Abstract

800 million of the 1200 million people in India have been classified as being poor. About 500 million are “below the poverty line” – a euphemism for per capita income of less than US$ 2 per day. Over 80% of these are the rural poor – living in conditions that cannot be described. These are the people “at the bottom of the pyramid” in the words of C K Prahalad. The country’s impressive economic growth in the last two decades is shadowed by the failure to lift this large mass of people out of poverty and degradation.

Traditional models – whether one wants to look at the Nehruvian model of socialism in which the public sector had a pre-eminent role to play or the half-hearted market economy model of the present Government – have failed to deliver. The Westminster model inherited from the British has created a new class – the politician bureaucrat nexus – that has systematically deprived the ever growing population of the fruits of development (L C Jain et al; Grass without Roots; Sage Publications; 1986). No less than three successive Prime Ministers have admitted that of every Indian Rupee spent on development; only 10% reaches the target group. In contrast, of every Indian Rupee spent through not-for-profit entities, 90% reaches the target group.

The case is about one of the most inspiring examples of Social Entrepreneurship in the last three decades. Dr Sudarshan graduated in medicine in 1973. He served as a doctor with the Ramakrishna Mission and in that capacity travelled to different places – the Himalayas in the north to a very backward village in the Southern Indian State of Karnataka. Appalled by the living conditions of the Soliga Tribe of B R Hills in Karnataka, and inspired by the lives of Mahatma Gandhi, Swami Vivekananda and Albert Schweitzer, he decided to devote his life to improving the conditions of the tribe. Thus was born the Vivekananda Girijana Kalyana Kendra (VGKK), a not-for-profit organization dedicated to transforming the Soliga Tribe in 1980 and Karuna Trust, a not-for-profit organization for the eradication of leprosy, tuberculosis and other diseases in 1986

“The so-called civilized society has a lot to learn from the tribals.”

Dr Hannumappa Sudarshan
Winner of Right Livelihood Award
INTRODUCTION:

Dr. Ram looked out of the window of the SUV. The view was breathtaking. Being the rainy season, there was a drizzle and a thick cloud cover. Much of the foliage appeared to be suspended in the atmosphere without any support. However, the fascinating aspect of nature was no longer his focus. He opened his journal and looked with satisfaction at the progress made in cultivating medicinal plants. A good harvest of Guduci (Tinospora cordifolia), Haritaki (Terminalia chebula), Karanja (Pongamia pinnata), Yasti Madhu (Glycyrrhiza glabra), Bilva (Aegle marmelos), Cangeri (Oxalis carniculata), Goksura (Tribulus terrestris), Tuvaraka (Hydnocarpus wightiana), and Ahiphena (Papaver somniferum) was assured. His interactions with his friends from Europe the previous week had been very fruitful. The first consignment of medicinal powders, pastes and liquids could be shipped in two months’ time. The journey that had started a decade earlier had been well worth it. Dr. Ram was pleased that he had undertaken that momentous journey at the behest of Dr. H Sudarshan. Indeed, he was grateful to Dr. Sudarshan and his Vivekananda Girijana Kalyana Kendra (VGKK) for having provided him with an opportunity to work with the tribals. Having witnessed the metamorphosis that had taken place with the Soliga tribes, he wondered why the model could not be replicated across the country. In his view, it was one of the finest examples of inclusive and sustainable development.

Two months later, as Dr. Sudarshan and Dr. Ram handed over the first consignment of herbal medicines manufactured from the plants grown at the B R Hills in Chamarajanagar District of Karnataka (India) for export, there was a serene smile on the faces of the two doctors – one an allopath and the other an ayurvedic physician. The VGKK had indeed come a long way. The Soliga tribes could now look forward to an even better quality of life, now that their produce would be bringing in precious foreign exchange. And since the concept had been accepted and implemented in two other states with three more in the queue, there was yet hope for the poorest of the poor in the country.

HISTORY:

“There are no pills for poverty.” – Dr H Sudarshan

The Biligiri Rangana (B R) Hills in the Chamarajnagar District of the South Indian state of Karnataka has been home to the Soliga tribes for hundreds of years. Growing their food in the little land available to them, and hunting to cater to their remaining needs, they have lived in harmony with nature, cut off from the rest of the world. Soliga means “people of the bamboo”, a name derived from their belief that their ancestors originated from the bamboos. The life of the Soligas has historically been intertwined with the eco-system. Their respect for and love of nature is reflected in their customs and tribal laws. For example, fruits and berries are harvested only from trees which flower in abundance. Further, very ripe or very raw fruits are not harvested. This leaves enough fruits for birds and animals that also depend on them. The Soliga form of cultivation is as environment friendly as one can imagine. A piece of agricultural land is not cultivated beyond 5 – 7 years. After this period, the land is left untouched for 50 – 75 years so that the land gets rejuvenated and the forest takes root once again. Their dependence on the forest for survival ensures a harmonious existence with nature. It is a symbiotic relationship where the people are connected to the land that nurtures them in an intricate web of life.
When India gained Independence in 1947, the country inherited the strong bureaucratic structure that the British had built during their rule. The bureaucrats and their political bosses became the new rulers. By the 1950s, a systematic exploitation of the tribes began, making full use of the illiteracy and gullibility of the tribes. One of the first tribes to be affected was the Soliga tribe in B R Hills. Their lands were expropriated and they were pushed to the brink of utter poverty and miserable living conditions. The exploitation continued for almost three decades. The Soliga tribe faced the distinct prospect of extinction.

Hannumappa Sudarshan (H Sudarshan) was born in December 1950 and graduated in medicine in 1973. He joined the health institutions of the Ramakrishna Mission and this took him to the Himalayas in Uttar Pradesh, Belur Math in West Bengal, and Ponnampet in Karnataka. Deeply influenced by the teachings of Swami Vivekananda, and inspired by the lives of Mahatma Gandhi and Albert Schweitzer, Dr Sudarshan decided to dedicate his life to work among the poorest of the poor. The exploitation of the Soliga tribe in B R Hills attracted him to that place and in 1980, he established the Vivekananda Girijana Kalyana Kendra (VGKK) for the integrated development of the tribals in the Chamarajnagar District of Karnataka.

VGKK is unique in the sense that it respects the traditions and culture of the tribes it works with and even perpetuates it while bringing aspects of today’s life to them in an evolutionary and seamless manner. In other words, VGKK has never tried to impose urban life-styles on the tribes. Instead, it has taken those skills that are relevant to the tribes and helped the latter to master the skills. Focusing on education, health care, livelihood and microfinance, VGKK has shown how tribal culture can contribute to a process that secures the basic rights and fundamental needs of indigenous people and conserves their environment. The Soliga Organic Village has been built by VGKK using environment friendly materials. The structures are designed to simulate the community living style of the Soligas, promote space sharing and cooperation, and blend with the surrounding forest area. The huts are simple, low-cost and functional, constructed from locally available stones and other materials. The Soligas love open and airy spaces and every construction in the Organic Village reflects this. Members of the tribe gather at regular intervals in the Community Hall for discussions, prayers and entertainment. VGKK recognized quite early that more than 50% of the income of the Soligas came from collecting Non Timber Forest Products (NTFPs). To conserve the bio-wealth of the area, the Soligas were given training in Participatory Resource Monitoring (PRM). They have learnt methods for mapping the resources, estimating productivity, quantifying the extraction and evaluating the extent of regeneration. One metric summarizes the success of the efforts. The percentage of overall collection of fruits has not had any negative impact on the natural regeneration of fruit trees, a measure of sustainability in extraction.

In the words of Dr. Sudarshan: “To eliminate disease you have to remove poverty. The only way to do that, I have realized, is to organize the people for their rights. You can have a good life in rural areas, if you want to. You can do research and original, innovative work. 28 years for me has never been boredom. I really enjoy doing this work and have never doubted it even once.”

In the initial stages, the tribals were afraid of Dr Sudarshan, mistaking him for another bureaucrat out to exploit them. He would carry his medicine bag and go after them. Gradually, the tribals realized that here was a man who really wanted to help them. As a
means of identifying himself with the tribals, Dr Sudarshan built a small hut on a rock and stayed there. The hut still stands as a testimony to the grit and determination of one man.

Identifying education as the key to upliftment, Dr Sudarshan started teaching tribal children in his hut. The first batch had 6 children. It is worth noting that of these, one went on to get a PhD and another obtained a Master’s degree.

Soon, a small hospital was built next to the hut. It is now a 20-bedded hospital with all necessary infrastructures – laboratory, X-ray, Operation Theatre and a well-stocked pharmacy. The hospital caters to a large population of tribals in the region including from the neighbouring state of Tamil Nadu. The hospital offers free treatment. Right from day one, Dr Sudarshan has been meticulous in maintaining the health record of the tribals. Computerization of the data is now under way.

Soligas and other tribals are indigenous forest people who have formidable knowledge of nature cures and medicinal herbs. Dr Sudarshan has encouraged this knowledge to blossom and has incorporated many of their methods in his treatment. Nearly 50 medicinal plants have been identified, documented, and are being cultivated in a scientific manner. Working with like-minded people (Dr Ram in the opening paragraph) many of these plants and herbs are now being sent to Bangalore for processing and export. A mobile health care unit has also been set up to cater to the needs of tribes living in difficult and inaccessible areas.

INITIATIVES IN EDUCATION:

The hospital served as a school at nights in the initial stages. With the tribes accepting education as a necessity, the place now houses a full-fledged school with 600 students, and offers primary, secondary, high school, college and vocational education.

Dr Sudarshan realized the need to ensure that the children were not cut off from their roots in the name of education. Therefore, along with their studies, the children were encouraged to learn about the rich flora and fauna of the region. They were also taught to cultivate vegetables, medicinal herbs, silk worms, bees and poultry.

Education by itself does not mean much to the tribes unless it can help them make a living too. To bridge the gap between formal education and a means to livelihood, vocational training is provided in the following areas:

- Tailoring
- Knitting
- Spinning
- Cotton, Jute and Silk weaving
- Cane and Bamboo work
- Carpentry
- Baking
- Poultry
- Agarbathi (Incense Sticks) making
- Bee-keeping
- Hand-made paper
- Food Processing
- Welding
With such an array of training facilities, the trainees are equipped to carry on a vocation of their choice. The Vocational Training Centre (VTC) was founded in 1982 and has trained over 800 girls and boys to date. Most of them have gone back to their villages and set up micro-enterprises with the help of finance provided as part of VGKK’s activities. More importantly, a significant number of trained craftsmen and women return to VGKK occasionally to help other trainees and to educate children. The loop of sustainability is thus completed.

**INITIATIVES IN COMMUNITY DEVELOPMENT:**

Like many other tribes, the Soligas too have been exploited for decades by the forest officials and the government. Their land entitlements that they had enjoyed for centuries were taken away. Against this background, it became imperative for VGKK to unite the Soligas living in the area, and to provide them a common forum and a voice to air their concerns and petition their grievances. VGKK organized Sanghas (Community Representatives) in every village and comprised exclusively of the local tribes. This model ensured that no one could accuse anyone of having vested interests. The tribes were essentially fighting for their rights. Thanks to this initiative, most of the alienated land belonging to the Soligas has been returned to them. Further, the Soligas have entered the mainstream, participated in and won many local elections.

VGKK also pioneered what is arguably the largest community health insurance project in India. The scheme offers fantastic benefits to the poorest of the poor. The premium is ultra-low (INR 30 or 75 cents) per year for wage loss compensation of INR 50 ($1.20) per day.

“Health is a good entry point into the community. But if you really want to help people, it has to be holistic development. Education and income generation cannot be ignored. Also, pure vertical programs don’t work. Pulse Polio is an example. Excessive focus on eradicating polio meant that routine and required immunization dropped.”

*Dr H Sudarshan*

**KARUNA TRUST:**

“Our Vision is for a society in which we strive to provide an equitable and integrated model of Health Care, Education, and Livelihoods by empowering marginalized people to be self-reliant.”

“Our Mission is to develop a dedicated service minded team that enables holistic development of marginalized people, through innovative, replicable models, with a passion for excellence.”

Dr. Sudarshan founded the Karuna Trust in 1986 as a response to the high prevalence of leprosy in certain pockets that he was familiar with – particularly Yelandur. The Trust was established to develop and deliver community based, people oriented, need based and culturally acceptable models using appropriate technology with minimum cost to the community.
The Trust has since enlarged its activities and is regarded as a role model in the concept of Public Private Partnerships (PPP). Here, the word Public generally refers to the Government. The word Private refers to either for-profit Corporations or not-for-profit entities (Non-Governmental-Organizations or NGOs). The word Partnership refers to active participation in Policy Formulation, Planning, Implementation, Monitoring, Evaluation, Training and Research.

It is accepted that the Government alone cannot solve all the problems facing society or a nation. The Government has resources but is found wanting in implementation. As more than one Prime Minister of India has pointed out, for every Rupee spent by the Government, only 10% reaches the target group. The remaining is eaten up by administrative costs, pilferage and corruption.

The Private Sector and in particular the not-for-profit sector (NGOs) do not have resources but are very good in implementation. For every Rupee spent through NGOs, it is estimated that 90% reaches the target group and only 10% being required for minimal administrative costs.

Thus, the concept of PPPs is to integrate and leverage upon the respective strengths – conceptually sound schemes of the Government backed by resources and the efficiency in delivery and implementation of the NGOs.

The primary objective of Karuna Trust was to bridge a vital gap in the health care system – the Primary Health Care (PHC) System – an ambitious project of the Government to deliver quality health care to the remotest corners of the country. Nearly 90% of PHCs do not have the required facilities – Doctors, Para-medical staff, Infrastructure, Medicines and above all a service orientation. NGOs on the other hand may have the passion, including volunteers willing to serve in remote areas on rotation, but lack the resources. PPP was envisaged as a model to make the best use of the Government’s intent and resources and NGOs ability to deliver.

Karuna Trust was the culmination of the successful partnership of Dr Sudarshan’s VGKK with various Government Departments and Agencies:

- The Tribal Hospital at B R Hills was partially funded by the Ministry of Tribal Affairs, Government of India, and the Government of Karnataka
- The Tribal Residential School at B R Hills was also partially funded by the same Government entities as above
- An Industrial Training Centre (for Vocational Training) was set up with partial funding from the Government of Karnataka
- A Technology Resource Centre was set up in cooperation with the Council for Advancement of People’s Action and Rural Technology (CAPART), an autonomous body under the Ministry of Rural Development, Government of India
- A Tribal ANM (Auxiliary Nursing and Mid-Wife) Training Centre was established with assistance from the Government of Karnataka

Spurred by the success and integrity of these initiatives, the Karuna (Compassion in Sanskrit) Trust was established to provide a new direction to the Primary Health Centres (PHCs). The PPP model has translated into the following:
26 PHCs in Karnataka, 9 remote PHCs in Arunachal Pradesh, and 6 PHCs in Orissa are being managed by Karuna Trust (having been handed over by the respective state Governments). The Trust has been approached to take over more PHCs in Andhra Pradesh, Meghalaya, and Jammu and Kashmir.

The Trust has successfully launched a Tele-Medicine Project in co-operation with the Indian Space Research Organization (of the Government of India – for communication and satellite bandwidth) and Narayana Hrudayalaya, a renowned private sector speciality hospital founded by the noted surgeon Dr Devi Shetty.

Community Health Insurance with the National Insurance Companies

Good Governance in Health Project in cooperation with the Lokayuktha (Judicial Ombudsman) of Karnataka

Karuna Trust has taken up a comprehensive program for the Control and gradual Eradication of Leprosy, Tuberculosis, Epilepsy and Mental Health. The program has the support of ten committed Voluntary Organizations (Not-For-Profit)

THE PPP Process:

- The process starts with a dialogue with the people who are sought to be served by the PHC
- Suggestions and Recommendations of the Village, County and District Level representatives obtained
- Application to the District Council – approval by the District Health Committee followed by resolution at District Council
- Application forwarded to the State Health Commissioner
- State Government issues order approving PHC to be handed over to Karuna Trust
- Karuna Trust signs Memorandum of Understanding with the State Director of Health
- District Health Officer hands over PHC to Karuna Trust
- Duration of arrangement is 2 years with an option to renew for another 3 years
- Infrastructure: Land, buildings and equipment are handed over to Karuna Trust
- Human Resources: Government Staff working at the PHC (if any) are given the option to continue or re-locate. Those who wish to continue (if any) are re-appointed by Karuna Trust. Vacant positions filled through recruitment by Karuna Trust (mainly volunteers)
- Financing: 75% of salaries + Rupees 25000/- per month towards medicines and administrative costs borne by the Government
- Current Scenario: Most of the PHCs managed by Karuna Trust receive 100% funding from Government based on Key Performance Indicators

MONITORING AND EVALUATION:

- Hospital Management Information System developed by Indian Institute of Management, Bangalore
- Monthly and Yearly reports generated for each PHC
- Community Monitoring – Village, County and District Levels
- Independent Evaluation by Private Financing Institute (PFI)
- Independent Evaluation by Institute for Hospital Management and Research (IHMR)

BRANDING OF KARUNA TRUST:

- The Medical Officer, Staff Nurse, Pharmacist and Laboratory Technician are required to stay in the same town / village where the PHC is located
The Auxiliary Nurse / Mid-Wife are required to stay where the sub-centre (branch of PHC) is located

- All Karuna Trust PHCs work 24 x 7
- Assured availability of essential medicines throughout the year
- Karuna Trust PHCs are people friendly – it is mandatory to treat women with respect
- Total Commitment to Cleanliness, Hygiene and Good Maintenance
- Zero Tolerance for Corruption

KEY FEATURES OF PHCs MANAGED BY KARUNA TRUST:

- Karuna Trust takes entire responsibility for the population covered by it thus avoiding duplication and redundancy
- People oriented, Community based, Cost effective, Culture and Region specific Primary Health Care
- Effective Implementation of Reproductive Child Health – pre and post-delivery care with essential Obstetric care
- Effective Implementation of National Health Programs
  - Leprosy (Mitigation and Eradication)
  - Tuberculosis (Multi Drug Therapy recommended by WHO)
  - Malaria (Treatment and Prevention)
  - HIV / AIDS (Prevention and Treatment)
  - STDs (Prevention and Treatment)
- Disease Surveillance, Investigation and Mitigation
- Specialist Services at PHCs (not envisaged by Government):
  - General Physician
  - Obstetrician and Gynaecologist
  - Ophthalmologist
  - Paediatrician
- Excellent referral system – Transport for emergencies with a staff member accompanying the patient to the nearest speciality hospital with which the Trust has a collaborative arrangement
- Exemplary address of context specific problems such as Sickle Cell Anaemia and Hot Water Epilepsy
- Sustainable PHC waste management system
- Community based rehabilitation of otherwise-enabled people
- Training Graduating Students of Medicine in Primary Health Care
- Senior Clerical (Administrative) Staff trained to be Administrators of PHC
- Development of True Community Needs Assessment through Village Health Committees (VHCs), Sub-Centres and PHC Committees
- Promotion of Self-Help Groups for Micro-Credit and Income Generation
- Rigorous implementation of anti-alcohol and anti-tobacco campaigns
- Convergence of Health, Nutrition, Potable Water and Sanitation towards a holistic approach to healthy living

INNOVATIONS OF KARUNA TRUST:

- Training of tribal girls (X standard passed) for 18 months leading to Certification as Auxiliary Nurse / Mid-Wife
- Introduction of Dental Health and Cancer Detection and Control Program at PHCs – Training of ANMs to take Pap Smears
Integration of Rehabilitation into Primary Health Care in addition to Preventive, Promotive and Curative Health care

Telemedicine in Primary Health Care in cooperation with Indian Space Research Organization, Narayana Hrudayalaya and Amrita Institute of Medical Sciences

Community Health Financing

Promotion of Traditional Medicine – 50 herbs identified and most of them being cultivated in the tribal regions – Integration of traditional systems of medicine AYURVEDA and HOMEOPATHY into AYUSH program

Promotion of Generic Drugs and Rational Drug Use Program (in cooperation with LOCOST- Low Cost Standard Therapeutics and BIOCON – a leading Bio-Pharmaceutical Company)

Introduction of Mental Health Program including Low Cost Management of Epilepsy

Establishment of Coronary Care Unit at Chamarajanagar District Hospital and special training to General Physicians in managing critical cardiac emergencies

Establishment of MANASA – Mainstreaming Mental Health into Primary Health Care. The initiative is a comprehensive system of care for the homeless, mentally ill people and includes a transit centre, help line and rehabilitation and reintegration with families

KARUNA TRUST AND COMMUNITY HEALTH INSURANCE: A UNIQUE MODEL

The Community Health Insurance launched by Karuna Trust in partnership with the Government is a unique model in affordable health care and insurance benefit for exigencies. The model works at three levels: Community Herbal Gardens have been established in all villages to take care of common ailments. County level Self Help Groups have been formed to provide micro-credit for out-patient care. Finally, a pre-paid insurance scheme has been introduced to take care of hospitalization and medicines. The premium is a mere INR 30 per year (in the first year reducing to INR 22 from the second year) per person. The premium cost is shared by the Community, Milk Co-Operatives, Self Help Groups, UNDP and District Councils. The model is unique because there are no exclusions, all age groups are covered and hospitalization can be due to any illness. In addition, patients are paid INR 50 per day for daily wages lost and another INR 50 per day for extra medicines that may be required during the stay at the hospital. The insurance covers both diagnosis and treatment with hospitalization being limited to 25 days. The amount (wages lost + cost of medicines) is paid to the patient every day through a revolving fund at the PHC or hospital. The National Insurance Company settles claims once a week. Karuna Trust has extended the scheme even to people Above Poverty Line through its Janarogya Policy at a premium of INR 70 per year with exclusions but with private hospitals also being included.

PPP FOR PHC IN ARUNACHAL PRADESH:

The Public Private Partnership in the North Indian State of Arunachal Pradesh started in the year 2005 with the signing of a Memorandum of Understanding (MOU) between Karuna Trust and the State Government. Under the agreement, Karuna Trust would manage a PHC in each district of the state in cooperation with a selected Non Governmental Organization (NGO). The services provided by Karuna Trust include:

- 24 hours casualty / emergency services
- Out Patient Services for six days in a week
- 5 to 10 bed inpatient facility based on space provided
- 24 hours labour room
- 24 hours essential Obstetrics facility
The Arunachal Pradesh PPP was for an initial period of three years and has been extended. In addition to the Process Indicators applied in the state of Karnataka, a State Level Steering Committee headed by the Commissioner and Secretary (Health) monitors the program. As far as financing is concerned, 90% of the funds required towards personnel, medicines, reagents, surgical material, health care consumables, administrative charges, civil works, furniture and equipment are provided by the Government of Arunachal Pradesh. The balance 10% is contributed by the participating NGO. The audited accounts are submitted to the Government every six months. The Project Cost has been estimated at INR 3 million per PHC per year. Of this, INR 2.7 million is provided by the State Government and the balance 0.3 million is contributed by Karuna Trust or the local NGO. The Governor of Arunachal Pradesh General J. J. Singh said during an interaction in December 2009: “You are doing a wonderful job. We deeply appreciate the yeoman service being rendered by you in the remote areas of the state. The PHCs under your care are functioning very well.”

CONSTRANITS FACED BY VOLUNTARY ORGANIZATIONS:

- The first PHC to be handed over by the Government of Karnataka to Karuna Trust (Gumballi PHC) had to face difficulties with the Private Nursing Home in the nearby town as the latter felt they would lose business
- Despite co-operation and Memoranda of Understanding being signed at the State Level, problems persisted at the district level with rampant corruption at the District Health Office for the release of essential medicines
- Delays between 6 and 12 months were observed in the release of Government grants and this placed enormous financial pressure on the Trust
- Local vested interests forced one of the District Councils to withdraw the approval accorded to Karuna Trust to manage the PHC in the district
- A clear discrimination between Government run PHCs and NGO run PHCs was discernible
- Although the Memorandum of Understanding stated that the Government would fund 90% of the requirement and the NGO had to raise 10%, in reality the proportion was 75% and 25% respectively, thus placing an additional burden on the voluntary organization
- There was a severe shortage of doctors with graduating doctors refusing to go to rural or semi-urban areas. Only the privately managed St John’s Medical College stipulated a mandatory 2-year stint for its graduates at the PHCs
- With the Government not even releasing the agreed portion of 90%, there was very little scope for capacity building

AWARDS AND RECOGNITION:

Besides holding a number of positions at the National and State levels on an honorary basis, Dr Sudarshan has been bestowed numerous awards:

- Karnataka State Award by Government of Karnataka – 1984
- Vivekananda Seva Puraskar (Service Award) – National – 1991
- Environment Award by Government of Karnataka – 1992
INCLUSIVE GROWTH AND DEVELOPMENT: A Viable Model

The significant achievements of Dr Sudarshan’s VGKK and Karuna Trust have to be viewed in the context of similar initiatives having failed in other states such as Maharashtra and Rajasthan. Dr Sudarshan’s efforts in social entrepreneurship assume special significance in a large and diverse country like India. Conservative estimates place the number of people living Below the Poverty Line (BPL) at 500 million. The definition of poverty itself is a nebulous one – ranging from US$ 1 per day to US$ 2 per day – the section of population identified by Professor C K Prahalad as the bottom of the pyramid. Dr Sudarshan has shown through his work that it is possible to transform this large segment into micro-producers and micro-consumers. It is a model worthy of emulation as a solution to the problems of poverty. The country is endowed with rich natural resources. As US Ambassador and Economist John Kenneth Galbraith once remarked: “India is a rich country with poor people.” The only way of bringing the poorest of the poor into the mainstream and to improve their quality of life is to encourage them to preserve their traditions even while being trained to learn new skills that would enable them to have alternate and better sources of income.

At the recently concluded Global Investors’ Meet (GIM) organized by the Government of Karnataka, Multi National Enterprises committed investments of over US$ 40 billion in the state. The promised investments were primarily in extractive industries like mining and development projects like infrastructure and energy. All these projects would inevitably lead to hundreds of thousands of the “poorest of the poor” being displaced from their habitats of several centuries. In fact, the resettlement and rehabilitation of tribes is a major sore point with large-scale projects across India. Against this background, the success of VGKK and Karuna Trust lend a high degree of credibility to what can be accomplished given the will of all stakeholders.

In an interview with the case writer, Dr. Sudarshan articulated his views on inclusive growth and development:

“Multi National Enterprises need to recognize that they have a responsibility towards local communities. They need to think beyond profits and look at the local communities as partners in development. Since any project in the extractive or metals or infrastructure sector takes years to materialize, large corporations have a huge window of opportunity to demonstrate that they care. After all, the amount approved
and being spent on the Primary Health Care Centres of Karuna Trust is just INR 3 million per year (US$ 66667 at current exchange rates). Surely, for large corporations willing to invest billions, this is a drop in the ocean. Why can’t they start health care centres, primary schools, vocational training centres, and sustainable growth models for the local communities before they take out the first ton of ore or the first bar of metal? Why can’t they pay appropriate (market-based) compensation for the land that rightfully belongs to the local communities? Why can’t they train the young people in the community and employ them in their enterprises? In other words, the model that VGKK and Karuna Trust have developed is scalable. It can be ramped up to include larger communities and make them part of the economic growth and development agenda, without having to give up their roots.

- The Government can play a catalytic role in ensuring that professionals – particularly doctors and educators – spend a minimum of 5 years in remote locations. It is a well-known and documented fact that higher education in India is heavily subsidized by the Government. A doctor graduating from a Government-run Medical College would not have spent more than the equivalent of about US$10000 over nearly six years of education. An engineer graduating from one of the prestigious Indian Institutes of Technology would not have spent more than the equivalent of US$ 5000 over four years and a half. Do these professionals not have a moral and ethical duty to serve in rural and remote areas at least for 10% of their working life? Why don’t we start talking about Individual Social Responsibility in the same breath as Corporate Social Responsibility?

- The Public Private Partnership (PPP) model appears to be the way to go forward. The statistic is quite telling. Karuna Trust has been able to bring down the leprosy rate from over 25 per 1000 to less than 0.2 per 1000 in the Yelandur area over a period of 20 years. Incidence of Tuberculosis has been brought down from over 60 per 1000 to less than 1 per 1000 during the same period. Awareness about the dangers of HIV / AIDS has been found to be better than in the urban areas. What better indicators are required to demonstrate that the model delivers results?”

In their seminal work “Grass Without Roots: Rural Development Under Government Auspices” (Sage Publications, 1986, ISBN 0803995008) the noted development economist L C Jain and his co-authors have provided a comprehensive review of the Indian Government’s development program and have examined the impact of policies at the grass-roots level. On the basis of extensive field studies, the authors have concluded that it is essential to include the people in the design and operation of rural development schemes. They argue that without democratic decentralization, efforts to alleviate poverty and hunger in India’s villages would remain exercises in futility. In his foreword to the book, the economist R Kothari is even more precise. He has singled out the Westminster model (inherited from the British) as the root cause for most of the problems plaguing government initiatives in India. He has blamed the model for centralizing tendencies and for re-positioning power in India in the hands of the bureaucracy. “The course of economic development is vitally determined by the structure of political power.” The solution that is offered is a complete decentralization of power to the community level.

It might have been a coincidence that Dr Sudarshan started his work at about the same time that “Grass without Roots” was being written but the empirical evidence appears to be loud and clear. Unless local communities are involved from concept to implementation, poverty alleviation and enhancing the quality of life for those at the bottom of the pyramid will
remain dreams. Viewed in this light, Dr Sudarshan stands out as an outstanding social entrepreneur.

THE WAY FORWARD: STRATEGIC ARCHITECTURE FOR INCLUSIVE GROWTH

- VGKK and Karuna Trust have demonstrated that it is possible to bring about all-round development for the poorest of the poor without destroying their traditions and culture. It is a lesson in co-operative strategy. The initiative started off as an experiment in social entrepreneurship. Dr Sudarshan earned the trust of the Soliga tribe by treating them as equals in an endeavour to bring about societal transformation. Starting with health care and education, and subsequently emphasizing vocational training, he was able to transform micro-consumers into micro-producers with micro-finance as the instrument for providing resources. Recognizing the usefulness of the model, the State Government of Karnataka was forced (by public opinion) to offer help in the form of the Public Private Partnership model. The Primary Health Centres (PHCs) managed by Karuna Trust are a refreshing contrast to the PHCs managed by the Government. As a result, at least one PHC in each of the districts of Karnataka is now managed by Karuna Trust. Good deeds cannot remain under wraps for long. The state of Arunachal Pradesh was next to follow when it asked Karuna Trust to manage 9 PHCs in the most backward districts of the state. Orissa was next and other states are in the queue. While this is laudable, the model once again exposes the lack of will on the part of the Government. Whereas the Memoranda of Understanding between the States and Karuna Trust indicate that 90% of the total costs would be borne by the Government, the reality shows a different picture. As shown in the Exhibit related to two PHCs, the contribution from the Government has been 79% in one case and 71% in the other. Such asymmetries place enormous pressure on not-for-profit organizations. In any cooperative strategy, the critical success factor is trust. The Government needs to do more than offering mere platitudes. One way perhaps is to insist in all such cases that Government funding should precede the implementation. The significant factor to be noted is that in a relatively short span of 24 years (of actual operations), the per capita income of the target group has increased more than 100 times in real terms. With medicinal plants being grown now and a huge export potential existing for the herbal extracts, one can extrapolate and say that per capita income can increase 300 times in the next decade. This is the fortune at the bottom of the pyramid. This is inclusive growth.

- As suggested by Dr Sudarshan himself in the interview, Multi National Enterprises that have decided to invest in this country particularly in extractive industries and infrastructure, can take a leaf out of VGKK and Karuna Trust. Since the gestation periods for such projects is several years, the MNEs can earn the trust of the local communities (who are in most cases similar to the Soliga tribes) by starting with health care and education and then branching out to vocational training. The MNEs can train the local communities (especially the women) in various crafts. The output can then be marketed globally by the same MNEs as part of their CSR initiative. This is creating wealth where it is needed the most. There is a need to look at Private – Private – Partnerships (also PPPs) as a way out of the poverty spiral that the nation is caught in. The National Advisory Council (NAC) headed by the Chairperson of the Present Coalition at the Federal Government has come out with a proposal (two days back) under which almost 800 million people would be supplied food at subsidized
rates. It is time that we said enough to subsidies and started creating opportunities for higher income generation. It may be prudent to remember that there really are no free lunches. The subsidies would without a doubt be funded by the remaining 300 – 400 million people.

- VGKK and Karuna Trust appear to have set off a ripple effect. The renowned cardio-thoracic surgeon Dr Devi Shetty (of Narayana Hrudayalaya with whom Karuna Trust has a strategic partnership) announced yesterday that 50 hospitals would be set up across the country over the next three years where as an example a heart surgery would be performed for about US$ 1000/- (INR 50000). The hospitals would be eco-friendly, would depend on natural ventilation for all units except the surgical rooms, and would have sustainability as a key theme. India requires 2.5 million cardiac surgeries to be performed each year. These affordable hospitals with the best of surgeons and pre- and post-surgical care would bridge the gap between demand and supply.

- The model can be replicated in other parts of the world notably Africa and Latin America. In that sense, VGKK and Karuna Trust can be the harbingers of a new world without hunger and disease on the one hand, and a means to a better life on the other.

EXHIBIT I

Where it all started: the hut where Dr. Sudarshan initially stayed in B R Hills, Karnataka
A Primary Health Centre

Another Primary Health Centre
Group of workers

A Mobile Health Care Unit
A paramedic with a rehabilitated person

Telemedicine
Bameng PHC

- 380 km. from Itanagar in East Kameng district
- The mud road from Seppa to Bameng is very often blocked by landslides

An Arunachal Pradesh Primary Health Centre – Then and Now
Another Primary Health Centre – Then (L) and Now (R)

Equipment being carried by boats to remote areas
Karuna Trust in Yelandur
All pictures courtesy of Karuna Trust

EXHIBIT II

ORGANIZATIONAL CHART OF KARUNA TRUST, ARUNACHAL PRADESH

Source: Karuna Trust
EXHIBIT III

INFANT MORTALITY RATE (IMR)

UNDER – 5 MORTALITY RATE
PERINATAL MORTALITY RATE (PMR)

Source: Karuna Trust

EXHIBIT IV
KEY INDICATORS – LONGITUDINAL STUDY

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<td>17.1</td>
<td>17.9</td>
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<td>18</td>
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<td>17</td>
<td>18</td>
<td>18</td>
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<td>2. Crude Death Rate</td>
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<td>5.6</td>
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<td>3. I.M.R.</td>
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<td>4. Still Birth Rate</td>
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<td>8.5</td>
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<td>7. Post Neonaatal Mortality Rate</td>
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<td>8. Child Mortality Rate (1-5yrs.)</td>
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<td>16.3</td>
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<td>9. Under 5 mortality Rate (0-5 yrs.)</td>
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<td>10. Maternal Mortality</td>
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Source: Karuna Trust
### Process Indicators - Gumballi PHC

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<td><strong>Birth Weight of Babies 2.5 kgs or more</strong></td>
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<td>86.1</td>
<td>89.1</td>
<td>83.1</td>
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<td>16.9</td>
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<td>3.5</td>
<td>5.5</td>
<td>5.9</td>
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<td>2</td>
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<td>3.4</td>
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<td><strong>Pregnant Mother receiving (ANC3visits)</strong></td>
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<td>92</td>
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<td>80</td>
<td>98</td>
<td>94.05</td>
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<td>87.5</td>
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<td><strong>Deliveries by Trained birth attendant</strong></td>
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<td>100</td>
<td>100</td>
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<td><strong>Institutional deliveries</strong></td>
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<td>89</td>
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<td><strong>Immunization coverage</strong></td>
<td>100</td>
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<td>102</td>
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<td>100</td>
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<td><strong>Children Immunization</strong></td>
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<td><strong>Couple Protection Rate (Cumulative)</strong></td>
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<td>74.4</td>
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<td>77.7</td>
<td>75</td>
<td>80</td>
<td>84.1</td>
<td>84</td>
<td>74.4</td>
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Source: Karuna Trust
EXHIBIT V

GAP BETWEEN PROMISE AND PERFORMANCE
STATISTICS FROM TWO PHC’S

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<td>KT</td>
</tr>
<tr>
<td>1</td>
<td>Salaries</td>
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</tr>
<tr>
<td>2</td>
<td>Medicines Purchases</td>
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<td>3</td>
<td>Admin &amp; Maintenance</td>
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<tr>
<td></td>
<td><strong>Total</strong></td>
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<td></td>
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</table>

ZP: Zilla (District) Panchayat i.e. the Government
KT: Karuna Trust

Source: Karuna Trust

*Professors Baragur V Krishnamurthy and Dilshad D Jalnawalla have prepared this case as a basis for classroom discussion at the graduate level. It is not intended to be a source of primary data nor an endorsement of correct and incorrect ways of approaching managerial problems. The case has been successfully tested in courses on Entrepreneurship, Sustainable Development, and Strategic Innovation. Instructors desirous of using the case may write, along with their affiliations, to caa@rimsbangalore.in for a teaching note.

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