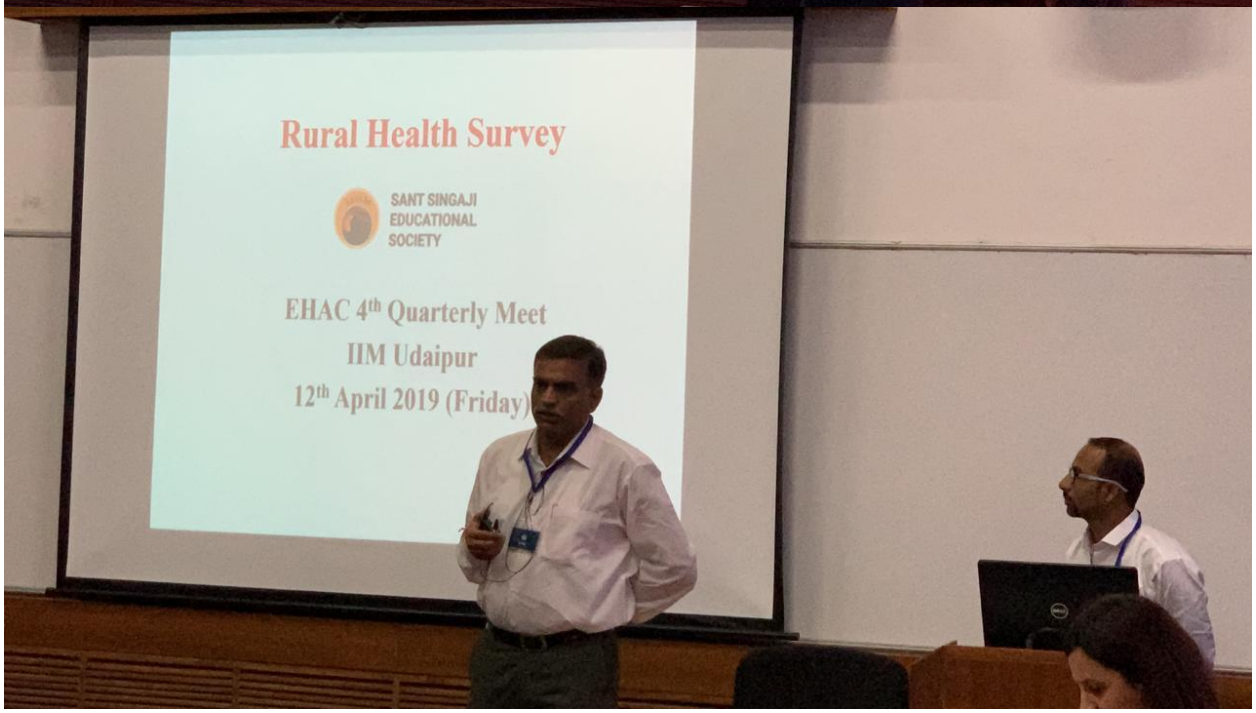
## Pictures from the Meeting



serve Energy


Educational Courses
FIHAC
1. Empathy – Deepa and Rajashree
2. Patient Rights and Medical Ethics
– Ritesh & Astha Mentor – Ratan Jalan
3. Linking the three levels of healthcare (primary, secondary and tertiary levels)
– Swati, Mentors – Dr. Pavitra & Prakash
4. Equitable Access to Healthcare
– Dr. Devendra, Mentor – Thulasiraj Ravilla
5. Personal Financing of Healthcare
– Bindu
6. Medical Representative Health Training
– Dr. Prachee Javadekar
7. Respectful Maternal Care
– Astha , Mentor – Dr. Evita Fernandez


learning, education and transformation.
II. Core Values – The 5 E's
1. Excellence in Healthcare
EHAC shall enable excellence and high-quality healthcare to everyone, regardless of race, age, gender, religion, location, caste, community and socio-economic status, irrespective of their ability to pay.
2. Encourage Collaboration
EHAC shall put in place systems and processes to bring together diverse skills by exploring collaborative and complementary initiatives and leveraging cross-learning to maximize the benefit to the communities it serves.
3. Enabling Environment
EHAC shall work towards creating enabling environments that foster creative ways in which different organisations can work together, innovate ways to bring together public health and private practice, facilitate formulation of suitable healthcare policies by the government, assist in devising means to ensure sustainability of the member organisations and explore ways to enhance healthcare inclusivity in the society.
4. Ethical Behaviour & Practices
EHAC shall endeavour to foster an ethical environment that motivates and supports young and idealistic professionals and organisations in the areas of healthcare, livelihood and education to work for the vision of EHAC. EHAC shall bring on board members who are ethical both in precept and practice.
5. Evidence-based Practice


Rural Health Survey
SANT SINGAJI
EDUCATIONAL
SOCIETY
EHAC 4th Quarterly Meet
IIM Udaipur
12th April 2019 (Friday)


EHAC
Equitable Healthcare Access Consortium
4th Quarterly Meeting
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