POLICY PAPER

TO PROMOTE AND/OR ASSIST

SMALL GROUPS / NGOS IN WEST BENGAL

TO HELP PEOPLE WHO ARE

POOR AND UNDER-PRIVILEGED

LIVING IN DISTRESS, SUFFERING

AND IN NEED

NGO SUPPORT SERVICE

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INTRODUCTION

Ever since its inception more than two decades ago, WBVHA has been working with small groups and NGOs in various parts of West Bengal. The experience of the last two decades has convinced WBVHA that though currently behind southern and western states in terms of NGO activities, West Bengal's potential for harnessing grassroot level voluntary action through small groups is immense and remains largely unharnessed.

Due to the interplay of various factors, the climate has not been fully conducive for greater development of NGO activities. But the climate has started changing for the better as we have analysed later in this document. This is the right time to make a concerted effort to bring together the large number of small groups already operating even if in a low key, provide them with necessary support both materially and in terms of developing a professional approach in them.

In its own way, WBVHA has already been doing this work, other than funding through its NGO Support Service Unit. But considering its importance, the task needs to be undertaken as a special project.

The present document is a proposal for this purpose developed by the Survey and Research Unit. It is divided into 10 sections. Sections 1-7 provide a situation analysis of West Bengal in terms of various socio-economic parameters.

Section 8 makes an attempt to classify the various districts of West Bengal in terms of their situation and priority they should be accorded in the task that WBVHA is setting for itself.

Section 9 analyses the NGO scenario in West Bengal and spells out, in broad terms, the tasks that need to be undertaken by NGOs. One important part of this section is WBVHA's detailed discussions with policy makers and senior administrators of West Bengal about their experience of working with NGOs and the areas which they think is appropriate for NGO interventions.

The last section (10) presents WBVHA's proposal and details out the support it needs for this purpose.

CONTENTS

LIST OF TABLES

SECTION - I

ADMINISTRATIVE DIVISION

Till recent years, West Bengal had 15 districts, excluding the metropolitan city of Calcutta. These districts were Bankura, Bardhaman, Birbhum, Darjeeling, Haora, Hugly, Jalpaiguri, Koch Bihar, Malda, Medinipur, Murshidabad, Nadia, 24 Parganas, Purulia, and West Dinajpur.(See Table I).

In recent years, two districts have been split into two. They are 24 Parganas and West Dinajpur.24 Parganas has been split into the districts of 24 Parganas (North) and 24 Parganas (South).W. Dinajpur has been divided into W. Dinajpur (North), West Dinajpur (South). However, district level data for the new districts are not always available yet. In such cases, data available for the pre-split district have been used.

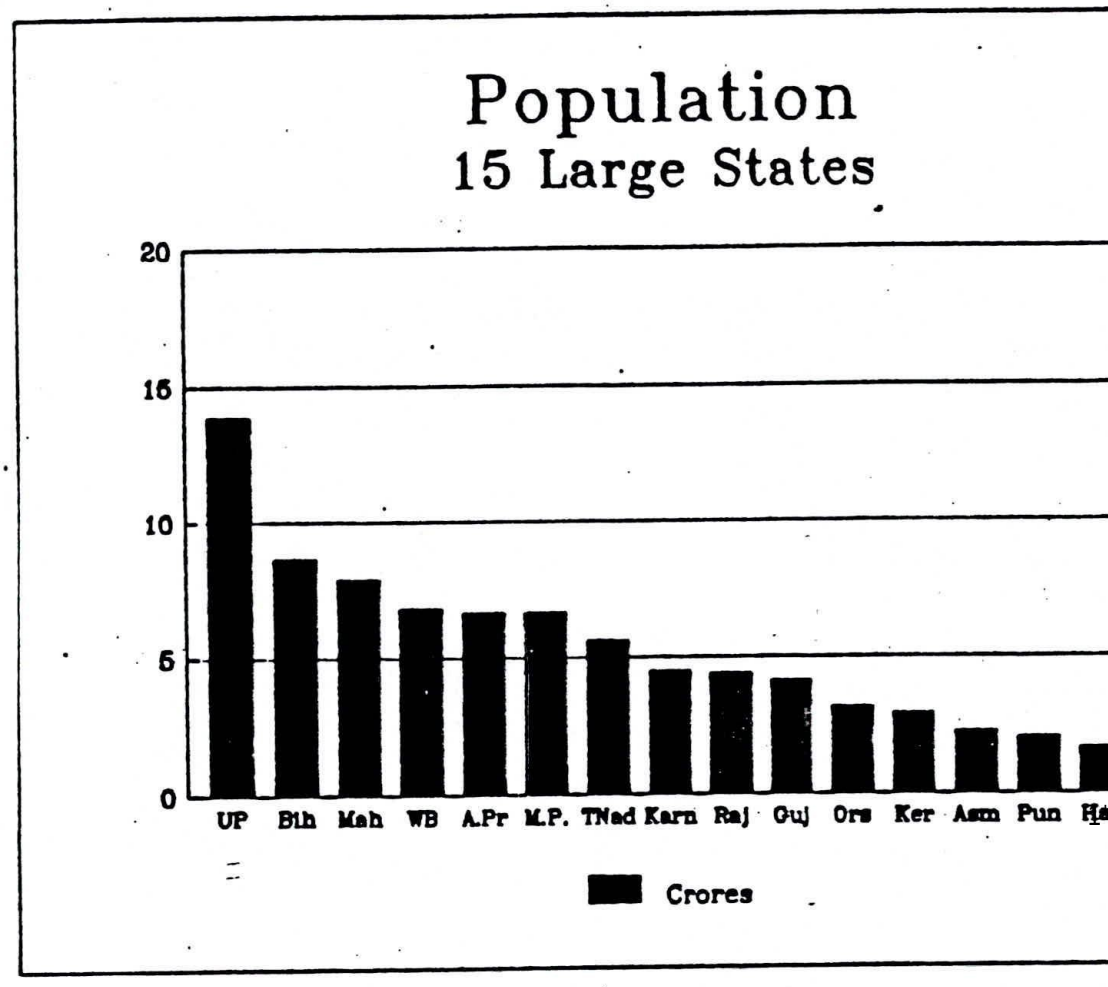
Below the district level, Community Development Blocks (CD BLOCKS) are the focal point of administrative and development activities. There are, in all 341 CD blocks in the state of West Bengal.

With the introduction of a vigorous rural local self-government system called Panchayat since the late seventies, focus has somewhat shifted to the Panchayat units. At the district level, the Apex of the Panchayat institutions is the Zilla Parishad. It plans, oversees and implements development activities for the district directly or through the lower level Panchayat units. It is very powerful and the administrative head of district, the District Magistrate has to serve as the Executive Officer of the Zilla Parishad. The second important layer of Panchayat institutions in a district are the PANCHAYAT SAMITIES. What the Zilla Parishad does at the district level is done by the Panchayat Samity at the samity level. THE area and jurisdiction of the Panchayat Samity are, roughly, the same as that of the Community Development Blocks. The principal government administrative officer of a block, the BLOCK DEVELOPMENT OFFICER or the BDO is the executive officer of the Panchayat Samity. Below the Panchayat Samity, a cluster of villages called GRAM PANCHAYATS constitute the lowest unit of the Panchayat institution.

For law and order administration, the rural and urban areas are divided into POLICE STATION areas.

For municipal administration of towns and urban areas having a certain minimum population, the local self government unit is called municipality.

Table No.1 gives details of the number of these units at district level. For the state of W. Bengal as a whole, there are 17 districts excluding Calcutta, 331 Panchayat Samities, 3246 Gram Panchayats, 102 Municipalities and 383 Police Stations (excluding those for Calcutta).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SECTION - 2

WEST BENGAL AND OTHER STATES.

2.1 Population Characteristics

According to the 1991 Census, there were 15 states which had a population of more than 10 million. West Bengal occupies the fourth position among the 15 large states. In 1991, India had a total population of 840.43 millions.

W.BENGAL that year had a total population of 6,79,82,732. W. Bengal, thus, has 8% of India's total population. But, with 88752 sq km, it occupies less than 3% of the area of the country.

West Bengal has a density of population of 766 persons per sq. km. It is the highest density among all the states of India.

The 15 "large" states and their respective population are given below in crores (1 crore = 10 millions).

15 MAJOR STATES OF INDIA

TOP 5		MIDDLE 5		BOTTOM 5	
U. P.	(13.90)	M.Pradesh	(6.61)	Orissa	(3.15)
Bihar	(8.68)	T. Nadu	(5.56)	Kerala	(2.90)
Maharastra	(7.87)	Karnataka	(4.48)	Assam	(2.22)
West Bengal	(6.79)	Rajasthan	(4.38)	Punjab	(2.01)
A. Pradesh	(6.63)	Gujrat	(4.11)	Haryana	(1.63)

The position of the West Bengal districts is described in table No. 3. It would be seen that among the districts, Medinipur is the most populous district is over 12% of West Bengal's population. The least populated district is Darjeeling. With a total population of 1299919, it accounts for less than 2% of West Bengal's population.

2.2 Urbanisation

27.48% of West Bengal's population lives in urban areas compared to 25.73% for the whole of India. West Bengal, thus, has a level of urbanisation which is higher than the national average. (See Table No.4)

Other than Calcutta, which is a fully urban area, the districts of 24 Parganas North and Haora are highly urbanised, with half of their total population living in urban areas.

Three districts, Bardhaman, Hugly and Darjeeling have urbanisation level ranging from 30-35%.

West Dinajpur, 24 Parganas South, Nadia, Murshidabad and Jalpaiguri fall in the next category, with urbanisation rate varying from 10-22% The least urbanised districts are (Less than 10%) Medinipur, Bankura, Birbhum, Koch Bihar, Malda and Purulia.

Between 1981 and 1991, the rural population of West Bengal has grown by about 23% whereas the urban population has grown by 28.90%.

With such high rate of urban growth for the state as a whole as well as for some districts, care and attention has to be given, to the problems which accompany urbanisation.

2.3 Sex Ratio

Sex ratio is a key indicator reflecting the overall socio-economic condition of women. In economically advanced countries for every 1000 males, the number of women would be 1000 or somewhat higher. In less developed countries, the proportion of women would be less.

While the sex ratio of 929 prevailing in India is a sad reflection on the status of women, the situation in West Bengal is worse. It is as low as 917 for West Bengal. West Bengal's sex ratio has been lower than the all-India average for many decades.

It was as low as 876 only in 1961. Though the situation has improved from that, developments in this respect need to be carefully watched. This is so, because, sociologists generally agree that other than migration of males to certain areas which would lower the proportion of women in that area,

which factors are applicable to WB?

for a country as a whole other factors contributing to an unfavourable sex ratio are neglect of women and discrimination against women right from their childhood. Access to food, nutrition education and other tangible and intangible resources is skewed against women. Thanks to selective abortions followed by sex determination tests which have started making inroads into West Bengal, discrimination against women is starting even before they are born.

The sex ratio needs to be given special attention because it has been shown in the case of Kerala - the only state in India having a sex ratio of 1040 which is comparable to the best prevailing in any country, that high sex ratio is also accompanied by overall better quality of life and access to resources for women.

West Bengal's position among other states can be seen below :

Sex Ratio In Major States

TOP 5		MIDDLE 5		BOTTOM 5	
Kerala	(1040)	Gujrat	(936)	Rajasthan	(913)
A. Pradesh	(972)	Maharastra	(936)	Bihar	(912)
Orissa	(972)	M. Pradesh	(932)	Punjab	(888)
T. Nadu	(972)	Assam	(925)	U. P.	(882)
Karnataka	(960)	West Bengal	(917)	Haryana	(874)

2.4 Religion

West Bengal's population is predominantly Hindu. Though a sizable section of other religions may be noticed here, particularly the Muslims. According to the last available figures, out of every thousand people in West Bengal, Hindus are 770, Muslims 215, Christians 62

2.5 Scheduled Caste and Scheduled Tribes

These two categories constitute the lowest strata of the Indian Society in terms of their overall social position,

access to social privileges, amenities and facilities. In many parts of India they are often subjected to physical oppression.

In West Bengal over oppression is not generally visible and their relative position is somewhat better. Yet, whether it is land, job, education etc., the position of these categories would be at the bottom of the scale. Among these two categories again, the tribals are the most underprivileged in India in general as well as in West Bengal.

Given this context, it would be interesting to see their distribution in West Bengal. District wise details have been given in table No.5.

Tribals constitute 5.63% o;f West Bengal's population. But their concentration is more in certain districts. For example, the high tribal districts are Jalpaiguri (22.20%), Purulia (18.79%), Darjeeling (14.75%), West Dinajpur (10.82%) and Bankura (10.55%).

In other districts the concentration is much lower, except in some pockets. A detailed list of the development blocks with a high concentration of tribals along-with the number of villages under them is annexed with this report (Annexure on ITDP). It may provide information for identifying areas for development programmes. These areas would also be the most poor, backward and underdeveloped areas in the state of West Bengal. This is so because despite professed public policies tribal areas are generally neglected by the administration much more then other areas.

The Scheduled Castes, the other underprivileged category, is however numerically stronger than the Tribals and are relatively more evenly distributed in the districts.

In West Bengal, they constitute 23.62% of the states population. But their concentration is very high (51.75%) in the Koch Bihar district - one of the most backward districts of West Bengal.

Districts or development blocks with very high concentration of Scheduled Castes and Tribes suggest themselves as the focal points of development activities and need to be taken up on a priority.

SECTION 3

VITAL STATISTICS

3.1 Crude Birth Rate

date?

According to the just published National Family Health Survey Data, (NFHS), West Bengal has a crude birth rate of 28.9 which is just better than the all-India average of 30.7. But even then, in this respect, West Bengal is behind 9 of the 15 major states of India. They are Kerala (20.3), T.Nadu (23.6), A.Pradesh (25.1), Punjab (26.5), Orissa (27.1), Karnataka (28.0), Rajasthan (28.3), Maharastra (28.4) and Gujrat (28.5). (Table 2).

3.2 Fertility Rate

In terms of total fertility rate, though West Bengal is doing better then the all India average, it is behind 8 of the 15 major states of India. The states doing better then West Bengal are Kerala (2.09), T. Nadu (2.54), A. Pradesh (2.67), Orissa (3.00), Karnataka (3.03), Punjab (3.09), Maharastra (3.12), and Gujrat (3.17).

West Bengal total fertility rate is 3.26 and the all-India average is 3.67. There is little scope for compliascese on this count. (Table 2).

3.3 Population Growth

With an annual population growth of 2.22, West Bengal is behind the all India average of 2.14%. It is also behind 9 other states. They are Kerala (1.32%), T. Nadu (1.42%), Orissa (1.80%), Karnataka (1.90%), Punjab (1.86%), Gujrat (1.91%), Assam (2.31%), and Bihar (2.13%). (Table 2).

3.4 Child Mortality

Child mortality that is death by the age of 5 is an indicator of the overall socio-economic-health-nutrition situation of an area. District level situation in the rural areas of West Bengal in this respect is described in table No.8. It may be seen that in the rural areas of West Bengal. Child mortality rate is 139. Districts which are relatively better-off that is those who have a rate lower 100 are Bankura (90), Hugli (93) and Haora (98).

Districts which have a rate between 101 and the state average are Koch Bihar (101), Purulia (104), Darjeeling (114), and Birbhum (117) districts faring badly in this respect, that is those with a rate higher than the state average are Medinipur (144), 24 Parganas (combined - 145), Nadia (149), Jalpaiguri (150), West Dinajpur (158), Murshidabad (162) and Malda (175).

Another point to note in this respect is that in 7 of these districts, child mortality among girl children is higher them general child mortality in as many as 7 districts. The districts are Bankura, Birbhum, Haora, Malda, Medinipur and Murshidabad.

SECTION - 4

HEALTH AND FAMILY WELFARE

4.1 Physically Handicapped

mentally retarded

The 36th round of the National Sample Survey conducted by the Govt. of India indicates that among every 1000 rural people, more than 16 are physically handicapped. The rate is somewhat lower among women in general and in urban areas. The situation is also marginally better than the all-India rural average which is 18.

4.2 Disease Profile

In 1991 West Bengal had 24787 cases of malaria detected of which over 54% were in only one district - Jalpaiguri. According to press statements of the state Minister of Health, till December 1994, more then 62000 cases have been detected, roughly in a period of 9 months. This is a substantial jump. What is also a matter of concern that more deaths (30) have been reported from Jalpaiguri district of West Bengal out of a total death toll of 40.(See Table 11).

Another major scourge of the poorer people of the state is the dreaded disease of tuberculosis. In 1991, West Bengal had a total of 669716 recorded TB patients under treatment. Of them, nearly one-forth were only from two districts - 24 Parganas South (over 12%) and Darjeeling (over 11%), Calcutta, the state capital, accounted for another 14%.

Leprosy is not a physical killer in the sense TB kills - yet the social ostracism that is inevitable in case someone has leprosy can make normal life impossible for the sufferer. Rehabilitation of the sufferers to normal life is as crucial as the issue of their treatment.

There were over 204096 leprosy cases on record in WEst Bengal in 1992 (see table No. 11) nearly one-fifth (18.44%) were from Burdwan and 16.05% were from Medinipur. According to unofficial estimates, the incidence of leprosy would be much higher.

4.3 Malnutrition

According to the 1978-88 ICDS Annual Survey, in West Bengal 30.9% of children in age group 0-6 yrs living in ICDS project areas nor malnutritional status and about 70% suffered from various grades of malnutrition.

According to a survey by the National Nutrition Monitoring Bureau (NNMB), in West Bengal the average calorie intake for the people was 12110 against the Indian Council Of Medical Research norm of 2150. There was also serious deficiency in Vitamin A intake. While recent nutrition data are difficult to come across, some earlier micro-studies suggest that malnutrition is greater among landless agricultural labourers and other labouring poor.

4.4 Drugs

Drug addiction is a serious problem in West Bengal. Tobacco, a major killer and crippler of people, is consumed as cigarettes and otherwise on a scale in West Bengal. Tobacco smoking has reached on a large in West Bengal.

According to the 43rd round of the National Sample Survey, in the rural areas of West Bengal, 44% men and 9% women were smokers, mostly regular smokers. Surprisingly, the proportion was a little less for urban areas. This rate is substantially higher than the all-India average. The rate is also much higher for the 45-49 age group in West Bengal. Among them 88% smoke. Apart from tobacco, the abuse of other drugs and alcohol is on the rise. All those require careful attention both for preventive awareness generation and for rehabilitation.

4.5 Health Care

In west Bengal, there are a total of 53777 hospital beds. Out of them 40823 are under the state government; 603 are under local bodies and 6912 are under private ownership. The government hospital beds are thus the main source of indoor treatment of the people and non-government and private enterprise has along way to go in this respect. Out of this 53777 hospital beds, 1/3rd (32.63%) are concentrated in the metropolitan city of Calcutta only. (See Table 12)

As a result, the situation in respect of hospital bed availability per 1000 persons has become highly skewed. For Calcutta, which is the state capital, seats thus available per thousand people are 3.98. The next best district is Darjeeling with 1.79 seats, followed by Nadia (1.09). The state average is 0.78.

At the other extreme are the districts with poor seat availability like West dinajpur (0.20), Malda (0.27), Medinipur (0.28) and 24 Parganas South (0.30). This does not take into account the rural health centres. Taking them into consideration the situation is marginally better (See table 15)

Apart from these hospital beds, the government health-care system for rural areas provides 12187 beds in government health centres. But their number is also highly inadequate. There are 12187 such beds for a total rural population which is nearly 5 million. (Table 13 and 14).

Of the total of 6912 private hospital beds in West Bengal, over 46% are concentrated in the city of Calcutta alone.

Consequently, the pressure on the limited number of beds all over West Bengal is extremely high and a very large proportion of people who would have probably opted to get their treatment at their nearby villages and towns are often forced to come to Calcutta.

Apart from the problem of bed availability, the service delivery as a whole is extremely poor both because of inadequacy of resources or poor quality of resource management. Training has a major role to play in the second case.

According to estimates available for 1986 (See Table No.16), a total of over 6 million people sought treatment in hospitals and dispensaries. Of them over 5.6 million availe of outdoor facilities and 0.4 million availed of hospital beds.

According to a survey conducted all over India by the National Sample Survey (NSS), though private doctors and hospitals play a minor role in indoor treatments, their role in the total health-care system is highly visible in West Bengal, as can be seen from the following table :

% OF THOSE TREATED IN OWN AREAS IN WEST BENGAL

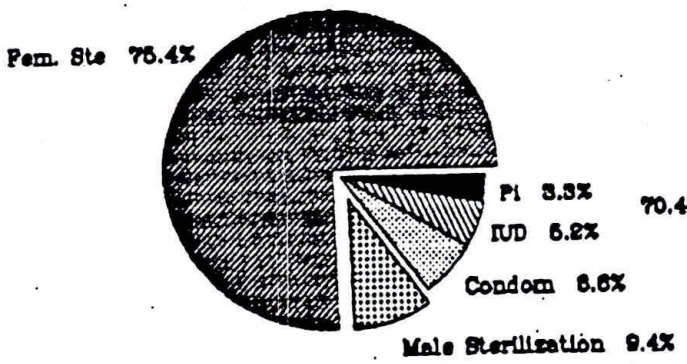
TREATMENT SOURCE	URBAN	RURAL
GOVT. HOSPITAL	12.48	19.52
PHC	6.08	0.58
DISPENSARY	0.89	0.74
PRIVATE HOSPITAL	0.93	1.95
NURSING HOMES	0.17	0.34
CHARITABLE INSTITUTIONS	0.18	2.03
PRIVATE DOCTORS	74.74	69.60
OTHERS	4.67	5.24

4.6 Family Planning

The just published report of the nation-wide National Family Health Survey(1992-93) throw valuable light on family planning in the country. (Table 18)

Slightly more than 40% of currently married women in India are currently using some method or the other for family planning. About 60% are not using any method. Among those who are following any method, about 4% are following traditional methods and 36% following modern methods. Out of these 36% terminal methods predominate, which in reality is sterilization of women. About 31% follow terminal methods but of them over 27% is sterilization of women and only a little over 4% is sterilisation of men. Temporary methods like condom, IUD, Pill etc account for only a little above 5%.
The situation in West Bengal is somewhat better in the sense that over 57% in the state follow any method; about 43% follow no method. However, a very high 20% in West Bengal follow traditional methods and 37.3% follows so called modern methods which is just about the Indian average. Among those following modern methods, the West Bengal situation is almost as bad as the Indian situation that an overwhelming proportion follow terminal methods. Among them, like India, female sterilisation accounts for 26.3% and male sterilisation only 4.3% modern temporary methods like condom, IUD or pills account for a little above 6%. The West Bengal situation is nearly as bad as the all-India situation on two

Fem Sterilization
India and W.Bengal



counts. 1) Overwhelming emphasis on permanent methods. 2) Among permanent method, the overwhelming focus is on sterilisation of women. This approach, in the long run, may prove to be counterproductive. In any case, it is unjust on women who are chosen as the masin target of the population control measure. Both these biases need to be corrected and NGOs have a big role to play in creating peoples awareness about these biases in the government policy.

4.7 Mother Child Health

The importance of safe motherhood practice and child survival programmes cannot be exaggerated in a country like India. Apart from their importance in their own rights, they are likely to contribute to the success of the countrys family planning programme.

Countrywide, the NFHS enquired about the MCH aspects in the case of 50000 live births, the largest sample ever taken for a study of this kind.
The findings suggest that in certain areas W.Bengal is doing well. But in many areas there is need for substantial improvement. The following table gives the position of W.Bengal visa-vis the all-India situation, for both rural and urban areas combined. The situation everywhere is worse for rural areas.

Ante-Natal Care

	India	W.Bengal	Kerala
% Preg Women Received Tetanus Toxoid	61.1	77.7	94.1
% Received Iron Folic Tablets	50.5	56.3	91.0
% Received Home Visits from Health Workers	21.0	13.7	26.5
% Got Check-up from Doctors	39.8	60.5	95.9

While in three of the four parameters W.Bengal is ahead of the all-India situation, it is way behind it in terms of home visits by health workers. Also, in parameter where W.Bengal is better off, it can be seen that it is way behind Kerala on all the parameters. Detailed tables annexed with this note would show that W.Bengal is not only behind Kerala in this respect, it is also way behind many other states among the 15 major ones (Table 19).

In terms of Institutional Delivery also, W.Bengal average is (31.5%) against the all-India average of 25.6% (Urban/rural combined). But Kerala has 88.4% institutional delivery.

While reliable data to show district-wise variation in West Bengal is not available, from available information it is seen that the situation of the North Bengal districts in general and particularly Malda, W.Dinajpur North and South, Jalpaiguri and Koch Bihar is particularly bad.

4.8 Immunisation of Children

Immunisation of children is key element of the MCH programme of the government. The situation of the major states including West Bengal is annexed with this note. Some highlights are presented in the table below, for rural areas only.

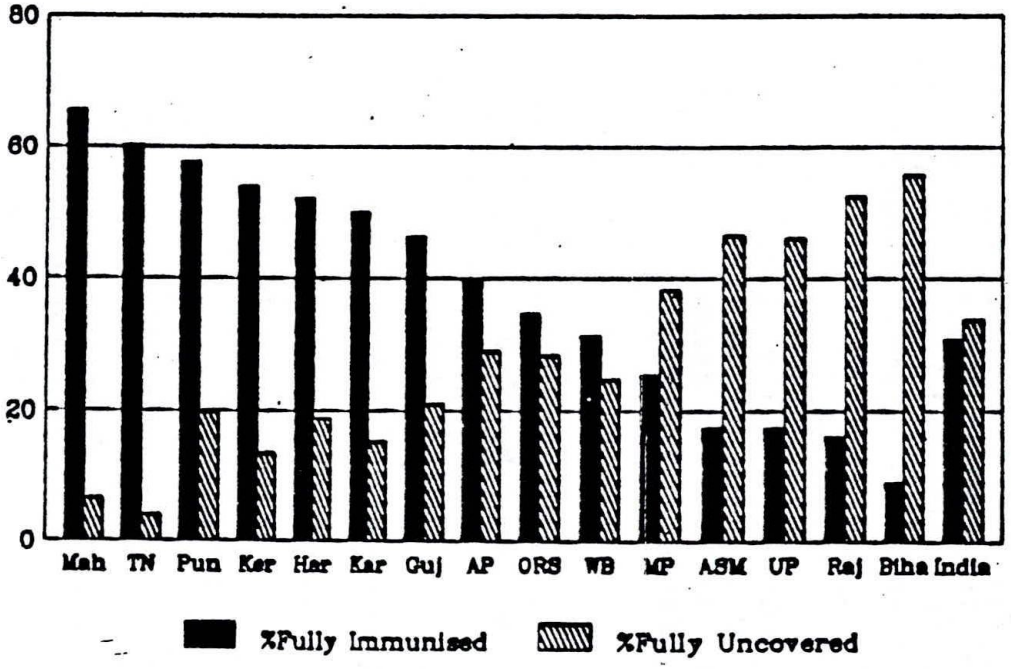
Immunisation Status of Children
in 12-23 Month Age Group

	India	W.Bengal	Kerala
% Children Fully Immunised	30.9	31.3	54.0
% Children Totally uncovered (no dose)	34.0	24.9	13.4
% Partly Immunised (Incomplete Vccn/Doses)	35.1	43.8	32.6

Here also, it is clear that a great deal remains to be achieved for West Bengal to catch up with a state like Kerala. But not only Kerala, West Bengal is far behind several major states in these respects as the detailed tables annexed with this note would show.

IMMUNISATION STATUS

Performance of States



%12-23 month children,rural

District level data available for two north-Bengal districts of Malda and West Dinajpore suggest that a very poor situation exists in these otherwise backward districts. According to a survey conducted by the Department of Community Medicine, R.G.Kar Medical College of Calcutta recently (1993), the proportion of children fully immunised was as low as 19.94% in West Dinajpur and 21.98% in Malda district.

4.9 AIDS Awareness

In recent years, considerable amount of resources have been spent through government and non-government sources for creating awareness about AIDS among the people. West Bengal's records in this respect would show that very little has been achieved and a lot remains to be done. The findings are from NFHS, ~~1992~~93.

later years?

% Interviewed Women Aware of AIDS

West Bengal	9.8	Delhi	35.8
Tripura	13.2	Arunachal Pradesh	16.2
Assam	8.4	Tamil Nadu	23.4
Nagaland	40.9	Manipur	72.5
Meghalaya	26.7	Mizoram	84.8
Goa	41.7	Gujarat	10.6
Maharastra	18.6		

SECTION 5

LITERACY

Literacy is a key indicator of development. Often India is accused of harbouring the largest force of illiterates in the world. Literacy in a country like India is higher in urban areas than in rural areas; among men than among women; among general categories than among less privileged categories like Scheduled Castes and Scheduled Tribes. In fact, female literacy is high, it would generally indicate that the area is backward in terms of other development indicators. So it is a good measure for ranking districts in terms of development.

In the 1991 census, the rate of female literacy in India was 39.29 % while West Bengal's rate was 46.56%. But among the 15 major states, West Bengal was behind Kerala which had a female literacy rate of as high as 86.93%, Tamil Nadu, Maharastra, Gujarat and Punjab (see Table 20).

Within West Bengal, the districts which are most backward in this respect are also backward in other respects, in general.

The districts are ranked in terms of illiteracy in the following order :

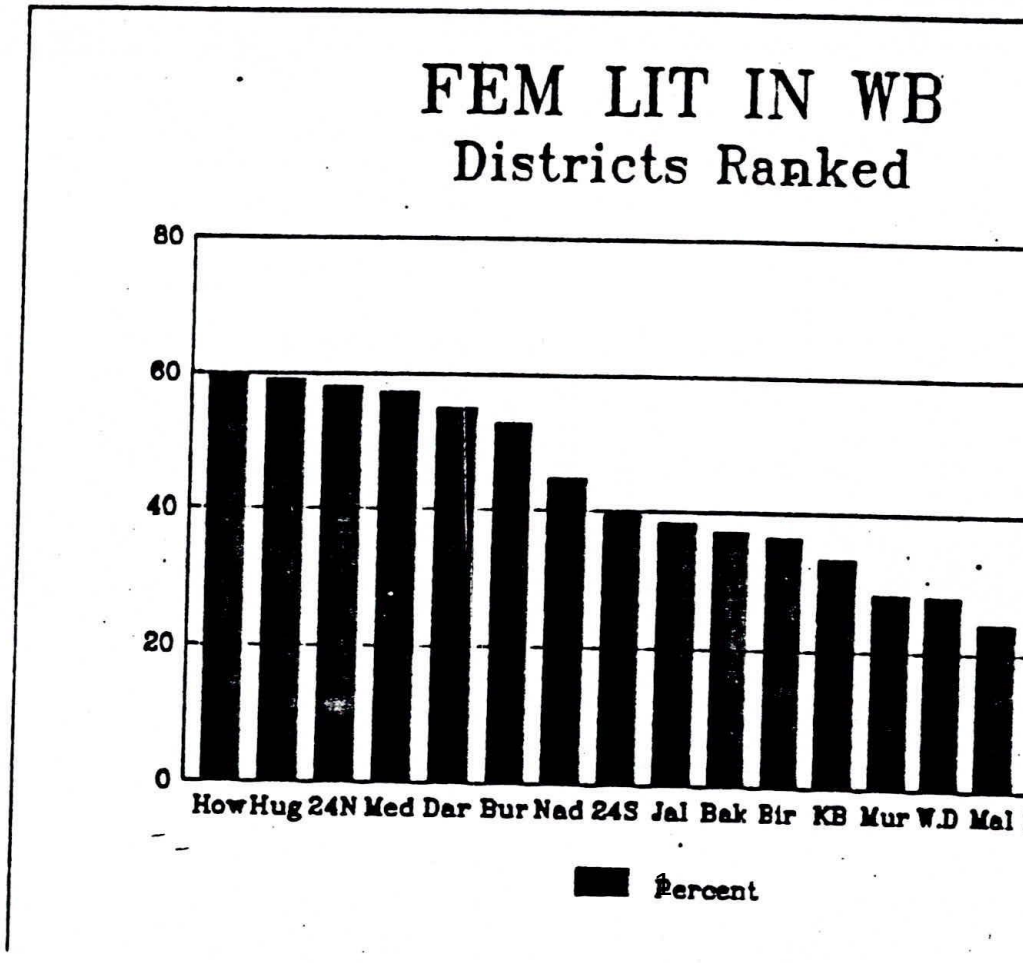
Most Backward : Purulia, Malda, West Dijanpur, Murshidabad

Backward : Jalpaiguri, Koch Bihar, Bankura, Birbhum, 24 Parganas (south), Nadia

Rest of the districts, it would be seen have an average which is better than the state average (Table 21).

In recent years, there have been some special efforts for raising the literacy level of the districts. Though the state government and Panchayats took the initiative, non government organisations played a very important role in this effort, which has been acknowledged by the government. In fact this literacy effort has offered a good platform to the NGO sector for carrying out their activities. It has also created a good reputation for the NGOs at the ground level as well as policy making level.

There is a great deal more to be done on this front. Literacy rate, as we have seen, is still very low and there is a long way to go in this respect. There is a tendency among neo-literates to relapse back to illiteracy for dearth of reading materials and rural libraries which cater to their needs.


FEM LIT IN WB
Districts Ranked
80
60
40
20
0
How Hug 24N Med Dar Bur Nad 24S Jal Bak Bir KB Mur W.D Mal
Percent

At the primary and higher education level, girls are behind boys and drop out rate is higher among them. There are thousands of Primary Schools in the districts of West Bengal which do not have their own rooms and houses. There are thousands of other schools without any toilet or drinking water facilities. Us in West Bengal have a major role to play in all these respects.

SECTION - 6

WORK, EMPLOYMENT & OCCUPATION

According to the 1991 census, work participation rate (Urban-Rural combined) in India is 37.68%. For West Bengal it is less at 32.37%.

If we take work participation rate of women, West Bengal is way behind many states. At the all-India level, work participation rate for women is 22.73% while for West Bengal it is half of that, 11.67%. In fact, if we consider all 30 states and Union Territories of India, West Bengals rank is as low as 25 in this respect. All these data relate to total workers only. If we consider only main workers, the situation is much worse. It is 34.10% for India and 30.23% for West Bengal.

Among the total main workers of West Bengal, a large majority depend on agriculture and allied activities (55.71%). Then comes industries of all categories including household industry, mining etc. (12.34%) and the last category is service, which is 12.34% for West Bengal (Table 23).

Districts which have been able to utilise very few options other than agriculture and who have very little industrial activities (75% or more depend on agriculture only) are Bankura, Birbhum, Koch Bihar, Malda, Purulia and West Dinajpur.

Other than Calcutta, Howrah, Burdwan, Hugli, North 24 Parganas and Nadia, all around Calcutta, have sizeable population depending on various types of non-agricultural occupations.

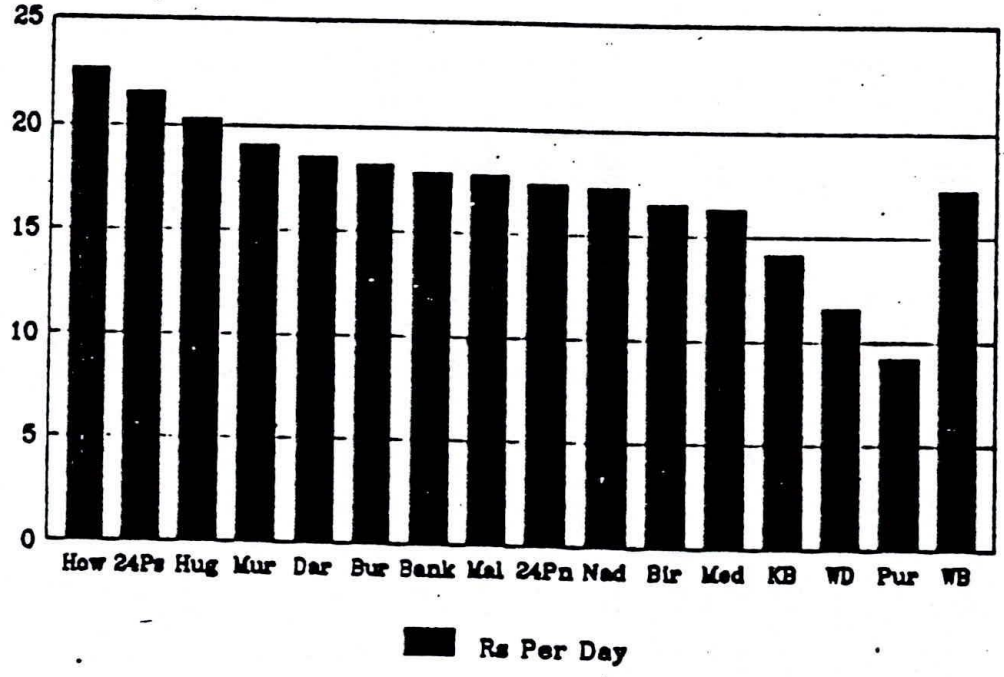
While the priority for the areas dependent on agriculture, is land reform, adoption of new and sustainable technologies, credit etc., higher wage for agricultural labourers, the industrially better of district also suffer from all sorts of problems which come with industrialisation and rapid urbanisation and they also merit some attention.

West Bengal has a total of 9262 registered factories offering daily employment to 889794 persons. More than half of these factories are however concentrated in Howrah, Calcutta, Hugly and North and South 24 Parganas, all around Calcutta.

Table No. 26 would show that there are nearly 5 million unemployed persons registered in employment exchanges. This does not take into account the unemployed and underemployed in the agricultural sector or those who because of various reasons do not get registered. In fact, registration as unemployed is higher

DAILY WAGE OF AG. LABOUR

For Male Labourers Only



average

(23A)

in the industrially developed districts. Roughly one-third of those who are employed in the organised sector are employed in the private sector. The rest are in the public sector and the the government.

The educated and unemployed offer a major challenge to the NGO sector in terms of their ability to induce these huge force to various avenues of self employment. This would require mobilisation of credit and training effort on an unprecedented scale in the coming years. The government sectors ability to offer employment is restricted and, with the structural adjustment plan entering the system, there may be a serious increase in the force of unemployed in the organised sector. This would require redeployment of the neo-employed in new areas. All in all, this is a major challenge that has to be faced in the coming years and the NGO sector cannot turn its face away from this challenge.

SECTION - 7

POVERTY

Poverty is an all-pervading feature of the social system and there is a great deal of debate among policy planners and implementors about its extent, causes and means of alleviation.

An expert group set up by the planning commission of India has recalculated the incidence of poverty in the states. The results indicate that West Bengal ranks in terms of poverty (rural-urban combined). The following table lists the major states and their relative position. Figures in parentheses indicate the percentage of people living below the poverty line :

POVERTY AMONG 15 MAJOR STATES

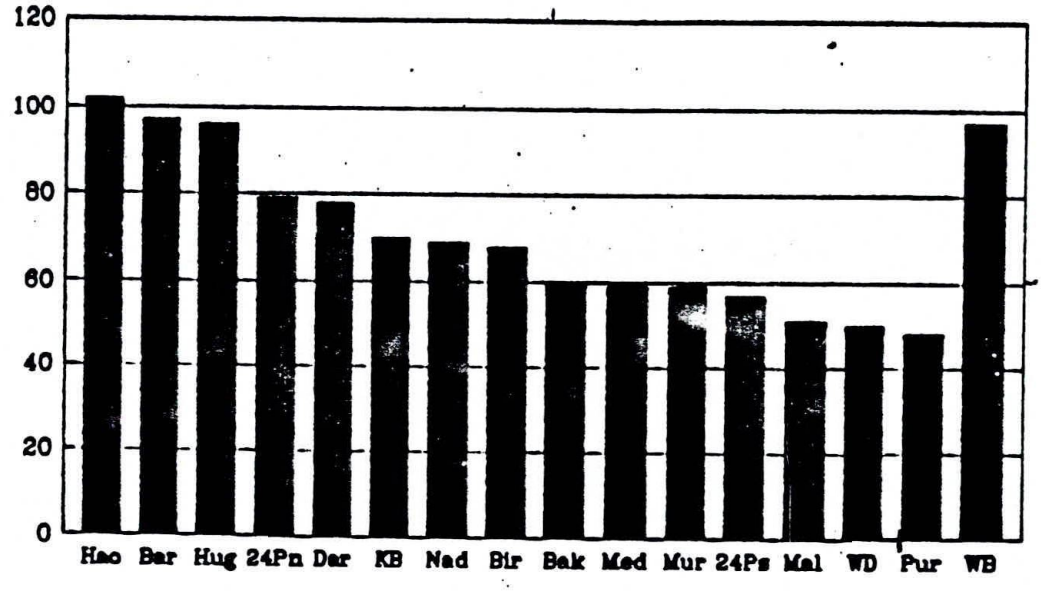
MOST POOR	MODERATELY POOR	LESS POOR
ORISSA (57.9)	KARNATAKA (39.5)	KERALA (28.5)
BIHAR (53.0)	MAHARASTRA (35.8)	A.PRADESH (26.1)
UTTAR PRADESH (47.6)	WEST BENGAL (33.5)	GUJRAT (22.0)
MADHYA PRADESH (46.2)	RAJASTHAN (32.0)	HARYANA (17.3)
TAMIL NADU (40.7)	ASSAM (29.6)	PUNJAB (14.3)

SOURCE : EPW, AUGUST 21, 1993.

West Bengal is exactly in the middle in terms of poverty level. If may be pointed out that according to this head estimate, there were, in all, 3018.3 Lakh people living below the poverty like in India in 1987-88. Out of them, 2947.8 lakh lived in the 15 major states. Among them 210.5 lakh (33.5% West Bengal's population) lived in West Bengal. This comes to a little over 7% of India's total poor. So, on an average, out of 3 persons living in West Bengal live below the poverty line. But what is worth noticing is that due to the interplay of a number of factors, incidence of poverty has sharply declined in West Bengal. This decline has been sharper than the decline in all-India poverty rate, as can be seen from the following :

WB DISTRICTS RANKED

Relative Index of Development



excludes Calcutta

(25 A)

PEOPLE BELOW POVERTY LINE 1973-74 TO 1987-88

(RURAL + URBAN COMBINED)

	73 - 74	77 - 78	83	87- 88
WEST BENGAL	54.5	52.0	47.9	35.5
INDIA	53.1	50.1	43.3	38.0

SOURCE : EPW, AUGUST 21, 1993.

The point to note is that in West Bengal which had higher poverty incidence twenty years ago has been able to bring down the rate more sharply that the all-India situation, in the last 10 years.

SECTION - 8

DISTRICTS OF WEST BENGAL : UNEVEN DEVELOPMENT

8.1 Critical Criteria

From all accounts, the various districts of West Bengal suffers from uneven paces of development. While the general problems of poverty, unemployment, illiteracy, lack of health facilities, credit, access to new technologies are true of all areas, more or less, there are some important criteria on the basis of which the districts can be ranked and categorised for the purpose of development action.

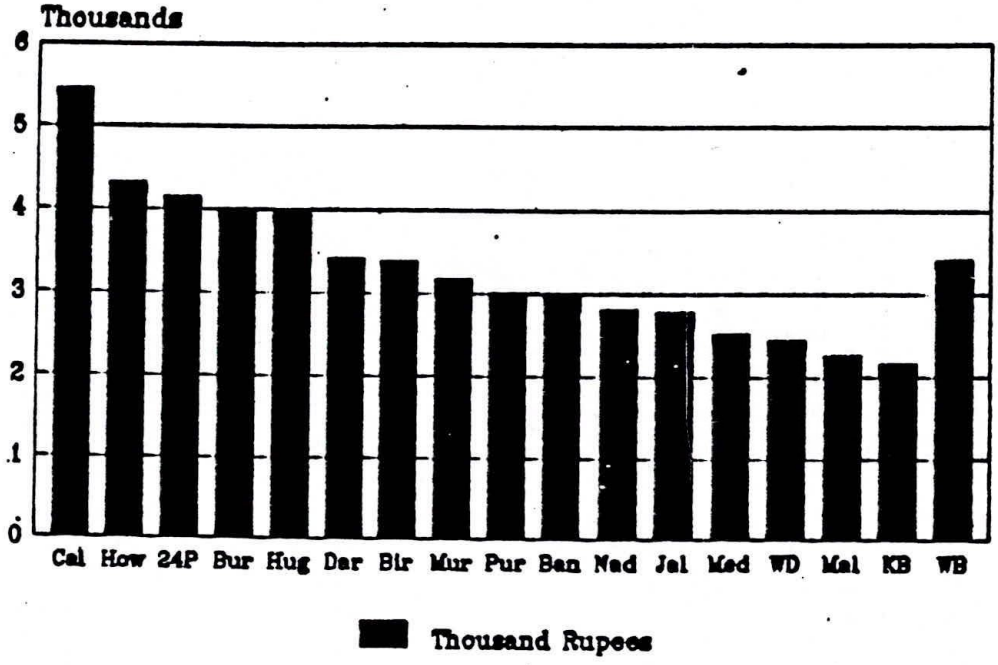
The criteria which are chosen for this purpose are :

i) Female Literacy Rate (Table 21)
ii) Child Mortality Rate (Table 8)
iii) Relative Index of Development (Table 24)
iv) Concentration of Tribal (Table 5)
v) Dependence on non-agricultural sectors (Table 23)
vi) Per Capita Income (Table 25)

These criteria are considered important because, on the whole, almost all of them are surrogates for overall socio-economic development of the region. As separate set of data are not often available for the two districts of West Dinajpur, the two would be treated as one for this purpose. The same may be true in some cases for 24 Parganas where separate set of data are sometimes not available yet for the two districts of North and South 24 Parganas.

PER CAPITA INCOME 1988-8

Districts Ranked



At Current Prices Per Year

SELECTED DEVELOPMENT INDICATORS FOR DISTRICTS AT A GLANCE
(See Detailed Tables)

District	F.Lit% *	Child Mort. (Rur)	RID	Tribal Popn % *	Depend ance on Agri %*	Per Cap Inc %
Haora	58	98	102	0	27	126
24 Parganas (North)	58	145	79	2	35	121
24 Parganas (South)	41	145	57	1	60	121
Bardhaman	51	117	97	6	53	116
Hugli	57	93	96	4	49	115
Darjeling	48	114	78	14	58	100
Birbhum	37	145	68	7	73	98
Murshidabad	20	162	59	1	63	92
Puruliya	23	104	48	19	76	88
Bankura	37	90	60	10	76	87
Nadia	44	149	69	2	54	82
Jalpaiguri	33	150	50	21	69	81
Medinipur	57	144	59	8	69	73
West Dinajpur (Combined)	28	158	50	10	75	71
Malda	25	175	51	7	72	66
Koch Bihar	33	101	70	1	75	63
West Bengal	47	139	97	6	56	100

* % Rounded off.

8.2 Ranking

The districts have been broadly divided into 4 categories - good, average, poor and very poor.

For any criterion, a very poor district would get 20 points, a poor district 15 points, an average district 10 points and a good district 5 points. After taking all criteria into consideration, the more points a district gets the poorer its situation and higher its need for development action. Similarly, less points a district gets, lower its priority. For the purpose of this exercise, Calcutta has not been taken into consideration.

One caution. As we have already said, all the districts have certain pressing problems and all of them merit development action, the present exercise is broadly to set priorities for choosing high priority areas. This should not be treated as rigid and inflexible framework to exclude the so called less poor areas from development action.

8.3 Basis

	% or score			
Criteria	V.Poor	Poor	Average	Good
Fem. Literacy	< 30%	30-45%	46-55%	56%+
Child Mort.	> 160	141-160	110-140	109 or less
Relative Index of Development	< 55	55-70	71-90	91+
Concentration of Tribals	> 20%	9-20%	5-8%	4% or less
Dependence on agricultural sector	> 70%	61-70%	51-60%	50% or less
Per Capita Income of Dt as % of per Cap. Income of State	< 70%	70-90%	91-100%	101%+

SCORE OF DISTRICTS ON SELECTED INDICATORS*

District	P.Lit	Child Mort. (Rur)	RID	Tribal Popn	Depend ance on Agri	Per Cap Inc	Total Score
Maora	5	5	5	5	5	5	30
24 Parganas (North)	5	15	10	5	5	5	45
24 Parganas (South)	10	15	15	5	10	5	60
Bardhaman	10	10	5	10	10	5	50
Hugli	5	5	5	5	5	5	30
Darjeeling	10	10	10	15	10	10	70
Birbhum	15	15	15	10	20	10	85
Murshidabad	15	20	15	5	15	10	80
Puruliya	20	5	20	15	20	15	95
Bankura	15	5	15	15	20	15	85
Nadia	15	15	15	5	10	15	75
Jalpaiguri	15	15	20	20	15	15	100
Medinipur	5	15	15	10	15	15	60
W. Dinajpur (Combined)	20	15	20	15	20	15	105
Malda	20	20	20	10	20	20	110
Koch Bihar	15	15	15	5	20	20	90

* Higher the score poorer the situation

8.4 Final Categorisation of Districts

Four Categories :

We finally can divide the West bengal Districts into 4 categories, in terms of the priority which should be given to them for development action.

In the highest priority group fall the district which have got a total score of 95 and above. They are MALDA, KOCH BIHAR, NORTH & SOUTH WEST DINAJPUR, JALPAIGURI and PURULIA.

These are the least developed districts of West bengal in terms of all development criteria. Among them, PURULIA, JALPAIGURI and WEST DINAJPUR also have high tribal concentration.

In the second highest priority group fall those districts which have got a total score from 80-94. In this category come the districts of BANKURA, MURSHIDABAD and BIRBHUM. Both BANKURA and BIRBHUM have a sizeable tribal population.

In the third category fall the districts which have got a total score of 60-79. This would include MEDINIPUR, NADIA, DARJEELING and 24 PARGANAS SOUTH. MEDINIPUR and DARJEELING also have sizeable tribal population.

In the last category would fall districts which have got a total score of below 60. This would include HAORA, 24 PARGANAS NORTH, BARDHAMAN and HUGLI. They have high concentration of industries. Their agriculture is also highly developed. They are all located around Calcutta. In general they are the more developed districts of West Bengal.

While the last two categories have a sizeable number of NGOs, the first and second category districts have very few of them.

SECTION - 9

LIMITATIONS OF GOVERNMENT RESPONSE AND POSSIBLE ROLE OF NGOs

9.1 Limitations of Government Programmes

There are large number of development programmes in the state for addressing some of the problems mentioned so far. The acievements of these programmes, whether in the areas of literacy, education, health and health care, Mother Child Survival, employment generation etc. are highly limited, as we have seen from the statistical profiles.

For addressing the problem of poverty of the poor, there are programmes like IRDP, Jawhar Rojgar Yopjana, TRYSEM, etc. For addressing the problems of rural women there is DWCRA. These are the major poverty alleviation programmes of the government.

Huge amount of resources are spent on these programmes but all evaluations indicate that the actual achievements are much below the targets. The governmental system, through its bureaucratic approach is unable to achieve as much as they should. Most of their project as have a high degree of leakage.

The reasons are many and of varied types. Some of them are indicated below :

- Centralised planning, bureaucratic approach, top heavy management
- Resource inadequacy
- Dependence on government staff for implementation who lack motivation and commitment
- Lack of coordination within departments
- Unwillingness to involve NGOs and the community and dependence on only government/Panchayat machinery, for planning, implementation, monitoring and evaluation.

9.2 NGO Scenario in West Bengal

Due to the interplay of several factors, the growth and development of NGOs in West Bengal has been much less compared to states like Kerala, Tamilnadu, Andhra Pradesh, Maharastra, Gujarat, Rajasthan, etc. Since the late seventies, the ground level socio political situation made it somewhat difficult for NGOs to operate at the grassroot level in rural areas.

Within West Bengal, the spread and distribution of NGOs is very uneven. While a few districts nearer Calcutta have more NGOs, those less developed and far away from Calcutta have very few of them. To give an example, according to a list available at CAPART, the nodal Government of India organisation for supporting NGOs, in 1991, 193 NGOs were operating in West Bengal in the area of Womens Development. Out of them 40 were located in south 24 Parganas, 39 in Calcutta, and 36 in Medinipur and 221 in Howrah. All these districts are around Calcutta and thus out of 193 NGOs, 136 were located within Calcutta or only short distance away from it. Birbhum, Jalpaiguri and Malda had 1 each, West Dinajpur had only 2.

This is a seriously skewed distribution and points to the needs of making special efforts for developing NGOs in districts where their presence is low.

9.3 Types of NGOs

There are various types of Non-Government Organisations and groups operating in West Bengal. In fact, West Bengal is one state which has a very long history of voluntary work and a very large number of organisations work here which would not normally fit into the definition of NGOs.

1. Those primarily engaged in relief, rehabilitation and post natural disaster management type of work. They are mostly traditional in approach and more visible after such disasters. They may receive some grants form the government but mostly depend on donations from the public.

2. Those engaged in more active welfare type fo work, but also traditional in appraoch. They are the social welfare and social service organisations who mostly work with women and children. They usually receive funds from social welfare boards of the government. they are almost totally dependent on government funding.

   Some of the organisations falling in the above two categories are now changing their spheres of activities and approaching n&w areas of work and funding sources.

3. Youth and Sports Clubs which operate in large numbers in both urban and rural areas of West Bengal. There are several thousand of them and many are affilliated to the Departments of youth and Sports of the state

government and of the Nehru Yuba Kendra of the Central Government. They are small groups, nearer to the community, run entirely voluntarily and may receive occasional small grants from government sources. Though they are called youth or sports clubs, they are actually involved in various types of activities in their own small communities.

It is a very large potential force of voluntary action and if these organisations can be brought under at least some common programmes, they may turn into a major instrument of social change. So far, very little effort has been made either to study the potential of these organsiations or to harness their potential. They do not fall under the traditional concept of NGO. But because of their large number and huge potential, they need systematic efforts for mobilisation. This is a challenging task and WBVHA would like to make a beginning to this direction.

4. The fourth category is formed of those who commonly claim and endowed with the title NGO. In terms of functions, they may be divided into certain broad types, though there may be overlapping of functions:

   i) Organisations directly involved in "service delivery" aspects of development, whether it is in the field of health, education, training, credit, environment and forestry etc.

   ii) Those primarily engaged in conscientization and awareness generation type of work.

   iii) Those providing research, documentation types of services either to the community or to other NGOs. They are mostly located in Calcutta or other urban areas.

Most of these organsiations falling in the last category are small in number and spread in various parts. This category is already oriented to development work in some form but may be lacking in ideas, funds, knowledge of funding sources, expertise in developing, implementing and monitoring projects. They are mostly lacking in professional approach, technical expertise, house management skills and ability for diversification of activities.

WBVHA proposes to concentrate on category 3 and 4.

9.4 State-NGO Relation in West Bengal

In West Bengal, the government - NGO relations suffer from a certain amount of ambivalence. On the one hand, the state government admits the importance of involving the NGOs in the development process. in policy documents this need is reiterated from time to tome. On the other hand, when it actually comes to involving NGOs in the development process, the government is extremely wary.

One possible reason is that under the existing situation in West Bengal, Panchayats, the local self-government system operating at the village level, has been accorded an almost all-pervading role in development activities. All public resources for rural areas are spent through the Panchayats. Development programmes are implemented through them and even monitored through them. Consequently, in the perception of the state government, very little space is left for others to operate in development activities. In fact, activities of non-Panchayat organisations including NGOs are virtually considered an impingement upon the pastures of the Banchayat.

Also, due to ideological reasons, NGO activities are not always favoured unless the activities of specific NGOs are considered harmless by powers that be

9.5 Views of Policy Makers and Administrtors

Before preparing this approach note, the issue was discussed with senior government officials and policy makers. Discussions with them indicate that the situation has started changing and the government of the state is now more amenable to the idea of involving NGOs in development activities. Dr. G.P.Dutta, an influential policy-maker in the state in the area of health and family welfare feels that

- NGOs should not try to become an "alternative" of the government but should come forward where govt. services are absent or inadequate.
- NGOs can draw the attention of the government to the shortcomings of the services.
- NGOs should help in making the government infrastructure run more efficiently.

- There are remote areas in the state which are not covered by medical personnel. In such areas NGOs can provide to the community health education and training and create awareness.

- NGOs can study medico-sociological issues and provide insights into attitude and behaviour of the people.

- NGOs can undertake awareness generation campaign in the areas of Breast Feeding, Prevention of Irrational Use of Drugs and Alcohol.

Dr. Dutta feels that the scope for involvement of NGOs is much higher in the area of Family Welfare. In this field, NGOs can undertake projects

- To integrate family welfare with women's liberation

- To study post-tubectomy hazard

- To create awareness against focus on tubectomy as the principal method for attaining family planning goals

Another area which Dr. Dutta feels can be an important area of NGO activity in West Bengal is the harmful effects of some modern technologies on peoples' health and on environment.

NGOs can also help in identifying community resource potential and in getting work done involving and utilising Panchayats in the field of irrigation, use of manure, promoting small production units, three-tier cultivation. Wasteland development and promoting high yielding seeds.

Dr. Prabhat Datta, an academic and advisor to the Department of Panchayat, Govt. of West Bengal, feels that the past relation between the government and NGOs is changing more positively. He feels that there is scope for NGO activities in cooperation with the government and Panchayats in the areas of

- awareness generation on development issues

- provide research and information service for development activities

- Health Education

- Prevention and Control of Drug and Alcohol abuse

Senior officials of the Government of West Bengal also feel that the scope of cooperation between the government and the NGO sector is better now compared to the past.

Mr. S.N.Haque, Joint Secretary, Department of Panchayats, Government of West Bengal identifies the following areas for intervention by NGOs :

- Primary Health Care and Sanitation
- Women and Child Development
- Non-conventional energy sources
- Low cost housing technology
- Waste land development
- Marketing of products made by income generating groups
- Social Marketing
- Training

This senior official also feels that there are certain development programmes where the level of achievement is low and support from the NGOs could be useful, i.e. Development of Women and Children in Rural Areas (DWCRA), IRDP, Waste Land Development, etc.

He feels that training is another areaa where NGOs could render valuable service both for beneficiaries in development programmes as well as for training of Panchayat functionaries.

On the whole, he feels that the scope for cooperation between the government and the NGOs are much better today compared to the past. However, the relationship between Panchayats and NGOs needs to be carefully managed. He also points out that the present activities for the NGOs are more concentrated in districts nearer Calcutta and there is urgent need to diffuse NGO activities in the more remote districts of North Bengal.

As a part of managing the relationship between the NGOs and the Panchayat, a possible thrust area for NGOs to pursue is to find accommodation in the various committees which exist at the district and the block level, i.e. standing

committees on small scale industries, relief and rehabilitation, public health, electricity and non-conventional energy. NGOs should be invited at the meetings of these committees and their plan of action and suggestions may be taken into account during preparation of the annual plans so that efforts are not duplicated and the wheel does not have to be reinvented every time.

Such a line of action on the part of the NGOs would have a long term positive effect on NGO activities and would give a position of credibility to them. This is of great importance because already there are plans, yet to be formally announced, that a certain portion of resources coming from the central government would be spent through NGOs.

Shri Dilip Pal, Assistant Director of the State Institute of Rural Development also feels that the earlier situation is changing and a more favourable environment now exists for the working of NGOs in West Bengal. He mentions two areas of crucial importance to the government where NGOs have made very valuable contributions

- Training of Panchayat functionaries
- Intensive Sanitation Programme

He feels that NGOs have also made good contributions in such areas as women's development programmes, training, monitoring and evaluation, and these can be areas for future activities.

He is aware that the constraints in the relationship between the Government, Panchayats and NGOs still exist, yet a some beginning of greater collaboration has been made. But he also feels that NGOs must discard the "Let alone" policy. NGOs should supplement government programmes and not turn into an adversary of the government.

Shri M.N.Roy, Joint Secretary, Department of Rural Development of the government of West Bengal, expressed the opinion that Panchayat and Rural Development Department of the Government of West Bengal seek the collaboration of NGOs in the following area:

- Skill development among rural youth for self-employment under TRYSEM
- Assisting DWCRA groups

- Information-Education-Communication relating to poverty alleviation programmes
- Providing continuous training to Panchayat members
- Organising sanitary marts for Water-Sanitation programmes
- Low cost Housing Technology
- Developing programmes for agriculture labourers during lean seasons
- To help in marketing of produce made by DWCRA-IRDP beneficiaries.
- Waste Development.
- Dissemination of technology for better resource management i.e. land, water, forest, animal and fishery resources.
- Taking up innovative projects in the area of social development, i.e. child development, adolescent gairls, primary health care, primary education which the government could promote.
- To build up and manage economic infrastructure to provide backward and forward linkage to micro-entrepreneurs like IRDP beneficiaries.

Shri A.K.Mitra, Additional Director, ICDS, Government of West Bengal feels that scope for work of NGOs has widened and his own department has started allocation of resources to be spent through NGOs.

9.6 Priority Areas

Some of the constraints which had prevented the expansion and growth of the NGOs in West Bengal still remain. Yet, there has been a great deal of change in the socio-politico environment and today there is a greater scope for NGO activities in West Bengal. The opinions of senior policy makers and officials presented above shows that there are a wide range of activities where NGO participation would be welcome provided sufficient care is taken to manage the respective boundaries of the government, panchayats and the NGOs.

While there are a wide range of activities where NGOs could contribute to the development process, as a beginning, certain broad areas may be identified for promotion in line with the priorities set by the West Bengal Voluntary Health Association and resources available to it:

- Environment
- Public Health and Family Welfare
- Women's Development Programmes
- Poverty Alleviation and Income Generation
- Literacy and Education

Within each broad area, a large number of activities may be undertaken (i.e. service deliver, communication, training, etc.) depending on the level of development of the respective NGOs and resource availability.

In promoting the small groups, WBVHA would focus on less developed areas, that is areas which are less developed in terms of socio-economic parameters as well as areas where the NGO activities is low.

SECTION - 10

WBVHA : PROPOSAL FOR A NEW ROLE

10.1 Focus

WBVHA aims at focussing on the last two categories of NGOs. That is the large number of Youth Clubs in rural areas and small NGO groups involved in some development aciton. They are not only spread unevenly in various parts of West Bengal, except a few, they lack a) technical manpower, b) technical knowledge, c) funds and last but not the least, a professional approach to whatever projects they are handling.

In their interaction with WBVHA over the last few years, many of the small groups have expressed their need for support in the areas of :

* Development of programme ideas
* Preparation of proposals both for funding as well as a blue-print for action
* Help and advice in a programme implementation
* Training of personnel
* Orientation in monitoring and evaluation of their own programmes
* Professional approach towards housekeeping and managerial activities
* Environment management in the wider context

Also many of the small groups are in need of financial support. In many cases there are a large number of such small groups which can, if resources are available, give a good account of themselves yet do not have much idea about where to turn for financial support. On the other hand, there are practical difficulties for the funding agencies to identify and support genuine small NGOs, monitor their activities and provide them, in the initial phase, the guidance and support they need. WBVHA is now ideally positioned to assume the new responsibility of promoting small NGOs in West Bengal because

- It already has close contact with a large number of such small groups in West Bengal. -It has already initiated the process of networking with smaller groups and providing them with support in various ways

- As a resource centre, it is well equipped to provide the requisite support to the smaller groups.

10.2 Specific Tasks

* To identify and select small NGOs with potential for work in priority areas, both in terms of geographical spread and in terms of activities.

* To identify and prioritise their possible role and activities

* To assess their needs in terms of money, materials and personnel, training and management and skill development

* To help them develop management systems and skill training to run the projects effectively and systematically within given time periods.

* To provide financial support to them in the initial phases so that they are in a position to "take off" at an early stage.

* To help them in monitoring and evaluation work in such a way that they are able to carry on these tasks on their own at the earliest.

* To provide them with communication and training materials which are relevant for their chosen areas of activities.

* To provide them with appropriate forum both at the district level and at the state level which helps them in developing themselves and managing environmental issues.

10.3 District level Networking

District level networking would be crucial importance for the success of the project. The aim of WBVHA is not to keep the small groups dependent on it for indefinite periods. As the small groups near the "take off" stage, WBVHA proposes to gradually withdraw its direct support. However, the relationship of cooperation and collaboration with them is expected to be a long term and continuing one. For this purpose, district level networking would be crucial help. This would be followed by state level networking depending on the needs and aspirations of the small groups.

10.4 Financial Assistance to Small Groups

If a consolidated grant is made available to WBVHA, then WBVHA would provide money to the small groups for a period normally not exceeding two years. The amount that would be provided to each would depend on the projects if wants to pursue, its needs, competence etc. Normally the amount made available to such a group would be in the range of Rs.50,000.00 to Rs.1,50,000.00 (Approx. US Dollar 1613 to 4839) per year.

TABLE - 1

WEST BENGAL : ADMINISTRATIVE DIVISION

DISTRICTS	POLICE STATIONS (EXCLUDING CALCUTTA)	MUNICIPALITIES	COMMUNITY DEVELOPMENT BLOCKS	GRAM PANCHAYAT	PANCHAYAT SAMITI
WEST BENGAL	383	102	341	3246	331
BANKURA	20	3	22	190	22
BARDHAMAN	32	7	33	293	31
BIRBHUM	17	5	19	169	19
CALCUTTA	-	-	-	-	-
DARJEELING	15	4	10	19	2
HAORA	19	2	14	150	14
HUGLI	21	11	18	201	18
JALPAIGURI	16	3	13	123	13
KOCH BIHAR	9	6	12	128	12
MALDA	11	2	15	147	15
MEDINIPUR	46	10	54	518	54
MURSHIDABAD	25	7	26	252	26
NADIA	16	6	17	178	17
NORTH 24 PARGANAS	33	24	22	218	22
SOUTH 24 PARGANAS	31	5	30	335	30
PURULIA	20	3	20	170	20
NORTH WEST DINAJPUR) SOUTH WEST DINAJPUR)	17	4	16	155	16

SOURCE : Health on the March in West Bengal.

TABLE - 2

WEST BENGAL COMPARED WITH OTHER STATES ON DEMOGRAPHIC INDICATORS

STATES	SEX RATIO (1991)	RURAL CRUDE BIRTH RATE (NFHS)	RURAL TOTAL FERTILITY RATE FOR 15 -49 YRS WOMEN (NFHS)	POPU-LATION GROWTH (1991)	POPULATION DENSITY (1991)
WEST BENGAL	917	28.9	3.26	2.22	766
ASSAM	925	32.0	3.68	2.13	284
BIHAR	912	33.1	4.15	2.13	497
ORISSA	972	27.1	3.00	1.80	202
ANDHRA PRADESH	972	25.1	2.67	2.17	241
KERALA	1040	20.3	2.09	1.32	747
TAMINADU	972	23.6	2.54	1.40	428
KARNATAKA	960	28.0	3.09	1.90	234
MADHYA PRADESH	932	33.3	4.11	2.40	149
UTTAR PRADESH	882	38.0	5.19	2.29	471
RAJASTHAN	913	28.3	3.87	2.50	128
PUNJAB	888	26.5	3.09	1.86	401
HARYANA	874	35.4	4.32	2.36	369
GUJARAT	936	28.5	3.17	1.91	210
MAHARASHTRA	936	28.4	3.12	2.29	256
INDIA	929	30.7	3.67	2.14	267

TABLE - 3

DEMOGRAPHIC FEATURES OF WEST BENGAL DISTRICTS (A)

DISTRICTS	TOTAL POPULATION	MALE	FEMALE	SEX RATIO
WEST BENGAL	68,077,965	35,510,633	32,567,332	917
BANKURA	2,805,065	1,437,515	1,367,550	948
BARDHANAMAN	6,050,605	3,185,833	2,863,772	898
BIRBHUM	2,555,664	1,313,285	1,242,379	946
CALCUTTA	4,399,819	2,445,328	1,954,491	797
DARJEELING	1,299,919	679,323	620,596	923
HAORA	3,729,644	1,982,457	1,747,187	878
HUGLY	4,355,230	2,271,792	2,083,438	917
JALPAIGURI	2,800,543	1,453,194	1,347,349	928
KOCH BIHAR	2,171,145	1,122,306	1,048,839	934
MALDA	2,637,032	1,360,541	1,276,491	938
MEDINIPUR	8,331,912	4,284,954	4,046,958	944
MURSHIDABAD	4,740,149	2,439,342	2,300,807	945
NADIA	3,852,097	1,989,841	1,862,256	938
24 PARGANAS(N)	7,281,881	3,818,107	3,463,648	909
24 PARGANAS(S)	5,715,030	2,962,214	2,752,816	929
PURULIA	2,224,577	1,142,771	1,081,806	946
WEST DINAJPUR) NORTH & SOUTH)	3,127,653	1,620,740	1,506,913	930

SOURCE : CENSUS OF INDIA, 1991.

TABLE - 4

DEMOGRAPHIC FEATURES OF WEST BENGAL DISTRICTS (B)

DISTRICTS	% URBAN
WEST BENGAL	27.48
BANKURA	8.29
BARDHAMAN	35.09
BIRBHUM	8.98
CALCUTTA	100.00
DARJEELING	30.47
HAORA	49.58
HUGLI	31.19
JALPAIGURI	16.36
KOCH BIHAR	7.81
MALDA	7.07
MEDINIPUR	9.85
MURSHIDABAD	10.43
NADIA	22.63
24 PARGANAS (N)	51.23
24 PARGANAS (S)	13.30
PURULIA	9.44
WEST DINAJPUR) NORTH & SOUTH)	13.34

SOURCE : CENSUS OF INDIA 1991

TABLE 5

DEMOGRAPHIC FEATURES OF WEST BENGAL DISTRICTS (C)

DISTRICTS	POPULATION DENSITY PER SQ.KM.	% SC.	% ST.	TOTAL % SC / ST
WEST BENGAL	767	23.62	5.59	29.21
BANKURA	408	31.36	10.33	41.69
BARDDHAMAN	861	27.44	6.21	33.65
BIRBHUM	562	30.68	6.94	37.62
CALCUTTA	23,784	6.45	0.19	6.63
DARJEELING	413	16.14	13.78	29.92
HAORA	2,543	15.78	0.27	16.05
HUGLI	1,383	24.11	4.05	28.16
JALPAIGURI	450	36.99	21.00	57.99
KOCH BIHAR	641	51.75	0.61	52.36
MALDA	706	18.12	6.50	24.62
MEDINIPUR	592	16.34	8.27	27.61
MURSHIDABAD	890	13.39	1.30	14.70
NADIA	981	29.01	2.35	31.36
24 PARGANAS (N)	1,779	21.48	2.33	23.81
24 PARGANAS (S)	574	34.44	1.23	35.67
PURULIA	355	19.35	19.22	38.57
WEST DINAJPUR) SOUTH & NORTH)	584	29.01	9.83	38.84

SOURCE : ECON. REVEW, GOVT. OF W.B. 93-94

TABLE : 6

BASIC AMINITIES IN HOUSEHOLDS
OF WEST BENGAL

% HOUSHOLDS HAVING ELECTRICITY

DISTRICTS	TOTAL	RURAL	URBAN
WEST BENGAL	21.09	7.02	57.86
BANKURA	14.40	10.47	62.46
BARDDHAMAN	26.65	11.28	59.10
BIRBHUM	14.42	-----	-----
CALCUTTA	83.66	-----	83.66
DARJEELING	23.90	10.10	60.19
HAORA	26.79	5.69	48.69
HUGLY	22.86	9.84	49.18
JALPAIGURI	14.01	9.17	44.50
KOCH BIHAR	7.61	3.23	70.99
MALDA	21.64	19.15	71.56
MEDINIPUR	7.27	3.75	44.11
MURSHIDABAD	7.67	4.35	38.63
NADIA	15.28	6.41	45.54
24 PARGANAS (NORTH & SOUTH)	23.09	4.08	50.61
PURULIA	6.73	2.80	48.23
WEST DINAJPUR (NORTH & SOUTH)	8.47	5223	37.33

SOURCE : CENCUS OF INDIA 1981,
OCCASIONAL PAPER NO 1 OF 1989

TABLE = 7

BASIC AMENITIES IN HOUSEHOLDS OF WEST BENGAL (2)
% OF HOUSEHOLDS HAVING

DISTRICTS	SAFE WATER SUPPLY			TOILET
	TOTAL	RURAL	URBAN	ONLY URBA
WEST BENGAL	69.65	65.78	79.78	
BANKURA	24.97	22.80	51.57	36.66
BARDDHAMAN	75.57	79.67	66.93	69.67
BIRBHUM	63.18	63.69	57.72	41.68
CALCUTTA	90.92	-----	90.92	92.97
DARJEELING	37.04	34.64	43.38	67.13
HAORA	85.54	92.57	78.15	78.43
HUGLY	90.68	91.96	88.10	77.73
JALPAIGURI	35.38	35.01	37.70	62.18
KOCHBIHAR	60.24	62.27	77.31	82.51
MALDA	54.69	53.51	78.43	72.44
MEDINIPUR	57.59	57.41	59.52	57.92
MURSHIDABAD	78.81	78.51	84.91	47.50
NADIA	87.66	89.26	82.19	70.66
24 PARGANAS (NORTH & SOUTH)	90.07	92.88	85.98	81.34
PURULIA	11.54	7.57	53.46	49.20
WEST DINAJPUR (NORTH & SOUTH)	43.94	42.04	60.84	70.50

SOURCE : CENCUS OF INDIA 1981
OCCATIONAL PAPER NO 1 OF 1989

TABLE - 8

CHILD MORTALITY (DEATH BY AGE 5)

(ONLY RURAL)

DISTRICTS	MALE	FEMALE	AVERAGE	RANK
WEST BENGAL	138	139 *	139	-----
BANKURA	90	91 *	90	1
BIRBHUM	148	143 *	145	8
BARDHAMAN	115	118	117	7
CALCUTTA	---	-----	---	---
DARJEELING	115	113	114	6
HAORA	95	101 *	98	3
HUGLI	93	93	93	2
JALPAIGURI	153	148	150	11
KOCH BIHAR	101	101	101	4
MALDA	172	179 *	175	14
MEDINIPUR	141	147 *	144	9
MURSHIDABAD	157	166 *	162	13
NADIA	151	147	149	10
24 PARGANAS (NORTH & SOUTH)	146	144	145	8
PURULIA	104	104	104	5
WEST DINAJPUR (NORTH & SOUTH)	158	157	158	12

* FEMALE CHILD MORTALITY HIGHER THAN MALE CHILD MORTALITY.

SOURCE: Child Mortality Estimate of India, Govt. of India, 1988.

TABLE = 2

TABLE = MOTHER & CHILD HEALTH I

WEST BENGAL COMPARED WITH MAJOR STATES ON ANTENATAL CARE (RURAL)

STATES	% PREGNANT WOMEN RECEIVED T.T.	% PREGNANT WOMEN RECEIVED IRON FOLIC TABS.	% PREGNANT WOMEN RECEIVED HOME VISITS BY HEALTH WORKERS	% PREGNANT WOMEN GOT CHECK - UP FROM DOCTOR	% PREGNANT WOMEN GOT CHECK UP FROM OTHER HEALTH PROFESSIONALS
WEST BENGAL	75.9	54.3	16.0	56.2	8.9
BIHAR	32.7	17.5	11.7	16.7	5.1
ORISSA	60.6	47.1	32.1	29.0	4.4
ASSAM	40.9	36.6	6.9	31.7	4.6
PUNJAB	85.4	71.3	8.6	29.4	55.1
HARYANA	66.7	56.0	13.4	22.1	40.0
UTTAR PRADESH	38.9	25.0	18.1	15.0	8.5
RAJASTHAN	30.7	26.5	13.0	11.0	8.0
MADHYA PRADESH	45.8	39.3	23.1	18.0	9.7
GUJRAT	64.9	65.5	46.2	27.5	10.5
MAHARASHTRA	77.7	69.6	35.7	45.4	11.8
KERALA	92.9	90.1	29.6	95.0	0.8
TAMIL NADU	92.0	81.6	49.5	61.2	9.6
KARNATAKA	74.0	73.3	52.5	52.0	5.9
ANDHRA PRADESH	78.2	74.1	49.3	55.0	4.3
INDIA	55.3	45.1	24.3	31.1	10

SOURCE : NATIONAL FAMILY HEALTH SURVEY 92 - 93

TABLE - 10

TABLE - MOTHER & CHILD HEALTH II

WEST BENGAL COMPARED WITH MAJOR STATES ON IMMUNISATION OF CHILDREN (RURAL)

STATES	% SHOWING IMMUNISATION CARD	12-23 MONTH CHILD FULLY IMMUNISED ALL DOSES OF ALL VACCINES	12-23 MONTH CHILDREN ONLY PARTLY COVERED	12-23 MONTH CHILD RECEIVED NO IMMUNISATION AT ALL
WEST BENGAL	45.2	31.3	43.8	24.9
BIHAR	15.7	9.1	35.1	55.8
ORISSA	41.7	34.7	36.8	28.5
ASSAM	36.5	17.4	36.1	46.5
PUNJAB	37.1	57.7	22.4	19.9
HARYANA	29.8	52.1	29.1	18.8
UTTAR PRADESH	21.5	17.4	63.5	46.1
RAJASTHAN	13.5	16.1	68.6	52.5
MADHYA PRADESH	19.0	25.6	63.9	38.3
GUJRAT	29.0	46.2	32.8	21.0
MAHARASHTRA	40.9	65.6	72.2	6.6
KERALA	55.7	54.0	32.6	13.4
TAMIL NADU	34.9	60.3	35.7	4.0
KARNATAKA	35.2	49.9	65.1	15.2
ANDHRA PRADESH	35.1	39.7	40.1	20.2
INDIA	28.5	30.9	35.1	34.0

SOURCE : NATIONAL FAMILY HEALTH SURVEY 92-93.

TABLE - 11

DISEASE PROFILE

DISTRICTS	DETECTED MALARIA CASES (1991)	T.B. PATIENTS UNDER TREATMENT AT THE END OF 1991	LEPROSY CASES ON RECORD 1991 - 1992
WEST BENGAL	24787	669716	204096
BANKURA	329	27535	9712
BARDDHAMAN	66	16254	37647
BIRBHUM	209	21543	14735
CALCUTTA	-----	94182	8765
DARJEELING	249	76490	3161
HAORA	12	50965	6199
HUGLI	9	44183	14569
JALPAIGURI	13523	16572	8669
KOCH BIHAR	1672	18035	3511
MALDA	269	15662	7009
MEDINIPUR	1865	27825	32770
MURSHIDABAD	54	26735	13296
NADIA	121	33365	9371
24 PARGANAS (NORTH)	166	44734	9603
24 PARGANAS (SOUTH)	476	85273	6787
PURULIA	5584	40205	9021
WEST DINAJPUR (NORTH & SOUTH)	62	30158	9271

SOURCE : Health on the March in West Bengal.

TABLE - 12
HOSPITAL BEDS IN WEST BENGAL

DISTRICTS	STATE GOVT. HOSPITAL	CENTRAL GOVT. HOSPITAL	LOCAL BODIES	PRIVATE	TOTAL
WEST BENGAL	40823	5438	603	6912	53777
BANKURA	1710	50	---	308	2068
BARDDHAMAN	2160	2928	---	85	5174
BIRBHUM	1170	52	---	18	1240
CALCUTTA	13167	840	329	3216	17552
DARJEELING	2096	18	24	194	2332
HAORA	2097	272	35	262	2666
HUGLI	2457	58	52	370	2937
JALPAIGURI	1062	215	---	626	1903
KOCH BIHAR	910	2	---	---	912
MALDA	557	100	---	75	732
MEDINIPUR	2360	386	---	92	2838
MURSHIDABAD	1889	53	---	85	2027
NADIA	3975	---	---	262	4237
24 PARGANAS (NORTH)	2510	72	95	313	3190
24 PARGANAS (SOUTH)	1466	---	68	200	1730
PURULIA	637	192	---	776	1605
WEST DINAJPUR (NORTH & SOUTH)	600	---	---	30	630
	40823	5438	603	6912	53777

SOURCE : HEALTH ON THE MARCH, WEST BENGAL, 1991.
TOTAL EXCLUDING 930 RESERVED BEDS AT RANCHI.

TABLE - 13

RELATIVE POSITION OF WEST BENGAL DISTRICTS IN TERMS OF NUMBER OF BEDS IN HEALTH CENTRE FACILITIES

DISTRICTS	BEDS IN HEALTH CENTRE FACILITIES	RURAL POPULATION (IN THOUSAND)	BED PER 1000 RURAL POPULATION	RANK
WEST BENGAL	12187	49370	0.24	----
BANKURA	835	2572	0.32	2
BARDDHAMAN	1196	3927	0.30	4
BIRBHUM	695	2326	0.29	5
CALCUTTA	-----	-----	-----	----
DARJEELING	360	903	0.39	1
HAORA	587	1880	0.31	3
HUGLI	780	2996	0.26	7
JALPAIGURI	542	2342	0.23	10
KOCH BIHAR	275	2001	0.13	14
MALDA	593	2450	0.24	9
MEDINIPUR	1745	7510	0.23	10
MURSHIDABAD	999	4245	0.23	10
NADIA	819	2980	0.27	6
24 PARGANAS (NORTH)	754	3551	0.21	11
24 PARGANAS (SOUTH)	967	4954	0.19	12
PURULIA	504	2014	0.25	8
WEST DINAJPUR (NORTH & SOUTH)	539	2710	0.19	12

SOURCE: Computed from Health on the March in West Bengal and 1991 census.

TABLE = 14

HEALTH CENTRE FACILITIES IN RURAL AREAS OF WEST BENGAL

DISTRICTS	RURAL HOSPITAL		BPHC		PHC		TOTAL	
	NO.	BED	NO.	BED	NO.	BED	NO.	BED
WEST BENGAL	86	3358	255	3714	917	5115	1258	12187
BANKURA	2	90	20	380	66	358	88	835
BARDDHAMAN	5	240	29	410	97	546	131	1196
BIRBHUM	3	140	16	320	58	235	77	69.
CALCUTTA	-	---	--	---	--	---	--	---
DARJEELING	3	80	7	135	21	145	31	360
HAORA	4	175	11	140	41	272	56	587
HUGLI	6	225	11	165	61	389	78	780
JALPAIGURI	5	235	9	135	38	172	52	542
KOCH BIHAR	1	30	7	85	31	160	39	275
MALDA	6	253	9	120	36	220	51	593
MEDINIPUR	12	435	46	560	134	750	192	1745
MURSHIDABAD	8	300	19	276	73	423	100	99
NADIA	8	325	7	125	52	366	67	816
24 PARGANAS (N)	7	255	15	191	51	308	73	754
24 PARGANAS (S)	12	420	19	231	61	316	92	967
PURULIA	1	30	19	245	52	229	72	504
WEST DINAJPUR (NORTH & SOUTH)	3	125	11	195	45	219	59	539

SOURCE: HEALTH ON THE MARCH IN WEST BENGAL,1991

TABLE - 15

HOSPITAL AND RURAL HEALTH FACILITIES
DISTRICTS COMPARED

DISTRICT	TOTAL BEDS (HOSPITALS & RURAL HEALTH FACILITIES COMBINED)	BEDS PER 1000 PEOPLE	RANK
WEST BENGAL	65964	0.96	
BANKURA	2903	1.03	5
BARDHAMAN	6370	1.05	4
BIRBHUM	1935	0.75	9
CALCUTTA	17552	3.98	1
DARJEELING	2692	2.07	2
HAORA	3253	0.87	7
HUGLI	3717	0.85	8
JALPAIGURI	2445	0.87	7
KOCH BIHAR	1187	0.54	12
MALDA	1325	0.50	13
MEDINIPUR	4583	0.55	11
MURSHIDABAD	3026	0.63	10
NADIA	5056	1.31	3
NORTH 24 PARGANAS	3944	0.54	12
SOUTH 24 PARGANAS	2697	0.47	14
PURULIA	2109	0.94	6
NORTH WEST DINAJPUR)) SOUTH WEST DINAJPUR)	1196	0.37	15

SOURCE: HEALTH ON THE MARCH IN WEST BENGAL,1991

TABLE - 16

TOTAL NO OF PATIENTS TREATED IN HOSPITALS AND DISPENSARIES (1986)

DISTRICTS	INDOOR	OUTDOOR	TOTAL
WEST BENGAL	515633	6664529	7180159
BANKURA *	38120	633338	671458
BARDDHAMAN	50237	539119	589356
BIRBHUM *	32407	184494	216901
CALCUTTA	122348	2572683	2695031
DARJEELING	11493	60397	71890
HAORA *	19146	220486	239632
HUGLI	29276	82303	111579
JALPAIGURI	13527	159596	173123
KOCH BIHAR	18428	158328	176756
MALDA	29853	189354	219204
MEDINIPUR	23657	331759	355416
MURSHIDABAD	31110	343195	374305
NADIA	31845	373036	404881
24 PARGANAS (NORTH & SOUTH)	22970	221219	244189
PURULIA	20833	362997	383830
WEST DINAJPUR (NORTH & SOUTH)	20383	232225	252608

* BANKURA 1985, BIRBHUM 1984, HAORA 1985.

SOURCE : STATISTICAL ABSTRACT, WEST BENGAL, 1978 - 89.

TABLE = 17

WEST BENGAL DISTRICTS IN TERMS OF ELIGIBLE COUPLES' PROTECTION

DISTRICTS	% COUPLES EFFECTIVELY PROTECTED	RANK
WEST BENGAL	35.57	------
BANKURA	47.61	3
BARDDHAMAN	52.45	2
BIRBHUM	44.46	4
CALCUTTA	52.52	1
DARJEELING	41.07	7
HAORA	25.69	12
HUGLI	40.18	9
JALPAIGURI	41.26	6
KOCH BIHAR	40.58	8
MALDA	19.61	16
MEDINIPUR	41.26	6
MURSHIDABAD	27.93	11
NADIA	34.73	10
24 PARGANAS (NORTH)	22.96	14
24 PARGANAS (SOUTH)	23.31	13
PURULIA	43.34	5
WEST DINAJPUR (NORTH & SOUTH)	23.31	15

SOURCE : HEALTH ON THE MARCH IN WEST BENGAL

TABLE - 18

WEST BENGAL COMPARED WITH MAJOR STATES OF INDIA ON USE OF FAMILY PLANNING (RURAL AREA ONLY)

% CURRENTLY MARRIED WOMEN (13-49) CURRENTLY USING

STATES	ANY METHODS	ANY MODERN METHODS	ANY MODERN TEMPORARY	FEMALE STERILIZATION	MALE STERILIZATION
WEST BENGAL	55.7	37.6	5.0	27.4	5.1
BIHAR	19.8	18.5	2.0	15.6	1.0
ORISSA	34.2	32.7	2.1	27.3	3.3
ASSAM	40.1	18.0	4.7	10.8	2.5
PUNJAB	57.2	50.2	14.8	33.0	2.4
HARYANA	46.7	42.8	5.8	32.0	5.0
U. P.	16.7	15.8	3.4	11.2	1.2
RAJASTHAN	28.2	27.1	2.0	23.0	2.1
MADHYAPRADESH	33.4	32.5	1.8	25.4	5.3
GUJRAT	47.5	45.7	3.2	38.9	3.7
MAHARASHTRA	54.3	53.8	2.9	42.3	8.5
KERALA	61.4	53.2	5.8	41.5	6.0
TAMIL NADU	49.2	45.5	3.4	39.9	2.3
KARNATAKA	47.7	46.4	2.9	41.8	1.8
ANDHRA PRADES	43.6	43.3	0.9	36.0	6.4
INDIA	36.9	33.1	3.4	26.3	4.5

SOURCE : NATIONAL FAMILY HEALTH SURVEY 92-93.

TABLE - 19

TABLE - FAMILY PLANNING II

WEST BENGAL COMPARED WITH MAJOR STATES ON MATAL SERVICE (RURAL)

STATES	% OF INSTITUTIONAL DELIVERY (BOTH PUBLIC & PRIVATE)	TOTAL HOME DELIVERY %	HOME DELIVERIES ATTENDED BY T.B ATTENDANT	HOME DELIVERIES ATTENDED BY DOCTORS
WEST BENGAL	21.4	78.6	40.3	2.1
BIHAR	7.6	92.4	60.9	2.7
ORISSA	9.7	90.3	39.2	1.7
ASSAM	7.3	92.7	21.2	2.8
PUNJAB	21.4	78.6	52.8	4.5
HARYANA	12.6	87.4	57.0	5
UTTAR PRADESH	6.6	93.4	34.0	0.8
RAJASTHAN	7.3	92.7	42.0	2.6
MADHYA PRADESH	7.6	92.4	34.0	2.2
GUJRAT	23.8	76.2	52.7	3.5
MAHARASHTRA	25.3	74.7	24.7	2.5
KERALA	86.0	14.0	10.0	0.4
TAMIL NADU	49.0	51.0	29.8	0.2
KARNATAKA	25.7	74.3	27.5	3.5
ANDHRA PRADESH	20.7	79.3	40.4	7.9
INDIA	16.1	83.9	39.0	2.4

SOURCE : NATIONAL FAMILY HEALTH SURVEY 92-93.

TABLE - 20

WEST BENGAL COMPARED WITHOTHER STATES ON LITERACY — SCHOOLING INDICATORS

STATES	MALE LITERACY 1991 *	FEMALE LITERACY '91 *	RURAL LITERACY '91 *	URBAN LITERACY '91 *	% 6 YR FEMALE CHILDREN ATTENDING SCHOOL (RURAL)'81 *	% 6 -14 YR FEMALE CHILDREN ATTENDING SCHOOL (RURAL) '81
WEST BENGAL	68 (6)	47 (6)	51 (6)	75 (6)	21 (6)	36 (4)
ASSAM	62	43	49	79	-----	-----
BIHAR	52	23	34	68	12	19
ORISSA	49	35	45	72	30	33
ANDHRA PRADESH	55	33	36	66	25	28
KERALA	94	86	83	92	73	87
TAMIL NADU	74	51	55	78	50	47
KARNATAKA	67	44	48	74	23	34
MADHYA PRADESH	58	29	36	71	13	18
UTTAR PRADESH	56	25	36	71	13	18
RAJASTHAN	55	20	30	65	7	11
PUNJAB	66	50	53	72	---	---
HARYANA	69	40	50	74	---	---
GUJARAT	73	49	53	77	24	42
MAHARASHTRA	77	52	56	79	31	45
INDIA	64	39	45	73	21	31

* % FIGURES ROUNDED OFF

FIGURES WITHIN PARENTHESES INDICATE WEST BENGAL RANK.

SOURCE : Census 1981 and 1991.

TABLE = 21

LITERACY IN WEST BENGAL IN 1991 CENSUS

DISTRICTS	TOTAL LIT.	MALE LIT.	FEMALE LIT.
Bankura	52.04	66.75	36.55
Burdhaman	61.88	71.12	51.46
Birbhum	48.56	59.26	37.17
Calcutta	77.61	81.94	72.09
Darjeeling	57.95	67.07	47.84
Howrah	67.62	76.11	57.83
Hooghly	66.78	75.77	56.90
Jalpaiguri	45.09	56.00	33.20
Cooch Bihar	45.78	57.35	33.31
Malda	35.62	45.61	324.92
Midnapore	69.32	81.27	56.63
Murshidabad	38.28	46.42	29.57
Nadia	52.53	60.05	44.42
24 Parg. North	66.81	74.72	57.99
24 Parg. South	55.10	68.45	40.57
Puruliya	43.29	62.17	23.24
W. Dinajpur	39.29	49.79	27.87
West Bengal	57.70	67.81	46.56

SOURCE: Economic Review, 1993-94.

TABLE - 22
BANKING ACTIVITIES IN WEST BENGAL DISTRICTS

DISTRICTS	BANK BRANCHES PER LAKH POPULATION	PER CAPITA BANK DEPOSIT	PER CAPITA BANK CREDIT	PER CAPITA BANK CREDIT TO AGRICUL.	PER CAPITA BANK CREDIT TO SMALL INDUSTRY	PER CAPITA BANK CREDIT TO INDUSTRY
WEST BENGAL	6.23	3508	1832	90	184	851
BANKURA	5.85	838	300	61	27	89
BARDDHAMAN	5.92	2287	816	110	79	387
BIRBHUM	6.77	910	401	109	40	72
CALCUTTA	20.80	34856	21835	323	1621	9117
DARJEELING	7.54	2748	1048	138	227	432
HAORA	5.66	2523	693	40	325	881
HUGLI	5.60	1915	563	91	102	546
JALPAIGURI	4.71	879	409	84	125	421
KOCH BIHAR	5.02	503	308	53	29	59
MALDA	5.35	635	317	72	29	66
MEDINIPUR	5.68	925	371	89	46	100
MURSHIDABAD	4.64	620	262	54	19	36
NADIA	4.65	1044	344	76	69	257
24 PARGANAS (N)	4.63	2288	552	57	81	229
24 PARGANAS (S)	4.06	987	288	62	136	595
PURULIA	4.99	861	299	47	41	75
WEST DINAJPUR (NORTH & SOUTH)	4.64	475	259	57	23	39

SOURCE : CMIE

TABLE - 23

EMPLOYMENT IN WEST BENGAL DISTRICTS

DISTRICT	AGRICULTURE & ALLIED ACTIVITIES	SERVICE SECTOR	INDUSTRY, MANUFACTURE OF HOUSEHOLD INDUSTRY, MINING ETC.
WEST BENGAL	55.71	12.34	31.95
BANKURA	75.82	14.50	9.68
BARDHAMAN	53.41	23.82	22.77
BIRBHUM	73.28	16.61	10.11
CALCUTTA	-	69.05	30.95
DARJEELING	57.57	32.81	9.62
HAORA	26.57	34.13	39.30
HUGLI	48.72	26.60	24.68
JALPAIGURI	68.68	22.39	8.93
KOCH BIHAR	75.46	16.67	7.87
MALDA	72.34	14.42	13.26
MEDINIPUR	69.30	19.04	11.66
MURSHIDABAD	62.67	15.76	21.57
NADIA	54.48	22.94	22.58
NORTH 24 PARGANAS	35.74	36.33	27.93
SOUTH 24 PARGANAS	59.58	23.22	17.20
PURULIA	75.92	14.20	9.88
NORTH WEST DINAJPUR } SOUTH WEST DINAJPUR }	75.36	13.98	10.10

SOURCE : Economic Review, 1993-94.

TABLE : 24

WEST BENGAL DISTRICTS

RELATIVE INDEX OF DEVELOPMENT

DISTRICTS	RELATIVE INDEX OF DEVELOPMENT	RANK OF DISTRICTS
WEST BENGAL	97	3
BANKURA	60	9
BARDDHAMAN	97	3
BIRBHUM	68	9
CALCUTTA	403	1
DARJEELING	78	6
HAORA	102	2
HUGLI	96	4
JALPAIGURI	50	11
KOCH BIHAR	70	7
MALDA	51	12
MEDINIPUR	59	10
MURSHIDABAD	59	10
NADIA	69	8
24 PARGANAS (N)	79	5
24 PARGANAS (S)	57	11
PURULIA	48	14
WEST DINAJPUR (NORTH & SOUTH)	50	13

SOURCE : CMIE

TABLE = 25

DISTRICTWISE PER CAPITA INCOME IN WEST BENGAL IN 1988-89 AT CURRENT PRICES

DISTRICTS	PER CAP. INCOME (in rupees)	As % of State Income
Calcutta	5450	159
Howrah	4307	126
24 Parg. (com)	4126	121
Burdhaman	3985	116
Hooghly	3945	115
Darjeeling	3412	100
Birbhum	3348	98
Murshidabad	3162	92
Puruliya	3003	88
Bankura	2994	87
Nadia	2799	82
Jalpaiguri	2776	81
Midnapore	2515	73
W.Dinajpur	2435	71
Malda	2254	66
Cooch Bihar	2154	63
West Bengal	3423	100

SOURCE : Paschimbangabasi (People of W.B.) by Sachhidananda Dutta Roy.

TABLE = 26

UNEMPLOYED REGISTERED WITH EMPLOYMENT EXCHANGES (IN THOUSANDS)
1993

DISTRICTS	UNEMPLOYED
Bankura	220.6
Burdhaman	538.8
Birbhum	178.1
Calcutta	498.8
Darjeeling	103.4
Howrah	229.6
Hooghly	302.3
Jalpaiguri	172.2
Cooch Bihar	145.4
Malda	129.1
Midnapore	491.1
Murshidabad	248.8
Nadia	242.7
24 Parg. North	638.0
24 Parg. South	307.1
Puruliya	156.0
W. Dinajpur	169.0
West Bengal	4771.5

SOURCE : Paschimbangabasi (People of W.B.) by Sacchidananda Dutta Roy, Calcutta 1994.

TABLE : 27

WEST BENGAL COMPARED TO OTHER STATES

ON URBANIZATION — COMMUNICATION

STATES	% OF URBANI-ZATION	ROAD LENTH PER 100 SQ.KM.	RAIL ROUTE LENGTH SQ.KM.	POST OFFICE PER LAKH POPULATION	TELEGRAPH OFFICE PER LAKH POPULATION	TELEPHONES PER LAKH POPULATION
WEST BENGAL	27	65	4	12	3	653
ASSAM	11	82	3	17	2	249
BIHAR	13	49	3	3	13	167
ORISSA	13	126	1	25	8	289
ANDHRA PRADESH	27	50	2	24	6	652
KERALA	26	322	3	17	7	1181
TAMIL NADU	34	128	3	22	10	1016
KARNATAKA	31	66	2	22	9	950
MADHYA PRADESH	23	28	1	17	5	460
UTTAR PRADESH	20	62	3	14	4	291
RAJASTHAN	23	31	2	23	4	501
PUNJAB	30	61	4	19	3	1250
HARYANA	25	54	3	16	2	834
GUJARAT	34	38	3	21	4	1331
MAHARASHTRA	39	67	2	15	3	1851
INDIA	26	60	2	18	5	800

SOURCE : CMIE

TABLE : 28

FORESTRY LAND USE AND AGRICULTURE IN WEST BENGAL

DISTRICT	FOREST AREA AS % OF REPORTING AREA	NET SOWN AREA AS % REPORTING	GROSS IRRIGATED AREA % OF GROSS CROPPED AREA	AVERAGE SIZE OF HOLDING (HECT.)	FERTILISER CONSUMPTION PER HECTARE (K.G.)	PER CAPITA FOOD GRAINS PRODUCTION
WEST BENGAL	12	60	24	0.92	95	152
BANKURA	20	58	33	1.13	77	259
BARDDHAMAN	4	62	63	1.59	124	215
BIRBHUM	4	72	54	1.21	127	306
DARJEELING	39	39	5	2.13	119	128
HAORA	NA	62	18	0.44	279	60
HUGLI	0.09	71	41	0.72	191	123
JALPAIGURI	28	53	0.25	1.66	52	113
KOCH BIHAR	2	74	3	1.01	78	181
MALDA	0.38	68	15	0.90	103	183
MEDINIPUR	13	64	21	0.77	81	207
MURSHIDABAD	0.15	74	29	0.77	74	169
NADIA	0.32	68	27	0.97	89	171
24 PARGANAS (N)	NA	68	31	0.69	103	85
24 PARGANAS (S)	41	36	3	0.70	76	94
PURULIA	14	51	3	1.01	96	186
WEST DINAJPUR (NORTH & SOUTH)	0.24	73	5	1.10	54	213

(ALL % ROUNDED OFF)

SOURCE : CMIE

INTEGRATED TRIBAL DEVELOPMENT PROJECTS IN WEST BENGAL (I.T.D.P.)

DISTRICTS	TOTAL I.T.D.P. BLOCKS	NAME OF I.T.D.P. BLOCKS	NO. OF MOUJAS IN ITDP AREA	TOTAL POPULATION IN ITDP AREA	TRIBAL POPULATION	% TRIBAL
PURULIA	6	* Jaipur	910	425158	247145	58.13
		* Jhalda 1				
		* Jhalda 2				
		* Baadoyan				
		* Manbazar				
		* Arsha				
		* Bagmundi				
		* Balarampur				
		* Barabazar				
		* Parcha 1				
		* Parcha 2				
		* Purulia Muffasil 1				
		* Purulia Muffasil 2				
		* Neturia				
		* Raghunathpur 1				
		* Raghunathpur 2				
		* Santuri				
		* Hura				
		* Para				
		* Kashipur				

DISTRICT	TOTAL I.T.D.P. BLOCKS	NAME OF I.T.D.P. BLOCKS	NO. OF MOUJAS IN I.T.D.P. AREA	TOTAL POPULATION IN I.T.D.P. AREA	TRIBAL POPULATION	% TRIBAL
BANKURA	3	* Raipur 1	747	265503	160526	60.46
		* Raipur 2				
		* Ranibandh				
		* Khatra 1				
		* Khatra 2				
		* Taldangra				
		* Simlipal				
		* Onda				
		* Indpur				
		* Bankura 1				
		* Bankura 2				
		* Chhatna				
		* Saltora				
		* Gangjalghati				
BIRBHUM	4	* Rajnagar	232	117794	60195	51.10
		* Sainthia				
		* Suri 1				
		* Suri 2				
		* Bolpur				
		* Labpur				
		* Mahammadbazar				
		* Rampurhat				

DISTRICT	TOTAL I.T.D.P. PROJECT	NAME OF I.T.D.P. BLOCKS	NO. OF MOUJAS I.T.D.P. AREA	TOTAL POPULATION IN I.T.D.P. AREAS	TRIBAL POPULATION	% TRIBAL
MALDA	2	* Habibpur	441	203678	106207	52.14
		* Gajol				
		* Malda				
		* Bamangola				
DARJEELING	1	* Maxalbari	136	94958	45336	47.74
		* Phansidewa				
		* Kharibari				
		* Siliguri				
JALPAIGURI	4	* Alipurduar 1	315	740970	395631	51.32
		* Alipurduar 2				
		* Kumargram				
		* Kalchini				
		* Falakata				
		* Birpara				
		* Matharihat				
		* Meteili				
		* Mal				
		* Bararhat				
		* Maynagunj				
		* Nagrakota				

DISTRICT	TOTAL I.T.D.P. PROJECT	NAME OF I.T.D.P. BLOCKS	NO. OF MOUJAS I.T.D.P. AREA	TOTAL POPULATION IN I.T.D.P. AREAS	TRIBAL POPULATION	% TRIBAL
WEST DINAJPUR	3	* Balurghat	564	247274	115607	46.75
		* Kumargunj				
		* Itili				
		* Gangarampur				
		* Itahar				
		* Japan				
		* Banshihari				
		* Kushmundi				
		* Karandighi				
		* Raigunj				
		* Chakolia				
		* Goalookhar				
		* Chopra				
		* Islampur				
MEDINIPUR	5	* Gopiballavpur 1	2043	478568	287472	60.07
		* Gopiballavpur 2				
		* Nayagram				
		* Jambari				
		* Jhargram				
		* Binpur 1				
		* Binpur 2				
		* Narayangarh				

POLICY PAPER

ON

PROMOTION OF SMALL GROUPS

PERFORMANCE ASSESSMENT SECTOR

CENDERET
XAVIER INSTITUTE OF MANAGEMENT
BHUBANESWAR

TABLE OF CONTENTS

CONTENTS

CHAPTER ONE

I N T R O D U C T I O N

CENTRE FOR DEVELOPMENT RESEARCH AND TRAINING (CENDERET) as a wing of Xavier Institute of Management, Bhubaneswar was entrusted with the task of looking after the Management problems and needs of the non-corporate, non-industrial especially the rural and informal sector in the whole of Orissa. "Consultancy" currently renamed as **"PERFORMANCE ASSESSMENT"**, opened as a sub wing under CENDERET to provide capacity building among the people and agencies that interface with rural poor and their problems, in handling rural projects.

The constituency of this sub wing covers whole of Orissa, South Bihar and boardering Andra Pradesh. The target group are individual activists, NGOs, Government agencies and donor partners. The services provided are pre-finance project feasibility, project formulation, project implementation, project monitoring and evaluation and long term organisational planning of NGOs.

Having worked with these objectives for five years since 1989, experiences indicates that further refinements and redefinition of earlier objectives and approaches are needed. It also necessitates to cover new emerging issues and trends which are not covered earlier. And finally to bring suitable strategical changes to respond effectively to emerging issues with more refined and redefined concepts.

This policy paper is based on CENDERET intensive interaction with various NGOs, individual activitists, Informal groups and Funding Agencies during last five years. It covers their perceptions and areas of interest in prevailing socio-economic mileau.

CHAPTER TWO : BACKGROUND

2.1 THE ORISSA STATE : A BRIEF INTRODUCTION

2.1.1 LOCATION AND TOPOGRAPHS :

Orissa, a small state spreading over a total area of 1,55,707 sq.km. lies between 17.49'- 22.34'N latitude and 81.27' - 18.29' E longitude on the east coast of Indian peninsula. it is surrounded by West Bengal in the North East, Bihar in the North, Andhara Pradesh on the South East, Madhya Pradesh on the west and 'Bay of Bengal on the east (Map). Morphologically the state is divided into five parts viz :

(a) The coastal plains
(b) The middle mountains country
(c) The rolling uplands
(d) The river valleys and
(e) The subdued plateau

Besides, it is drained by three great rivers, the Mahanadi, the Brahmani and the Baitarani along with a number of small rivers all of which flow into the Bay of Bengal. Chilika the largest brackish water lagoon of Asia is also in Orissa. Originally it was part of the Bay of Bengal and was subsequently closed up by sand dunes. Further the state being situated on the east coast, is endowed with the longest coast line of 482 kms. It has an equable climate, neither too hot nor too cold. However extreme of climate are experienced in some part of the Western districts of Bolangir, Sambalpur and Sundergarh. The average rainfall of the state is 150 mm and there is no desert or semi-desert area in the state.

2.1.2 ADMINISTRATIVE SET UP :

Orissa, in its present shape was formed during 1949 after the merger of ex-princely states. Until recently it was comprising of 13 districts, 58 Sub-divisions, 147 Tahasils, 314 Community Development Blocks, 420 Police Stations, 4380 G.Ps and 50887 villages. During the year 1993, the state has been reconstituted and some new districts have been formed and proposed. Presently the state is having altogether 27 districts and 3 more districts namely, Jharsuguda, Baudh and Debgarh have been decided to be newly formed (Map).

2.2 ORISSA - SOCIO-ECONOMIC ENVIRONMENTS IN CONTEXT OF INDIA :

2.2.1 DEMOGRAPHIC INDICATORS :

Orissa is one among the few most backward states of India. Appendix - I shows that in respect of most of the socio-economic indicators the position of Orissa is far below that of the National average. According to the 1991 estimates the total population of the state is 315 lakhs, which is 3.78 percent of total population of India, estimated at 8443 lakhs. Of the total population of Orissa, males constitute 160 lakhs and females 155 lakhs. The decennial growth rate of population of Orissa during 1981-91 shows a decreasing trend at 19.05 percent against 23.56 percent at the national level. However a pertinent factor of concern is the significant increase in the density of the states population from 169 per sq.kms in 1981 to 202 in 1991 as against the all India figures of 216 and 267 respectively (Appendix - I). The sex ratio of the state registered a fall from 1981 females per 1000 males in 1981 to 972 females per 100 males in 1991. Further the state has a sizable proportion of SC and ST population which taken together accounts for 37.1 percent of its total population as per 1991 census as compared to 23.6 percent at the National level. The population of SC and ST in 3866 lakhs (14.66) percent and 59.15 lakhs (22.43) percent respectively.

2.2.2 LITERACY :

In the literacy front Orissa has registered a literacy level of 34.23 percent according to the figures of 1981 compared to 36.20 percent at the all India level.

2.2.3 MAIN WORKERS :

While 75 per cent agriculture labourer and cultivator of total main workers in Orissa are engaged in agricultural in case of all India it is only 66 percent of the total workers that have been engaged in this sector. In the state only 6.92 percent of workers are working in the manufacturing, processing and servicing sectors.

2.2.4 HEALTH :

Regarding health, the situation of Orissa is very much appalling. Due to poor health condition, the estimated annual death rate and infant mortality rate per 1000 population in 1988 was 12.7 and 122 respectively as against the all India average of 10.3 and 94 respectively.

Above all the state has lost most of its natural forests. Even though the area covered under forests in Orissa is estimated at 38.3% but half of the area is forest only by name. The rapid denudation of the extensive forest have created ecological imbalance intensifying the effects of natural disasters such as flood, cyclone and drought which frequently hit the state. The process has also caused disaster for the tribals whose economy is forest based and who constitute about one fourth of Orissa's population. The practice of shifting cultivation is deep rooted in the state. About Ø.18 million hectares of the states land area is affected by this, which causes heavy floods and soil erosion. Air and water pollution caused by industries, mines and vehicular traffic are stated less at the moment but increasing. The state is experiencing perceptible climatic change in the form of reduced and irregular rain fall (Appendix - I)

CHAPTER THREE : THE DISTRICT SCENARIO

As discussed earlier, the state has been reconstituted and 27 districts have already been formed. But since information in relation to the newly formed district is not available, the old districts (13) are considered here for analysis.

3.1 DISTRICT SCENARIO INDICATES THE FOLLOWING :

Districts	Positive Points	Negative Points
In case of 4 districts of Coastal Orissa (Puri, Balasore, Ganjam, & Cuttack)	- High literacy rate - Better irrigational facilities - High yield of crops - High consumption of fertilisers - Better comunication link (road & rail) - Better primary sector (agriculture) - Better banking/cooperative facilities with credit/deposit ratio - Better health facilities and health status - Women status is better than average state condition	- High density of population - High growth rate - Poor forest coverage - Less backward population - Less industries - Secondary & tertiary sector is not developed - Main workers engaged in agriculture primarily
In case of 4 Drought Prone Districts (Kalahandi, Phulbani, Bolangir & Sambalpur)	- Better man/land ratio - Better natural resources - Low density of population - Less growth rate of population - Better forest coverage (but decreasing rapdily)	- Low rain fall - Low literacy - Poor agriculture yield - Poor utilisation of fertilisers - Poor irrigational facilities - Poor infrastructure (road and rail) - Less industries - Primary, secondary & tertiary (all sectors are underdeveloped) - Poor health facilities and services - High death rate and infant mortality - Death due to starvation

		- High concentration of S.C. and S.T. people - Main workers employed in unproductive and unremunerative agriculture
In case of districts like Koraput Dhenkanal, Keonjhar, Mayurbhanj, Sundergarh	- Good forest coverage - Full of natural resources - High percentage of S.T. people - Good number of industries (big/medium/small) - Good number of mines/Quarries - Average agriculture production	- Decreasing forest - Exploitation by outsiders specially in industrial belt - Average literacy but poor among tribals - Poor health coverage and health status - Poor development of tertiary sector - Poor condition of village & cottage industries

3.2 PROBLEMS, ISSUES AND TYPES OF SUPPORT :

PROBLEM DISTRICTS	I S S U E S	TYPES OF SUPPORT
Category One		
Phulbani, Kalahandi, Bolangir, Sambalpur	Illiteracy, Poor Agriculture, Unemployment, Poor secondary and Tertiary Sector, Poor Health, Poor Women Status, Exploitation, Death due to Starvation, Maximum people below poverty line, Decreasing forest	Health Programme, Educational Prog., Awareness & People Organisations, Income Generations & Employment Creation, Agricultural Project, Non-formal Projects, Forest Protection Programme
Category Two		
Koraput, Dhenkanal, Keonjhar, Mayurbhanj, Sundergarh	Illiteracy, Subsistance Agriculture, Unemployment, Poor Tertiary Sector, Poor Women Status, Poor Status of Village Industries, Poor health Status	Same as above

Category Three

Cuttack, Puri Balasore, Ganjam	High Density of Population, High Growth Rate, Decreasing Forest, Low Status of Industries, Low status of service sector	Project related to - Small & Cottage Industries, Improvement in service sector, improvement in environment and forest

3.3 Besides, there are issues which have emerged in recent past and affecting all the district equally viz. :

- Environmental issue (pollution, deforestation, soil erosion, drought, flood);
- Drug addiction;
- HIV / AIDS;
- Gender sensitization;
- Child labour/oppression to Dalits;
- Communal tension/seperatist movement.
- People unrest (NAXAL Movements)

CHAPTER FOUR : GOVERNMENT RESPONSES TOWARDS DEVELOPMENT

In last four decades of planned development, the Government both at centre and state level has taken enough pains in ameliorating persisting mass poverty through various centrally and state sponsored schemes. To begin with, it was the "**Grow More Food Enquiry Committee**" which recommended and paved the way for launching of "**Community Development Programmes**" followed by : "National Extention Schemes" which covered the entire country in 1952. With growing need for self reliance in food, the emphasis of rural development shifted almost exclusively to increase agricultural production. This resulted in launching of **Agriculture District Programme (IADP)** in 1960 in selected districts followed by **Intensive Agricultural Area Programme (IAAP)** and **High Yielding Varieties Programmes (HYVP)** in 1965. This led to loss of cohesiveness in community development programme due to falling budget and staff allocations and the Green Revolution benefited only to large farmers and areas (districts) with better resources.

By early seventies the need to take special measures for benefiting poor sections of population and for development of disadvantage and backward areas, was sharply felt. Accordingly four categories of programmes were launched, viz;

(i) Individual beneficiaries oriented programme such as small and marginal farmer development (SFDA/MFAL) latter supplemented by integrated Rural development programme.

(ii) Programmes for additional wage employment opportunity viz **Crash Scheme for Rural Employment (CSRE), Food for Work Programme (FWP).**

(iii) Programmes for development of ecologically disadvantaged areas - such as Drought Prone Area Programme (DPAP) and Desert Development Programmes (DDP).

(iv) And minimum needs programme to raise level of living in rural areas with some basic social consumption inputs and vital component of rural economic infrastructure,

Launching of all those programme accompanied by some new programme, created overlapping confusion and tendencies to work as independent line functioning as opposed to integration. Thus SFDA/MFAL/DPAP were modified as separate registered bodies. In late seventies, District Industries Centre (DIC) were opened to boost small scale and village industries.

In the 6th plan again the SFDA/MFAL were merged with IRDP due to this confined role. Food for Work Programme was also restructured inform of National Rural Employment Programme (NREP) and made regular from 1981. In 1983 - 84 another special programme "Rural Landless Employment Guarantee Programme" (RLEGP) was launched.

In addition to the major rural development programmes of IRDP, NREP, RLEGP, DPAP and DDP a number of other programmes were also implemented like Minimum Need Programme (MNP), Command Area Development Project (CADP), Tribal Sub Plan, Hill Area Development Project.

The recent addition as Jawahar Rojagar Yojana and Nehru Rojagar Yojana. There are also programmes like Development of Women and Children in Rural Areas (DWCRA) and Integrated Children Development Scheme (ICDS) which are sponsored by United Nations Development Agencies. Besides, a number of state 'owns' poverty alleviation programme has been launched to deal with mass poverty!

An over view of all those development efforts indicate that the Government is constantly reviewing these programmes and accordingly changing its strategy. Thus it started with growth centre approach to area development followed by sectoral development to individual development. Finally it is concentrating on integrated development.

There are a number of positive evidences of alleviation of worst form of poverty from many pockets within India due to untiring efforts of Government. However the pace is very slow. The major bottlenecks in mediocre impact of Government programmes can be summerised as follows :

- Centralised planning, dubious plan, lack of political will.
- Inadequate budgetary allocation.
- Lack of motivation and commitment in Government staff.
- Lack of integration and coordination at inter and intra department level.
- Lack of people's participation (planning, implementation and monitoring)
- Rigidity in approach.

Some of these weaknesses in Government functioning can very well be overcome by the NGOs. They have motivation and commitment, have rapport with people, enjoy people support and have flexibility in approach. They can provide strong support in grassroot level planning and implementation. They can make people active partners in development efforts of Government which has been lacking till now. Considering their viability, the Government in 7th plan recognised their importance and accordingly devised ways and means to link NGOs in supplementing Government development schemes.

CHAPTER FIVE : NGOs SCENE AND CHANGING ROLES

5.1 The role of the Voluntary agencies is well recognised. These agencies have long been working in their own humble way and without adequate aid for the achievement of their objectives with their own leadership, organisation and resources. They are universal in their origin as old as philanthropic motive in human beings. All reformist in 19th and early part of 20th Century in India started by one or other kind of voluntary organisation. Its origin can be attributed to inequality among individuals as a perenial source of motivation for voluntary action in any society, whatever be the state of its development. In equality may be in material, moral and intellectual therms. Voluntary organisations constitute a societal mechanism for filling up the gaps created by the pressing needs of people and the inadequacy of existing formal organisations and social institutions to attend to those needs.

Like India, Orissa has also a chequered history of NGOs. In Orissa, NGOs originated during 18th Century with reform movements basically out of individual inspirations as part of social obligations and led to various social services and welfare activities. This followed by Gandhian era which was marked by nationalism, patriotism, Swadesi spirit and awareness of people. Post independence era witnessed a marked change in NGOs role assuming more diversified and expanded activities, viz. relief, rehabilitation, welfare and development. The seventies and eighties witnessed more pronounced change in NGOs role which started questioning the societal structure and social justice. They are more radical, activist and aspire for total change. Such aspirations gained ground after Jayaprakash Narayan movements during emergency and based on his concept of total revolution. The student activists during J.P. Movements organised in form of various NGOs are at present pursuing concept of people's organisations, people's power, people's control over resources, decentralise power, social justice and social equality. These NGOs are getting inspirations from various development activities within and outside countries and also taking up issue based development initiatives.

5.2 In Orissa, a fairly good number of NGOs exist. District wise they may not be properly distributed but their presence in all the districts and regions is fairly well established. Like other regions of the country in Orissa also many people with diverse background are attracted in NGOs field with professionalism and technical skills. Mushrooming of NGOs over the last few years has also become a growing trend. The credibility of a few NGOs has weakened due to mismanagement of position/funds, programmes, family involvement, one man show, concentration of power, undemocratic approach, etc. Donors are equally responsible for such state of affairs due to overfunding, personal contact, expansion/continuation without evaluation, inadequate analysis, and sometimes duplication of funds.

Inspite of these limitations and eroded credibility, NGOs are one of the best alternative for meeting people's inspirations where existing government and social institutions fail in filling the gaps. They continue to be the best in terms of independency, flexibility, adaptibility, grassroot perception of problem, rapport with people, concern for people, motivation and commitment to their works.

5.3 In Orissa, the NGOs scenario presents various types of NGOs viz. Social, Religious, Political, Secular, Sarvodaya, Gandhian, Relief Oriented, Developmental, Activist, Reseach Oriented, etc.

The existing NGOs can be classified on various grounds, viz.:

i. Based on ideology, concept and approach

ii. Based on type of activities and types of programmes

iii. Based on area of intervention/issue based/documentation

iv. Based on resources (manpower, material, infrastructure, geographical coverage)

v. Based on affiliation/member of an umbrella/partner organisation/network

The basis of classification may be debatable but the general perception indicates that the state has four types of NGOs viz.

MEGA NGOs	BIG NGOs	MEDIUM NGOs	SMALL NGOs	YOUTH CLUBS/ GRASSROOT NGOs/PEOPLES GROUPS
1	2	3	4	5
Few in Number (2-3)	Few in Number (5-10)	Few in Number (15-20)	Large in Number (50-100)	Large in Number (more than 200 which are active)
Operating in 5-10 district(s)	Operating in 2-5 districts	Operating in 1-2 district(s)	Operating in 1 dist. particularly in 1 block or few GPs	Operating in few villages
Resource Rich (both material & human)	Resource rich (both material & human)	Adequate resources	Insufficient resources	No resources
Decreasing contact with rural mass	Decreasing contact with rural mass	Having working contact with rural mass	Good contact with rural mass	Good contact with rural mass
Sound, high & favourable contact with outside agencies (Govt., Donors, Resource Agencies)	Sound, high & favourable contact with outside agencies	Favourable and sound contact with limited agencies	Frequent contact sometimes favourable or unfavourable	No contact with such agencies

5.4 The inference from the above tabular analysis indicates that NGOs falling in 4th and 5th column are the most potential groups with good people contact but no resources. These are also in good number and spreaded throughout the state. They are able to bring desired changes in the socio-economic condition of state of properly guided and supported. They are small and beautiful. Considering the whole situation of NGOs and after a number of interactions with them, CENDERET observed the following ¥

- Small NGOs lack proper understanding of development concept, lack of clear long term vision;

- Lack systematic and organised intervention, lack common forum to share experiences, lack minimum of material resources, etc.

Thus, if one wants to bring a change among the people of state one has to consider small/grassroot level NGOs as potential group with farily wide presence at village level. This potential group can be rebuild, reoriented and recharged with adequate skill, training and resources to act as harbinger of change.

CHAPTER SIX

CENDERET - NEW ROLE UNDER EMERGING CHALLANGES

So far, CENDERET has assumed the role of facilitator in helping Funding Partners in taking up suitable decisions regarding development projects. Conducting pre-funding assessment study and final evaluation of projects has remained main activities with occassional support in management of projects in case of limited projects. The projects are usually submitted to funding partners by NGOs and they ask CENDERET to conduct feasibility study. Barring a few cases where CENDERET has recommended small NGOs with small projects as "Promotional Projects", majority of projects are appraised after channelising through funding agency.

6.1 Last four years of experiences indicates that the existing arrangement between funding partners and the CENDERET is quite reliable and works smoothly. However, there exists a few gaps which needs immediate action to fill up. CENDERET's perception of problems and new challenges can better be realised in the light of already discussed "status of small NGOs" and "problem districts". Those perceptions are as follows :

i. Majority of small NGOs/Youth Clubs/Village Organisations are deficient in informations related to mode and means of getting outside support (including the funding agencies).

ii. Majority of projects channelised through CENDERET belong to either medium or small NGOs (The latter has limited number).

iii. There exists many genuine small groups whose very survival is threatened without any outside support. They require small and immediate support.

iv. Concentration of projects in certain developed area/district while problem districts remained unaddressed/uncovered. Same is the case with NGOs also.

v. Administrative and operational problems on part of small NGOs and funding partners. In case of funding partners dealing too many small projects become uneconomic and overburden. There is also question of credibility and sustenance of small groups to become long term partners. In case of small NGOs - they lack administrative pre-requisites, experience, staff and infrastructure to prove their credibility and competency.

vi. Domination of big brothers in the functioning of NGOs. Sometimes it tends to curb independency of small NGOs.

vii. Lack of systematic interventions based on problems and area.

6.2 These all necessiates CENDERET to assure new role where it can fill these gaps by taking up suitable actions. The time is opportune now to set on new activities because of a few positive and favourable conditions, viz. :

i. CENDERET has close contact with almost majority of groups in whole of Orissa.

ii. It has initiated networking and presence of District Action Groups in majority of districts provides enough scope to take up new role.

iii. As a Resource Centre it has also well developed training wing both for central and field level which can provide required skills to small NGOs.

6.3 New Role of CENDERET : Promotion and escorting of small NGOs/Youth Clubs/Village Organisations.

6.3.1 Objectives :

- To identify and promote small groups in whole state.
- To help them in identifying problems based on priority.
- To develop their skills (technically and managerially) in managing small projects.
- To help them financially to carry on small projects.
- To empower them and link them to outside agency for sustenance.

6.3.2 Duration : One Year

6.3.3 Target Groups : Small NGO groups/Youth Clubs/People's Organisations (100 such groups)

6.3.4 Target Area : Priority districts/Problems

6.3.5 Planned Activities :

i. Identification and selection of 100 groups.

ii. Identification of issues/problems.

iii. Development of skills (technical & managerial) regarding project management.

iv. Financial support for small projects.

v. Networking at district level.

vi. Escorting and follow up.

6.3.6 Required Staff at CENDERET :

FACULTY (PART-TIME)	-	Ø1
PROFESSIONALS	-	Ø4
TYPIST	-	Ø1
ACCOUNTANT	-	Ø1
DRIVER	-	Ø1

6.3.7 Implementation :

(A) i. Identification and Selection of 1ØØ Groups : CENDERET has already initiated Networking among small groups of NGOs in whole of Orissa. The ceaseless effort of CENDERET during the last two years has resulted in establishment of District level Action Group (DAG) in 15 districts of Orissa. These DAGs are forums of NGOs (majority of them are small groups/people's organisations) with common understanding and approach. On an average each DAG has 3Ø to 5Ø NGOs. Thus CENDERET is in contact with approximately 4ØØ small NGO groups. This wide contact can provide better scope for selecting 1ØØ small groups for the said project.

ii. Identification of Issues/Problems : During the formation of DAG, CENDERET involved all the member NGOs in the "process of people's oriented planning". Each NGO was assigned to undertake such process on experimental basis in five villages in their operational area to identify problems, prioritise it and develop people's plan of action. Such exercise helped in identification of priority problems based on people's perception. Besides, the secondary information will also help in indentifying most pertinent issues (statistical figures of block, district and state).

iii. Developing Skills Among NGOs : As mentioned earlier, these small groups are deficient in required skills to carry on the project formulation and management, mainly due to poor human resources. CENDERET is doing its best by upgrading skills of personnel engaged in small NGOs through its centrally and field based training programmes. Under this project such efforts will be doubled to upgrade the skill of NGO personnel to take up more responsibility and accountability in dealing with developmental projects.

iv. Financial Supports to Small Groups : A consolidate grant will be made available to CENDERET which will be directly channelise to NGOs groups. The amount of money provided to these groups will depend upon the capability and competency of NGOs in relation to proposed project. The amount will range from Rs.50,000 to Rs.1,50,000 per group.

v. Networking at District Level : The networking of NGOs will be continued at district level. CENDERET would take efforts to strengthen these groups by initiating number of common actions. These groups will be made cohersive, inter related and inter dependent so that a symbiotic relationship can develop. Latter on state level networking can also be started depending upon the need and aspirations of these groups.

vi. Escorting and Follow-up : Initially for one year CENDERET would provide escort and follow up support to these NGOs. Once the capacity of NGOs is developed by upgradation of human skills and provision of financial support to take up and manage small projects, the responsibility of CENDERET ends. It is now all depend upon the NGO to seek further assistance from CENDERET or from outside agency.

(B) **Staff Responsibility :**

Part-time Faculty would be responsible for overall project monitoring, evaluation and reporting to funding partner.

Professionals : Each Professional will look after 25 NGO groups / projects.

Accountant and Typist would provide supporting services in time.

6.3.8 Monitoring and Evaluation :

CENDERET would monitor the project every quarter. Quarterly report related to project progress and financial details will be provided to funding partners by CENDERET. The NGO groups will provide financial and physical reports to CENDERET every quarter and CENDERET would compile and send it to funding partners.

CENDERET would directly receive the funds and would accountable to both Ministry of Home Affairs and funding partners regarding the channelisation, financial reporting, auditing and accountability.

6.3.9 Other Details :

The proposed arrangement is only for the said project. The long term projects or the NGOs outside the existing arrangements will continue to follow the earlier/existing arrangements, i.e. their projects will be channelised through the funding partners, entrusted to CENDERET for appraisal and final decision by the agency concerned. In case of small NGOs who directly approaches to funding partners can be accommodated in the said project on decision of funding partner. Thus earlier arrangement will continue unchanged. The said project is only for small groups mainly of DAG members. After one year of implementation the continuation can be thought of based on emerging trends.

B U D G E T

A)	ADMINISTRATIVE COST :		
i.	Salary to One Part-time Faculty Member @ Rs.4000/-p.m. (4000 x 12)	48,000.00	
ii.	Salary to 4 Professionals @ Rs.4000/-p.m. (4000 x 12 x 4)	1,92,000.00	
iii.	Salary to 1 Accountant @ Rs.2500/-p.m. (2500 x 12 x 1)	30,000.00	
iv.	Salary to 1 Typist @ Rs.2000/- p.m. (2000 x 12 x 1)	24,000.00	
v.	Salary to 1 Driver @ Rs.2000/- p.m. (2000 x 12 x 1)	24,000.00	
vi.	Cost of one Four Wheeler	3,00,000.00	
vii.	Fuel & maintenance @ Rs.10,000/- p.m. (10000 x 12)	1,20,000.00	
viii.	Stationery and Audit	30,000.00	
ix.	D.A. to 1 Part-time Faculty Member, 4 Professionals and 1 Driver @ Rs.1500/-p.m. per person (1500 x 6 x 12)	1,08,000.00	8,76,000.00
(B)	Support to 100 NGO groups ranging (Rs.30,000 minimum to Rs.150,000 maximum)	75,00,000.00	75,00,000.00
	TOTAL COST OF THE PROJECT		**83,76,000.00**

(RUPEES EIGHTYTHREE LAKHS SEVENTYSIX THOUSAND ONLY)

N.B. : THE COST OF THE JEEP WILL BE INCLUDED ONLY IN THE FIRST DISBURSEMENT. FROM SECOND YEAR ONWARDS ONLY ADMINISTRATIVE COST WILL BE DISBURSED.

APPENDIX - 1

MAJOR SOCIO-ECONOMIC INDICATORS OF DIFFERENT DISTRICT

Sl. No.	Districts	% Distribution of Geographical Area	% Distribution of Population (1991)	% of Decinnial Growth Rates (1981 - 91)
1	2	3	4	5
01	BALASORE	4.05	8.87	24.13
02	BOLANGIR	5.73	5.41	16.77
03	CUTTACK	7.16	17.46	18.89
04	DHENKANAL	6.95	6.03	20.08
05	GANJAM	8.06	9.97	17.72
06	KALAHANDI	7.56	5.05	16.77
07	KEONJHAR	5.33	4.17	18.03
08	KORAPUT	17.32	9.52	20.77
09	MAYURBHANJ	6.69	5.94	18.33
10	PHULBANI	7.12	2.72	19.70
11	PURI	6.54	11.33	22.72
12	SAMBALPUR	11.25	8.53	17.86
13	SUNDERGARH	6.24	5.00	17.23
	ORISSA	**100**	**100**	**19.50**
	INDIA	-	-	**23.56**

% of SC Population to total population (1981)	% of ST Population to total population (1981)	% of Backward population (SC + ST) to total population (1981)	% of main workers to total population (1981)	% of Agrl. Labourer to total main workers (1981)	% of C ators total worker (1981
09	10	11	12	13	14
17.94	6.84	24.78	27.20	25.63	53.56
15.64	19.22	34.86	34.90	30.84	51.00
17.67	3.13	20.80	27.65	23.71	44.72
15.83	12.26	28.09	31.53	27.87	46.01
15.02	9.48	24.50	34.75	32.46	42.13
15.76	31.28	47.04	35.94	35.59	50.74
11.16	44.82	55.98	32.41	22.67	50.48
14.06	55.22	69.28	38.85	28.47	53.99
6.58	57.67	64.25	38.26	33.60	46.92
18.55	38.94	57.49	38.88	29.58	52.88
12.93	3.45	16.38	29.14	23.25	44.25
15.35	27.21	42.56	36.39	30.46	42.62
8.52	51.26	59.78	32.41	18.11	37.65
14.66	22.43	37.09	32.75	27.76	46.94
15.80	7.80	23.60	33.50	24.90	41.60

% of SC Population to total population (1981)	% of ST Population to total population (1981)	% of Backward population (SC + ST) to total population (1981)	% of main workers to total population (1981)	% of Agrl. Labourer to total main workers (1981)	% of C ators total worker (1981
09	10	11	12	13	14
17.94	6.84	24.78	27.20	25.63	53.56
15.64	19.22	34.86	34.90	30.84	51.00
17.67	3.13	20.80	27.65	23.71	44.72
15.83	12.26	28.09	31.53	27.07	46.01
15.02	9.48	24.50	34.75	32.46	42.13
15.76	31.28	47.04	35.94	35.59	50.74
11.16	44.82	55.98	32.41	22.67	50.48
14.06	55.22	69.28	38.85	28.47	53.99
6.58	57.67	64.25	38.26	33.60	46.92
18.55	38.94	57.49	38.88	29.58	52.88
12.93	3.45	16.38	29.14	23.25	44.25
15.35	27.21	42.56	36.39	30.46	42.62
8.52	51.26	59.78	32.41	18.11	37.65
14.66	22.43	37.09	32.75	27.76	46.94
15.80	7.80	23.60	33.50	24.90	41.60

Yield rate of food grains in Quintals per hect. (1989-90)	Normal rainfall (in mm) during 1989	Actual rainfall (in mm) during 1989	% distribution of agricultural credit cooperatives (1988-89)	% of literacy (excluding population ag group 0-6 yrs (1981)
25	26	27	28	29
11.96	1568	1641	8.94	42.06
11.67	1444	1047	7.77	25.63
12.98	1501	1396	20.01	45.43
10.53	1421	1299	6.74	36.88
14.18	1296	1177	18.30	31.31
8.22	1378	1072	3.62	19.42
10.05	1535	1504	1.70	30.22
10.49	1522	1236	2.13	16.13
10.01	1648	1524	1.95	25.71
9.91	1597	1340	2.27	27.08
13.55	1449	1245	19.08	45.50
12.73	1527	1171	5.82	33.83
7.92	1648	1040	1.67	36.17
11.44	1500	1260	100	34.23
N A	N A	N A	N A	36.20

Persons employed in registered factories in '000 (1987-88) (P)	% of villages electrified (1989-90)	Length of roads (as on Mar. '90) per 100 Km² of area (in Kms.)	No. of medical beds per lakh of population (1989-90)
33	34	35	36
3	77.78	24.98	23
3	73.40	18.18	37
16	83.27	37.00	51
5	73.21	17.30	34
3	63.62	13.91	64
1	50.92	14.92	48
3	75.70	16.19	49
5	40.73	14.00	45
2	56.51	23.11	38
S	27.56	14.69	68
35	81.13	27.45	50
14	69.20	16.31	70
29	79.82	15.54	84
119	64.02	19.52	50
N A	80.20	N A	91

NOTE : Figures given against the year 1991 are provisional
S = NEGLIGIBLE P = PROVISIONAL N A = NOT AVAILABLE * = DUR

SOURCES : 1. ECONOMIC SURVEY 1990-91, PLANNING AND COORDINATION DEPARTMENT, D
FEBRUARY 1991, PP. ANNEXURE A-79 - A-99

2. STATISTICAL ABSTRACT 1991, DIRECTORATE OF ECONOMICS OF STATISTICS


BIHAR
SUNDARGARH
SAMBALPUR
KEONJHAR
BARGARH
SONEPUR
ANGUL
DHENKANAL
BALANGIR
CUTTACK
NAWAPARA
PHULBANI
NAYAGARH
KHURDA
NOWRANGPUR
KALAHANDI
GANJAM
RAYAGADA
KORAPUT
GAJAPATI
ANDHRA PRADESH
MALKANGIR
BAY OF B
State boundary
District boundar
Railway

Workshop health care policy Memisa and Partner organizations in India.

Some issues for discussion.

The outline of Memisa's policy in the promotion of health in India is reflected in a separate document.
The **main objectives** of this policy as relevant to the assessment of project proposals are:

1. The prevention of untimely death from preventable and treatable diseases.
2. Enhancing the quality of life through sound and culturally appropriate interventions in main determinants of health and disease.
3. The strengthening of community organizations and empowering of communities in examining their own situation and in shaping their own health care system.

As the main **strategies and methodologies** as mentioned are:

The promotion of Organised Community Participation
The promotion of Effective and good quality curative and preventive services available to the population
Fostering Cooperation between Community, NGOs and the Government.

Criteria needed to assess to what extent the project proposal includes above main objectives and uses the mentioned strategies can be determined, based on local as well as international standards.
One can distinguish criteria concerning the organization and its effective management as outlined by Mr. Joost van Pijenbroek and criteria towards desired interventions and goals. Criteria are not only measurable indicators but also limitators, they can be used as outcome or as starting point, but are certainly related of what is desirable, what can be achieved and at what cost to the community, the NGO or the funding development agency.

Let us take the **infant mortality rate** as indicator and as criterium. If the rate is 120/1000 than the position of children is certainly a sign of a serious wastage and reflecting a state of severe underdevelopment of that community.
It is therefore a criterium to start an intervention and to examine ways and means to improve the humane condition. Lowering the IMR is at the same time an indicator for achieving ones goals. It is a limitator if a community has an IMR of say 50/1000 in view of a country's average IMR of say 100. In that case a good project is carried out in the wrong place, as long as their are areas where the IMR is still much higher.

Should one ask for an ultrasound apparatus in a hospital if the nearest place for a women to deliver is 30 km from her home or should one undertake a training programme for TBAs and assist in building a small clinic with a delivery bed and with a midwife near her home. Criteria can be formulated as to **accessibility of essential health care services** for pregnant and delivering mothers. It is a positive criterium if mothers can not reach a HSF with the means of transport available (criterium 80% of population within 1 hour travelling distance of a HSF). It is a negative criterium if there is duplication of services .

An important criterium is the **financial feasibility** of health interventions. Given the aim of self-reliance or community empowerment and the fact of very limited resources available for health care, methods and means to be made available should be within the affordable limits of resources available to the community.
The cost of a choice of first line and certain second line curative care should in principle be born by the consumers, if not on an individual bases than on a collective bases. To put services on a higher level, initial investments in infrastructure and human resources can be above what can be carried by the population (estimated at 5-10% of annual per capita income) if these investments will not result in permanent running costs above the affordable. It should be clear in this case that $5 per capita running cost is very high, but as a one time investment may be feasible in poor communities.

On this basis transport requests, especially for cars, have to be measured against the level of financial support/benefit to the population. Depending on community's income a car should serve at least 40.000 people to become feasible. Else the car is rather for the NGO than for the project's beneficiaries. Alternative means of transport, affordable by the beneficiaries like bicycle and moped should be examined. should one burden the community with a big car.

A **quality criterium** applies to human resources and its deployment. Matching need, function and qualification is often neglected or inappropriate.
For instance, at the first line rural clinic, catering for up to 4000 people one needs a qualified, supervised and supported ANM, equipped to do MCH functions, conduct safe deliveries and treat most of the common and life threatening condition according to safe, sound and laid down procedures (protocols). Such a rural clinic should at least have one delivery bed and one resting bed. It should have basic equipment for a normal delivery and means to sterilize those.

Quality criteria also apply to the use of **essential drugs**. They should be of proven quality and staff using drugs should be well trained in diagnosing and treating common condition according established protocols. One still find applications containing dangerous drugs and obsolete practices from NGOs who claim to have a MBBS doctor in the board.

Quality criteria also apply to training and supervision. If the good willing retired doctor still prescribes drugs banned in the 60-ties, than it is no wonder people turn to so called alternative often unproven systems of treatment.

Criteria in community health also apply to **coverage**. Which section of the population is benefiting from which services. And how is coverage measured. Scientifically sound but simple surveys, involving the community itself (Participatory Research Action, focus group discussions) are both useful to follow progress and to set new criteria for achievement. Without advocating the so-called selective PHC, any community health programme should address health problems that are a major concern to the people, are frequently happening, are serious enough as causing death and disability and that appropriate tools for its prevention and cure exist. Clear coverage figures like 100% of all children in the project area should get all immunizations and 100% of all pregnant women should be seen by a qualified ANM at least once during her pregnancy are universally accepted. Possibly 40% of all women should deliver with the assistance of an ANM, all others with the assistance from a TBA.

An other aspect of quality is **efficiency** as it relates to cost/benefit ratios. What good does an intervention do and at what cost, Can the same be reached at lower cost. Can a temporary expensive outreach service with a jeep be changed into a permanent community based one with locally developed skills? There are many examples of Charity NGOs who live 60 or more km away from the project area, going up and down every day. At what cost to the community?

It also relates to **effectiveness**. Is the method employed the best and the cheapest to reach the objectives.

Quality is also a **question of balance**. Should a hospital have an X-ray if it does not even have a qualified midwife to do normal deliveries and a doctor to do a simple caesarean section. Or have a cobalt radiation unit if it can not even provide itself with basic equipment.

Criteria as towards community participation can be formulated. Often projects apply standard methods like "one health worker per village" which have proven to be ineffective in promoting community participation. Criteria as to broad based group wise activities should be determined where possible. Such social group members should not be paid for activities for their own interest by **outside** funders. For training an investment can be made.

Criteria for Appraisal, Monitoring and Evaluation

1. The NGO

1.1. Organisational criteria

- The NGO should be a legally registered body
- Composition of governing Board should be looked at, the number of women members and disadvantaged group members is to be taken into account.
- the vision, mission and objectives of the NGO should be clear
- The NGO should have an accountancy system that is according to international standards; the internal financial controlling mechanism should be looked at, only double signaturies of bank accounts are allowed.
- the NGO should have an annual activities report and audited accountancy report
- the system of decision taking should be looked at and a fair participation of all levels of the organisation should be there. The system of internal reporting should also be looked at with an assesment of the internal monitoring.
- The NGO should be capable of executing the project according to plan. Factors that should be looked at are previous experience of the NGO, composition and competence of staff (qualification, experience), previous reports, number of contacts and activities to be maintained/executed by every senior project officer working in the NGO, detailed planning of work for the first year, etc. A SWOT analysis (strenghts/weaknesses and opportunities/threats) is to be made for each appraisal.
- The NGO should have an as much as possible equal presentation of men and women at all levels within the organisation. If not the NGO should have an adequate explanation why not.

1.2. Institutional criteria

- The target group should, in one way or another be involved in the NGO at decision taking level. The target population should also, and not only in a passive way, take part in the evaluation of the program, be aware of it's report and it's follow-up. Only through local participation in financial contribution, in participation in decision taking and by justifying it's activities toward the communites institutional sustainability can be obtained. The NGO should be service and client oriented. Members of the communities involved should explicitly be present in the board of the NGO and should have proven influence.
- The NGO should collaborate with all other actors in the field of health in the region concerned. This implies state activities, other NGO or PO activities, religious health institutes, etc.
- The NGO should as much as possible define linkages with other sectors and activities therein such as agriculture, education, etc. It should know what other actors are working in those sectors, (be able to) define where synnergetic collaboration is possible and realise this as much as possible.
- an institutional map is to be drawn for eacht proposal

2. The program

2.1. sustainability

- Financial sustainability should be obtainable in the short term for all curative activities. Only a starting subsidy can be considered.
- Those activities that enhance the knowledge and capacity of people are to be considered as an investment in human resource and do not require financial sustainability. For reasons of avoiding charity and all it's negative side-effects a local participation should though be

required.
- no reservations for depreciations are required.
- running costs of community health care can in the present stage of development not be considered as feasible to be brought up by the community and are elligible for external funding with the remark though that local financial participation is required (no charity) to the maximum extent.
- institutional sustainability is to be assured in networking and local participation
- what other sources are available on the long run for the program
- There should be a fair relation between the costs of the program and the expected result.

2.2. PHC

Memisa is supporting programs in all elements of PHC but is putting it's emphasis on the following main aspects of PHC:
- Community Based Health Care.
- the provision of good quality health care to deal with local endemic diseases at the level of the community, the peripheral HSF and the first level hospital.
- the promotion of the use of essential drugs and the prevention of bad prescribing habits of medical and para medical staff.
- the prevention and treatment of tuberculosis, leprosy, STDs including HIV, cholera and other epidemic and endemic diseases
- the prevention of neonatal tetanus and common childhood diseases by immunization of pregnant mothers and children.
- the promotion of reproductive health, including the prevention of unsafe abortions, addressing specific health care problems of women; the prevention and treatment of STDs, education and training for reproductive health and health care including family planning. The promotion of safe deliveries by antenatal and post natal care for mother and infant.
- the promotion of good nutrition and growth, especially of children.
- the promotion of hygiene, water and sanitation to prevent water related infectious diseases.
- the promotion of appropriate care of persons with mental illness, the promotion of oral health and the prevention and treatment of eye diseases and blindness.

2.3. Project design

- Each project should be designed according to the logical framework. This includes well defined indicators and assumptions at all levels (i.e. intermediate results, project purpose and overall objective)
- Each program should indicate at the phase of presentation on which topics monitoring will be effectuated and at which level.
- Each program should indicate on which topic reporting to the support agency will be done.
- Each program should be based on a proper problem analysis of the region and population concerned.
- A base-line survey is to be executed ultimately in the first phase of a program if it concerns a long-time integrated regional health program.

REFLECTIONS ON THE PAPER? ' PARTNERS IN HEALTH: CHALLENGES FOR THE NEXT DECADE.

We at CHAI take this opportunity to appreciate the well worked out paper based on various factors by Dr.Ravi & Mrs. Thelma.Though CHAI fully agrees with most of the points, it also wants to put on records some of the observations and concerns.

THE SHIFTS:

1) The shift from South to other parts of India to be carried out in phased manner. Though South seems relatively better of than other parts of the country, still the same issues/problems are verymuch present and in certain pockets very acute than the other parts of the country.

2) In this shift, the CHAI member institutions will get much affected as most of them are functioning in very remote and equally deserving areas in South.

3) In the shift from large projects to smaller, we do need to have two points in mind:

a) Too many smaller projects will eat up more money in terms of salary and other administrative expenses. On an average any given project has 40% to 60% expenses slated for the above. Hence we need clear understanding in this issue.

b) Certain larger projects are also necessary as training and research activities could be carried out by such organizations only.

c) Focus also need to be given to People's Organizations network and not necessarily all NGOs consortium etc.

NETWORKS:

1) To initiate networking at each State level, we could also think of using the already existing federal network of the RSOs.

b) If we think in terms of othernetworks, then the network to be studied and the nearest RSO could be asked to verify the credibility before accepting the network by MEMISA.

c) Criteria to be worked out to identify such networks.

DESK STUDY:

Criterias could be worked out to reject projects at desk study level itself and this could be the common yard stick for MEMISA and RSOs.

SUSTAINABILITY:

1) The question of sustainability to be thought of not only on financial viability, but also in terms of HRD, and also the withdrawl of the field partners.

2) In planning sustainability, a definite time frame could be suggested for the projects, though exceptions can be allowed.

INTER FUNDING AGENCY DIALOGUE:

1) This is a must. But we need to fix the party responsible and also a time frame for the event to take place.

2) This could also be a forum to network and to create understanding to avoid duplication of work in a given area or a particular partner.

HEALTH HUMAN RESOURCE DEVELOPMENT:

1) The quality of training is to be focussed as mushrooming of nursing schools is the trend of the day. and in addition nurses are much wanted outside the country.

2) New courses to meet the current need could be encouraged and a network of training centres to be identified and recommended for this purpose to make MEMISA scholarship available.

TRADITIONAL SYSTEMS OF HEALTH CARE:

1) TSHC has been verymuch commercialised. So, even in promoting the system, caution has to be taken as to how this is going to be promoted by the NGOs.

2)

GOVERNMENT RECOGNITION: PARTNERS IN DEVELOPMENT:

Though partnership is often talked about, the NGOs are used more at the implementation level than planning. Hence both MEMISA and other partners have to lobby for real partnership.

GRASSROOT PARTNERSHIP:

1) More clarity needed in terms of its practicability. Once such an initiation taken,during mid or post evaluation the RSO finds discrebancies, the RSOs are scorned at.

2) In case MEMISA strongly beliebes in free partnership, then criteria needs to be worked out and also the levels of partnership.

3) Clarity needed on the relationship like;

MEMISA - RSO - NGO - People

CRITERIA FOR PARTNER SELECTION:

1) For Block grants, the criteria could also include the following: geographically backward area, lack of availability of resources in that area, other interventions in the area.

PROJECTS TO MOVEMENTS:

We need more clarity, and also the criteria to assess such movements.

BLOCK GRANTS:

1) CHAI has already requested to increase the block grant amount and thus from discretionary fund, it has become CHPF and this idea could be further strengthened.

2) CHAI's support goes roughly 50% to 60% to non-church related groups only and this trend will continue and hence there is no need for fear of supporting only church groups.

STATEWISE ANALYSIS:

The statewise analysis has brought out the need for searching RSOs. Our recommendation would be that the federal units of the existing RSOs could be made use of as they are already exposed to such experiences.

BUDGET PROFILES:

The infrastructural development is no more supported by CHAI and CHAI screening committee also ensured this.

MONITORING & EVALUATION:

The AME paper of CHAI could clearly state that definite format is available for monitoring & evaluation.

FEEDBACK FROM PARTNERS:

We also agree with the idea of project period support to be increased and our recommendation would be the minimum period could be 18 months and the maximum could be 5 years.

J.V.

DRAFT

Policy options of Memisa for supporting health care development in India.

PHC

Memisa's policy in health care in developing countries largely follows the Alma Ata formulation of primary health care, including as it does all aspects of preventive, promotive and curative care.

It aims at strengthening health care institutions and making them relevant to the health needs of the community they serves. The policy puts emphasis on strengthening communities in shaping their own health services and to work for conditions that promote a healthy living. It links the community efforts with their own health care institutions of which they form an integral and determining part and to which they contribute to its upkeeping.

It aims at making available sound, effective, proven and scientific justifiable technologies at the appropriate level and affordable to the community and the state.

The role of the health services.

The health services should respond to observed and perceived health needs of the community. It is characterized by a mix of institutional investments and a professional and ethical body of staff. It is primarily geared towards serving the community rather than itself. It is therefore non-profit in nature but not charitable in its approach, as its ownership or at least its mandate should be or come from the community itself or be an organization rooted in the community (church, NGO, CBO etc.)

The role of the community

In the area of health care, communities can be defined as a group of people characterized by a certain geographical location. A health care service should therefore be accessible for all people in the locality without discriminattion on sex, race, tribe or religion.

However as it comes to sustainable community organizations, social grouping may have to be accepted, especially as the poor are often victims of discrimination themselves and only as a group they may succeed in attaining equitable access to health care.

Emphasis within the organization of community based health care should be put on the group formation process, rather than in appointing, training and managing from outside individual community health workers.

It has been shown in the most successful CBHC programmes that health action groups or care groups are able to attain fundamental changes in society, which may lead directly or indirectly to better living conditions and an improved health status.

Differentiation in function and capability of members within the group through specific training of latent or existing skills (TBA's, Traditional. Healers, first aider, etc.) can be stimulated. The group should be structured in such a way as be cultural viable and internally sustainable as an organization. It will have the capability to obtain and to manage its own resources, to set its own objectives and to carry out and evaluate its own activities.

The ultimate intermediate goal is a sustainable community organization changing it self and the community of which it forms an integral part, with the aim of attaining better health for all (see annex for logic framework).

The role of NGO's and CBO's.

NGO's as intermediate organizations between a funding source and the ultimate beneficiaries, should be duly registered and constituted according to Indian law. They maintain a transparent financial accounting system, open to scrutiny from the funding agent and representatives of beneficiaries and/or the public. The NGO produces an annual activities report and audited accountancy report, in which it makes clear in what way funds have been spend and who benefited from the funds and in what way.

CBO's are small unregistered organizations of beneficiaries, who manage their own resources in a group process.

They may receive co-funding or support in kind, such as training and materials from a coordinating or supervising NGO.

Memisa may support directly NGO's and through them indirectly CBO's. A **functional** relationship between NGO and CBO should be existing and be continuous until such time the CBO has become self sufficient.

Funding of CBO's should be limited to a maximum of 25% of their own input on an annual bases. In that case labour and opportunity cost can be monetized.

The role of the government.

In the Indian context, a large share of the curative and preventive services are provided by a more or less dense network of government health service facilities, offering a variety of health services according to the specific level. Some vertical, often not integrated, programmes(FP, EPI, TB) are attached to the units. Perception of quality of care is very variable.

Through community health action groups and the mechanism of the Panchayat Raj the availability and quality of care may be influenced. However in practice, the medical and paramedical employees, being civil servants, have no obligation towards the consumers as treatment is in principle free of charge. However in practice people have to pay for decent services, either through a direct charge or through the purchase of drugs in sometimes provider related private pharmacies at high prices.

The low perceived quality of care and the cost of (non)essential drugs and the poor prescription of unnecessary drugs with inherent side effects, turn people away to seek alternative ways of treatment.

Programmes aiming at influencing proper care at government institutions could be supported by Memisa.

The role of the government in community based care is limited by nature of the vertical organization itself.

Cooperation between CBHC groups and the government health service facilities could result in improved health coverage and care. Memisa would consider support to local, ward, block or possible district size programmes with this aim.

In view of the expected dissolution of government executed health services, NGO's should be prepared to take over those health service facilities which are useful to serve the community. Study and training support to run health service facilities efficiently could be a part of Memisa's policy, as it empowers local people to manage their own health services according to their own needs. The same would account for existing NGO health services.

Training and support of traditional birth attendants and nurse midwives(ANM) at peripheral level are important aspects for support.
The main aim is to reduce the infant mortality from around 120 to 50/1000 live birth. Areas where this lower figure has been achieved are not priority areas for Memisa as long as high infant mortality areas are present in the country.

Reproductive health

Memisa does support the intentions of the Cairo declaration on reproductive rights and care. This declaration aims at improving basic education of women, knowledge of reproduction and reproductive rights and access to reproductive services.
Specific elements arising from the declaration are: lowering maternal mortality by diminishing unsafe abortions; by good medical care and support for survivors of unsafe abortions; by prevention of unwanted pregnancies and by safe deliveries.
It further addresses gender roles, discriminatory practices disadvantaging women or limiting access to food, work, education and the right to self determination of reproductive abilities.
The prevention and treatment of STDs, a major cause of ill health in women is part of the policy to improve women' health.
The role of males in this process of change is essential to its success.

Family planning should be available at community level (CBD) or at nearest dispensary or health centre, be convenient to its users, offer an informed free choice of available methods, including short term methods, medium term methods and permanent methods. Training of staff in client centred reproductive care is an important aspect for support.

Memisa will not support "natural family planning only" programmes as its cost/benefit has been generally very low.

Other common diseases/ health problems.
The development and application of appropriate technologies to deal with common endogenous diseases and its prevention and, where possible, to put those technologies in the hands of the community and its organizations, will be part of Memisa's policy. This may include Oral Rehydration Therapy, safe water supplies, sanitation and hygiene measures, home treatment, safe and economic fire places to prevent burns and safe the environment, better housing, malaria prevention, local weaning food production etc.
Coordination and integration with a local health care provider should be aimed at.

Alternative, endogenous, traditional health care systems
Every culture has its own traditional system which people use for the relief of common symptoms. It is part of folk wisdom, and does not always need to reflect a proven effectiveness. As it is very difficult, in fact often impossible to assess its objective value(like the German system of homeopathy), it is Memisa policy not to intervene nor to invest in alternative systems of treatment.

Health economics.

As many governments and NGO's find it increasingly difficult to meet basic health needs of populations, a critical analysis of accessibility and affordability of quality health care is becoming an important subject of concern.
Memisa would therefore support studies and pilot interventions in health service facility

Specific programmes

TB/HIV/STD

Tuberculosis is together with AIDS/HIV an important contribution to ill-health in communities. It is primary the responsibility of the government to make provisions available, but it may be the role of community organizations to link those who need treatment with the available services.

Care and follow-up of clearly felt community needs can form a strong motivating factor in the shaping of community health activities and action groups. A process that would be the core of Memisa policy towards improving health care through community participation and government or NGO technical support. National guidelines have to be followed where feasible.

Preventive and promotive measures, and change in attitude and behaviour of people is within the realms of community health and could be supported. Within such a framework, training, follow-up and at a limited scale TB drugs[SCC 2RHZS(E)/4HE(T)] and certain drugs for opportunistic infections related to HIV infections may be made available by Memisa.(see annex for logic framework).

Concerning the HIV/AIDS epidemic, activities should, as much as possible, be integrated with other community health concerns . The set up of parallel vertical programmes, although initially maybe useful to focus attention, are difficult to maintain in the long run.

The focus will be on awareness creation, studies on sexual and reproductive behaviour and STDs and based on that, to search for possible avenues for an effective approach aiming at changing behaviour. The promotion of safe(r) sexual practices and the use of STD prevention devices(condoms) to groups at risk is recommended within the broad frame work of gender relationships in society.

Essential drugs.

Memisa encourages the use of essential drugs. This would include the promotion of its principles and the training of prescribing staff at hospital, HC and the village level, as well as staff engaged in procurement, stocking and distribution of essential drugs.

The main aim would be to have essential and affordable drugs available and prescribed according strict protocols as to promote its usefulness and to prevent abuse, polypharmacy and side effects.

Traditional drugs and practices belong to the community practice.Those traditional methods identified as not harmful to health can be a compliment in the treatment of certain symptoms. They do however not replace essential drugs for life threatening conditions and infectious diseases. Memisa will not fund specifically traditional forms of medicine or research thereof as a priority.

Integrated Care

MCH including Immunizations.

One of the core groups targeted for Memisa support is the mother and her child. Continuous care from the the earliest stage of pregnancy, through safe delivery at the appropriate level (home or under professional supervision) and the care of the mother and her infant. This would include immunizations for mother and child, nutritional and growth monitoring, the promotion of breast feeding, the prevention of infectious diseases and the promotion of a safe environment for mother and child.

management and health care financing systems.

Sustainable health care at the level of the institution has several determinants.
These being:

- the level and type curative services needed for the appropriate population level;
- the cooperation with referral health institutions;
- the optimal management of the health care institution;
- the mix of personnel employed according to defined tasks and roles;
- the organizational frame work of the health service facility and the role of the community in such an institution;
- the potential contribution of the population towards cost recovery;
- the possibilities of community financing systems (HSO's., Insurance systems, Gramin banking system);
- the contribution from local and central government;
- the level of external support.

Sustainability at the level of the community is a function of the community organization, with directly or indirectly health as its goal and motivating power.
Memisa is prudent in financing community level activities as not to endanger the focus of the community or its CBO towards the donor but to the community as its resource basis.
Inputs at community level should therefore be limited by initiating conditions under which a viable community health action group can be functional. **Supporting a process** rather than financing its structure would be the chosen Memisa policy. (see annex for logic framework)

Health Service Organization.
It appears that hospitals, Health Centres and Dispensaries(village level health service facilities) have been closed, not due to lack of mission but due to lack of economic sustainability. These problems may arise from lack of efficiency on the one side, and insufficient linkage with the the community and its needs.
While private for profit institutions and practices are sometime flourishing, the NGO hospital is unable to cope.
Memisa would support studies to examine the role of NGO health service facilities in a particular community and to study efficiency issues and to determine which health service model would be economically feasible and fulfil its obligation to deliver decent health care also benefiting the poorer section of the communities.
It is realized that any health care institution will have to act within an emerging market economy and not in a single supply monopoly as in the past.

There seems to be an imbalance between the number of doctors and nursing staff available in peripheral health units. Doctors are underutilized and relative expensive in comparison with overutilized but inadequately trained and supervised nurses. The imbalance is partially caused and maintained by entrenched power structures of medical and nursing councils.

Greater emphasis may have to be given to the training of all round doctors for rural services, able to treat all common diseases and carry out basic surgery and obstetric care (including Cesarian sections). An important second aim of Memisa is to increase the participation of nurses at all levels of the health services. In this regard improved and adapted training

programmes and facilities for nurses to take up PHC roles could be studied and supported. It would aim at extending the roles of nurses as primary providers of health care, to improve its quality and to improve the status of nurses within the medical profession. It would also enhance the role of women in the health care system and the population as a whole.
Appropriate community nursing training could be studied and supported.

Having observed the lack of professional support to peripheral health service facilities in carrying out all aspects of PHC, including community participation in health promotion, there appears to be a great need for training and guidance to increase the capacity of such HSFs.
Within the church health system, Memisa would consider to support the **professional coordination** of integrated health care activities within a diocese.

Health information systems(HIS) are not used at all level of the health services in such a way as to make self evaluation possible. Memisa would support initiatives to investigate the needs for and assist in the design and introduction of an appropriate system of HIS. The WHO/Medicus Mundi system and the Memisa/Bilance assessment system for small health units may form the basis for such an undertaking.

In monitoring health care support provided by Memisa cluster sample surveys and other appropriate surveillance tools may be designed and employed to monitor changes in parameters connected to stated objectives of health interventions.

Management and financing.

Projects directly or indirectly supported by Memisa would ensure to have a professional management and a clear internally efficient and democratic organization. Financial transparency should be maintained within the organization and towards fund providers and to its beneficiaries(c.q. the public). Authorization for major expenditure should be by double signatory, reflecting unrelated persons within the organization. Official Bank accounts should be kept while an audited annual financial report indicating all funds received from all donors (local and internationally) and all expenditure by project is presented.
It is Memisa's policy to examine the constitution of NGO boards of government/management board with the aim of promoting the participation of women in leadership roles within the NGO's and their programmes.

Integrated approach
In considering support to health programmes Memisa would promote the cooperation with all health providers in the area as to prevent competition or duplication of services. Such an approach finds it reflection in the proposed **district health care concept** or smaller entity within the district as is feasible.
As the smallest administrative entity the coordination of health service at the Panchayat Raj level is indicated.
Centrally is the health service area concept, in which the HSF and the community determine priorities and the health services in the area.
Memisa would, where feasible, promote that different types of services are made available at the same HSF at the same time (supermarket approach) and the organization of a feasible bi-directional referral system.
Memisa would support studies to set up quality control systems and to provide means for appropriate training to enhance the quality of care at all levels.

The multi-sectoral approach.

Health has many determinants besides those directly dealing with cure and primary prevention of endemic and epidemic diseases. As health determining sector the following can be mentioned:

the role of primary education, literacy (health educational)
the role of income generation in financing health care.
the role of food, food production and nutrition
environmental health
water and sanitation
human rights, the poor and the rich
religion and politics.

As Memisa will not be able to finance all related sectors within one programme. Cooperation with other partners in the field as well as with other funding agencies has to be sought. However within such consortium or cooperation, the transparency of the Memisa supported health section should not be lost.

Desirable mix.

Memisa will not support single items to curative or community health. Preference is given to project or programme support providing the full and integrated mix as defined by the PHC strategy, including decent curative care **and** empowering communities in promoting their own health.

The provision of services should be part and parcel of a development strategy to enhance, measurably, the health status of the community.

	A	B	C	D	E
1	**Indicators of achievement.**				
2	**Planning stage**	**Managerial indicators**	**Methods of measuring**	**Epidemiological indicators**	**Methods of measuring**
3	Priority setting and strategy setting	Health sector problems analysed; needs and demands; existing service model; resources and personnel	Policy document present; Programmes planned according needs; research data available	Health status data; morbidity; mortality; and demographic indicators	Available district health reports; regional hospital reports; Census data; community expressed concerns; researched needs; participatory action research; community cluster sample surveys
4	Establish service objectives	To provide health services that deal with identified health problems	Policy adapted; programme formulated; activities planned; resources identified; staff trained and in place; institutions appropropriate equiped for the task.	To meet epidemiologically defined needs by health services.	Measure the size of the problem; Who is affected by the problem; How many are affected by the problem; What can be expected in reducing the problem; How long will it take?
5	Identify indicators to monitor achievements	Service management and coverage measures; resources used; activities undertaken; output quantified; coverage of target population/specific group.	Identify health service delivery area and target (sub-)populations; set coverage targets programme activities .	Health status measurements; morbidity, mortality; fertility; nutritional status	Morbidity. -------- How many children get measles, polio, whooping cough, neonatal tetanus; have parasites (schistosomiasis, ankylostoma, ascaris, pinworm, etc; have scabies, trachoma; etc.)
6					Mortality; --------- Infant mortality; child mortality; maternal mortality; disease specific mortality (measles, pneumonia, TB, AIDS, diarrhoea; malnutrition; malaria)

	A	B	C	D	E	F	G
1	**The Community Based Health care Approach**						
2	**Planning stage**	**objective**	**Indicator**				
3	Establish community based health care programme	Identify and train community health staff and establish community health department	Community health staff available and trained (TOT/TOF);				
4	National and district policy guidelines studied.	Community identified on bases of perceived health status. Identify obstacles	Community leaders and women groups meetings; awareness created; obstacles identified				
5	Select culturally appropriate approach to community	Motivate local people for participation in planning and activities	Local people motivated and trained				
6	Provide ongoing support and linkage with health services	Health action group or care group established in community	Volunteers are clear about the health problems and possible actions				
7	Select appropriate tools for participatory action research	Establish community health needs	Participatory action research planned and carried out	Analyse problems and set priorities for intervention	Decide which problems can be solved within scope of financial and technical possibilities.		
8	Identify resources	Health intervention programme for each defined priority	Plan of activities; resources identified				
9	Plan and provide appropriate training and health learning materials	Health action group members trained by TOT	Number of health action group members trained	Health action group identifies health problems and solutions	Health Action Group or Care Group activity participates in problem solution	Health action group monitors achievements	
10	Provide logistic and technical support; assist in identifying financial resources.	Community Health action group autonomous	Have their own TOT.	Have their own internal structure and action programme	Monitors own achievements	Are member of their own association	Manage their own financial resources

	A	B	C	D	E	F
1		**Reproductive health care**			Indicators sheet 4	
2	**Planning stage**	**Objectives**	**Managerial indicators**	**Methods of measurement**	**Epidemiological indicators**	**Methods of measurement**
3	Priority setting and strategy setting	Reduction maternal and perinatal mortality and morbidity	Problems of health care for pregnant mothers and their children analysed	Measure the size of the problem; Who is affected by the problem; How many are affected by the problem; What can be expected in reducing the problem; How long will it take?	Maternal mortality lower than 1/1000 births; absence of vescico vaginal fistels ; perinatal mortality lower than 30/1000 births	Community survey; sister method; hospital records VVF operations/patients
4			Needs and demands determined	Measure the size of the problem; How many are affected by the problem; What can be expected in reducing the problem;	Number of expected pregnancies in target population;	Census data; compare present utilization of ANC/maternal services with expected utilization..
5			Analyse existing service model; resources and personnel	Accessibility target population; utilization HSFs by target women; number of trained staff in relation to expected workload	ANC coverage (> 3 visists/ pregnancy); coverage tetanus prophylaxe (2 TT).	Community cluster sample household survey
6	Establish service objectives	To establish antenatal care to all women in the targte population	Clinic staff trained in ANC and posted; Antenatal clinic equiped and operational; all women issued with ANC record card;	Women appreciate and understand importance of ANC; Cards are properly filled and understood.	Target set (100%) for ANC coverage (> 3 visists/ pregnancy); coverage tetanus prophylaxe (2 TT).	Utlization of ANC (new attenders) related to target population (4% of population); average number of ANC visists; community survey TT-coverage.
7		To have all women delivered by trained (traditional) midwives	Clinic staff trained and posted; maternity equiped and operated 24hrs; referral system in place.	Staff monthly supervised; antenatal and delivery records properly used; emergencies timely refered.	50% of target women deliver in clinic; Maternal mortality in clinic less than 4/1000; perinatal mortality in clinic < 30/1000	Number of supervised deliveries related to target population; records analysed from record book.
8		To have women delievered by trained traditional midwives in target community;	TBAs identified and trained; regular meetings held; TBA accepted by clinic staff and community;	Number TBAs trained and active and number of deliveries performed; Number ferred for ANC and delivery to clinic;	Number of women referred with delay of >10 hours; Maternal mortality of deliveries by TBA less than 8/1000; Perinatal mortality > 40/1000	Logbook by TBAs maintained and analysed. Community survey.
9	Identify indicators to monitor achievements	Supervison and Training for monitoring, using selected indicators, in place.	Full coverage ANC and delivery services; resources used; staff trained; output quantified. Constraints analysed and dealt with.	Records kept of indicators; labour graph used and analysed; staff assessed on performance monthly.	Coverage antenatal and delivery services; perinatal and maternal mortality;	Recordbooks and labourgraphs by clinic staff and TBAs maintained and analysed. Community survey.
10	State policy and strategy to attain reproductive rights.	To enable women and men to choose the number of children they want.	Women and men aware of individual rights and national reproductive health policy	Community survey on reproductive needs and preferences.	Demographic data; birth rates; national formulated targets.	Census data; KAP study.
11	Establish service objectives	To provide reproductive health services to target communities.	Clinic staff trained in reproductive health care and posted; Clinic equiped and operational; all clients issued with patient retained health card;	Women appreciate and understand importance of family planning; know about proper use and side effects; Cards are properly filled and understood. Have knowledge about HIV/STD.	Target set eligible women (12% of total population) for FP coverage; target set for men(5% total population) accepting protective metods.	Utlization of ANC (new attenders) related to target population (4% of population); average number of ANC visists; community survey TT-coverage.

	A	B	C	D
1		**Expanded Programme on Immunization**		
2	**Planning stage**	**objective**	**Indicator**	**Method of measuring**
3	Priority setting and strategy setting	Eradicate childhood diseases preventable by immunization		
4	Establish service objectives	Set up Expanded Programme on Immunization	Resources identified	Average cost per fully immunized child.
5	Identify indicators to monitor achievements	Health information system to monitor childhood diseases	Target childhood population determined	Accessible area (10 km); static and mobile; district census data; birthrate..
6		All eligible children immunized	Number of immunizations performed	Relate annual number of immunizations to birth cohort.
7			Immunization coverage	Immunization coverage survey
8		Children protected from diseases preventable by immunization.	Measles annual incidence	Clinic and hospital records; community survey
9	Establish quality control immunization programme	Viable vaccines administered		
10		Well functioning Cold chain	Refrigerators working within temperature range; vaccines properly stored and transported	Temperature charts and fuel supply maintained; measles protection rate measured
11		Staff performing immunizations according rules	Vaccines and syringes well maintained; hygiene well kept; sterilization procedures followed proper techniques	Supervise handling vaccines , injection technique; register side effects; check age child;
12	Engage community participation	Health education on immunization performed	Mothers return with children for completion of immunizations	Survey "Reasons for non-completion of immunizations"
13		Staff attends clinic regularly	Clinic schedule and mobile schedule maintained	Clinic and mobile schedule indicates more then 80% of scheduled immunization clinics held at agreed time.
14	Establish community based health care programme.	**see "The community based health care approach".**	Community health action group organizes immunization clinics and follow-up;	Monitors all new births and immunization status of children in community; surveillance of measles cases

	A	B	C	D	E	F	G
1	**TUBERCULOS**		**LOGIC**	**FRAME**	**WORK**		
2							
3	**Problem**	**Activities**	**Process**	**Output**	**Output Indicator**	**Outcome**	**Outcome Indicator**
4	TB patients reporting in clinic	Clinic register	Report to District TB control officer	Monthly report; Included in TB scheme	Consistent monthly reporting;	Included in national TB Scheme	
5	Patients with suspected TB	Diagnosis of TB by medical staff	Examination of patient	Patient entered in TB register and notified and patient retained record card issued	Proportion of patients reported diagnosed and put on correct treatment	Patients treated and followed up	Proportion of patients detected and cured
6			Sputum investigation by laboratory (2-3x)	Smear positive AFB	Proportion of smear positive patients (>10%)	Confirmed TB case	Quality of sputum investigations
7			Weight recording monthly	Weight recorded monthly	Patient growing when taking treatment correctly	Patient recovering	
8			X-ray in selected cases	X- rays made in <30% of suspected patients	Correct interpretation of X-ray examination	TB diagnosis confirmed/ rejected	
9	Patient with confirmed TB	Make treatment plan	Patient put of treatment according national guidelines	Clinical in-patient treatment if no community treatment possible	Patients Patients receiving full short course chemotherapy (SCC)	Patient sputum negative; patient cured	Proportion of patients cured over those diagnosed.
10			Organise Directly Observed Treatment (DOT)	Organise Community based treatment	Patients Patients receiving full short course chemotherapy (SCC)	Patient sputum negative; patient cured	Proportion of patients cured over those diagnosed.
11	Multiple TB Drug resistance	Establish size of the problem	Examine TB register	Establish cure rate; defaulter rate and failure rate	Cure rate; failure rate	Action taken to improve system	Effect of actions taken
12			Establish mortality rate	Mortality rate	High mortality rate (>20%);	Mortality rate improved	Mortality rate <10%
13			Examine treatment failure rate	Patients still sputum positive after 2 and 5 months of treatment	Positivity rates > 2%	Positivety rate lowered	Positive sputum rate <2%
14			Establish drug resistance rate	Bacteriological culture sensitivity tests	TB resistant to INH and Rifampicine	Multiple drug resistant TB established	Measures taken to combat MDR-TB; MDR-TB absent
15	Drugs not available	Establish treatment scheme (SCC); 2HRZS/4TH; 2HRZE/4HE; 2HRZE/6HE	Calculate expected number of patients	Annual Drug requirements calculated	Annual drug requirement obtained	TB- SCC treatment schedule can be established	Proportion of all patients cured by TB-SCC
16		Establish procurement procedures	Obtain, finance, receive and control drug stocks	Drugs registered, properly stored and distributed	Drugs obtained, distributed and used according schedule and registered patients	Drugs available in all treatment centres	Number of patients receiving full treatment according national schedule
17	Funds for the TB programme	Estimate cost per patient and submit budget	Calculate cost of drugs per patient	cost of drugs range $15-20	Establish real cost of drugs with estimates	Funds adequate for the TB programme	Financial report showing use of funds efficiently
18			Calculate cost of establishing diagnosis	Cost of diagnosis $ 5-25	Establish real cost of diagnosis with estimates		and effectively.
19			Calculate cost of follow-up	cost estimate follow-up $10-25	Establish real cost of follow-up with estimates		
20	pk 496						

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Memisa's response to the assessment report on It's Indian partners in development.

It has been the first time that a representative of a recipient country has in fact reviewed Memisa's work in support of health care activities in the Indian sub-continent.
This on itself is meaningful as it contains the notion that Memisa is open to outside scrutiny and is therefore implicitly willing to seriously consider, if not fully accept in principle, the recommendations of such an exercise.

In this regard the report does reflect the expectations of Memisa and hopefully of the major partners of Memisa in India. It is an excellent starting point for a constructive dialogue in which Memisa seeks to incorporate the views of its major partners into its policy to support health care initiatives in India.

In summary it concludes:
a. that the trend has been to enhance and utilize more and more the local capacity for project appraisal, follow-up and evaluation, including sometimes training components.
b. that the primary health care policy has been clearly shared and understood, forming the benchmark against which projects can be held for policy content.
c. that there is also agreement on the gradual shift from the better developed areas of India, noticeable the south to the more needy states or parts thereof in the north.

There is also a lot mentioned in the report which will provide sufficient input into the formulation of Memisa's development policy towards India.

We can mention the strengthening of core partners and principal cooperants in India with a view of empowering these organizations to enable Memisa to delegate its development role in the country. The needs arising from such strengthening is therefore a subject for further discussion, agreement and implementation.

In the framework of Primary Health Care the emphasis may have to shift from material and output oriented support to more attention for process towards sustainable community involvement.
Reliance on structure should be secondary to reliance on community social development.
Still it will be imperative to develop measurable criteria for whatever activities supported by Memisa. It is clear however that these criteria for monitoring may be of a process nature, rather than hard epidemiological data on outcome as these are often the end result of a multitude of inputs and influences.

As far as the shift in states is concerned, Memisa has up to now may be not enough invested in investigating areas of need, although the recent support to RUPCHA and the Delhi South peri\urban area and the investigations into Jammu, Naguar, Bihar and Jabua are serious attempts to shift the emphasis to the northern partners as suggested by the report.

The recommendation to develop policy tools for the positive engagement of local partners in development is well taken and will be the subject on the next partner consultative meeting in April 1996 and will have to continue afterwards.

It will also be necessary to develop standardised and appropriate tools for evaluation of

grassroots organizations and their activities to enhance the health status of the people.
The same will account to the needs of the core partners to enhance their capacity to fulfil the assigned delegated task.

The project has not gone deeply into the financial side of project management or the health needs in economic terms of rural and urban slum populations. Rather wide per capita expenditures and or results in the sense of cost/benefit may be observed. Guidelines for transparency in financial management and appropriate levels of health financing will have to be developed.

The recommendation of strengthening interpartner relationships is a valuable one, although one has to consider existing relationships, and to examine the functional aspects of these relationships, before recommending and supporting new ones. It would be time consuming if every donor creates its own recipient/partnership network as if the donor organization is the main focus of interest.
The report does mention useful areas for exchange and cooperation.
The consultative meeting has to suggest efficient and effective means of following up this recommendation.

The meeting will also have to consider what level and intensity of exchange between Memisa and its partners will be desirable and affordable.
Is an intermediate person, Memisa liaison officer or office needed/desirable for coordinating purposes?

Areas of special concern are mentioned in the report, and possibly some more can be added.

Mentioned is the skew deployment of health staff with a bias to doctors at the cost of intermediate staff more suited at peripheral level. Also the role of hospitals in support of community based health care or within the framework of district and Panchayat Raj's role towards health care is a subject for further examination.
The low level of curative health care at the peripheral level in coexistence with an abundance of medical personnel and an overwhelming array of modern and traditional drugs, is a matter of concern. Looking at entry points for appropriate and good quality care, connected with CBHC, would be one of Memisa's perceived priorities and a subject for discussion.
Strengthening the training component at various levels of the operants in health and social development have to be taken more seriously.
In view of the above, training of community nursing may have to be considered for enhanced support.

Regional options.

1. Tamil Nadu.
The relationship has been project oriented with little organizational commitment, limited to traditional catholic partners.
Options are to link the rising demand for project support from a wide network of grassroots NGO's concerned with social welfare and AIDS(AIDS NGO-SMI) with professional Network and resource organizations as Emma, VHA-TN and Christian Medical College in Vellore.

2. Kerala.
It is assumed that the overall development has taken a momentum which can evolve on it self.
Options for consideration are innovative approaches to health care.

3. Karnataka.
Selection of some needy districts and involvement of St.Johns college as resource and training partner could be considered for further cooperation.

4. Andhra Pradesh.
Support to institutions moving into comprehensive community health could be considered.
Resource centre for training and monitoring could be CHAI and APVHA.
Selection criteria of grassroots NGO's seems indicated.

5. Madhya Pradesh.
Accepted as one of the more needy states as part of BIMARU. Cenderet induced MIDAS in Eastern MP and the ISI researched Jabua district initiative in western MP may become a focus for health care support. The feasibility of district health system support is a challenge to be studied further.

6. UP.
As the most populated state of India, 1 out of every Indian is from UP, the experience has been very mixed. Parastatal institutions have largely failed as partners in urban health care. RUPCHA and the suggestion of the regional office of UP VHA are potential partners, the latter needing more investigation.
The Urban PHC project in Kanpur is slowly evolving into a viable community health service model.
The linkage with institutional care of traditional catholic partners with CBHC could be further investigated.

7. Bihar.
Also here linking church related groups in health care with community approach may yield tangible results. The potential of BVHA to support such development in a meaningful way may be investigated. The state wide project led by Fr. Jose Kananaikil (Bihar Vikas Samiti) may offer an inroad into supporting health activities of poorer dalit communities.
Also Aditthi may offer scope for further development. Linkage with Cenderet and WB VHA is suggested in the report.

8. West Bengal.
The WB VHA is the prime partnership organization with Memisa developed in the last few years and its role of strengthening local grassroots NGO's is recognized as a potential beneficial activity recommended as the focus of Memisa's support.

The Social Welfare Institute of Raiganj Diocese is a partner recognized to move to community health.
The supported AIDS programme for CSWs is developing into an example of an urban STD/AIDS programme.

In conclusion, the review exercise has certainly contributed to focus Memisa' limited potential on specific geographical areas and communities therein, and aims at consolidating existing partners and strengthen new partners to a long term and beneficial relationship.
In content Memisa's health policy may need some different emphasis but overall agreement at that level is there. Much effort will have to be spend on developing further the methods of project management and communication.
New avenues of activities will be studied with the assistance of the core partners.

PARTNERS IN HEALTH - CHALLENGES FOR THE NEXT DECADE

A PROCESS REVIEW OF THE INDIAN PARTNERSHIP OF MEMISA

1989-1994

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October 1994

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A PROCESS REVIEW OF THE INDIAN PARTNERSHIP OF MEMISA (1989-1994)

SUMMARY/RECOMMENDATIONS

The Desk Review of the Partnership between Memisa and its partners in India, included:

* a brief overview of the Health and Health care situation in India including the role of the Voluntary Health Sector;
* an overview of Memisa's Health Care funding policies; * a socio-epidemiological profile of the partners (both national/regional core partners and field partners);
* a profile of partnership in some states in India;
* a review of some aspects of the management of the partnership - including selection, funding monitoring, and evaluation; and a SWOT analysis highlighting strengths, weaknesses, opportunities and threats.

Throughout the report suggestions were made in the context of the findings and observations. Key recommendations are summarised here for consideration by Memisa and its core partners in India.

1. Circulation of Review Document: entitled 'Partners in Health: Challenges for the next decade' to all concerned to build up complementary/ supplementary response analysis and reflections on the 'partnership'

2. A field review to be considered of all the projects in the three key states of Andhra Pradesh, Orissa and West Bengal as a complementary exercise to the desk review. This should focus more specifically on four issues:

   a) Conceptual understanding of CH/PHC and consequently understanding of long-term role in area
   b) Location of project in context of existing health infrastructure both governmental and non governmental
   c) Emerging needs of partners in terms of training, continuing education, and support to programme/process management and staff development
   d) Assessment of long term sustainability of process and efforts made towards that goal.

The field review could emerge from a collective planning exercise by the three core partners - CENDERET, CHAI and WBVHA to build in objectivity and a certain degree of standardisation while also taking into account inter-state differences. This could be a practical outcome of the interactive workshop mentioned later in (4).

3. Policy papers by core partners. A short policy paper by CHAI and WBVHA identifying regional disparities and priorities of their state and/or an interactive response to CENDERETS policy paper on 'Promotion of Small Groups'.

4. Promotion of greater collegiality between three core partners identified in the document) through regular interactive dialogues and networking. Such meetings or workshops could consider the following agendas over a period of time:

a) Building a consensus on the strategies for Community Health and Primary Health care in the Indian context.
b) Identifying regional priorities and emerging needs both i) interstate and ii) intra state
c) Evolving common guidelines for pre-selection assessment, concurrent monitoring and accompaniment and post funding assessment.
d) Evolving common guidelines for baseline surveys and concurrent inbuild monitoring and evaluation strategies by field level partners.
e) Identifying specific common thrust areas and strategies.
f) Evolving mechanisms of communication and sharing of resources and expertise.
g) Providing continuous assessment and feedback to Memisa about ground-level realities and emerging needs and problems.

Such a collegiality could be initiated with the first interactive workshop in 1995 in the context of the Desk Review. The work could be followed up by the field review mentioned earlier in (3).

5. Consolidation/Repriortization

As a process of consolidation and perhaps reprioritization in the Indian partnership, Memisa and its core partners could consider the following shifts in emphasis:

(i) From PHC project orientation to a process orientation.

(ii) From 'adhoc', partial, infrastructural inputs into many projects, to focus on a few seeking programmatic support.

(iii) From infrastructural development emphasis to human resource development ie, training, continuing education, participatory evaluation and networking.

(iv) From Southern India to other parts of India, particularly Central-Northern-Eastern belt.

(v) From less disadvantaged districts to more disadvantaged districts in all the states of focus, in the future.

(vi) From individualised partner focus to greater linkages and networking in the partnership between grass roots and core and between grassroots themselves to promote sharing of resources, experiences and perspectives.

South further, in its attempts to satiate the overconsumption of non reviewable resources by the North) is better understood, there is need to enhance the South-North dialogue in the partnership to explore policy initiatives and programme support that will address these broader issues and challenges. With International Public Health efforts and Drugs and Technology transfer becoming subservient to global market economy some more concerted efforts at promoting South-South and South-North dialogue will have to be explored to counter the trend. Memisa could play a catalyst role especially in the areas of Primary Health Care promoting dialogue on the issue with all its partners in the South including India and raising it with Northern groups as well.

We believe that Memisa is keen to move from a more typical funding agency-beneficiary orientation in this partnership to a more relevant partnership based on greater dialogue, more equality between partners and greater decentralization in its planning and monitoring.

These recommendations, it is hoped will help Memisa to qualitatively enhance its existing Indian partnership towards a more meaningful and sustainable effort - building it on the 'learning experiences of the past, a critical overview of the present and responding to the emerging challenges of the future.

1. INTRODUCTION

This document brings toget
partnership between MEMISA
governmental organization in th
of health care services and p
include voluntary agencies prov
national networks / associatio
groups for community level ag
review is based on four assump
concerned.

1. Donor agencies, shou
perspectives generated by spe
overview of their work with pr
broader collective experience

Ind
local specifics viz. geograp
availability of local resources a
invaluable but not always extra
agencies exist and evolve. T
overview studies of all project

2. Donors and their partne
orientation, which is preoccup
community and is usually eva
and reflect on broader 'social
the long term. It is now widel
a social process that seeks to
enable them to be healthy as a
a perception that should be ce

3. There is need to provide
country partners to evaluate all
Evaluation is often focused o
level of field action, and seld
interaction, between partners a
the partnership is a donor-ben
partners see themselves as 'eq
in need.

4. Finally it is assumed t
collective overview; that move
that allows opportunity for all
perceptions, lessons and ideas
of the partnership itself.

Ideally, such a review shou
of the planning cycle of the p

processes.

This document is primarily intended to serve as a stimulus for a participatory and collective review between all the partners. It raises questions for consideration and outlines issues for further reflection. While offering some suggestions, it does not claim to provide solutions problems and challenges in the evolving partnership. This is a task for the partners themselves.

It is said that **'if one does not know where one is going, one may never know when one reaches there!'**. We hope this document will help to raise questions and possibly help clarify where 'we promoters and supporters of health' want to go in the years ahead.

2. A PROCESS REVIEW OF MEMISA PARTNERSHIP IN INDIA

2.1 Background and Objectives

In the period 1989-94 MEMISA received over 965 (?) applications for project support. Of these 263 (27.2%) were funded during the period 1989 to 11th April 1994. 534 (55.3%) were rejected by MEMISA on its own or due to a negative report by Indian core partners. 168 are still pending decision regarding support.

The overall majority are located in South India. By MEMISA's own parameters the projects are assessed to be small in terms of budgets. Apart from this little else was known was known about all the projects taken together as a whole. The focus during the past years was on specific projects, their requests, their problems, their dynamics on an individual basis.

The MEMISA Asia- Oceania Desk perceived some problems :

a) It was unclear what the impact of the programmes funded by MEMISA during the past five years had been.

b) There had as yet been no overall evaluation of the total set of projects being supported in India.

c) The desk received continuous requests from new NGO's - unknown to MEMISA and often to their core partners as well. The majority of these requests came from the South, where health status and health care services were relatively better. There were difficulties in prioritising and in making selections for funding.

d) Pre funding screening and post funding monitoring was difficult to do from a distance. MEMISA had depended much on its national core partners for advice and had involved three of them viz. CHAI, Secunderabad; CENDERET, XIM, Bhubaneshwar; and WBVHA, Calcutta. They conducted pre selection studies, and reviews / monitoring and evaluation of projects post funding in some cases. This new dimension of partnership had not been subjected to assessment or review. With the above considerations in mind MEMISA initiated a comprehensive review of its Indian partnership with the following general and specific objectives.

4. To attempt a categorisation of the different kinds of NGO's per state if possible in the context of the whole NGO universe in India. Were groups selected the most needy among the NGO's ? Were they innovative in their health approaches so that lessons could be learned in order to use their experiences elsewhere.

5. To attempt to categorise health approaches used in the different projects - eg. experience of working with voluntary health workers (paid/ unpaid), cost recovery / cost saving strategies, integration of curative and preventive care or preventive care only.

These three additional objectives were requested and added by the MEMISA Desk staff.

The consultant researchers added a further two objectives as preliminary steps.

6. An overview of MEMISA's pamphlets and policy guidelines to locate MEMISA 'S efforts in the broader context of international efforts to promote primary health care & community based health.

7. A brief overview of the health and health care situation in India in the early 1990's, and the role, contribution and challenges of voluntary agencies in the health sector.

3.5 METHODOLOGY

Initial dialogue between the coordinator of the MEMISA Asia-Oceania Desk and the consultant researchers suggested a three pronged - three phased methodology for the review.

1. Desk Review

An initial study and analysis of Desk data made available from MEMISA desk and some complementary materials from three of its national core partners - CHAI, CENDERET and WBVHA.

2. Field Review

A field review exercise of project partners primarily in Orissa, West Bengal and Andhra Pradesh undertaken by the above mentioned core partners in their respective States in the context of the overall objectives of the process review and focusing primarily on all issues and questions, data for which would be unavailable or inadequate solely from a desk review.

(It was planned that before the field review exercise the consultant researchers would visit the core partners and plan the nature and process of the complementary field review.)

3. Interactive dialogue with partners

The desk and field reviews to be presented and discussed at a meeting of core partners

and a representative sampl
comprehensive and sustai
interactive discussion as a

3.6 PROCESS OF RI

* The background mat
relevant policy documen
pending during the period
prepared and dispatched t

* The Desk Review b
could not proceed accordi
demands on the consultan

*Since some of the co
projects, particularly conc
selection / rejection,justif
to allow for some transla

*Since the consultants
for interactive discussions
Review was completed, si
of the visits and the conv
partners. Visits were mad
18th July 1994 ; to Calcu
6th July 1994 ; and to Bl
19th - 20th July 19

*During the visit to Ca
also arranged. These were
in Howrah District.
While the main purpose
discussions on the possib
review, it also provide
programmes of the core p
core partners were also b
of the School Health an
strategy, whereas in Bl
CENDERET's efforts
participatory planning exe

* Due to prior commitr
prior to and enroute to a
delayed. However during
MEMISA office and the
work / review that had b
team.

*Further analysis was done in October, and this report is an integrated compilation of the findings of the desk review and discussions with staff of national core partners and the Asia Oceania Desk of MEMISA.

3.7 MID - COURSE MODIFICATION

After the field visits and the interactions with the core partners, it was felt that for various reasons including the varying degrees of intimate knowledge of core partners with grassroots projects in their respective States; the varying orientation, objectives and styles of the core partners and their understandings of health care and development; and different degrees of support received through the beneficiary status of the core partners themselves -there would be some difficulties particularly methodological, in evolving a standardised field review exercise in all the three States. There were also varying degrees of perception of how meaningful or productive in terms of cost effectiveness and cost benefit, detailed field reviews in these three States at this stage would be. It was therefore decided as a mid term modification of the original methodology, that the proposal for field review of grassroots partners would be dropped at this stage and a preliminary document bringing together the key findings from the review to date would be circulated to all concerned as a preparation for the next step of the review. This was discussed and agreed upon at the meeting with the Desk staff in Rotterdam in Sept. 1994.

3.8 THE NEXT STEP

It is now suggested that this preliminary document with all its component parts be: a) whetted by the Asia Oceania Desk staff,
b) shared with the national core partners, and c) shared with other core and long term partners who could also be likely invitees for an interactive discussion and for their comments, reflections, responses and additional suggestions, which could be sent by a mutually convenient date, perhaps early in 1995. A compilation of these responses would then form an additional document. The whole set could become a background paper for a detailed interactive participatory reflection between MEMISA Desk staff and its national core partners and a selection of key and long term grassroots and other partners in 1995.

At this meeting a Plan of Action towards a more sustainable and comprehensive partnership in India could emerge, including the framework and instruments to operationalise it. Suggestions and ideas for alternative approaches or initiatives given by the consultant researchers as a preliminary framework for change in this document, may be considered only as a signpost for action at this stage. They need to be discussed, assessed critically and to be endorsed if found to be relevant by all partners concerned at this final meeting.

If these preliminary efforts by the consultant researchers help not only to clarify ' where one wants to go in the years ahead, towards the goal of health for all, but also stimulates reflections among MEMISA staff and its Indian partners about 'how to get

gradual improvement.

4.1.3 Women's Health

There is a worsening of the gender ratio (934 in 1981 and 929 in 1991). This along with continuing disparities between rural and
urban health indicators for women as compared to men, are an increasing cause for concern.There is however a slow increase in female literacy rate - 29.8 in 1981 and 39.2 in 1991. There are also new initiatives at the national level with integrated approaches and the involvement of women's groups /NGO's.

4.1.4 Regional disparities

The 1991 Census supplemented by data from other sources show increasing regional differences in the health and health care situation in India (see Tables 2.a and 2.b). Kerala , Goa, Pondicherry and some of the North Eastern States have shown much improvement in health status. Larger States like Tamil Nadu, Maharashtra, and Karnataka show positive trends as well. On the other hand Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Orissa have health status indicators far below the national average, in fact among the lowest in the world. The development of the acronym 'BIMARU' for the above States in planning circles reflects the need to specifically focus on these backward regions with a sense of positive discrimination, and with urgent ,innovative, locally relevant programmes.The word 'BIMARU' also means ill in Hindi, but is not used in any derogatory way.

4.1.5 Health Problems

Morbidity and mortality statistics show Infant and Maternal Mortality Rates still quite high in some pockets. Mild to moderate mal-nutrition, diarrhoea, and Vitamin A deficiency continue to be high in children particularly in under-fives. Communicable diseases such as malaria, tuberculosis, leprosy, filaria, cholera, and STD's are still major problems. There is a continuing lack of safe, potable water supply and sanitation facilities, particularly in rural areas and urban slums. Along with these 'diseases of poverty' there is a rise in the 'diseases of industrialisation or development ' ie. cancer, cardiovascular disease, accidents etc. resulting in a double burden on people as well as on the health services.

4.1.6 National Health Programmes

Since the Fifties the Government of India launched several national programmes to deal with specific diseases and health problems. While these programmes are vertical at Central and State Ministry levels, they integrate at the primary health centre (PHC) network at the peripheral level as multiple functions of the staff and the PHC's.Programmes include eradication of malaria and leprosy, control of tuberculosis, filaria, kalaazar, STD's, blindness, goitre, guinea-worm, and more recently mental health, cancer and AIDS.The package of Maternal and Child Health and Family Welfare programmes include the Universal Immunization Programme (UIP) against

the six vaccine preventable
Rehydration Therapy, Diar
Control, training of Traditi
recently following WHO
regrouped under the Child

4.1.7 Selectivisation tr

There is a growing concer
(USAID) supported by In
target oriented, vertical (
equally important health p
services. The recently intr
the same trend and potent

4.1.8 Intersectoral Co

In contrast to the above, t
functioning of programme
services, minimum needs p

4.1.9 Health Human

This was undertaken on a
over-investment in the tra
year from 144 allopathic
On the other hand ther
professionals trained. Adc
at all levels of training is
great need for continuir
Education Policy for Heal
these issues.

4.1.10 The Growing

All indicators of health ar
urban areas. However the
indicators mask the grow
the rest of the urban pop
population is fairly subst
increasing, with estimate
based by 2000 AD. There
water supply, sanitation
poor. Due to problems
migrant families, job and
amenities and access to
services.

The recent plague epidemic in Surat, Gujarat, and recurring epidemics of infective hepatitis in other cities including the capital, are indicators of a deteriorating and inadequate public health system. There is therefore a need for basic and primary health care services for the urban poor to be on the top of the agenda for health planners and donors.

4.1.11 Traditional Systems of Health Care

The last decade saw the beginning of a greater openness in attitude of the allopathy-western medicine trained health professionals, who dominate health planning,to recognising the role, scope and contribution of the Indian Systems of Medicine (ISM's) and local health traditions. During the past three decades there has been minimal State support (approx. 1-5% of the health budget) to : ISM academic centres; research councils for each of the ISM's; and for integration of ISM's into the primary health care network. Some States like Kerala, Gujarat, Maharashtra and Punjab have done more than others. In terms of actual numbers of trained physicians the ISM's account for about 51% of the total in the country. Various factors account for the more recent resurgence of interest viz. greater awareness regarding the widespread availability and utilisation of these services which are in essence local health resources, growing recognition of the limitations of allopathy, increasing respect for peoples choices and cultural factors in health care, and the cost factor.

4.1.12 Health Finances

This important area is also beginning to receive greater attention with policy planners, researchers, and health action initiators at field level focusing more specifically on costing of health care, cost recovery, low cost alternatives and studies on patterns of expenditure on health care at individual, family and community level. These have led to the recognition of inadequate public investment in health care; the major role played by the private sector in health care delivery; and innovative financing strategies experimented with by some voluntary agencies in the country. Much more needs to be done in this area in the years ahead.

4.1.13 Decentralisation

India has an ancient tradition, dating from pre-Mauryan times, of village based Panchayats for local self governance. Legislation in the early 1960's sought to strengthen these institutions and increase their involvement in the community development effort . Several factors led to a failure of these efforts to involve people through panchayats in the planning and organisation of development. These included inadequate devolution of funds to the lower levels; resistance by the States and the bureaucracy to share power; irregular elections; negative influence of traditional vested interests who often dominated the panchayats, among others.

The 73rd and 74th Constitutional Amendments regarding the Panchayati Raj Act were passed by Parliament in Dec. 1992 after years of discussion.It has new features that allow greater scope for the concept of local self government and decentralisation to be effective instruments of development. Key features are: devolution of greater financial powers to the elected committees at gram (village), taluk and Zilla (district)

our efforts in this complex, dynamic scenario to ensure that efforts support HFA 2000 goals, rather than delay or block it.

4.2 VOLUNTARISM, NGO'S AND HEALTH CARE IN INDIA

4.2.1 Tradition of voluntarism

India has a long tradition of voluntarism, with local voluntary workers carrying out many local programmes, without too much dependence on centralised government ~~dependence~~. Traditional healers, birth attendants, bone setters and herbalists provide services to the community in a low cost and decentralised way.

4.2.2 Independence movement to community development

Voluntarism was a major force during the political movement for independence. After independence several of those groups, especially Gandhians, those from the Sarvodaya movement and many others were involved in community development efforts.

4.2.3 The 1950's and 1960's

During these decades the voluntary sector grew. Funds were available from government, from local sources and from foreign funding agencies supporting development. Groups emerged from diverse religious and ideological backgrounds. Christian, Gandhian and charitable groups were predominant.

4.2.4 The 1970's and 1980's

By the 1970's the voluntary sector had shown a rich diversity in ideological motivation, strategies, organisational patterns, objectives and management structures. There was a sharper ideological response in the 1970's, shaped by the radical politics of the late 1960's.The sector also moved to a more technical/ appropriate technology focus in the late 1970's. This continued into the 1980's, along with the emergence of alternative training experiments and focus on networking, research and issue raising. The decade also saw a gradual move of some, from the traditional alternative service provider role to greater involvement with community organisation and empowerment.

4.2.5 Size of the voluntary sector

It is estimated that currently there are about 15,000 voluntary agencies in India, with around 6-7,000 involved in health work. Another estimate is that 20% of the total bed strength in hospitals is in the voluntary sector. In comparison to the total health and development sector in the country, the quantitative contribution of the voluntary sector is small, however qualitatively its contribution is significant.

4.2.6 Strengths and weaknesses

Operating on a not for profit basis the sector provides fairly good quality service accessible to the poor, in curative, ~~preventive,~~ preventive and promotive care. Among its strengths are flexibility, innovation and commitment. Limitations too are increasingly being recognised. Besides being small in number, they are often initiated

and sustained by charisma
to the development of se
coverage it tends to get
commitment to people gett
→ Over dependence on extern
voluntary agencies is also

4.2.7 Alternative appr

Reviews and studies have i
sector towards evolving m
economic- political-and
community based workers,
and non formal methods
involvement of local healer
cost health care, innovat
responses to various proble
and carry out health action

4.2.8 Government rec

For the first time the 1982
Documents identified the
development. Government
also now directing its o
development is an indicatio
it is also a cause for concer
for creativity and for a criti
of the new economic poli
responsibility - especially

4.2.9 The 1990's

This decade has also seen a
an increasing emphasis on
funds. The 'alternative de
social entrepreneurship tha
those who can afford a ser
The commodification and

4.2.10 Negative trends

Increased and excessive av
mushrooming of projects
Besides duplication of effo
do not have adequate techn
or clarity of roles and obje
classified as having dubiou

4.2.10 National netwo

India has a rich diversity
increasing number of midd

support groups. In the health field CMAI - Christian Medical Association of India, (established in 1921), CHAI- Catholic Hospital Association of India (established in 1943), and VHAI- Voluntary Health Association of India (established in 1975), are the three major national networks providing support, orientation, direction and continuing education to their member organisations.

There is a need for further strengthening of these groups to continue their analytical, support and training role. Advocacy on broader health sector issues also need to continue as on rational drug policy, women's health, campaigns against harmful pesticides and additive chemicals, commercialised baby foods, deteriorating public health standards,medical malpraxis, and on health policy issues.The move from being providers of an alternative heath care to that of building a peoples health movement is a challenge for the voluntary health sector and its funding partners.

4.2.11 Funding agencies and international NGO's

The large network of voluntary agencies in India are supported not only by local funds and government, but by a large number of overseas charities and funding agencies. The pattern and quantum of funding has not been adequately studied. There are estimates that over 130 foreign donors provided over 7000 million rupees in 1990 to India's development NGO's ( ).

Well known foreign donors include OXFAM, ACTION AID, and CARE. In the mission related sector Misereor, Cebemo, EZE, Bread for the World are the larger ones. Slightly smaller are MEMISA,HIVOS, and various European Church related Lenten Funds, along with an increasing number of smaller secular groups. More recently support from North American groups has increased. Bilateral and Multilateral agencies are also beginning to work through NGO's.

Priorities in the funding of health work has been shifting. Many donors have begun to shift support from infrastructural development to programme support and human resource development (training). The last decade has also seen some shift towards community organisation and empowerment. Some support has been given to networking, continuing education, alternative research and issue raising / advocacy. The relationship between foreign donors and local partners has its problems too. Most donors are oriented towards project implementation rather than to social processes . Often an excessive amount of funds are made available or scaling up is encouraged . This could be counter productive with an emphasis on quantity over quality. Some donors impose ideas and strategies not always relevant to local realities. Many develop a provider beneficiary relationship rather than build an equal partnership or joint trusteeship. There is also sometimes a too frequent shift of priorities and change of contact persons in the India desks causing problems for the building of understanding and linkages and for continuity of processes. Very few tap local professional resources sufficiently, relying more on desk reviews and remote control ad hoc management. Some are bureaucratic thrusting too many reports, forms and indicators on their partners. Too few support networking and collective exploration of local experience among their country partners. However some agencies are acutely aware of these inadequacies in the existing process of partnership. Interesting

These are some of the challenges of the 1990's.

5. HEALTH CARE FUNDING POLICY OF MEMISA: A BRIEF CRITICAL OVERVIEW

A review of MEMISA pamphlets and some policy documents made available to the researchers show the following salient characteristics of MEMISA as an NGO donor agency, as well as an NGO promoting health care in developing countries. These have been kept in perspective during the review of the Indian partnership.

5.1 The beginnings :

MEMISA was founded in 1925 by two medical doctors and a priest who were concerned with the high mortality rates among young missionaries working in tropical countries. This led to MEMISA's offering short courses in tropical health and hygiene to development and health workers proceeding to developing countries. This was followed by initiatives to provide medicine and medical instruments to support health initiative abroad as well. Later it gradually developed into a professional organisation for development assistance.

This historical fact explains three features of MEMISA's present framework;

* Its focus on medical work / health care as an entry point for community development.
* Its professional approach to project & programme initiatives.
* Its links predominantly with church related groups, primarily Catholic.

5.2 Alma Ata and after:

Since the 1980's, particularly post Alma Ata (1978), MEMISA has accepted the primary healh care strategy and made overall changes in its policy.

* **Towards community based health care** - As part of the PHC strategy , health care is promoted in which the community actively participates in planning , execution and evaluation of activities meant to ensure and improve health. The community process needs the support of professional health workers who should offer at least four components of a back up service. These have been identified as a) taking care of health problems that cannot be solved at village level, b) training of village based health workers, c) assistance in future planning, d) liaison with government and other authorities.

MEMISA therefore attempts to support both community based health workers and skilled professionals through its support. Incidentally, one of the projects supported by MEMISA in Africa was among the precursors to the Alma Ata concept.

* **From a Christian charity to a development agency** - MEMISA has moved beyond a charitable missionary oriented organisation to a development agency. Its partners overseas are no longer only Church related voluntary agencies/NGO's but all types of NGO's that share the same goals. In some instances, more recently, partnership with Government bodies has also been initiated in some countries.

* From provision of m
improvement _ MEMIS
education and continuing
information pertaining t
housing; sufficient sanit
supplementation; immuni
employment and just w
facilities.

5.3 Supplying of means

MEMISA sees its main
the means to put the PH
a) finance to initiate a
b) personnel (doctors,
c) basic health care eq
d) essential drugs,
e) sponsorship for trai
f) expert advice, resea
Additionally, MEMISA
g) medical relief assis
h) liaison with Europ
purchase of drugs, equi

An important role clarif
and not directly in the f
partner organisations
meaningful linkages,
crucial to the success

5.4 Criteria for part

These have evolved
documents, they can al
applications, considerat
for evaluation of block
Based on these docum

a) a set of objectives
from the essential elem
b) solidarity with an
society (low income, o
c) contributing to
population and local p
d) an organisational
between all concerned
e) a certain level of

f) contributing to decentralisation of the health care system by involving the target group,

g) cooperative attitude with governmental authorities and optimal cooperation with local health infrastructure to avoid duplications.

h) clear and obvious integration of projects within national / regional and local PHC strategies,

i) political and cultural acceptability,

j) those with plans to become self reliant / self sufficient and independent of outside assistance.

These criteria are quite comprehensive. What is unclear from the policy guidelines is how important each or all these factors are in the actual selection of partners. Are they definitive in selection or do they provide a broad operational framework used in part or whole? Are they used to short list potential partner projects from an increasing number of requests over the years? On the other hand are they a gold standard towards which partners are encouraged to move?

The guidelines for applications for large health projects and the considerations for appraisal of project proposals (confidential) show the strong professional style of MEMISA in both the technical (primary health care / public health)and management aspects of project implementation. These include:

* attention to organisational structure (including legal status, approach, objectives, administrative set up, activities, staff position etc.);

* relevant general background on project area (geographical situation, catchment area, and existing health infrastructure)

* and fair detail of the project outline (including general and specific objectives, area of operation, target group, problems of area, proposed activities, time frame work, implementation strategy, expected outcome, monitoring and evaluation, reporting, follow-up, sustainability, staff needs - recruitment, budget and relations with other development projects and health institutions.).

This is a very useful framework for project selection, support and assessment. However it also suggests the strong project orientation in MEMISA's funding strategy, as well as in its understanding of the primary health care strategy for the third world ie. focusing on 'providing services' rather than 'enabling and empowerment'.

5.5 New options for support in the 1990's

The 1980's saw a large increase in voluntary agencies seeking to organise and operationalise primary health care strategies to reach marginalised and disadvantaged sections of communities in different developing countries. These groups had needs for project / programme support for their efforts from agencies such as MEMISA. However the decade of experience has thrown up some important lessons and challenges for those wishing to support primary health care and community health. These call for new policy approaches and strategies that need to go beyond the PHC project orientation of the 1980's. Some elements of the new approaches are :

in operationalising primary health care / community health through close contact with the positive and negative aspects, of the experiences of their country partners. **However these issues do not seem to find adequate place in existing policy guidelines. The 1990's require definitive responses to these emerging needs. Donors are increasingly challenged to identify their role and support strategies in this context.**

5.6 Strengthening decentralised regional partnerships

As the number of projects in a region /country increase many of the selection, assessment, planning, monitoring, evaluation support strategies would need to become more decentralised and locally based. This is a pragmatic reason in addition to the primary reasons for this emphasis indicated earlier. This has already started occurring in MEMISA's experience in India during the past few years. The role is played by national/ regional core partners. These need not necessarily be project implementing agencies, but would provide much more active support to those working at the grassroots. There is scope to further clarify the nature of this role and of the partnership - its objectives, the nature of relationships at various levels. **Both sides need to consider whether they are ready for a more equal relationship- ie. equal involvement in decision making about what needs to be done, what should be supported and how etc.** At present there is the more typical relationship with national / regional partners being mainly extensions, (trusted links of the donor),providing some support in selection, doing occasional pre or post funding assessments when there is a doubt, and less frequently providing some technical support to the field project. This tends to continue maintenance of initiative and control by the head office with the national/ regional partners being supplementary/ secondary. There is greater sharing of experience, decision making and power in the former alternative. Policy papers still have inadequate clarity on this point. However the concept of Block Grants through Indian partners is a positive step in this direction. This experience could possibly be looked at more closely.

5.7 Selectivisation and integration

A comprehensive, 'bottoms up' approach to primary health care was at the core of the Alma Ata Declaration. There has been a constant counter process that is selective, top down and vertical in programme content and management. This has been largely induced by bilateral / multilateral international donor agencies working through governments and by other donors offering and promoting package deals of predetermined priorities. Market economy factors, often to the benefit of the North and at the cost of the South, have also been a determinant of this trend.

In practice this can mean that from time to time donor agencies set their own priorities or change them based on interests of
their professional resource groups. Partners in the developing countries then modify their projects or at least the terminology
and jump onto the band-wagon to continue getting the support required. Thus one year the focus is on training village / community health workers, the next year could be tackling gender bias, the third year AIDS etc. While the issues themselves may be

important, the crucial ques
What is the impact on t
confront reality in their da

MEMISA has recently ou
reveals that it is well awa
the assessment of AIDS p
a) AIDS project proposal
health or other developme
b) AIDS project proposal
indigenous coping mechan

These are are indeed posi
policy shift seen as hitch
HIV/AIDS /STD's is imp

5.8 South North Dialog

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MEMISA pamphlet stat
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However as internationa
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focused on health, educa
programme support that

It is significant that an in
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'an active policy to put
organisation is dynamic

Building a critical, objective review of existing funding strategies into the regular planning cycle, with openness to dialogue and reflection with its national/regional developing country partners could be an important step towards these broader goals.

6. MEMISA'S INDIAN PARTNERS : A SOCIO-EPIDEMIOLOGICAL PROFILE

The Indian partnership of MEMISA has been reviewed in the following ways :

a) For the broader aspects of the review the period 1989 to 1994 has been taken as the phase of focus.

b) For an indepth review, all current project partners as of April 1994 have been included (ie. 153).

c) In some areas, due to time constraints, the three states where MEMISA has good working relationships with core partners ie. Andhra pradesh, Orissa and West Bengal, have been considered in greater detail. These are the areas where alternative options or experiments in new forms of partnership can take place.

d) To help appreciate the broad trends and not get too distracted by detail and minutiae, this chapter brings together salient findings as trends. All the detailed data is in the supplement for ready reference.

e) The supplement provides additional notes and check-lists, which would be useful when action is being planned.

f) Some tables use the computer analysis of data provided by the MEMISA desk and some are from data extracted by the researchers from the project material made available. The classification and categorisation used by the MEMISA desk (apparently for accounting purposes) and by the consultant researchers (for policy review) are somewhat different. These result in small discrepancies in numbers / totals. Since it is the broad trends that one is interested these minor discrepancies should not cause much of a problem.

6.1 The Partnership Universe

6.1.1 The partnership universe of MEMISA is primarily focused on the Southern states of India (47%). This is particularly in Tamilnadu, Andhra Pradesh, and Kerala and much less in Karnataka. There is increasing support to the Eastern States of Orissa and West Bengal (28.7%) and a little support to the North-Central BIMARU States (15%), primarily in Bihar and Uttar Pradesh.

Small numbers of projects ranging from 1-5 have been supported in Maharashtra, Gujarat, Madhya Pradesh, Rajasthan, Assam, Manipur, Tripura, Punjab, Haryana, Goa , Himachal Pradesh, and
Jammu and Kashmir, but these are not significant.
No projects have been supported in Sikkim, Arunachal Pradesh, Mizoram, Meghalaya, and Nagaland (see map).

6.1.2 During the last five years there seems to be a definitive trend to move away from Tamilnadu and Kerala and to some extent from Andhra Pradesh and move East and North. This is evident from the larger number of rejections (Kerala- 14.1%, Tamilnadu- 34.1%,and Andhra- 14%), lower number of selections, and higher number

though some of them have had one or two in the recent past (as indicated earlier).

6.2.4 In keeping with the overall health planning realities of the country, MEMISA like most other agencies is in the relatively more advantaged areas and in regions with better health status. A word of caution is however necessary here. Just as all-India figures hide regional disparities, state level figures also hide regional disparities within the State. Though A.P., W.B., and Orissa may be slightly better off than the BIMARU area, there are disadvantaged districts, villages and population groups within these regions. In West Bengal, the tribal and central districts of Maldah and Murshidabad, and in Orissa, the drought prone districts of Kalahandi, Phulbani, Bolangir and Sambalpur are very disadvantaged with poor demographic and health profiles. However looking within West Bengal and Orissa, one finds that MEMISA project partners are not predominantly in the disadvantaged areas as well.

6.3 Grassroots partners - Socio epidemiological profile

The 153 projects of MEMISA as of 1st April 1994 consist of 119 projects which are field projects. An overview of these show the following characteristics.

6.3.1 Rural / Urban distribution

73.1% are rural and 26.9% are urban. This is opposite to the situation in the country, with urban areas bagging over 70% of the resources, and rural areas being underserved with less than 25-30% of the resources. West Bengal and Tamilnadu have more urban projects, while Orissa has all rural except one urban.

6.3.2 Nature of partners

62.1% of partners are Church related, the large majority being Catholic Church related. A very small number are from Protestant groups, and are often registered as secular societies. 37.8% are secular voluntary agencies. In Orissa and West Bengal, the partnership is primarily with secular groups (92% and 77.8% respectively), showing a new trend. In Tamilnadu and Kerala there are very few non- church groups (4.5% and 0% respectively), showing traditional, historical linkages. Andhra Pradesh, Uttar Pradesh and Bihar show a moderate change in this direction ie 36.9%, 37.5% and 12.5% respectively of secular partners.

6.3.3 Focus of work

In keeping with the overall focus and priority of MEMISA funding policy about 95 projects are focused on primary health care /community based health care and action (77.3%) of one type or the other and about 37 projects are focused on support to vehicles, equipment and construction (31.1%), some of it also linked to PHC/ CBHC. Unlike many other agencies who have larger projects and often focus on much infrastructural development, the focus of MEMISA on field projects, building local capacity, training capacity etc. is very significant (more details in later section).
The regional distribution of PHC/CBHC projects is also very interesting. Orissa has 100% of the partners with this orientation; U.P., A.P., W.B. and Kerala have over 70%

and only Tamilnadu sho
55%. Orissa and Andhra
of these strategies are al
from the experience of t

6.3.4 Type of work pro

The 119 grassroots and
following categories. Th

a) Community health
These include communi
based health animators
health programmes, co
awareness building and

b) Basic primary medi
These include small di
camps like eye camps,

c) Provision of protec

d) Rehabilitation, Trai
through institutional /
community based rehab
These include support t

e) Some programmes
- 3.
Include primarily suppo
for TB sanatoria, lepros

f) Health professional
Include support for nu
workers training school

g) Equipment or othe
This includes support t
unit, a laproscope, a st

h) Slum development

i) Three projects are
one on the promotion
and nutrition garden (th
and one focused on tra

6.4 CORE PARTNERS - SOCIO EPIDEMIOLOGICAL PROFILE

Of the 153 projects currently supported in India (as of 11th April 1994) 34 projects support various needs and programmes of 13 regional and national resource groups, which are primarily supportive of other field based / grassroots voluntary agencies in the country.

For the purpose of the review, all these 13 partners are labelled as 'core' though in MEMISA desk, the usage of core partners usually refers to the first three. The reviewers are convinced that all these 13 partners represent a special group of resource centres in the country with a rich diversity of functions, skills and experience. Though the existing relationship is more limited and focused in some cases, these 13 (or more) could be a core group for a more sustainable partnership in the future. Hence 'CORE' is being used here in a more comprehensive and futuristic sense.

Table 2 in the supplement shows a profile of this group of projects and partners, the key features of which are :

a) These 13 partners are distributed in 8 States. Andhra has 2 (with 13 projects); West Bengal has 2 (with 8 projects); Orissa has 1 (with 1 project presently); Karnataka has 1 (with 2 projects); Bihar has 1 (with 2 projects); Tamilnadu, Kerala and U.P. have 1 each (with 1 project each). In addition the capital, Delhi has 3 (with 5 projects).

b) 9 of these are church related (with 20 projects). These are CHAI, EMMA, Seva Kendra, Rajgiri, RUPCHA, CARITAS, ISI- Delhi, CENDERET, and St. John's medical college. 4 are secular with 15 projects. These are VHAI, New Delhi, and its federally related State Associations in Andhra, Bihar and West Bengal.

c) 5 are membership organisations, though their mandates do not preclude them from supporting non member organisations. All of them are committed to supporting community health oriented programmes. These are CHAI, APVHA, WBVHA, BVHA, and RUPCHA.

d) 5 are training and research centres with varying commitment and mandate to extension services that support voluntary agencies in health and also development. These are CENDERET, RAJGIRI, ISI, Seva Kendra and St. John's.

e) MEMISA supports them in two ways -

** contributions to core infrastructural costs like office space/ rentals, salaries, loans, computer technology, running costs, vehicles, building construction, scholarship for students,training for staff and support to extension units or production /distribution of newsletters, and publishing/ translating health related books.

** in a few cases it supports programme costs for specific programmes including training of voluntary agency team members or trainers of health workers, school health, AIDS/ HIV, urban health, health communication and seminars. It also supported post disaster relief and development work through CHAI after the Maharashtra disaster.

Table 5A shows additional features about these 13 partners and includes 10 more

Bengal (Social Welfare Institute to Raigunj Diocese); 4 in Kerala (PSS - Peermade, VDS -Pulianmala and VDS- Marayoor, and MEDCHA (AYUSHA in Changanacherry); and one not identifiable- GP91D1A-72.

The supplement shows some of the key programmes and features of their projects. Some are more standard or routine approaches to community health extension work, while a few are definitely innovative and could become good working examples for other project partners.

However the exact nature of long term commitment, ongoing or proposed, was not at all very clear. The overall pattern that emerged was that these were primarily church related partners (68%), except 7 who were secular (31%). The church related groups drew much more support than the non church ones. Much of this was for infrastructural development, except ASSIST which had a large budget for its work on water supplies and sanitation. The church related ones (diocesan society in West Bengal and congregation society and mission hospital in Andhra) do not show any particularly innovative feature and are fairly typical of their type. The projects in Kerala, the Chaitanya Lepakshi group in Andhra, and many of the Orissa partners, seem to be much more relevant.

The 'long term partners' group of projects need to be looked at in greater detail, to learn from their experience and to review the process. They could be good peer supports to other projects supported by MEMISA in the future. However groups like St. Anne's in Andhra and SHED in Orissa need to be reviewed carefully, since various assessments in the past by core partners and others have not always been positive.

6.7 BLOCK GRANTS

The concept and practice of block grants is an interesting development . In a guideline drawn up in 1991, the objectives of this new form of project support were enumerated as :

a)To increase independence of partners,
b) Strengthen partner relations,
c) Accelerate project processing,
d) Promote primary health care / CBHC,
e) Activate/ stimulate and assess capacity of partners.

While this move was obviously an attempt to relieve administration at MEMISA ,it was a step in the right direction. 'Decentralisation' of decision making regarding project selection, support, monitoring and evaluation closer to grassroots partners, at national or regional levels could be a relevant way of enhancing the promotion of PHC/ CBHC by the practice of its concept and spirit even within the functioning / relationship of MEMISA and its country partners. It also helped to reduce the tensions and inadequacies of remote control management.

Two partners of MEMISA were invited to be partners in this experiment viz. CHAI, (Secunderabad) and CARITAS, (New Delhi). The block grant project to the two (while having overall similar purposes) evolved slightly different objectives and framework over time.

6.6.1 The CARITAS Bl

** The maximum amo
scheme was Rs. 40,000 - R
Project selection was base
a) Projects aiming at mate
services or community bas
b) Support should focus
be reproducible through th
c) Requests for running a
support teachers salaries f
d) Investments should air
e) A local contribution if

** Out of 39 projects w
showed that 47.8% were
the North East, Orissa and
supplement it is seen tha
medicines and transport,
medical camps, health tra
church related partners -
societies or related groups

** Since CARITAS has
since actual data was n
infrastructural developme
supporting PHC or involv
A more detailed interna
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insights.

6.6.2 The CHAI Block

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primarily complementary
small dispensaries, c) he
education programmes
supplement shoes that ou
available with reviewers)
to projects in South India
West Bengal, and the No
** In terms of focus 79
out of 40 projects used n
hopefully for immunizati
field programmes and h

were for interesting purposes - TB clinics, anti alcohol / deaddiction programmes, substance abuse, promotion of indigenous medicines, model herbal gardens and in one instance a Hindi typewriter for health care publications in the vernacular.

** The review shows that the Block Grant project results in wide dispersion of money in small amounts and provides supplementary/ complementary support to ongoing programmes. However the large proportion of disbursals for equipment and medicines is of questionable value in the promotion of PHC in the absence of other elements of strategy. Since it is also called a 'discretionary fund', must at intervals be analyzed internally and reported, to ensure that the broader goals are always kept in focus.

** The small grants could be used to support more innovative ideas with 'seed money' and also to promote more training efforts for health centre staff as part of human resource development in areas such as the North East where there is both interest and an increasing need for such effort.

** Accounting procedures and methods are not insisted upon, probably because of the small amount of each grant. However taken together the total 'Block Grant' is fairly big and some practical and useful method can be evolved by both MEMISA and core partners in the years ahead.

6.6.3 The 'Block Grant' experience

Overall the block grant scheme seems a good idea, working well. It needs to have greater focus on primary health care/ community health aspects ni general, and human resource development (training) and community awareness in particular, for it to have a meaningful long term effect. Also its use as seed money to be risked on potentially innovative ideas needs to be strengthened, with the more usual requests being channelled elsewhere.

Greater coordination between CARITAS, CHAI and MEMISA as a consortium would help ensure that there is not only no overlap, but perhaps a greater complementarity in efforts, with small and longer term needs identified by both groups, being appropriately referred to one grant or other.

A move to support more efforts among smaller non church NGO'S should be considered by both CARITAS an CHAI seriously not only in a spirit of dialogue with the larger universe of potential partners but also recognising the tendency for institutionalisation among church groups.

6.7 ADDITIONAL FEATURES

There are additional features from the review of computerised categorisation by MEMISA of project types and focus of support. In the supplement two sets of categorisation used by the administrative staff (according to different budget lines) are shown. The categories in both the sets are not all mutually exclusive and support to one project could figure in more than one category, especially the categorisation on forms of support. In addition the categorisation is somewhat arbitrary, especially in categories such as 0 -line basi-. health care, 1 -line health

6.7.2 Types of support

As in the previous section the alphabet in brackets refer to the code used by the Desk.

a) Funds for personnel (A)
Some funds for personnel figure in most project proposals for staff at various levels - field based health workers, animators and supervisors and professional support staff like doctors, nurses and nurse midwives. Social workers, health educators and community organisers have also been provided for.

b) Medicines/ bandages (C) and instruments/ equipment (D)
these lists show the same range of needs and projects supported. It may be a good idea for MEMISA to evolve a basic medicine/ equipment list catering to small primary health centres and peripheral dispensaries. This can be done with the collaboration of some of the core partners so that the Indian context is considered. It could also build in a perspective of rational drug choice, the concept of essential drugs and appropriate technology. For the key larger equipments provided to projects a longer term review to identify problems of maintenance and repair may be necessary. This review may help the list by bringing in the context of suitability, costs, logistics and repair potential.

c) Training courses and meetings (G) & educational materials (F)
This list shows that training is supported at field level and primarily intra project. However there is no project for continuing education of all those already trained in the list. With greater involvement of core partners and networking among projects this lacunae in educational effort needs to be tackled urgently. All core partners organise training programmes and some produce newsletters and other educational material. Better coordination of these efforts with greater potential for he utilisation of these resources and opportunities by field partners is a crucial task for the future. 'Accompaniment' as it is sometimes referred to among policy and donor circles needs greater coordination and strengthening.

f) Construction/ infrastructure/ buildings (I)
This is always a difficult policy matter. Some institutional base is required for most projects , even the process oriented ones in the long term. However the context of construction and
access / use by the community needs to be given importance. With long term sustainability in mind greater use of local, available buildings eg. schools, community halls etc should be increasingly promoted. Support from government, local agencies, local bodies and donors should be sought. Too much construction often sends wrong signals of land ownership and landlordism to people and process dimensions/ empowerment/ local responsibility get could adversely affected. Assessment by core partners in this decision could be of help.

g) Transportation
Like all other donor agencies MEMISA also provided support to its partners for purchase of cycles, motor bikes, jeeps, cars, vans minibuses etc. While mobility is

important, particularly i
must be assessed more
project partners to revie
use and under use.

h) Water and Sanitatio
Presently 4 projects out
During the phase 1989-
projects are in the So
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facility and sanitary lat
environmental hygiene
projects show the dime
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need to be reviewed
educational effort may

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In this connection i
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6.8 Community H

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supported and
primary health

service provider' and extension of health care.

(ii) The second one is more in the form of a social process where organising the community and making them 'health aware' through informal education effort to enable and empower them to get greater control over their health and the facilities and needs that make health possible, is the predominant emphasis. A demand is made on the existing government health infrastructure and collaboration with it is increased.

Most projects fall into the first and some in the second category. Most have an element of both. One needs a 'community health manager', the other one needs a 'community health awareness builder'. Training strategies for either would be slightly different. These are already reflected in the different training programmes.

(iii) CENDERET'S six days training programme on 'management of rural health programme in the voluntary sector' covers the following. Health scenario of Orissa, comparison to India, Concept of CH Programme; commissioning of CH programme; NGO's and Community Health; Formulation and management of a health project; techniques of monitoring and evaluation; environment and CH; infrastructure and facilities of the Government health structures, how to link effectively with the government; case analysis of successful health projects, ways and means of tackling medical legal cases and formulation of a health project.

(iv) WBVHA's 40 days training covers more areas which include - Relationship between health and development, CH-conceptual clarity, Primary Health care, roles and responsibility of health worker; society. Superstition and health; human relations, effective communication, audiovisual aids, home remedies, MCH care, Food and Nutrition, child care and psychology, family welfare planning, common communicable diseases, TB, Leprosy, AIDS. Environmental sanitation, Accidents, First Aid, Womens problems and rights, School Health, Survey health management, MIS, evaluation etc.

(v) CHAI's Community Health Department has long and short training programmes with all the above areas but a greater emphasis on alternative systems of medicine, urban health and on organising for health. The courses are changing all the time.

These differences and similarities should be put together to clarify both the options in Community Health as well as the need to balance them or emphasise one or the other approach in a particular situation or region.

An extract from a post funding report carried out by CENDERET on Memisa partner symbolises this dialectics very well. It notes:

> "Thus, the overall opinion of the evaluation indicates that the project was implemented earnestly by the agency but it stressed more on physical

wider consequences.

7.2 KERALA

In Kerala, all dioceses and congregations have access to probably too much money and resources, leading to over institutionalisation, over medicalisation and sometimes a crisis in 'mission'. All forms of infrastructural support are not therefore relevant.

Paradoxically however there is some need for community health initiatives of an alternative type to counter the overmedicalisation and empower those who do not have access to existing services especially in the few Adivasi (tribal) regions.

The projects supported by Memisa have a fairly strong community health and development approach, though being church linkages the project budgets tend to be on the higher side raising questions about sustainability. Groups like Rajgiri Institute and Ayusha in Changnacherry are doing very relevant work in the Mission health scene countering market economy, the former through health awareness, Arogyamelas, exploring community Mental health and so on and the latter promoting the integration of medical systems and Holistic health. Memisas support to them is relevant.

However, not being a priority state the support should become more qualitative than quantitative.

7.3 ANDHRA PRADESH

The partnership in Andhra shows a very mixed profile. It has some church related institutional partners who emphasise institutional development though they are also moving towards community health approaches in focus and training. The presence of CHAI is very important since the linkage is long-term and it has received substantial infrastructure support (1). Being an important national core partner, its involvement in selection and support to smaller projects is increasing. There is a growing number of smaller, more secular field based groups who are community health oriented though 'providing services' may be much stronger than 'empowerment'. The links with APVHA is potentially a good one and the ASSIST partnership focusing on the special priority needs of water supplies and sanitation is significant. However Andhra is experiencing the phenomena of mushrooming of NGO's with not very clear and sometimes dubious agenda. The process of selection, follow up support and monitoring should be strengthened involving CHAI and APVHA. Some present partnerships need to be critically reviewed and perhaps phased out as well. An intra-state regional focus towards more disadvantaged districts within Andhra, could be explored. Focus on training, supporting networks, continuing education and issue raising should be enhanced. Mega budgets to be reviewed and reduced.

7.4 ORISSA

The Orissa partnership is better organised and better focused on priority groups, substantially, because the regional core partner CENDERET has a clarity of vision and a definitive commitment to the promotion of small NGOs and groups and supporting

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7.5 WEST BENG

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inevitable but there needs to be a greater long term clarity in the partnership with WBVHA.

7.6 UTTAR PRADESH

This is India's largest state and a major component of the disadvantaged - north central - BIMARU belt. In spite of a larger investment of the country's development resources it is still a problem state not only because of its unwieldy size, but also because of feudal attitudes, political corruption and the status of women and the marginalised sections of society. Recently an awakening among the lower casts and minority groups and a political partnership has led to very significant socio-political alignment of forces, that have countered upper caste/ religious fundamentalism politically but has also raised the aspirations of marginalised groups all over the country. UP is therefore a politically and socially volatile state.

The Memisa partners are however primarily church linked and though there has been a shift from institutional medical work to a greater community health orientation, the focus is still on providing alternative services with demands for infrastructural support- hence somewhat larger budgets. There is need for greater efforts is reorientation, training and networking towards community health with an increase in numbers of linkages with small secular voluntary agencies as well. The 'mega mega' urban community health project with involvement of the prestigious Banaras Hindu University Medical college and VHAI at national level seems to be having major problems of focus, process and bureaucracy - as most mega projects invariably have. However, the emerging interest in RUPCHA as a more regional network within CHAI, and the development of UPVHA with its four regional subunits are all potential partnerships that can serve to promote community health through small interventions but in larger numbers.

7.7 BIHAR

Bihar is another complex but high priority component of BIMARU. Its needs are diverse and its socio-political situation rather confused and constantly changing. With Memisa linked projects spread out over 5 districts in Santal Parganas, Palamau, Muzaffarpur, Ranchi and Patna, it would be unrealistic to expect a major impact from the existing partnership. The linkages are mostly with church related groups with the usual focus on construction/equipment/ vehicles. These would therefore mainly be referral centres supportive of community health.

The secular links are few. However the partnership with BVHA is potentially a good one and needs to develop further if support to Bihar emerges as a regional priority. Projects in the field need sustained technical, and information support in many places because governmental infrastructure is weak. However in spite of the complex socio-cultural-political situation, health projects with an enabling/empowering dimension are very relevant and there is increasing number of efforts in this direction which could be supported. The presence of CENDERET and WBVHA in neighbouring states with long term linkages is important since they could be tapped as additional resources for new initiatives in the state.

project proposals including preselection assessment by core partners. (ii) the review of the budget allotments and its trends (iii) the process of monitoring and evaluation including post funding assessment by core partners (iv) the role of the health department and foreign/local expertise (v) the 'sustainability issues and (vi) some feedback from the core partners about the partnership as a 'whole experience'.

8.1 Selection Criteria

The overall criteria for selection of partners, available in the policy guidelines have been enumerated in section 4.4 and are a comprehensive set. The commonest reasons for rejection of project proposals is mentioned in section 5.1.3. Both these show a very definitive commitment to promotion of community health action.

8.1.1.

A review of the item entitled 'Afwegingen' in the project memoranda for three states - Andhra, West Bengal and Orissa show that the selection system in practice included the following factors/criteria:

(i) The two commonest criteria listed are a) the project has good contact/experience with people b) the project has been reviewed and recommended by one of the core partners. This includes the project having been modified, reoriented, replanned or reworked out with the help of the core partner showing a healthy reliance on core partner assessment.

(ii) Other criteria included/mentioned are well known organisation; well organised and reliable organisation, good record of similar projects; experienced project holder; target group is the poorest, most neglected, lowest income group; focus on women; no previous financial support for target group from government; problems listed out well; project systematically built up; well planned project; support of government to project; experience with project good; focus on backward area of state; local health infrastructure poor due to governmental neglect; trained field workers and experienced staff; good motivation of team; consistent plan with self supporting activities built in; good knowledge of area; good local structure; commitment to sustainable development; small organisation; no overlapping of services with other NGO's; share resources with other NGOs; approved by local authorities; good contact with government; developing linkages between government institutions and people; promoting self financing schemes like health insurance schemes; focusing on priority area; good experience with pilot project preceded by education and awareness building efforts scheme; professional organisation etc. Taken together the reasons include organisation structure, vision, capacity, links with government and other NGOs, reliability, accountability and motivation all of which are very important. In fact the above list drawn up from the project memorandum can itself become a check list for the future. However it would require some rearrangement.

(iii) The criteria for rejection or concerns about continuation of support would be

the absence of the
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8.1.2.

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or deserving areas; feasib
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organisation of youth and
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and or committees; lack
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information; lack of rec

8.1.3.

This study shows that t
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them are presently in th
schedules for the proces
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crucial differences as w
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form of networking and group learning and dialogue at this stage.

8.1.4.

On the whole the preselection process, when it involved core partner or health unit was carried out fairly rigorously through a few partners with dubious records did seem to have slipped in. Perhaps inadequate attention was paid to comments of the assessors and this needs to be geared up more. Decisions based only on field assessments by core partners would prevent this in the future.

8.2 The budget review

The table in the supplement shows the broad features and trends identified by a review of the budget of the current partners.

8.2.1 By size

50% of the projects are less than 20000 df (3.6 lakhs Rs) 30.4% are between 21-50000 Df (3.6-9 lakh Rs), 13.5% are between 51-1000 DP and 9 mega projects are above 100000 Df. (These will be analysed later). By foreign funding agency standards, the Memisa grants are relatively smaller through by Indian standards they are not necessarily so. The grants have also to be seen in the context of the phase of the project into which they are being introduced. As starting funds they are more than is really required or absorbable by small NGOs initiating community action. But for later in the process eg, third or fourth year they are quite adequate. The problem with too much funding is that they are obstacles to increasing community involvement and send the wrong signals to the community - so long term sustainability is affected. Also most grassroots projects need to spend time understanding the local situation and building good rapport with the marginalised and deprived sections of the community. Action of any type including adhoc services must be initially only a means to education, awareness building and community organisation. The process dimension in our experience is inversely proportional to the budget input. The more the input the less the 'process emphasis'. The core partners have in most cases or reduced the budget estimates in their effort to reorient or reprioritise the projects proposals. If all eventualities are budgeted/catered for (seen as being practical in financial planning and budgeting) than what is left for the community to contribute?

8.2.2 Megabudget projects

Nine projects have a budget for 100000 Df or more and three of these are more than 200000 Df. These are EMMA-Tamilnadu (148000); Urban PHC project-kanpur Mirzapur-UP (967000 Df); School Health Programme - WBVHA - Calcutta (101400 Df); Rural sanitation programme. ASSIST Andhra (476912 Df); Training of Trainers of village Health Workers - VHAI-Delhi (375000); Prevention and control of HIV infection/AIDS in West Bengal - WBVHA (140500 Df); Promotion of Community Health in urban area - CHAI (166800 Df); WBVHA Office space - Calcutta (117700 Df) and the Block grants with CHAI and CARITAS. While most of them were for programmes that are relevant, the scale of operations and inputs would require a more

be reviewed indirectly.

(i) All projects are assessed primarily by the Desk staff and monitored through ongoing correspondence and reports received by partners. No definitive format of concurrent or terminal reporting or evaluation had been laid down.

(ii) The core partners were requested to undertake post funding assessment usually after one year of the first grant though this was not in all cases and not also all projects in the state in which the core partner was situated. It seemed that only if there doubts, concern or negative feedback about a partner, then this assessment was initiated. Of late post funding has become routine with CENDERET focusing mainly on Orissa projects. It is still occasional/adhoc with CHAI and WBVHA.

(iii) The Health Services Department in MEMISA also helps not only with advise at the pre-selection stage by raising questions of context, methodology, orientation and so on but also comments on reports and data available from field partners. This is also only when the desk requires such review.

(iv) Baseline surveys are suggested before the project gets off the ground so that impact on the initiative can be measured at the end of the project phase. No guidelines were available from MEMISA or its core partners on baseline surveys. While it seems a logical idea, from the practical point of view a preliminary baseline survey especially if done too early in the contact phase with the community is neither relevant nor valid. Work in the first two years of any project is primarily around establishing rapport with the people, understanding the local situation. No service at this stage makes any impact so soon on the indicators. After one or two years when the community knows the project team they are likely to give more authentic responses. If at all required guidelines should be provided for some basic information using some quantitative and more qualitative approaches. Some projects spend too much money on baseline surveys which are not very useful later. Some clarity on this issue is required by MEMISA and its core partners.

(v) Asia desk staff visit India occasionally and sometimes they send out experts from the Health or other departments to visit certain projects, dialogue with local partners and sort out local problems and explore certain concerns about specific project proposals or funded projects.

(vi) A review of 22 projects sent to the Health Services department (in house) was made.

a) The projects ranged from building a referral hospital; high-technology diagnostic and lab equipments; rhinolaryngofibroscope; building alcohol treatment centre; health centre for rehabilitation of drug addicts; community health and MCH programmes; office space for a core partner; eye camps; quality assurance lab for CHAI; essential drug support for health units; workshop on health information for Tibetan refugees; education and

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8.4 Feedback from Partners

During the field visits to the core partners the reviewers got an opportunity to discuss the MEMISA partnership and some interesting feed back was obtained.

(i) The core partners appreciated the partnership and the increasing trust that MEMISA placed on their suggestions and assessment and recommendations.

(ii) There was an adhocism is sending requests for prefunding. Some were sent and some were not, even in regions directly accessible to the core partners. A clearer policy on this and some common guidelines should be evolved.

(iii) Sometimes recommendations by core partner were not accepted and a contrary decision taken without dialogue eg Core partners recommends a vehicle and Memisa does not accept. It is one sided if there is no dialogue on the justification or context of the recommendation.

(iv) Involvement in follow up and monitoring by the partner who did the preselection would be helpful to the process. A policy on this is required with some guidelines as well.

(v) Three year funding cycles are too short and there is need to phase out gradually beyond the third year through a sort of bridge fund idea.

(vi) Memisa's own policy guidelines are not communicated adequately or effectively so the partnership context is not clarified.

(vii) The core partners vision and initiatives may not always be complementary to Memisas goals and also core partners may vary in their orientation. So more networking among key partners is required.

8.5 Impact Evaluation

All funding agencies would necessarily be interested to know the impact of their interventions in a project or in a region. However this is not easy to measure Small inputs of some equipment here or a vehicle there are too incidental to make a direct bearing on impact. If the support is to a programme then the project partners must have clear goals that are both achievable and measurable. Measurements may be quantitative or qualitative. Ideally they should be part of the concurrent internal review system of the project. In the present context of funded projects this is a major lacunae and little time or focus is given for such measurement. The core partners should focus on this aspect and facilitate the evolution of a common guideline.

8.6 Sustainability

Whether financial or in terms of human, material and monetary resources sustainability can be established only if it is a concern from the very beginning and built into the

training of workers and project staff and to health education materials and awareness building processes.

c) Lack of clarity about the scope and role of core partners in the accompaniment and support to grassroots field partners resulting in a somewhat adhoc involvement of them in networking, training and monitoring and evaluation efforts as well as in the selection or post funding assessment.

d) Inadequate and infrequent mechanisms of communication and review with core and field partners as well as lack of transparency in information flow back to partners resulting in an overall style of 'remote control funding'.

e) Strong project orientation to primary Health care and hence emphasis in linkage, support, project assessment etc to quantitative provision issues rather than qualitative process issues of empowerment.

f) No real clarity, on the part of MEMISA, and its core grass roots partners about what sustainability actually means and hence very little emphasis in planning of projects, is given to the issue of preparation for sustainability. In the new environment, of availability of too much funding by too many organisations, sustainability is increasingly though unfortunately recognised as a continuous entrepreneurship in tapping resources from the large number of donors available and not the necessary stress on increasing community capability and participation in decision making and contributions to cost recovery etc.

9.3 Opportunity/s

a) To review the India partnership critically with its core national/regional and key grassroots partners and developing new directions and thrusts, building collectively on past experiences, present skills and competencies and a clear vision for the future. This vision and action plan would include perhaps an identification of (i) geographical/regional priorities (ii) key thrusts in the context of emerging needs in the country eg, women's health, urban poor, integration of medical systems, preparation of panchayat leaders for health decision making in the context of the emerging processes of decentralisation (iii) an increased commitment to qualitatively improve existing and evolving partnerships through emphasis on training, staff development, networking and continuing education and concurrent monitoring and evaluation primarily as a team and group learning process.

b) To promote and strengthens and field partners and equally to promote and support their involvement in increasing regional/national networking so that there is increasing sharing of field experiences and increasing commitments and solidarity to broader issues like national drug policy, commercialization of professional education, medical malpraxis, and a host of other emerging movements on women's issues, sustainable development, promotion of local traditions and organisation of the marginalised with health care/PHC being means and not just ends.

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9.4 Threats

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few) could be classified in this category. With inadequate care to pre-selection assessment and concurrent supportive supervision and monitoring and review by core partners, the number of projector partners with dubious motivations would increase. Greater local and field level assessment procedures involving core partners would be a preventive measure.

e) Finally the key threat would be that of having unrealistic expectations of the partnership and the impact of project action. Promoting primary health care and community based health action is not an easy process. At the field level, operationalising it can be even more difficult, though challenging. There are vested interests in maintaining the abundance of ill health at all levels - local, regional, national, international and global. The quest for equity is very complex. Expecting 'impact' too soon, and that too at micro level when macro level changes - economic and political are actually increasing impoverishment and decreasing investment in health and welfare expenditure, is being unrealistic, perhaps uninformed and simplistic as well. Funding agencies are still very strongly immersed in the donor-beneficiary paradigm. There is an overemphasis on field projects and inadequate clarity on the need, nature and focus of professional/technical support groups at regional and national level and hence finding the funds for such work directly is not an easy proposition. In this complex situation all partnerships must evolve with patient, and mutual understanding. The impact of project partnerships will therefore have to be measured not just in terms of services provided or targets reached but in the quality of the mutual understanding and dialogue relationships established at all levels - between funder and partner, and partner and community.

10. THE WAY AHEAD. Towards a more comprehensive and sustainable partnership

Having identified the key trends and the salient features of MEMISAs Indian partnerships including its present strengths and weaknesses and some of the opportunities and threats, we list out some ideas and suggestions for MEMISA and its Indian core partners to consider as steps towards a more comprehensive and sustainable partnership in the future.

It is important to clarify at this state - that these are only suggestions and arise from our desk review and we are well aware of the limitations, since project memoranda, computers printouts, policy papers and guidelines and bits and pieces of correspondence cannot give the complete picture of the realities of the partnership process. The dialogue with the staff of three core partners CENDERET, WBVHA and CHAI during the short contact visits, and with the MEMISA Asia desk staff on 15/16 of September (1994) was very helpful, to further contextualise the findings and understand other dynamics of the partnership process.

The suggestions are offered not as recommendations of 'outside experts' but as a stimulus for study, policy reflection and action by 'insiders' who are themselves

The framework of the field review will have to be evolved by three partners together because as indicated in a table in the supplement there are differences in the states, differences among the understanding of the partners about community health, role and scope of support and emphasis and priorities in field action. A collective exercise will build both consensus as well provide adequate flexibility for the regional differences.

All the additional information available to the receivers will have to be made available to the core partners as well because there are projects in each state, who have not been referred to them in the past.

Some care will have to be taken in the planning of the field reviews for maintaining objectivity and certain degree of standardisation (check lists and so on so that field reviews can be compared).

It is also important that the review is seems as a practical study-reflection-action process and not a very rigorous research study.

10.3 An Interactive Dialogue/Workshop

Based on the papers and reports that emerge from the supplementary action suggested in the previous section (10.1 and 10.2) an interactive workshop should be organised some time in the future to evolve new directions and action priorities as well as plans to consolidate the existing partnerships and thrusts that are already seen as being meaningful and relevant.

The objectives of the workshops would include:

(i) Building a consensus on Community Health/Primary Health Care in the Indian situation and based on that consensus, building common guidelines for pre-selection assessment, concurrent monitoring and 'accompaniment' and post funding assessment (The existing Memisa guidelines evolved in other situations could be additional background material).

(ii) Identifying regional priorities - both interstate and intrastate

(iii) identifying specific thrust areas/strategies in funding - (some areas of importance have been mentioned in the initial chapters and some during the presentation of findings as well).

(iv) Evolving a ongoing mechanism of communication and dialogue between MEMISA and all its core partners and perhaps some key field partners as well so that this review document and the workshop that follows it, is not the end of the process, but the end of the beginning - and ongoing review, group reflection and policy evolution becomes a integral part of the planning cycle for the partnership. For this purpose the concept of a network, forum or consortium may have to be considered.

10.4 Consolidation and

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10.5 Towards greater

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(i) A willingness on the part of MEMISA desk to decentralise decision making process further and share information in a more participatory way and through a more collective exercise.

(ii) A willingness on the part of the three existing national/regional care partners to be willing to review the whole partnership in the context of needs and priorities to which they would be willing to mount responses and initiatives, and not be too preoccupied with their own infrastructural and in-house or programme needs.

(iii) A willingness on the part of some of the grassroots partners (especially those with whom MEMISA has established or would like to establish a longer term partnership) to be willing to participate in a sharing of resources, perspectives, skills and experience with a larger network of project partners and not be too preoccupied with their own infrastructural and programme needs.

At the first two levels, the reviewers believe there is already such willingness and an enthusiasm for strengthening the partnership. From the desk review it is obvious that there are grass roots partners, perhaps a small number who could definitely participate and contribute to such process.

We hope this desk review will assist and stimulate such a process.

10.6 Dialogue with other Funding Agencies

In recent months other agencies funding voluntary agencies in Health care in India, have also initiated reviews of their partnership. Cebemo and Icco with the Dutch Ministry of Development Cooperation has initiated a review of their partners in Community Health in India. The review will focus primarily on the role of national/regional resource groups and their increasing response to the emerging needs within the enlarging grassroots groups in the country. Misereor has initiated a review of its involvement in Orissa, West Bengal, UP, Andhra and parts of Bihar and Madhya Pradesh and also its increasing support to CBR and urban Health Projects. Misereor has also begun to experiment with National Level forums of its partners as a new from of support group involved also with selection of new partners and initiatives. At present groups in Education and vocational training have been initiated while efforts to evolve one for CBR projects is going on as well. The disability unit of Action Aid in India has been networking with its partners on a regular basis evolving common monitoring and evaluation strategies and exploring issues of sustainability.

There is therefore an urgent need for Memisa to initiate a dialogue with key funding agencies in Europe who have a similar orientation and perhaps a common and overlapping clientele to share information and perspectives and to dialogue around new thrust and regional initiatives.

Actually this should be going on all the time because there are indications of overlapping and too much focus on some areas and some groups as well.

11. A STATISTICAL SUPPLEMENT/ADDITIONAL NOTES

A. MEMISAS PARTNERSHIP IN INDIA

1. A Partnership Overview (All potential partners 1989-94)
2. Projects in India (As of 11th April 1994)
3. Field Project partners - Socio epidemiology
4a. Memisa Desk categorisation by Focus
4b. Memisa Desk categorisation by Means
5a. Core partners profile (current and potential)
5b. Core partners current (further details)
6. Long term partners - profile
7. Block Grants - profile
8a. Budget Analysis - Trends and distribution
8b. Budget Analysis - By desk categories
9. MAP of Memisa Partnership - Past, Present, Future?
10. Diagram - Towards a new Framework of Partnership.

TABLE-
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S.No	STATES	Proj curr
1.	ANDHRA	5
2	TAMILNADU	4
3	KERALA	23
4	KARNATAKA	10
	(SOUTH INDIA)	(1+
5	BIHAR	15
6	MADHYA PRADESH	8
7	RAJASTHAN	2
8	UTTAR PRADESH	12
	(BIMARU)	(5+
9.	ORISSA	42
10	WESTBENGAL	21
11	NORTH EAST	7
12	MAHARASHTRA	5
13	DELHI	15
14	HARYANA	1
15	GUJERAT	1
16	HIMACHAL PRADESH	1
17	JAMMU AND KASHMIR	1
18	GOA	–
19	PUNJAB	–
		26
20	Inadequate data in computerlist	–
21.	TOTAL	26
	→	(27

APPENDIX-B

(HEATH SITUATION IN INDIA – TEXT AND STATISTICS)

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8.9.1994

TABLE-2

(As of

S.No	STATE	No. of Projects
1	ANDHRA PRADESH	32
2	ORISSA	27
3.	TAMILNADU	23
4.	WEST BENGAL	17
5	KERALA	12
6	BIHAR	10
7	U.P.	9
8	DELHI	6
9.	KARNATAKA	5
10	MAHARASHTRA	4
11.	MADHYA PRADESH	4
12	NORTH EAST	3
13	HARYANA	1
14.	RAJASTHAN AND OTHERS	-
15.	TOTAL	153*
16	(1+3+5+9) SOUTH INDIA	72
17	(2+4) EAST INDIA (UP+ORISSA)	44
18	BIMARU (6+11+14+7)	23
19.	AP+ORISSA +West Bengal (Core)	76

The computer print
* projects. The state

This does not includ
1989-1994 but were

TABLE-3

FIELD PROJECT PARTNERS : SOCIO-EPIDEMIOLOGY (119 PROJECTS)
(As of 11th April 1994)

SNo	STATES	Number of Projects	% RURAL	% URBAN	% CHURCH RELATED	% SECULAR	% PHC/CBHC	Infrastructure % Vehicle Equipment Construction	Mean Support (Rs)**	% of All India PHC/CBHC
1.	ANDHRA	19	84.2	15.8	63.1	36.9	78.9	33.3	22150 (18)	16.3
2	ORISSA	26	96.1	3.8	7.7	92.3	100	0	19536 (26)	28.3
3	TAMILNADU	22	45.5	54.5	95.5	4.5	54.5	45.5	23020 (22)	13
4	WEST BENGAL	9	55.5	44.5	22.2	77.8	88.8	44.4	19520 (9)	7.6
5	KERALA	11	72.7	27.3	100	0	72.7	36.4	29500 (11)	8.7
6	BIHAR	8	75	25	87.5	12.5	62.5	62.5	17840 (8)	5.5
7	UP.	8	75	25	62.5	37.5	87.5	37.5	34270 (7)	7.6
8	OTHERS*	16	75	25	87.5	12.5	76	50	15180 (15)	13
TOTAL		119	73.1	26.9	62.1	37.9	77.3	31.0		
	OTHERS ↓	↓ Numbers only - Not percentages								
(i)	Karnataka	3	3	0	3	0	2	2		
(ii)	M.P.	4	3	1	4	0	2	3		
(iii)	Maharashtra	4	3	1	3	1	4	–		
(iv)	Assam	3	3	0	3	–	2	2		
(v)	Delhi	1	1	–	1	–	1	–		
(vi)	Haryana	1	–	1	–	1	1	–		
–										
9.	SOUTH INDIA	55	67.2	32.8	85.5	14.5	67.3	34.5		40.2
10	EAST INDIA →	35	85.7	14.3	11.4	88.6	97.1	11.4		36.9
11	BIMARU	20	70	30	80	20	70	55		15.2
12	AP+orissa +west Bengal (core) →	54	85.1	14.9	29.6	70.4	90.7	13		53.3

* OTHERS INCLUDES ITEMS (i) TO (vi) SHOWN BELOW

** NUMBERS IN BRACKETS REFER TO PROJECTS INCLUDED TO CALCULATE THE MEAN. MEGA PROJECTS HAVE BEEN EXCLUDED TO GET A MORE REPRESENTATIVE AVERAGE.

TABLE-4B MEMISA-DESK CATEGORIZATION (MEANS)

NUMBERS -(NOT PERCENTAGES)

S.No	STATES	PERSONNEL	MEDICINE /BANDAGES	INSTRUMENTS /EQUIPMENT	TRAINING /COURSES /MEETING	REHABILITATION MATERIALS	EDUCATION MATERIALS	TRANSPORTATION	BUILDINGS	BLOCK GRANTS	WATER/ SANITATION	CAPITAL INJECTION	COMBINATION OF CATEGORIES	MISCELLANEOUS	TOTAL
		A	C	D	G	ET	TT	H	I	J	K	L	M	Z	
1	ANDHRA	11	-	4	6	0	3	5	4	3	4	1	9	8	58
2	ORISSA	11	-	-	4	-	1	1	-	1	-	-	17	7	42
3	TAMILNADU	6	-	1	9	-	2	3	7	-	5	-	5	3	41
4	WEST BENGAL	1	-	-	6	-	4	2	1	-	-	-	5	2	21
5	KERALA	3	-	3	2	1	1	3	-	-	3	1	4	2	23
6	BIHAR	-	1	1	1	-	-	1	6	-	-	-	4	1	15
7	UP	-	1	1	4	-	2	1	2	-	-	-	1	-	12
8	DELHI	5	-	1	-	-	1	-	1	6	0	1	-	1	16
9	KARNATAKA	-	1	2	2	-	2	-	2	-	-	-	1	-	10
10	MAHARASHTRA	-	-	-	3	-	-	-	1	-	-	-	1	.	5
11	M P.	-	-	3	1	-	-	2	1	-	-	-	1		8
12	ASSAM/ NORTH EAST	-	-	1	3	1	1	-	-	-	-	-	-	1	7
13	YANA	-	-	-	1	-	-	-	-	-	-	-	-	-	1
14	RAJASTHAN	-	-	-	-	-	-	1	1	-	-	-	-	-	2
15	HIMACHAL PRADESH	-	-	-	-	-	1	-	-	-	-	-	-	-	1
16	GUJERAT	-	1	-	-	-	-	-	-	-	-	-	-	-	1
17	J & K	-	1	-	-	-	-	-	-	-	-	-	-	-	1
	TOTAL	37	5	17	42	2	18	19	26	10	12	3	48	25	269
	PERCENTAGES →														
18	SOUTH INDIA	54		58·8	45·2		44·4	57·8	50				39·6	52	50·2
19	EAST INDIA	32·4		0	23·8		27·7	15·8	3·8				45·8	36	23·9
20	BIMARU	0		29·4	14·3		11·1	26·3	38·5				12·5	4	14·1
21	AP+OR+WB	62·2		23·5	38·0		19·0	42·1	19·2				64·6	68	46·0

@ All projects sanctioned/supported in phase Jan 1989 to 11th April 1994 including those closed/completed before 11th April.

TABLE. 5B CORE PARTNERS - CURRENT

FURTHUR DETAILS

SNo	FEATURE	CHAI	CENDERET	WBVHA
1.	TYPE OF ORGANISATION	National Membership Association of Catholic Health Institutions	Development Extension Training & Research Unit of an Institute of Management	State level membership association of voluntary agencies in Health care
2.	SUPPORT TO MEMISA	MOSTLY PRE FUNDING & POST FUNDING ASSESSMENT (ALL OVER INDIA EXCEPT ORISSA/WB)	PRE-FUNDING & POST FUNDING ASSESSMENT — (MOSTLY ORISSA OCCASIONALLY OTHER STATES)	MOSTLY PREFUNDING & POST FUNDING ASSESSMENT (ONLY WEST BENGAL)
3.	SUPPORT FROM MEMISA			
A:	INFRASTRUCTURE SUPPORT	VEHICLES FOR i) CHAI STAFF ii) DESK-TOP TECHNOLOGY iii) TOUCH FOR HEALTH COURSE BOOKS iv) INTERNAL EVALUATION - ANNUAL GENERAL MEETING v) ELECTRONIC PABX vi) GENERATOR AND FAX MACHINE vii) INCOME GENERATION SUPPORT	i) SUPPORT TO REGIONAL RESOURCE TEAM AND CENTRE	i) OFFICE SPACE - purchase ii) ASSISTANCE TO JOURNAL (CHANDER HATH) iii) BENGALI BOOK EYE CARE (Translations) "VILLAGE STRUGGLING FOR EYE HEALTH" iv) FOR NGO SUPPORT SERVICES NETWORK v) CAR FOR SCHOOL HEALTH PROGRAMME
B:	PROGRAMME SUPPORT	1. BLOCK GRANT SCHEME 2. COMMUNITY HEALTH PROMOTION IN URBAN AREAS 3 EARTHQUAKE RELIEF IN MAHARASHTRA	PROMOTION OF SMALL GROUPS (Developing Skills, Financial support, Networking and Escorting and follow up)	1. SCHOOL HEALTH PROGRAMME 2. AIDS CONTROL PROGRAMME 3 INDIA-AFRICA EXCHANGE PROJECT
4.	PRIMARY HEALTH CARE/COMMUNITY HEALTH VISION	+ CHURCH PARTNER ORIENTED BY MANDATE	+ DEVELOPMENT PROJECT ORIENTED (WITH HEALTH ALSO AS A FOCUS	+ NGO PARTNER ORIENTED BY MANDATE
5.	TOTAL FUNDS RECEIVED (1989-94)	i) Infrastructure 406600 ii) Multi EQ 110700 iii) Block Grants 250000 767.3K 767300 Df - Grand Tot..	104000Df	456900 Df
6	NO OF PROJECT UNITS	13	2	8

TABLE-7 - BLOCK GRANTS

A PROFILE

S.No	CHARACTERISTIC /FEATURE	CARITAS	CHAI
1.	Period Reviewed	1991/92	1990
2a	No. of Projects included	39	98
2(b)	Grant Allayed	2183696	1607506
3.	Limit of Grant	40000-50000: (Now raised to 100000 Rs)	10000 Rs
4.	Procedure of Approval.	Project recommended by Bishop and Diocesan Society. Then put up to Project Selection Committee 10 Meetings/Yr	Project approved selected by CHAI-Exec committee
5.	FOCUS/CRITERIA	'See Text'	'See Text'
6.	MONITORING	By Caritas (Final Evaluation by Regional Project officers)	By CHAI (letters and reports received)
7.	Regional DISTRIBUTION	(out of 23)	(out of 98)
	i) SOUTH INDIA	11 (47.8)	50 (51.0)
	ii) BIMARU	7 (30.4)	34 (34.7)
	iii) East India (Orissa & WB)	1 (4.3)	9 (9.2)
	iv) Other States	4 (17.4)	5 (5.1)
8.	FOCUS OF SUPPORT**		
a)	CONSTRUCTION	6	-
b)	EQUIPMENT/LAB	13	40
c)	MEDICINES	1	38
d)	TRANSPORT	1	-
e)	TRAINING PROGRAMME	5	7
f)	FIELD PROGRAMME	7	10
g)	MEDICAL CAMPS	2	
h)	HEALTH EDUCATION	6	
I)	OTHER	-	7@

** SOME PROJECTS HAD MORE THAN ONE FOCUS

@ OTHERS INCLUDE
(i) TB Clinic
(ii) Anti Alcohol Deaddict
(iii) Model Herbal Garde
(iv) Treat Victims of Substance Abuse
(v) Promote Indigenous Medicine
(vi) Hindi Typewriter for Health Care Publi

TA

S.No	CHARACTERI /FEATURE
1.	SIZE OF BU
a)	< 10000
b)	11-20000
c)	21-50000
d)	51-100000
e)	101-200000
f)	>200000 D
2.	TOTAL BUDG INDIA (CURRE
a)	ANDHRA (-
b)	ANDHRA (CH
c)	ORISSA (-
d)	CENDERET
e)	WB (-WB
f)	WB VHA
g)	Kerala
h)	Tamil Nadu
i)	Bihar
j)	Uttar Prad
k)	Karnataka
l)	Madhya Pr
m)	Others
3	RURAL
	URBAN
4	CHURCH
	SECULAR

TABLE-8B BUDGET ANALYSIS (CONTINUED)

BY DESK CATEGORIES

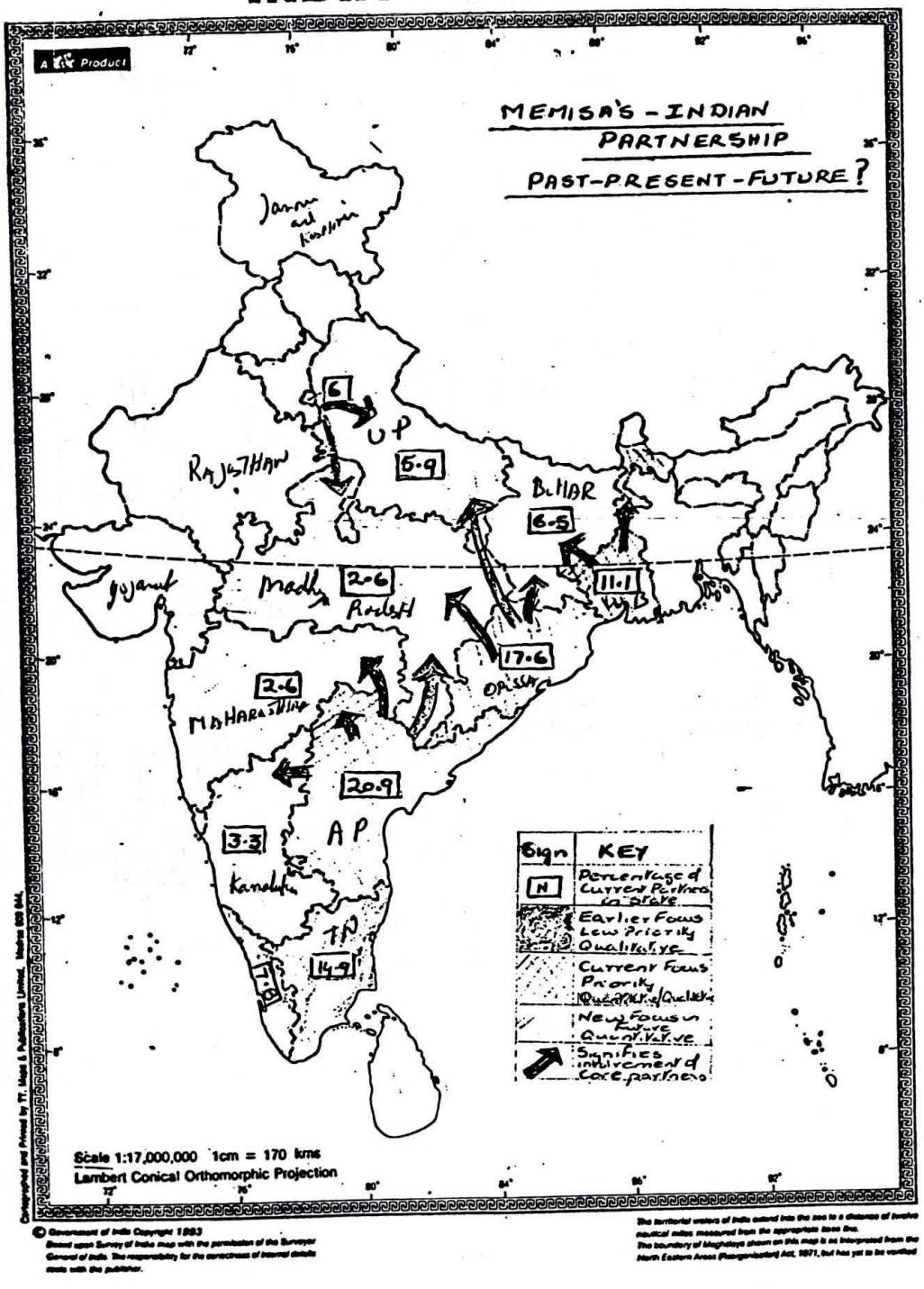
DESK CATEGORY CODE	CATEGORY	NUMBER OF PROJECTS	TOTAL (DM)	AVERAGE DM PROJECT COST	COMMENTS
0	0-line basic health care	142	3450808	24301	
1	1-line healthcare	42	1835400	43700	
2	2e-line healthcare	20	278050	13902.5	
4	Training/studies	19	716833	37728	
6	CORE PARTNER ORGANIZATIONS	27	1178250 +84500	46768	
7	AIDS PREVENTION	2	148500	74250	
8	TB/LEPROSY PROGRAMMES	3	37900	12633	
9	PHYSICALLY HANDICAPPED	3	129100	43033	
12	REFUGEES	1	11700	11700	
13/14	EMERGENCY/RELIEF ACUTE / CHRONIC	3	201304	67101	
15	OTHER	1	8000	8000	
A	LOCAL PERSONNEL	37	855886	23132	
C	MEDICINES/BANDAGE	5	50700	10140	
D	INSTRUMENTS /EQUIPMENT	17	336950	19820	
E	REVALIDATION MATERIAL	2	17200	8600	
F	DIDACTIC/EDUCATION MATERIALS	18	1386510	77028	
G	TRAINING/MEETINGS	42	871323	20745	
H	TRANSPORTATION	19	384450	20234	
I	INFRASTRUCTURE /BUILDING	26	740400	28476	
J	BLOCK GRANTS	10	641200	64120	
K	WATER/SANITATION	12	604812	50401	
L	CAPITAL INJECTION	3	189100	63033	
M	COMBINATION OF CATEGORIES	48	1471984	30666	
N	MISCELLANEOUS	25	432735	17309	

SOURCE: Projektanalyse Printouts For Period 1 Jun 1984 To 11th April 1994 From Memisa Desk

ITEM-9 (11AM)

11-A

INDIA – STATES



B. HEALTH AN

1. POPULATI (DEMOGRAP
2. POPULATION (1991).
3. LITERACY/W
4. BIRTH RATE
5. FERTILITY F
6. RURAL-URB
7. NATIONAL
8. LEVELS OF
9. HEALTH SER
10. SOME KEY