MEMISA MEDICUS MUNDI
short outline of policy

MEMISA is the largest Non-Governmental Organisation in the Netherlands for development of Health Care in Developing Countries. In 1990, the organisation celebrated its 65th birthday. More than 150 medical and paramedical professionals of MEMISA are offering support to local population in developing countries to build up their own system of health care. Moreover, MEMISA provides financial and material assistance to structural projects as well as emergency aid.

Official name: Stichting MEMISA Medicus Mundi

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The Netherlands

Tel.: ** 31 - 10 - 414 48 88
Fax: ** 31 - 10 - 404 73 19
Telex: 24541 memis nl

General Goals:

- Ensuring and improving health care to the poor: "Health for all in the year 2000"
- Enabling partner organisations working for health care to become self-sufficient and independent of outside assistance.

STRATEGY:

With the WHO, MEMISA is of the opinion that the most effective way to reach this goal is to pursue the Primary Health Care (PHC) strategy, as formulated in the Alma Ata declaration (see annex). On this basic policy, MEMISA acts as a development organisation, rather than a charity organisation.
Many different interpretations exist, so we feel the need to clarify that for MEMISA, the PHC strategy ideally starts with Community Based Health Care activities, in which the population actively participates in planning, execution, and evaluation of the activities meant to ensure and improve their health.

This community process needs the back-up of services of professional health personnel to:
- take care of those health problems (diseases) that cannot be solved at village level: basic health facilities with referral service
- train village workers to enable them to effectively execute the village activities and enable the population to take part actively in the process
- to assist in the future planning
- to liaise with government and other authorities.

In short: to have an effective PHC strategy, effective community participation needs to be coupled with effective basic health care institutions and other development sectors.

The main actors in this approach are the community members together with skilled health personnel.

The smallest area where an effective PHC strategy can be realised is the district (District Focus). It is estimated that at this level the population, health personnel, and other sectors can interrelate and complement one another to reach full coverage.

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The smallest area where an effective PHC strategy can be realised is the district (District Focus). It is estimated that at this level the population, health personnel, and other sectors can interrelate and complement one another to reach full coverage.

However, some conditions/criteria are:
- an organisational structure and communication strategy that allows exchange between all concerned
- co-operation between non-governmental and governmental authorities
- the presence of basic health care facilities accessible to the whole population, in view of their income level
- a certain level of autonomy to plan and execute the directly necessary activities
- clear and obvious integration of each new project within the national/regional and local PHC construction, which should already be apparent in the first application for assistance
- a set of objectives described in operational terms, based on parameters chosen from the essential elements of PHC, which can be evaluated
- projects being a contribution to the decentralisation of the health care system, as decentralisation is imperative for involving the target group in controlling and running the system with the proper means and know-how
- absence of political objectives when the choice to provide or not provide assistance is being made, 'though the political implications of the choice made should be accounted for. The only considerations regarding the choice made are solidarity with and compassion for the groups placed at a disadvantaged position in society
- contributing to transfer of knowledge and awareness towards both target population and local professional health workers.

Programme areas are:
- CBHC programmes
- AIDS control, care and prevention programmes
- malaria community based control programmes
- mother and child care, safe motherhood and family planning
- water and sanitation
- essential drug programme

MEANS:

MEMISA's main function is to supply to our partners in the developing countries the means to put the PHC strategy into effect. The real work can only be realised by the local organisation who is, with MEMISA, committed to this goal.

Thus, the means which MEMISA can supply are:
- finances to initiate activities or to establish facilities
- personnel (doctors, para-medical personnel, trainers, experts)
- basic health care equipment
- essential drugs
- sponsorship for training, preferably in one's own region
- expert advice/research/evaluation

MEMISA can also be of assistance in some other ways:
- in case connections/communications between our partner and European suppliers are difficult, our Purchasing Department can act as liaison and do the purchasing and supping, or advise on matters concerning purchasing of drugs, equipment and shipping facilities
- medical relief assistance in case of disasters

WHO ARE MEMISA'S PARTNERS, PARTNER ORGANISATIONS:

We consider as partners Non-Governmental Organisations (NGO's) in the Developing Countries, that share with MEMISA the goals formulated above.

As awareness in the developing countries grows and MEMISA becomes more widely known, contacts with other NGO's are increasing.

In some instances a governmental body together with an NGO become our partner, when the need of the population and the commitment of all concerned request such co-operation.

In order to ensure continuity and to stimulate self-sufficiency, we try to focus more and more on:
- long-term (3 years) or medium term planning programmes
- strengthening of partner organisations
- strengthening of co-ordination within a region or country

SHORT DESCRIPTION OF PRIMARY HEALTH CARE (PHC)

PHC deals with essential health care:
- based on methods and technologies applicable in all situations
- scientifically justified
- socially accepted
- accessible to individuals and families in the community
- organised and maintained in full co-operation with the people of the community
- financially accessible to the community and the country, taking in account the different phases of development
- contributing to liberation of disease, and striving to self-reliance and autonomy
- including valuable, locally applicable and acceptable traditional health care

PHC elements:
- public information on health care
- promotion of good nutrition and eating habits, including stimulation of breast-feeding and careful counselling after the breast-feeding period
- promotion of public hygiene, sanitary provisions and availability of safe drinking water
- mother and child care including family planning and education of women and (expecting) mothers
- general immunisation against infectious diseases
- prevention and controlling local diseases
- treatment of the most common diseases, affections and injuries
- general distribution of essential drugs
- promotion of rehabilitation of handicapped persons within their own community, including counselling of the terminally ill
- promoting essential mental health care in the immediate surroundings of the habitat

Enclosed is an outline application form.

VII (K)

DRAFT

MEMISA

Medische hulp aan de derde wereld

Health for all in the Third World

OUTLINE APPLICATION FORM FOR LARGE HEALTH PROJECTS

Title of the project
Country
Province/state
Village/city
Applicant: Name
Address
Function
Nationality

Responsible institution:
Name
Address
Fax/Tel.

Organisation
Legal status
Approach and strategy
Objectives of the organisation
Administrative set-up
Operational area of the organisation
Activities of the organisation
Number and competency of the staff

Background information project area
Geographical situation
Catchment area: a. number of population
b. means of existence
c. standard of living
d. health situation (quantified as much as possible)
Health infrastructure: in project area/district (private and governmental)

Project
General/specific objectives
Area of operation
Target group
Problems of the area/target group
Proposed activities
Time frame
Implementation strategy (as specific as possible)
Expected outcome (qualitative/quantitative)
Monitoring and evaluation
Reporting
Follow-up and sustainability
Staff of the project
Recruitment of staff
Detailed budget
Relations with other development projects/health institutions (if any)

Please enclose if possible:
1. Recent annual report (activity and financial) of the organisation
2. Recommendation letter from Memisa's national counterpart or a legal health authority
3. Banking details
4. List of other donors to whom the project (or parts of the same project) has been submitted.

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Extra

VII (K)

DRAFT

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VII (H)

MEMISA
(confidential)

CONSIDERATIONS FOR THE APPRAISAL OF PROJECT PROPOSALS

1. Does the project fit into the policy guidelines of Memisa

General policy: " To improve the health care in the Third World countries, specifically for the benefit of the low income groups".
The PHC strategy of Memisa is based on the Alma Ata conference of 1978. All projects have to fall within these guidelines in the way of workingmethod and objectives. Focal points of the strategy are: food, water, hygiene, MCH, vaccinations, basic medicines. Furthermore the four conditions: acceptability, affordability, adaptability, accessability.

2. Limiting conditions: partner NGO

Financing of the project; from own budget or is co-financing requested
Personnel (sufficient supply of qualified candidates)
Professional capacity within Memisa (sufficient for backstopping of the project or is external help needed)

3. Limiting conditions: implementation of the project

Is the project proposal a consistantly set -up plan. The project proposal should give no misunderstanding between Memisa and the project holder considering the implementation of the project. Objectives and activities should be clearly described in order to make a visualisation of the project and to enable a clear monitoring and evaluation of the project.

The project holder should have a sufficient capacity (qua organisation, financing and personnel) to manage and implement the project.

4. Suitability/efficiency project proposal

Does the proposal contain a suitable strategy for the implementation of the project. Is the proposal realistic qua workplan and time schedule.

Is there an optimal cooperation with the local health infrastructure (in order to avoid duplications)

What is the price/output ratio of the project; what are the total costs of the project per beneficiary.

5. Sustainability

In order to provide structural aid or to start a development proces it is important for a project to become self-sufficient eventually.

Will the project have sufficient income(internal or from outside) to continue the project after the financing period of Memisa.
Is the project politically and culturally acceptable for the target population.

VII (1)

CONCEPT.
Guidelines/criteria for evaluation of block grants.
(T. Puls; 25-03-1991).

A. Original objectives.
1. Increase the independence of the partner.
2. Strengthen the partner relation.
3. Accelerate project processing/relieve administration at Memisa office.
4. Promote PHC/CBHC.
5. Activate/stimulate assess capacity of partner.

Condition:
Sufficient/adequate reports should be forwarded after implementation of the project. Evaluation should take place in cooperation with Memisa (comments and dialogue) with reference to the reports.

No 1 and 5 are closely linked with each other.
a. Is a protocol for decision making available?
b. Is an Advisory Board installed?
c. Who is represented in this Board (composition)?
d. Since when is this Board functioning?
e. How often does this Board meet?

B. Questions towards implementation of the project (ad 1,2,5).
- What is the amount of funds involved with the block grant?
- How many project are involved ?
- How fast did expenditure of funds take place for implementation of the projects and are all funds used?
- Does the partner have any other block grants available? If possible details.
- What are the overhead costs of the partner?
  Does the partner appreciate the block grant and can the partner agree with the set criteria?

C.What is the time gap between the request and assessment of the project by the partner and what is the time profit compared to projects handled by Memisa office in Rotterdam?

What is the saved by Memisa within one year with regard to personnel time and costs?
How many requests were received by the partner and how many were rejected and for what reason(s)?

D. Assessment/evaluation appraised projects.
<u>General.</u>
-Are all funds received acknowledged by the project holders?
-Is information available on the actual expenditures of the project holders (random test)?
<u>Specific PHC/CBHC.</u>
Are the expenditures in line with PHC/CBHC criteria?
How have funds be spent: target areas?
<u>Conclusions/recommendations.</u>

Extra

VII (L)

MEMISA

Medische hulp aan de derde wereld
Health for all in the Third World

SPONSORSHIP POLICY OF MEMISA

The request should be submitted by the management of the hospital, or the Diocesan Medical Coordinator together with a letter of recommendation from the (Arch)bishop.

The project description should contain, next to the standard background:

- information about the institution applying - a recent annual report is obligatory;
- motives concerning the need for this particular training in view of improving the healthcare services within the hospital/diocese, as foreseen in a midterm or longterm healthplan and training scheme;
- the qualifications of the candidate;
- character statements of the candidate from 2 independent parties;
- the future jobdescription of the candidate;
- a copy of the bondage contract of 3 to 5 years between employer and candidate (depending on cost and course duration);
- confirmation from the school that the candidate can indeed be enrolled;
- the curriculum of the planned course;
- an itemised estimate for the training period of all cost involved;
- the estimated local contribution.

MEMISA's principal aim is to assist the poor in acquiring adequate healthcare, and that a sponsorship is thus looked at as one of the means through which we can assist our partners in the developing countries to reach their aims in this field.

As our budget is limited, and as training received in the region is ofter better adapted to the work environment of the candidate, MEMISA is reluctant to sponsor training courses abroad and on other continents. A review of alternatives in the region should be considered.

If the diocese and the hospital are of the opinion that a foreign course in question is the only option, it is imperative that we receive a clear and extensive motivation for this choice.

J.A.M. van Eijndhoven
Head Projects Department

January 1993

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Draft-
(E)
ComH 20.2

A PROCESS REVIEW PROPOSAL

Based on some preliminary discussions which were held with **Ms. Monique Lagro** - Project Co-ordinator, Asia/Oceania Desk, MEMISA on 07th and 09th of April, 1994 at Bangalore and a very preliminary review of some summaries and memorandum sheets of MEMISA partners in India, the following "**Process Review Consultancy**" is outlined for consideration by MEMISA and its core partners in India.

1. **Background**

MEMISA has approximately 107 project partnerships in India (May 1993). The State-wise distribution at that point of time was Andhra Pradesh - 26, Orissa - 24, West Bengal - 14, Kerala - 11, Uttar Pradesh - 8, Bihar - 6, Karnataka - 5, Assam - 3, Tamil Nadu, Rajasthan and Maharashtra - 2 each and Manipur, Meghalaya, Madhya Pradesh and Himachal Pradesh one each. The three states of Andhra Pradesh, Orissa and West Bengal account for more than 50% of the projects and 42% of the budget.

There is a felt need by MEMISA to get a comprehensive overview of this partnership in the context of the larger 'voluntary health sector universe' in which these project partners exist and are evolving. A need has also been expressed to review the overall approach adopted so far in selection and follow up of projects, with a possibility of evolving new approaches in response to areas of greatest need.

Three core partners of MEMISA in the States of Andhra Pradesh (CHAI-Secunderabad), Orissa (Xavier Institute of Management) and West Bengal (WB-VHA) have been involved in preselection studies/review of project partners and the monitoring and evaluation of projects thereafter. It is suggested that thay be active participants of this review process.

2. The **Review Process** will have the following broad objectives:

a) To undertake a Desk study of the current project partners supported by MEMISA in India with a view to evolving a process, leading to a more comprehensive and sustainabile partnership in Community Health Care.

The overview will assess the partnership (within the limitations of desk data) in the following areas:

i) broader context of the Volag sector in India;
ii) the goals/objectives and situation of partners in terms of community health orientation and focus on marginalised/ vulnerable groups;
iii) the ongoing process of partnership;
iv) the emerging needs in networking/information sharing/training and continuing education;
v) the linkages between partners and emerging middle level/ regional resources centres and core partners; and
vi) potential problems and possible problem solving approaches.

2..

b) Though the review will have to be in the context of the existing MEMISA vision statement and policy guidelines it will also explore new thrusts and possible evolutionary changes in these guidelines from the collective partnership exercise.

3. The **Steps of the Process** could be:

A) **Desk Review** - Two weeks.

i) Study and Analysis of the following Desk data.

a) MEMISA vision statement/policy guidelines.
b) Project Memorandum of current partners.
c) Project reports and follow up reports of key project partners at `grass-root´ and `middle´ levels. [Focus will be on those projects who have been long-term partners or the most representative of the sorts of programmes MEMISA wishes to support. The choice is left to MEMISA, Asia Desk and its core partners.]

d) Any other papers/studies/information/reflection recommendations by Asia desk and core partners to help the review process, in the light of their own field experiences with project partners. [This will be completed by 15th June, 1994 preferably].

B. **Field Review Planning** (Nine days including travel)

i) After the Desk Review Report is prepared in draft format, a copy will be sent to MEMISA and core partners for their comments/interactive dialogue.

ii) A field review process can be initiated focussing on three states primarily Orissa, West Bengal and Andhra Pradesh.

This could be done by a staff member of the core partners in each state in consultation or supported by one or two community health resource persons from that state identified by the review partners through mutual consultation.

iii) The Desk review consultant/s will visit the three core partners, spend 2-3 days with each one and evolve a field review framework and methodology so that there is some consensus/consonance with the field review process in the three states. Provisions will however also be made for regional diversity and the special situation/problem in each state. During this short visit one or two projects close to core partners could also be visited.

C. **Field Review Process**

The field review process could be done over a period of time mutually decised by the core partners and MEMISA.

D. Plan of Action through interactive dialogue with partners

The Desk review and field reviews could be presented and discussed at a meeting of core partners and a representative sample of grass-root partners, so that a plan of action for a more comprehensive and sustainable partnership can be evolved through a participatory interactive discussion at the final step of the review process.

4. Organisational Dynamics

i) The main data for the Desk review could be sent to the consultants by Asia Desk - MEMISA, along with necessary translations if required (not later than 20th May 1994).

ii) Supplementary information/reports could also be posted to the consultants by the core partners in consultation with Asia Desk (not later than 20th May 1994).

iii) The dates for the 'field review planning exercise' (that is, visit to three core partners will be fixed in consultation with them. These could be separate visits of 2 - 3 days each or linked together if that is feasible.

iv) In terms of funding provisions - the process review consultancy will have to atleast provide for:

a) Community Health consuntant/s for 2 weeks and 1 week (field review planning).

b) Travel grant to cover three field review planning exercise:
   i) Bangalore - Hyderabad and back.
   ii) Bangalore - Bhubaneshwar and back.
   iii) Bangalore - Calcutta and back.

c) Small additional provisions for secretarial assistance, photocopy and postage for Steps-A and B be begin with.

d) Steps C and D will have to be budgeted for later but the estimates will depend on the process that is evolved in consensus with core partners after Steps A and B.

5. Since the consultant/s will be based in Aachen, Germany for the whole month of August 1994, a two-three days visit to MEMISA Head Office for interactive discussions with Asia desk staff and other MEMISA in-house resource persons could be explored further. MEMISA - Asia Desk is requested to co-ordinate this with Mr. G.Krause of MISEREOR, who is organising the Aachen based consultancy. The visit to MEMISA would be good opportunity to explore further details and perspectives from the Desk review and also be an additional opportunity for South-North dialogue which is the main objective of the consultants sabbatical. (refer note on Sabbatical Framework).

10th April, 1994.

Com H 20.3
VI (B)
(exh.c)

Draft report werkbezoek

India February 1992.

P.W.Kok, Memisa Medicus Mundi.

Thursday 6/2.

Afternoon meeting with **West-Bengal VHA.** Mr. Aminal Ahsan and Dr. Soumitra Dutta and others. Mr. Poddar is in Europe.

The WB-VHA is an association with over 1000 members. Cooperation through consultation works well. The VHA is doing project evaluations on behalf of donors, something other VHA's seem unable to do for political reasons (dependance on members, preventing critical assessment).

VHA provides NGO's with leadership training as a priority as many NGO's have well motivated people but lack managerial capacity. Community involvement is generally good, but one is not sure if it leads to something. There appears a need for management by objectives and to have a set of indicators.
Models of training like TOT and TOF training within the context of a PHC system were discussed.
WBVHA interacts with members of the association, with training institutions as well as at grass root level.
They train 1000 to 1500 people annually. They are planning a special course for the religious.
Their publication of a VHW-magazine reaches an edition of 10.000 copies. The content shows interaction with and from the public.
In the second edition of "Where there is no doctor in local language, a chapter on AIDS will be included.

The limited office space shows a beehive of activities. The staff present is well motivated and they know what they are talking about. Health education materials are present, printing quality is moderate.

Dr. Soumitra has a MBBS and 2 years further training. He is actively involved in the Essential drug programme, something which, in the presence of an overcommercialized health care system, is of great importance. However, the problem raised by having good and well trained staff is the expense of employment, as other organizations especially the international ones may offer better pay.

It is advisable that Memisa discusses this issue with the director during his visit to Memisa.

VHA West Bengal functions also in an advisory capacity towards donors, something not entertained by other VHA's.

AIDS training programme WBVHA.

A report on the first AIDS meeting was received. On the 12-13th of February their will be a meeting with NGO's on AIDS.
Dr. Swarup Sankar of NICED(National institute of Cholera and Enteric Diseases is an important person in the AIDS programme. Some groups are active in the red light district. Testing is referred to the virology centre.
A risk factor like migration is very much present in Calcutta with many people working in Calcutta spending the weekend at home.
Anonymous testing can be done, but this issue should be followed-up and guarded.
Limited counselling and treatment is available.
Counsellors are being trained.

The issue of voluntary blood donation is being taken up as a first activity of limiting transmission has been taken up.

The Society for community development(SCD), turns sex workers into health educators like in the Nairobi programme.

Condoms are available. Their popularity was low due to irritating lubricant and poor quality. Nowadays the quality and availability is better. At each stall condoms can be bought.

Sex education at school is difficult. This makes linking of school education programme with HIV information and education programme difficult.

AIDS is certainly not yet generally acknowledged or accepted as a disease that can spread though the population. The newspaper tells the story of a doctor removed from the same building with other private practices because he treated AIDS patients.

WBVHA is in favour of organizing PWA groups.

School health programme.

This programme appears feasible. Implementation parameters in the form a KAP survey, pre and post-testing will be done. A pilot programme has been financed by Memisa, now they would like to proceed on a larger scale. About a 1000 schools got an enquete. NGO and government schools are involved. The Government is interested in the programme, but can offer little financial support. The school health department is defunct, although there are some active people in it. The government is not prepared to pay for 3 days leave or the per diem (Rs. 50-100) for the training of teachers. Training will therefore take place in the same area to enable teachers to come and go on bicycle.

The Video material from Memisa is not used as only one film is present and no transport is available for the transport of the video and screen. A small car could be considered and more film material has to be obtained. Use of public transport only, limits the number of schools that can be visited, considerable.

Memisa is advised not to provide Video recorders unless picture material and transport is guaranteed.

Orissa State. 7-11 February

Visit to Boulakani village, Mohalkalpada Block, Cuttack district.
Organization: **VARRAT.** Voluntary Association for rural reconstruction and appropriate technology. GP 89 DIA 111; F. 67.400. Mr Mishra and Mr. Bisha.

This area consist of extensive waterworks providing the irrigation network for extensive rice fields. Most the land is in hands of a few distant landowners, on which the landless villagers are employed for short but intensive periods during the year. It gives the impression of extreme poverty amongst abundance.

The meeting started with a colourful reception by a reception committee, representing health volunteers from 30 villages in the area. A meeting ensued where an exchange of perceived problem/needs took place. Lack of schooling, lack of income and poor water quality (salty or dirty) were mentioned. Health problems clearly rank lower in priority.

The project started in April 1991. The staff consists of a sociologist, an economist, an ANM., a retired health inspector and a homeopathic healer (specifically trained at the homeopathic training school at Bhubaneshwar).

The programme has been followed-up by Cenderet, who has been critical about their work, especially where it concerned the speed and efficiency of executing the programme. To many (sub)projects(women, day care centres, patchwork, coconut fiber, water), supported by Cebemo and Danida threatens to overload the leadership.

In all 30 villages VHW have been elected and are active. They are well organized in 3 regions with a regional leader and do have scheduled meetings regional and centrally.
Census and health data have been collected and await analysis at Cenderet and reporting.
Rapport with the district government health services is established which resulted in EPI and ANC services becoming available to the local communities. If enough people are coming forward to these mobile services, the government is prepared to have clinics at 2 different sites.
Hygiene, water and sanitation, MCH, ANC including FP are important programme elements.

The level of medical care is low. No essential drugs are available while the knowledge on rational drug therapy is limited to the ANM and the HI. The lady homeopathic healer has some diagnostic skills, but lacks any knowledge of essential drugs. Even a the simple penicillin tablet or injection to treat a pneumonia in a child is not present. Such cases have to be referred to the Primary Health Care Centre 35 km away....public transport being virtually out of reach. Drugs available are expensive items wrapped in silver paper or other fancy packaging. ORS is present and home methods are taught.
No weighing is done and road to health charts are not used. All typical WHO programmes are not known.
The available HE material is unspecific, but posters are present and used.

The community health expertise present is low. The need for expert advise is felt. Neither O-VHA neither Cenderet is in a position to give public health advise. Cenderet does provide management advise.
The motivational level is rather high.
Dispensary building.

This building is not yet completed as funds run out. Especially the price of cement has gone up from 70 to 110 Rs per bag. The team even took a loan to continue the present phase of the building. (First floor Concrete structure and foundation for two stories). Another 36.600 Rs is required, for which a quantity survey estimate was requested and received 2 days later. Local labour is provided free of charge.
An access road will be built at a later stage. The dispensary is well placed in relation to the 30 villages.

The functionality of this project and especially the function of the clinic in providing decent MCH and ANC and curative services should be followed up. Staff training in PHC functions (MCH/ANC) should be considered. The use of essential drugs, available from Bhubaneshwar at very low prices should be promoted.

Transport, mopeds, for senior staff and circle(region) staff is present and adequate.

The quality of the government HC, having 3 doctors, but usually hardly present, is reported as low.

The matter of cost recovery at least as regards the curative side, was discussed.

Visit Hospital Barati. 11/2 hrs from Bhubaneshwar.

On the road to this cottage hospital we pass stone crushing sites where women and female children are employed as day laborours at 18 Rs per day under unhealthy conditions. Severe silicosis may be expected in some of the women employed in extremely dusty conditions.

This cottage hospital was started as a dispensary in the 50-ties by Mrs. ....., following the Ghandi philosophy of selfless help for the poor. Orissa state was at the time one of the poorest states. She has a charismatic attitude. The place consists of a small OPD block, an office block, a maternity, a large and well equipped theater and a large X-ray room with a 3 year old Siemens(India) X-ray apparatus (1.5 lak).
There are 3 "doctors" of which one is homeopathic trained only.

The attendance rate is low, the number of clinical procedures offered is at the level of a dispensary, including immunizations. To the management's surprise, the attendance rate went up after introducing a small consultation fee of 2 Rs 2 years ago. The aim has never been self-reliance or on development, rather soliciting donations and provide medical hand-outs to the people.

No essential drugs are used, no Road to Health chart is used, WHO/PHC policies are not known, a laboratory for simple procedures is not functioning. ORS is used. The theater is not used because of lack of skills from the 3 doctors present(we have no specialist anesthetist, and no surgeon!), the same for the new X-ray which has made 78 pictures in 3 years. No x-ray laboratory assistant is present, and apparently no other person or the doctor is trained to make simple pictures.
The maternity is functioning at a reasonable level. No waiting maternity facilities are present. The place is clean, a jeep for patient transport is available.

The level of health care provided by the 3 medical staff is pathetic. The outlook on development is lacking. Unless a new management and properly trained medical staff can be attracted, this project should not be supported by Memisa.

Organization: **Seva Baratl. Phulbanl ,GP90DIA108. Discussion Mr. Pattanail**

A programme for community health has been apprroved by Memisa for the first out of 3 years.
They are active in training 40 lady village health workers in 20 villages.
They got a revolving fund for medicunes from Memisa. The advantages of the EDP were discussed, its affordability and potential source of income to cover some running cost. The project does get support from Cebemo.
They do also promote herbal medicine and gardens and had a 2 day seminar with TH's. It is a very difficult area with poor communication and access. They recently had a meningitis problem (120 cases, 14 deaths)for which they used sulfadimidin. The support from the district health authorities is limited. The training of the doctor in community health principles was advised. Evaluation to be done towards the end of the firdst year to assess efectiveness. The need for baseline data was discussed.

Fish. Forum for Invention and services in Homeopathy.
Mrs. Shradhanjali Mekap, Mr. Pradhan (all homeopathic healers).

Fish is an Bhubaneshwar based organization with 20 homeopathic trained healers(4-5 years) at the homeopathic college at Bhubaneshwar. This training provides basic medical knowledge but not the level of MBBS. Pharmacology has not been taught. Only homeopathic principles are provide, using Hannemans textbook from 1854.

To my question why a foreign religious medical practice was introduced and became popular in this area, the following answers were provided:
1. It is cheaper than allopathic drugs, and therefore the people can afford it.
2. The people like it better than allopathic drugs, which are known to cause side-effects.
3. It is very effective, we had recently a "Scientific congress" in which the effectiveness of homeopathic treatment was proven. The report was handed to me for study.

The scientific report consist of 8 presentations using homeopathic drugs. Not one of the papers does contain any proof that any drug used had any action whatsoever. No drug was compared with giving nothing or any other treatment, but other homeopathic drugs in which case contrary to the statements no positive difference in effect could be shown.
What has failed Western science in 140 years to elucidate the value of homeopathic treatment, seems to have failed here as well.

These findings however do not influence the religious zeal with which this imported type of medical care is being promoted.

The staff of FISH runs an urban clinic in an apartment where also FP services are provided. There main trust is however at the slum areas around the university and at the riverside. In these 2 areas they attempt to introduce some hygiene and sanitation, providing limited MCH and ANC.
Next to a multitude of homeopathic drugs from the magic box, iron tablets, folic acid and vit A and B are provided, and nutritional advise is given.

The OPD function is at a low level, no diagnostic facilities other than a stethoscope are present. Patient do provide a small local fee (50 p).

This project does not follow the standard PHC procedures. Its curative value is if any of low standard. Still the staff in the project is well motivated, appears to have a good rapport with the slum people on the basis of which they can promote hygiene and sanitation which might result in better health for the slum dwellers.

The main problems of the slum dweller however are not really addressed, as people could live better by improving their housing standard if they were given the guaranty that their houses would not be buldozed. This uncertainty prevents any investment in better housing and sanitation and water facilities.

Advice: Memisa could consider a limited support for the hygiene, sanitation and health education efforts made by this well motivated team.
However the level of public health and medical care is extremely low.

Jana Vikas
Phulbani district **GP90DIA058**
Fr. Augustinus Karinkuttiyil.

Phulbani is a very rural district, 260 km from Bhubaneshwar with a largely tribal population living in difficult circumstances.

Jana Vikas has a board consisting of 1 Muslim Dr.Almas Ali(also Board of Governors OVHA), 1 Hindi Dr. BK DAS, and 1 Catholic. This combination seems to work well as in this way no discriminatory tagging on the organization can occur, while remaining its effectiveness to execute projects with the rural poor. Fr. Augustin is secretary of J.V. , as well as Chairman of the Orissa State VHA.

JV executes a CBHC programme involving 42 villages with 60 CH-organizers, attempting to reach 126 villages in a period of 3 years. The requested financial contribution is Fl. 167.000. The project appears to be willing to do too much in too short a period. There were also questions as how CHW are selected and if local Mahila samities are involved.
Basic health services are provided through a network of 19 centres plus outreach. The organization appears to be solid and can be expected to manage the health programme well. Through 6 HC 50 villages are now covered.

Essential drugs are used in the project for malaria, dysentery, worms, scabies. e.o. David Werners book in local translation is used as a guide.
Government drugs are poorly controlled- bribing by manufacturers of government officials results in substandard or dangerous drugs.
The project intends to start issuing medicine kits to CHW after 6 months.
Patients will contribute to at least the curative provisions of the project.
The project staff will increase from 6 to 10 divided in 3 divisions: training; information(linking with VHAI) with production of HE material, translating existing HE-material and administration. Road to health charts will be introduced, a health newsletter is produced. Behavioral research in view of the AIDS epidemic was discussed as a tool for specific and timely health behavioural intervention.
Existing nursing staff has been used, and upgrading (orientation) in training for 3 days was given by Fr. Augustin. Survey methods for base-line data and there function were discussed as targets in the project proposal were ill defined.
Immunization services are poor. Fridges are present to maintain cold chain and extend the services. The field staff are all women, forming new groups.
Unicef does not make immunization services available to NGO's, even not in view of the shortcomings of the government EPI.
The future need for a public health expert was discussed.
JV is active in the field since 1978.

After one year evaluation has to be done by Cenderet(opdracht geven).
Enough funds are present on the moment to bridge the gap in funding caused by the evaluation. This is on account of inflation/devaluation.

Memisa's impression is that Fr. Augustinus and his team executes his projects with considerable knowledge and experience. PHC elements are present within the programmes. Aspects of community participation and self-reliance are part of the philosophy and practice of the programme.
No other donors are involved.

Orissa Voluntary Health Association. OVHA.
Discussions on OVHA were held with the director Mr. Jayant Kumar Bag, and on separate occasions with Dr. Almas Ali, (board member) and fr. Augustinus, (Chairman of the board) and Cenderet.

OVHA is not an effective organization according to Cenderet and Members of the Board of Governors, which can be confirmed by Memisa.
The director lacks vision, technical skills and managerial skills to give leadership to the organization. Also no technical staff is present to be of assistance to projects in the field. The training done by them in Phulbani district was not successful at all. No public health expert is present. Within the Board of Governors, substantial experience is available but these members have their own work and are not able to spend much time on advising member organizations.
Political/personal ties prevents the board to appoint a new director. Presently OVHA is being evaluated by "Child in Need Institute"(CINI) from Gujarat on behalf of Norad who finances the VHA at the request of the Board.. Discussions with a member of Norad were held on the desirable functioning of OVHA towards its partners in the field and its possible role as evaluating and advisory body for partner organizations and donors.
VHAI is aware of the poor functioning of OVHA, but is constitutional unable to do much about it. Still members did ask VHAI to consider assisting ailing VHA's in management and policy to maintain their functional quality.

Although the office of VHA does produce some health education material and provides training, at the level of the field one does not hear about any support received from OVHA.

AKSS GP91DIA185 Mr Subarna Keshari Baliyarsingh, 10-2-92

Community health programme Kanas block, Puri district. 3 years. Fl.69.000.

Discussed were some of the inconsistencies of the proposal submitted to Memisa.
Top down approach: "We have discussed with the people and they asked AKSS to implement the scheme" . Village health action committees will provide a community bases. CHW are trained, one for each 5 villages, which seems little to us leading to a type of health extension worker. Dais will be trained. One doctor(MBBS) will be present and cover 5 villages in one day. They also would like to start a health insurance scheme in view of self-reliance. Memisa suggested to start with contributions from patients for the curative part of the project using available essential drugs. In the mean time experience from Prodata who is setting up an insurance scheme could be They intend to this after proper training. The problem is that doctors are prescribing too many drugs.

Memisa should provide means for the training programme of the health workers. Attention to the proper training in community health and the PHC approach of the doctor to be appointed, should get a high priority.

Instead of a constant budget item for drugs, Memisa suggested a revolving fund for essential drugs.
Care should be taken that it does not become a service project only, sufficient development aspects are to be stimulated and evaluated. Only properly trained local staff could ensure this.

Evaluation by Cenderet indicated.

GP89DIA039 and GP91DIA094 by Banabasi Seva Samiti, Mr. UC. Jena.
A 6- months evaluation report was submitted. Commentary from Cenderet is critical as regards the development policy.
Evaluation to be done. **Cenderet to be requested to execute the evaluation.**

The 6-monthly report provides incomplete and inconsistent data on maternal mortality, crude death rate and birth rates. Conclusions can not be drawn, because the rates are not expressed as rates by absence of a denominator. The project clearly lacks public health expertise. The social sector is strongly represented.
Memisa should make sure that in future project approval, sufficient PHC trained expertise is present or available.

GP90DIA102. SNAENA. Koraput, Orissa. M.Luther Raj.
They did not come for discussions with Memisa. Commentary from Cenderet: this organization should be critically followed up and no further engagement without the advice of Cenderet. See evaluation reports 1/8/91. The project has not reached its target in community development, neither in quantity, nor in quality. Follow-up was poor. Training targets were not met, and where given, done in the wrong language. Village awareness training has been insufficient. No input and outcome surveys were properly executed, and therefore impact can not be measured.
From the 3 years project 2 years have passed. The request for 1 more year is at Memisa's desk.
Cenderet has put forward changes to be made in the project. These concern mainly strengthening technical staff and tightening objectives.

Looking at the whole programme, and especially as Memisa indicated in 1990 already the shortcomings of the management, Memisa should not continue this programme. This advice to be communicated first with Cenderet.

GP91DIA160 Antyodaya Seva Kendra. Mr. Bhaktabastal Mohanty
Project in Keonjhar district, tribal area.

This proposal on Environment, literacy, health care and demonstrations had been rejected on account of the very limited target group, the limited health component and the relative high cost/capita involved, preventing self-reliance in due course.

Mr. Mohanty came to Cenderet, on their invitation, to discuss the project and the need for assistance with Memisa.

The area is 200 km away from Cuttack and the population belonging to the Juang & Bhuyan's is threatened by extinction.

Prof. S.K.Das visited the place for 1 months to analyses the situation. He recommends a limited health programme. Memisa is the only organization requested to support health activities in the area.

Concluded was that the organization would come up with a new proposal which would better reflect local health needs and local possibilities.

A new proposal was received 11.2.92.
It concerns a target population of 2964 people in a hilly poor area. There are 4 centres for ICDS(MCH) in the area, but only 1 is functioning. Lack of support from regional HC(18 km). The programme now limits itself to health, hygiene and sanitation. They intend to make use of paid trained health workers. Better base-line data have to be provided in the first part of the project. It is advised to provide a starting fund for better project planning. Local resources should be developed. Essential drugs should be used. Total requested 1 year: est. F.10.000.

Meeting with Mr. Shanti Ranjan Behera of SODA. 11-2-92

SODA stands for Society for Developmental Action.

SODA is a legalized NGO active in Bihar and Orissa. It is an association of young academic professionals. Fields of activities: Non-formal education(NFE), research(child labour), training, community organization, legal support to the rural poor and health in Mayrbhanj district Orissa and Dumka in Bihar. 158 paid staff(part-time and full-time are working in different projects. The aim is self-reliance through community participation from inception to completion of a project.
They have funding relations with Diakonia Schweden, Fastenopfer de Schweizer Katholiken, Terre des Hommes, Puna; Unicef and Government of India.
Mr Bahera was the first one to express concern about the AIDS/HIV epidemic in India. We discussed the various needs for launching an effective health education. Research in sexual health and behaviour are very much needed for such undertaking. SODA may have the capacity develop a research and education programme on sexual health with the aim of preventing STD's including AIDS. Their public health strength, besides a study on ICDS, has to shown.
Mr Behera attended a programme on AIDS training in Indonesia. Heard of Memisa's Dr. van der Tas. He has been engaged in Danida sponsored programmes. Is in favour of trying social marketing of FP. He is a journalist-lawyer. He would like to attend the Amsterdam AIDS congress, which I discouraged at this stage. Concentrating on regional meetings may be more useful.
Annual budget of SODA is 16 Laks.

Meeting with DNSS, Society for the poor. Mr. G.C.Mallick (Managing director and Dr. Basantibala Jena(ex-State Director of Medical Services) from Council for Tribal & Rural Development, 505 Sahid Nagar, Bhubaneshwar 751007.

Dr. Jena has considerable experience in health administration and has retired to an advisory function to DNSS. The is the co-author of a book of health care in India, providing very useful information of which

Memisa was presented with a copy. Mr. Mallick is a former student of Xavier Institute of management. They are a member of OVHA. There are 3 branches each with a project coordinator. Pati has a full time job at the University(Population council). His availability and Dr. Jena for project implementation can therefor only be marginal.

Area representatives came to them to ask for help. A development policy was drawn up and they intend to execute a programme for maximum 3 years enabling the community to be self-reliant. Under the heading Each one teach one, they wish to establish a health movement.
Participation of women is foreseen. Of the 9 members of the board, 3 are at least women. Only 18 out of 63 workers are women, they intend to involve more women.
They perform health camps-eye camps at village level. They entertain a mixture of modern and traditional medicine.

An annual report for 1990-91 has been submitted.
Any project from DNSS and CTRD should be evaluated by Cenderet on its feasibility for implementation.
Both organizations have submitted a proposal:

1. Integrated development of community health care project in rural areas(DNSS).
2. Demonstration family planning & MCH project, 3 years.(rather dated, updated for the occasion of my visit, earlier submitted to ? ?).

Meeting staff and director Regional India Medical Research Council. 11.2.92

Prof Krishnamurthy has wide experience in epidemiology in various parts of India. We discussed the relationship between research and public health policy. Main problems are malaria, EPI diseases, Leptospirosis, and Leprosy. Bacteriological surveys are being done on diarrhoeal disease agents.
No Schistosomiasis is present in India, although vectors and a suitable environment are present.
As regards AIDS/HIV, IMRC is carrying out a continuous sentinel survey is hospitals in the state. Up to now no case of HIV infection have been found. The authorities have acted against prostitution in the town. They admitted to expecting through the transport routes from Calcutta to see infection entering the state in the future. Not much is done on awareness as the problem does not yet exists in the state of Orissa. (PK to send polio paper).

Kanpur Urban Primary Health care programme.
12-14 February 1992

Meeting with Christina de Sa, Senior Project Officer(VHAI).

Ms. Christina de Sa appears to have some problems with the Co-director Kanpur Medical College as well as with Indo Dutch Project(IDP). The main reasons seems to be the lack of communication on where and when they may expect her presence in the project area. So far she has been engaged in the training and motivation of the Community Health Volunteers(CHV) and the Health Extension Workers(HEW).
This part of the programme has been established well. Still there is a need for a more structured health education intervention and especially the design, testing and production or acquisition of the needed health education material.

The SPO may not altogether function as SPO in charge of the overall process of management of the Kanpur UPHC, a function that is called for but not supported by her job description of the inception report. Besides she has work to do for VHAI in Delhi and also is engaged in activities for Mirzapur(workshop together).

Recently however, following Dr.Ory's intervention the tasks of the project are clearly delineated. Ms. CDS will concentrate the following 3 months on the development of health education structure and material.

Concept beleidsnotitie AIDS

AIDS POLICY

Memisa Medicus Mundi.

The AIDS pandemic as it is evolving in the nineties will influence deeply all health and social services of the countries involved. MEMISA as donor organization in the health field has taking up the issue of AIDS as a matter of priority from 1986 onwards.
It is clear that the HIV-infection is spreading fast to all continents, but will affect particularly severely urban poor communities, extending rapidly into rural areas. AIDS among adults is now the primary cause of death. Although posing a formidable medical problem, the AIDS pandemic will primarily be expressed as a tragedy for individuals and families, and for communities as a serious social and economic problem.
Policy formulation will have to reflect the different levels at which the HIV-epidemic unfolds.
It follows that health care will have only a limited impact on the prevention and control of the epidemic.
In general all interventions should be placed within the concept of primary health care, being made operational within the district (diocesan) health care system. In some countries other social or health care structures can, exceptionally, be considered. Moreover, all health and social programmes should incorporate prevention of AIDS as a matter of policy.

1. The disease:

AIDS is caused by the Human Immunodeficiency Virus (HIV),belonging to the retrovirus group. It attacks particularly the T-helper cell which is an essential element in the defense system. Once the number of T-helper cells, characterized by the CD-4 locus, reaches a level below 200/ul., clinical, opportunistic disease usually follows. Disease is caused by a wide variety, and often a combination, of pathogens: bacteria, viruses, fungi, yeasts and parasites. Some are readily treatable (TB, fungi, some bacterial infections), some are very difficult to treat, requiring levels of sophistication and expenses usually not available in developing countries.
Up to now the disease invariably leads to death. The average period between infection and death is about 8 years in Africa, in children 1-2 years. Some long survivals are reported from the US.

2. Epidemiology:

Africa:

AIDS disease and mortality: 1.5-2 million adults, expected to rise to 3.1 million by 1995. Children 0.5 million death, expected to rise to 1.3 million by 1995.
HIV sero-prevalence 0.5 to 30 % of adult population. 10 million people infected, half of them women(1993).
20-40% of children born to HIV infected mothers are HIV positive.
By the end of the nineties the annual AIDS specific mortality will be 3 to 4% of the adult population in the presently most affected areas in Eastern, Central and Southern African countries. Tuberculosis is increasing with 30% on account of the HIV epidemic after years of gradual decline. In West-Africa both HIV-1 and HIV-2 variants are present. STDs are present in 10-30% of the population; especially women are affected with non-clinical disease.

Latin-America:

1 million people infected(20% women). 0.1 to 1% of adults infected. Some urban areas show a rapid increase. Mainly homosexual-bisexual men and IVDU's involved, but also spreading into the hetero-sexual population. Caribbean 310.000 (130.000 women). Street children are a special risk group.

Asia:

1.000.000 HIV infected people, (30% women) mainly urban poor(Bombay, Delhi, Calcutta, Madras, Manipur, Bangkok). Prostitution/IVDU's. Rapid transmission.
Other countries e.g. Birma, Malaysia, Philippines, Indonesia and the Mekong are following.

In most countries women are infected at an earlier age than men.
Towards the year 2000, 40-100 million people will be affected by AIDS/HIV, after 2005 2/3 of infections in Asia.

Social impact:

In affected areas, up to 30% of children will be orphans. The support structure will come under pressure. Stigmatization, discrimination at local or national level. Labour relations. Political changes. Risks involved in finding a life-partner. Religious and cultural stress. Changes in customs. Role and status of women are affected.
Change in burial rituals. In some heavily infected regions a population decline may occur after the year 2010.

Economic impact:

Direct cost: for treatment, testing, information, education; care and counselling for patients and families. Loss of income. Transport and funeral cost.

Indirect cost: loss of skilled labour. Loss of production, especially at the household food supply level. Burden on health infrastructure and personnel. Loss of schooling for affected families and children.

3. Intervention policy.

Prevention.

In the absence of a foreseeable treatment or prevention by vaccine, preventive measures are the only way to diminish the rate of transmission of the HIV in populations.

The transmission rate of HIV in a community depends on only two major components: the number of different sexual partners over time and the presence of an other Sexual Transmitted Disease (STD). The first factor determining the chance of a HIV-positive sexual encounter, the second factor determining the risk of actually becoming infected during such encounter. The nature of sexual behaviour, being hetero or homosexual does not influence the rate of transmission, it only determines the group in which transmission of HIV will take place. IVDU's and bi-sexuals may form a bridge between such groups. Vertical transmission from mother to child (15-40%) accounts for approximately 15% of transmission while blood transfusion accounts for 5%. Some other minor cofactors have been indicated.

One can discern long term and short term preventive actions:

Long term:

-Activities aiming at changing sexual behaviour; elevating the status of women.

-Prevention and treatment of STDs.

Short term:

-Counselling HIV infected persons to prevent further transmission to partners and children, and to increase coping with living with HIV and clinical AIDS.
-Provision of safe blood transfusions
-Establishing/promoting safe clinical procedures
-Promotion of use of STD prevention devices (condom)

Changing sexual behaviour is acknowledged as difficult, especially for groups of people who because of their status in society have no or little say over their sexual behaviour. To this group belong especially the rural and urban poor. Women and their children varying by country and cultural setting are especially at high risk of infection, lacking the means to protect themselves in situations of sexual, social and economic abuse. Economic systems promoting migrant labour facilitate urban rural transmission. Also displaced communities due to civil war or natural disaster are at high risk of infection. Prison populations and commercial sex workers can be considered as high risk groups when adequate provisions and care are absent.

A priority group for intervention is the youth as new sexual patterns are being developed. School health education and information programmes are essential.
Changing relationships between men and women, sometimes contrary to established cultural or recently in history grown habits, creates a formidable challenge. "The mental fixation that glorifies traditions of male sexuality now hinders collective behaviour to stop the spread of HIV".

Advocacy at the level of community and political leaders to prevent discrimination, to ensure protection of the family and orphans, and to improve the position of women in society, and especially improving literacy, can create the necessary framework for changing behaviour. Policy and programmes should be aimed rather at whole communities than narrowly be focused on risk-groups.
Vertical transmission of HIV can be prevented to a certain extent by counselling and the availability of effective methods of family planning.

A strategy for the prevention and treatment of STD has to be followed vigorously. Early detection and treatment of especially asymptomatic STD has to be integrated as part of maternal service and health services for women. Education and counselling should be part of epidemiological control programmes. STD protection devices (male and female condoms) have to be made widely available to those at risk of infection .
Appropriate treatment schedules and drugs should be available at peripheral health units. Training for its use should be provided.

Safe blood transfusions. All blood for donation should be screened by one appropriate HIV antibody test with high sensitivity. No second or confirmatory test is indicated for this purpose (see annex 1: HIV-testing policy).
Prevention of anaemia is most important as to lessen the need for blood transfusions, especially in children and women. Malaria control and nutritional education therefore have a high priority .

Safe hospital procedures should be ensured by regular training and supervision of all departments that handle potential infectious material. Protective materials are indicated.
An AIDS Policy Committee (APC) should be present in all institutions and will be a condition for support by MEMISA (see annex 2: safety in the work place).

4. Support of people with AIDS/HIV (PWA).

-Counselling of HIV-positive people
-Counselling and clinical care of PWA
-Home care and family support
-Support of orphans

Support programmes for the care of HIV infected persons and patients with AIDS at the level of the hospital and the community are indicated. To be effective, care will be as much as possible integrated within the primary health care strategy and aims to strengthen community based health care.
Mobile teams for assisting and supervision of home care and community counselling may be indicated. Any counselling programme should also include care for counselors.
In principal only essential drugs should be used, or drugs which can be safely used at the level of the basic health services and are of proven value to deal with symptoms of AIDS.

Support of affected families and orphans in regard to medical and preventive care can be considered . Other social and educational needs can best be dealt with in cooperation with other multisectorial programmes.
Orphan support through direct assistance and the promotion of community care for affected families should be supported. The training of community health workers or community social workers and the possibility for establishing day care centres at the local level can be considered for support .
In the programmes for education and information as well as in home based care programmes and the organization thereof, PWA/HIV should be involved as active partners as much as possible. They are often well motivated and their engagement provides an opportunity for living positively with HIV/AIDS.

5. Research, training and management.

Operational research in the formulation phase of an HIV/AIDS prevention and control programme is indicated. These studies are specifically related to social- and sexual behaviour , STD prevalence, transmission, appropriate treatment schemes and health education intervention strategies.
Training for project management, clinical care, STD prevention and treatment, counselling and home care at the appropriate level are important fields for support.
Within the context of training, attending local and regional meetings (with the exception of international meetings), on AIDS, STD and project management can be considered for support.
South-south programme exchange could be promoted.
In managing national or regional programmes, verticality in execution should be limited. The aim should be in training trainers at local level as to enhance the capacity for sustainable programmes.

At national level participation in the National AIDS Control Programme (NACP) and the GPA/WHO policy is of great importance, as initiatives should follow mid-and long-term national AIDS control programmes and as feedback from the NGOs to the NACP.
Support to NGOs who are established for HIV/AIDS only should be judge carefully. NGOs coming forward from PWA/HIV (ASOs) for creating awareness and increase coping mechanism, should be seen differently from NGOs targeting populations in general for intervention.

MEMISA will maintain working links with national and international networks on AIDS prevention and control. Such networks can be supported in their functioning, including support for international publications and advocacy work.

Criteria for funding.

Those have been formulated within the Caritas/CIDSE organizational structure (see annex) for a wider range of activities than could be considered by MEMISA, as they include other development sectors.

The following three basic and minimal criteria will be applied in the assessment of all AIDS project proposals:

1 Criterion: AIDS project proposals should not stand alone but relate appropriately to existing health or other development activities.

2 Criterion: AIDS projects should provide objective, non-judgmental and non-discriminatory information and services.

3 Criterion: AIDS project proposals should as far as possible help to create and to strengthen indigenous coping mechanisms which will be characterized by self-help and community involvement.

It should be mentioned that concerning the criterion of integration within an existing health or social structure, the emphasis on applying this criterion may differ for the various regions. In Latin-America and to a lesser extent in Asia, NGO's are often not actively engaged in the provision of health care directly as this is done by the government. AIDS prevention and care programmes in these regions could make a valuable contribution complementary to the government services.

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2/94

Com II 20.5
VII (C)

Memisa Cebemo health care policy.

1. History
2. PHC
3. Policy dialogue
4. General Policy
5. Relationship to international networks
6. Specific concerns.
7. Ethics: Rome and Athens
8. Tanzania
9. General issues
10. specific issues.

1. History.
Memisa started in 1926 as an initiative of private medical practitioners and a priest in response of requests for health care and advice for missionaries in the southern countries, experiencing a very high mortality. As missionaries gradually took up health care for the population amongst whom they performed their missionary work, the role of Memisa gradually expanded to advice and support health care delivery through missionaries and congregations.
With the development of a professional church related health service, Memisa and since the early seventies, also Cebemo took part in the development of such services in the newly in dependant countries.
Cebemo arose out of the possibility that Dutch church related NGO
could get support from the Dutch government for their work in developing countries.
Although Memisa and Cebemo are having their roots in the Catholic church, neither Cebemo, nor Memisa are Catholic organizations
in the sense of falling under the hiarchy of the Catholic church.

Memisa gets its funds from the Dutch community in response to perceived health needs of the communities in the south.
At their request NGOs like Memisa, Caritas Neerlandica and Lenten
Campaign, Cebemo can act as a co-funding organization. Besides that the main channel of funding for Cebemo is the co-funding of
NGOs in developing countries.

2. Memisa follows largely the policy of PHC as laid down in the
Alma Ata declaration, which reflects the health developments which had taken place in the 60-ties and early seventies, especially in the church related health services. Alma Ata was not new, it was the result of health care initiatives of NGOs, rather than governments. Memisa and Cebemo promote the application of the PHC policy to the situation pertaining in specific regions and countries in the developing world.

It has to address itself to the issues of ill health

It has to address itself to the issues of ill health considering
and analyzing the determinants of health: poverty, political violence and suppression, cultural and religious obstacles, gender issues affecting health; and the environment as it has a
physical expression and influence on health: water, waste, soil
and air, height, temperature and rainfall. The social and economic environment with factors as education, development level, ethnicity, population pressure, the level of democracy and
distribution of wealth are important determinants of health status and determine possibilities to attain better health.

3. Policy dialogue. Funding agency policy is sometimes experienced as constrictive by the partner organization: are we
not having our own policy? Don't you trust us?
Who is the recipient of aid/assistance- who is our partner? Primary our partner is the community which can only be approached
by their own community organization. Our partners are therefore
both church and non-church related NGOs or where a legitimate government is present also they can be our partner in development. The main criterium is does the community benefit from the funds provided by the Dutch community. The aim is therefore not explicitly to strengthen the church, but those for
whom the church can be meaningful in improving the health status
of the people.
4. Memisa and Cebemo are development organizations. The notion of
development, aiming at self reliance, participation and independence form the basic ingredients for criteria for financial and other ways of assistance. Memisa is not a recruitment bureau for medical personnel, such personnel has to
be engaged in positions which are optimal to share in a creative
development of health services within partner organizations.

5. Memisa and Cebemo relate to international bodies as WHO, Caritas Internationalis, CIDSE and Medicus Mundi Internationalis
as well as to national networks. From these association some common policy is derived.

6. It is felt as a moral obligation for the people in the north
to share wealth with those in the south, realizing that we are part of the same global community. It includes an awareness of the wholeness of the creation and the common interest to care for

this creation.
It is also realized that this can only be attained by limiting

the consumption of non-renewable resources in the north.
The obligation of all of us is to attain peace as without peace
development is impossible.
An active policy to put our own house in order, without blaming
past historical events in the first place, is an obligation of all of us.
As the world political constellation is not anymore divided between eastern and western dominance, new positions and political arrangements are being sought. This has led to certain
instabilities in regions with significant religious and tribal differences.

7. Ethics. Although Memisa and Cebemo have roots in the catholic
church, their policy is not determined by a particular brand of
Christian church and therefore not restricted by internal church
policies. Our partners, especially in the east are members of eastern religions, who have there own set of criteria.

As far as they do not contradict ethical consideration based on
universal notions of human rights, such organizations can be meaningful in developing health services for their communities.
We can not deny however that such ethics are mainly formed by the
Greek tradition as expressed by Hippocrates and the christian churches. Medical action is primary determined by the interest
of the individual and the community and only secondary by the religious association. Also the catholic church does recognize that it is the individual who has to take ultimately responsibility for its own actions to preserve life.

8. Tanzania policy.
Historical changes. The changing role of the church in health care asks for a reconsideration of its internal management structure to cope with the legacy of the past and the challenges
of the future.
The assessment of the health service infrastructure has laid bare the need for a reorientation in the management of health services. Memisa and Cebemo recognize the need for a sound health
infrastructure in the attainment of health for all at some time.
That essential elements as community participation and efficient
and effective response based on needs expressed by a participating community or observed and researched health needs
are essential ingredients towards this goal, would not be denied

government
should be complementary. No overlap but constructive cooperation at local level is essential as not to waste scarce resources. In supporting each other parochial thinking can be an obstacle. As already put forward at the Dodoma conferences, designated health areas for each unit should be determined. The recent example of Bukoba district showns ways how such concept can be designed.

13. The basic change in the cooperation of Cebemo and Memisa with
the partners in Tanzania is that the approach of supporting unlinked activities will be replaced by a structural mid to longterm cooperation. This will need a clear understanding of each others role and capacity. It asks for an open dialogue and a
complete transparency in its planning and execution.

Increasing the capacity of the diocese to take up this responsibility will need a continuous training in all fields of
running a health service, management in the first place.

The basis of the church activities has to be formed by a consistent diocesan health policy and plan. Without such basic document, there will be no firm foundation on which cooperation
between the diocese and its development organizations, whoever they may be, can take place.

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Medical advisor
Memisa Medicus Mundi.
September 1993.

FIELD REVIEW OF ANDHRA PRADESH PARTNERSHIP OF MEMISA

A REPORT FOR PRESENTATION IN THE WORKSHOP FOR CORE PARTNERS OF MEMISA

1 - 3 AUGUST 1996 AT HYDERABAD

PREPARED BY

D SREENIVAS RAO
JULY 1996

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FIELD REVIEW OF MEMISA PARTNERS IN ANDHRA PRADESH

I. INTRODUCTION

The desk review of the partnership between MEMISA and it's partners in India, conducted by Dr. Ravi and Dr. Thelma Narayan of CHC, Bangalore had suggested a field review of all the projects in the three key States of Andhra Pradesh, Orissa and West Bengal as a complementary exercise to the desk review. CHAI, the core partner of MEMISA in Andhra Pradesh agreed to the idea of field review and after a detailed discussion with Dr. Ravi Narayan and MEMISA had undertaken the assignment. This paper attempts to bring out the insights and learnings drawn from the interactions with the field partners at the grass root level which would be raised in the workshop be held from 1 - 3 August 1996 at Hyderabad for further discussions.

I.1. Objectives of the field review

a) To understand the feasible models of health care developed and evolved in the field by the partners.

b) To learn the strengths and weaknesses of MEMISA partners.

c) To review the lessons learnt from partnership process between MEMISA and partners and give suggestions for future.

d) To understand the emerging needs of partners in terms of training, continuing education and support to programme process/ management and self development.

e) To assess long term sustainability of process and efforts made towards the goal.

I.2. Methodology

a) **Check list for field review.** CHAI took the lead in developing a check list for the field review and sent to MEMISA and CENDERET and WBVHA, the core partners in Orissa and West Bengal respectively for their comments. The check list was revised based on the suggestions and was used for field reviews by the core partners.

b) Sampling of Field Partners for review : There are about 16 projects supported by MEMISA in Andhra Pradesh. Due to time constraints, a sample was made and 6 projects were selected for field review based on the following criteria.

a) Projects managed by women exclusively

b) Projects aimed at empowering Dalits and managed by Dalits

c) Two projects run by Catholic Church (M.Is of CHAI)

d) Two projects by secular NGOS

Out of six projects studied, five were recommended by CHAI and one, ie. Assist India has been supported by MEMISA directly.

I.3. Process of Field Review

The field review visits began in mid April 1996 and concluded by mid July 1996. Two members of the Community Health Department paired up for all the field reviews to avoid any subjective impressions except for one project which was done by one team member due to personnal and time constraints.

During the visits to six field partners, the team had discussions with the project holder, field staff and visits to a few target villages and interactions with target group members and leaders keeping the checklist for field review in mind. After the field visits the respective team made reports for each visit which were compiled into this report.

II. PROFILE OF FIELD PARTNERS

II.1. Where are MEMISA partners located:

There about 16 projects being supported by MEMISA as on 31 July 1996, which are recommended by CHAI and seems to be two more projects directly supported by MEMISA in Andhra Pradesh. These 16 projects located in 11 districts and the other two projects are also located in one of the 11 districts.

Following table gives the break up district-wise location of the projects.

S.N.	District	S.N.	Project Holder
1.	Warangal	1.	Catholic Mission, Kamalapuram
2.	Mehaboobnagar	2.	RAISES, Shadnagar
		3.	Y.F.A. Kothakota
3.	Adilabad	4.	Catholic Church
4.	Khammam	5.	CHRESHE
5.	Ananthapur	6.	CHAITANYA, Lepakshi
		7.	ARIDS, Bukkapatnam
		8.	SAVE, Vajrakur
6.	Cuddapah	9.	Vimala Community Development Centre, Maliapuram
7.	Chittoor	10.	SEVABHARATI, Tirupathi
		11.	RORES
8.	Krishna	12.	SNEHA
9.	Guntur	13.	Nava Chaitanya M.P.H.W. (F) Training
10.	Prakasam	14.	BIRD, Bestavarapet
		15.	WELFARE
	Directly supported by MEMISA	16.	ASSIST India (Guntur & Prakasam)
		17.	PASCA
11.	Srikakulam	18.	Grama Abhivruddi Kendra

Out of 18, five projects are located in four backward districts of Telangana, six in 3 districts of drought prone Rayalaseema and seven in Coastal Districts of Andhra. Out of 6 projects visited for field review, two are located in Anantapur district (Chaitanya and ARIDS),

one in Prakasam (BIRD), two in Guntur (St. Ann's and ASSIST) and another one in Warangal (Catholic Mission). While the Telengana and Rayalaseema projects deserve support based on the backwardness of the area, the other projects may have deserved support based on specific health problems in particular area or their focus in Dalit or tribal groups.

II.2. **Nature of field partners**

Rural & Urban:

All the six projects visited are rural based except the one (ASSIST) located in small municipal town but not having any urban programmes. In the context of rapid urbanization process even in Andhra Pradesh, a few urban health projects may be encouraged.

Church & non-church

Out of 16 projects recommended by CHAI four are Church related. The reamining are secular voluntary organisations.

Out of six voluntary organisations reviewed two are church related and four secular voluntary organisatinns. Of the two church related, one (Catholic Mission) Kamalapuram is a parish based group run by a priest and the other one is Social Service Society run by local congregation which has various developmental programme. The four voluntary organisations are basically developmental organisations not exclusive health groups or organisation with health specialization.

Size

Majority (88%) are small and medium size and only two (ie. 12%) are larger voluntary organisations among those receiving MEMISA support in Andhra Pradesh. This shows the conscious efforts from the core partner as well as MEMISA to promote smaller grass root organisations.

Management

One among the four secular groups (ARIDS) is managed by a woman, one by a Dalit by himself (BIRD), the other two by two persons who had previous experience with big NGOS. Of the two Catholic groups, one is run by a Parish Priest and the other one by women Congregation. Five voluntary organisations have a Governing Board with about 7 members. The founders are the chief functionaries in all the four voluntary organisations who are the 'key' persons. The role of Board is very minimal in all voluntary organisations except in one.

All the six, except one, have informal way of functioning with out too much of professionalism which seem to have both advantages and disadvantages. But one organisation in the course of time, has grown itself in to a bigger professionally managed group was has the support of five to six funding agencies. Of the two Catholic groups, one, run by the Congregation, is also big with various programmes in a number of areas of Andhra Pradesh, which is in the process of getting professionalised. By and large, the groups, supported are small in size, committed and who can operate in smaller jurisdiction.

Focus group

Though the target group of all the six groups is by and large the disadvantaged sections of the people, one group focuss exclusively on Dalit women, three on women in general Dalit and other backward classes, one on the poorer sections without exclusiveness, one on women and children in a tribal area including SC Dalits. By and large, the focus group emerges to be women and children with more focus on Dalits and tribals. It may be a welcoming trend.

Focus of work

The focus of work of the six groups is mostly empowering the women through awareness building while one focussed on providing sanitation facilities besides health education. Almost all the organisations have various developmental activities as their focus like non-formal education, thrifts, watershed, MCH (CRS), vocational training, social forestry, etc. Community Organisation and saving schemes are common activities in almost all the organisation.

III.1. Primary Health Care/Community Health Approach

All the six groups have received support from MEMISA towards Primary Health Care/Community Based health care programmes in the last 4-5 years. Out of six, four have received financial support for exclusively community based health care programme, while one group (ASSIST India) received support for providing sanitation in two phases and another one for 18 months M.P.H.W. training (St. Ann's Social Service Society).

Many of them understand primary health care as integral part of their developmental work. But they do understand it as a programme package to address the common health problems in the local areas and to increase health consciousness among the masses. A few of them feel that being a health programme, it has to be meant for all. The logic expressed was that they cannot differentiate people for health grounds. Basically it is taken as a programmatic approach by many while two have taken it as an opportunity to organise women especially Dalits and conscientize them for empowerment. A common understanding and consensus on the broader vision of community health need be arrived at.

III.2. Activities/Components of PHC/C.H.

The review of 6 field projects highlight commanalities in some projects while some show diversity in their programmes. The degree of focus on each programme component varies from one group to the other. Following is the list of the activities as part of their P.H./C.H. programme.

1. Training of Community Based Health Workers (CHWS)/CHVs/VHWs (6)
This is one of the important component of Community Health Programme, observed in almost all the programmes. Though the success of the programme depends on C.H.Ws, there seem to be constraints in getting resource persons to train them properly.

2. Health Education (6)
Another important component observed is health education. The PHC/C.H programme revolves around this important activity. Though the focus of all the groups is health education, there seem to be constraints/limitations in this area also.

Majority (4) are involved in giving 'Health messages' like Do's & Don'ts, while a few (2) are involved in developing critical consciousness to a certain extent. The content and methodology need to be more thought about and systamatized. The smaller groups need greater support from outside in these areas ie. training and health education aspects of the programme.

3. Immunization (3)
Importance of immunization and ORS are some of the common aspects of Health Education.
Increasing immunization levels of under five children and pregnant women is one of their important agenda. Majority of these

partners supplement the local Government efforts in increasing the immunization coverage. By and large in all the places of the partners' operational areas, the coverage seems to be quite high. Due to the efforts of Government and NGOs, it is becoming culturally acceptable which is a very good outcome.

4. Health Camps (4)

Health camps, usually the one time events, are very common and popular activities of almost all the voluntary organisations. Local doctors from PHCs are involved in organising such camps besides their own staff. Mass awareness and detection of some of the common diseases like cataracts, T.B., Leprosy, Gynaecological problems etc. are the primary objectives of such camps. Camps would be relevant if there is a continuity of education and follow up action whirh doesn't seem to exist. In one organisation, it is positive to note that the women's organisations of all the target villages take the responsibility of organising such mass camps.

5. Promotion of kitchen garden (4)

Malnutrition is one of the major health problems all the partners confront in their field areas. Nutrition education is important aspect of their health education. They promote kitchen gardens around the homes of the target groups. Various seedlings are supplied to them as part of the programme. In many places this doesnot seem to be a successful programme as the people are not able to maintain kitchen garden properly due to either water scarcity or lack of proper care. In one place, we could observe minimum of 4-5 fruit trees around all the Dalit houses where it seems to be working.

6. Sanitation programme (1)

One of the six partners is involved in construction of latrines with the support of MEMISA, State Government and local contributions in a large scale in part of coastal Andhra. After a process of health education for two to three years, providing infrastructure seemed to be necessary. In the expansion of the sanitation programme, whether the same amount of education was gone in, is a question.

7. Promotion of Alternative systems of medicine (5)

Out of six groups five are trying to promote herbal and home remedies to treat common ailments, which is positive to note. As people are made aware of the preparations for some of the common ailments, they can manage some of the common ailments on their own which leads to empowering process. At present all of them are trying to promote with limited exposure and knowledge. They need to equip themselves to promote herbal and home remedies in an effective way. This is culturally acceptable, low cost and is accessible to more people.

8. Thrifts & Savings (6)

Thrifts and savings is one of the most common activities, all the groups are involved. In most of the places, the groups of women are organised around savings. This is one activitiy all the women seem to be interested. In a few places (2-3) the sanghams are enabled to manage their own savings while in a few places (2-3), they have just started and so more controlled by the NGO. In a few places (2), the community (group of women) meet once in a month only for this purpose i.e to collect each individual's savings and distribute loans to needy members.

9. Community Organisation (6)

All the six groups are involved in organising groups of women (6) and in a few places youth (1). The groups have taken a number of issues such as women's harassments (3), problems related to public distribution system (PDS) (ration cards), local infrastructural facilities, such as bore wells and land pattas etc. Of late, the issues related to health have come on the agenda of these community organisations which is positive to note again. They seem to be moving from providing health services to enabling the people to demand health as their right.

10. Collaboration with Government (6)

All the six groups are trying to collaborate with Government in reaching the poor with developmental/welfare programmes. The degree of collaboration varies from one group to the other. Out of six, two groups (ASSIST & St. Ann's) seems to have excellent relationship with Government and involved in implementing Govt. programmes, while others are trying to make the community more aware of Government programmes meant for the them and try to access such programmes.

The trend of involving NGOs is increasing more and more, NGOs need to think of this seriously and make a critical collaboration.

IV. FACTORS AFFECTING HEALTH

a. DIRECTLY

Following are some of the activities/factors that seem to be affecting improvement of health directly.

1. Immunization
2. MCH services (supply of iron and folic acids, immunization to pregnant women)

3. Treatment of minor ailments through ANMs and trained health workers.
4. School health
5. Sanitation
6. Promotion of Family Planning methods
7. Use of ORS

b. INDIRECTLY

Following are some of the factors that affect improvement of health indirectly.

1. Health Education
2. Thrifts and savings
3. Training of health workers and T.B.As.
4. Nutrition education and demonstration
5. Community Organisation
6. Balwadis
7. Income Generation activities
8. Provision of safe drinking water
9. Making use of Government programmes.

V. EMPOWERMENT PROCESS

All the six groups aim at empowering the communities they are working with. Two women's groups and one Dalit group focus more on this. Awareness building and organisation of people is aimed at empowering the community, so that they could withstand exploitation and take control over their lives. As far as health is concerned, they are becoming more aware of their health problems, causes of such problems and able to take responsibility to do something on their own to a certain extent. Still in a quite a few organisations, when it comes to health, they still take soft line approach of providing services like MCH services, treatment of minor ailments, etc. though they are

important. Developmental groups need to understand their health work more as part of the empowering process of the disadvantaged groups.

VI. SUSTAINABILITY

Sustainability is one of the major issues they have to grapple with. Majority of these groups, except one (ASSIST), has any concrete plans towards sustainability. Ofcourse some of the activities or strategies they use might help in sustaining the programme such as health committees/community organisations, and training of health workers identified by the community. The knowledge and capacity of the community seem to be increasing as far as health workers are concerned. In many places community health workers are paid by the community. In one place a parish based group is trying out identification of health volunteers through a health committee. In one place, the community health programme in about two villages with a dispensary was supported for three years. A recent visit to the place, after withdrawal of support, gave us a satisfied feeling seeing the continued interest of the women on health matters, may be because the programme was implemented in a smaller area. Sustainability issue need to be thought over right from the planning stage, which does not seem to occur.

VII. ORGANISATIONAL CAPACITY

All the groups except one have very informal way of functioning. The management style seems to be democratic and feasible in many places. Out of six, three groups have one man/one woman show though they have a team of community health workers where second line and third line leaders need to emerge.

Another group, which is quite big, has gone into a professionally

managed group with a core team of management (3 members), monitoring and evaluation, and training team with decentralisation of powers and responsibilities (field centre wise) etc. They have developed very a good system for planning, management, information systems, reporting, job discription, line of authority etc. which could be learnt by other groups. Caution could be at this point of time, not to professionalise so much that participatory, democratic, team functioning ethos of voluntary sector can be lost.

At the same time many of the smaller group could come out of single man leadership and increase the management capacities to organise, plan and manage well.

Information system and reporting in many organisations need to be developed and improved upon.

VIII. TRAINING AND OTHER SUPPORT NEEDS OF PROJECT-PARTNERS

One of the most important needs emerging is a good support group who could help them and guide the smaller groups in terms of training grass root level workers in local language, educational material, planning, monitoring, information systems and documentation, creative and innovative experiments are not many. The groups should try to be more creative in their health education process.

All the groups are facing limitations in getting resource persons who could train grass root community health workers in line with the vision and philosophy of their organisation. The local PHC doctors are not able to give right orientation or they may not have participatory training skills.

Similarly, the partners are not able to plan and carryout health

education effectively which is the important component of PHC/Community Health programme. Either they lack enough material or skills to do it. They do need support and training in this aspect.

Majority of them seem to lack participatory planning and management skills to run community health programme. Though they may not need high technological management, they still need to increase their skills in Participatory Planning & Management.

IX. TRANSPARENCY IN FINANCIAL ASPECTS

It varies from one organisation to other. A few smaller groups seem to have transperency at the Governing Board level. The bigger group seems to have at the staff level too. In a few cases only the Chief Functionary has the knowledge about the find position. Budgets in many places are not always prepared in consultation with the staff and the people. Involvement of staff and the people right from planning the budget could be encouraged.

ADVOCACY AND NETWORKING

Out of six, four seems to be part of district level networks of voluntary organisation. One of the partners was even the President of network of a district for some time. A trend of smaller groups, especially the Dalits groups, networking at district level is emerging in some parts of the State.

All the six groups have one way or the other association with the Government departments. Two or three groups have limited themselves to involving the Government in health camps, immunization, family planning etc. and making people more accessible to Government programme. Two or three partners have taken up programmes with the financial support of Government. One group is involved in child labour rehabilitation programme in a big way with the support of

Ministry of Labour, Government of India & ILO.

There is a history of networking of NGOS at the District or State Levels in A.P. Attempts are made several times but there seems to be constraints in networking. Personal egos and vested interests play the major role coming in the way of networking though positively there are alliances emerging on particular issues or group interests.

X. STRENGTHS AND WEAKNESSES

All the observations, made so far, in different headings, throw light on different strengths and weaknesses of the partners. Our focus is not to evaluate any project partner, and pass judgements, but certain observations may be given here in the form of strengths and weaknesses which may be useful for discussion and future planning.

Strengths

1. Majority of the groups supported (4) are smaller and medium size groups who have commitment and can be effective in their operational villages. Most of the partners come from the same areas and so they are aware of the local culture and local problems.
2. Majority of these groups are community based.
3. All the six field partners adopted integrated development approach and health is seen as part of it.
4. Majority of the groups are health action oriented groups.
5. Majority of them are open to working with the Government.
6. Networks of smaller groups is emerging.

Weaknesses

1. Majority of the groups seem to lack expertise in PHC/CH as they are primarily developmental groups.
2. Insecurity among several smaller groups about the sustainability/continuation of support.

3. Non availability of good resource persons to train community level health workers in local language.

4. Lack of planning and management skills among the smaller groups.

5. Lack of second and third line leadership.

6. Lack of competent staff.

7. Too many programmes and less staff.

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CHECK LIST FOR FIELD REVIEW OF PROJECT PARTNERS

I. Profile of the project partners:

1. Since when in existence, location (rural/urban/tribal etc.);
2. Vision, mission, objectives, target group and activities;
3. Composition of Governing Board, no. of women members, representation from disadvantaged groups and the role and functions of the board.
4. Composition, competence (qualification, specific trainings, experience) of staff., no. of women staff and their role;
5. Any other, as deemed necessary

II.A. Conceptual understanding of P.P. about CH & PHC

1. Components/Aspects considered essential for promoting PHC and CH.
2. How do the project partners contextualise PHC/CH in the overall context of development.
3. Approach of the Project Partner - Process oriented, Project oriented. What are the constraints.

B. Understanding of PP's role in promoting CH and PHC in their operational area

1. PP's assessment of its role in promoting CH and PHC in the target area/to the target group; (provider or enabler)

III. Various activities of the Project Partner in the field of Community Health/PHC.

1. Which activities have directly contributed to better health?
2. Which activities have indirectly contributed to better health?
3. Are there any activities which affect health negatively?
4. Do the activities contribute towards the empowerment of the community.

IV. Assessment of long term sustainability:

1. Which are the activities which enhance the knowledge and capacity of people.

2. What level/type of participation is observed in the programmes.

3. Strategies used by the partners to secure people's participation towards sustainability.

4. For which components of community health programmes, financial assistance, support and collaboration were tapped from Government and other sources?

5. For which other components of community health similar assistance/support/collaboration are possible.

6. What are partners' views and plans to ensure long term sustainability.

V. Organisational capacity

1. Planning, monitoring and evaluation and information systems exisits in the organisation and how far they are effective.

2. The Management style of the project partners within the organisation.

VI. Training and other support needs of PPs:

- What are the areas of support, assistance, trainings required for Project Partner in implementing PHC/CH programme.

- What capacities and skills need to be developed among the PPs
  a. To respond to the grassroot needs.
  b. To manage the organisation.

VII. Strengths and weakness (programmes and processes:

VIII. Transparency in financial aspects
* Within the organisation
  - Board level
  - Staff level
* With the target group
* Public at large

IX. Involvement in advocacy and networking.

a. With government, other voluntary organisations.
b. Are they part of any networking organisations?
c. If yes, does that have a positive influence.

Is the network membership any guarantee for professionalism? eg. good standing. Are there criteria for membership related quality?

****

4.1 Our Mandate

The CHAI Golden Jubilee evaluation study and the subsequent action plan have re-affirmed that promotion of community health should be our first priority in the decades to come. Other priorities identified, namely health, healing and wholeness, preferential option for the poor are in the ultimate analysis complementory to the over riding priority of community health.

As a strategy to promote community health in India, the Projects and Evaluations Cell of CHAI has been established. The overall goal is to promote community health in India through supporting, guiding, associating and assisting member institutions and other NGO groups in various parts of the country.

With regard to project studies, the CHAI would be willing to take up

1. Projects/programmes which contain larger components of community health.

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5. STAKE HOLDER - ANALYSIS

The following individual organisations and others who are in a position to influence our work or place demands on us, who are effected by or who can affect our work, who have an interest in our work or who can lay claim to our work.

* Disadvantaged and vulnerable people of AP.
* CHAAP - Regional Unit of CHAI in AP.
* Peoples Movements.
* Similar and Donor Agencies in AP.
* Member institutions.
* Board of CHAI.
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* The Catholic Church in AP.
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* National Health Organisations (CMAI and VHAI)
* State Government of AP.
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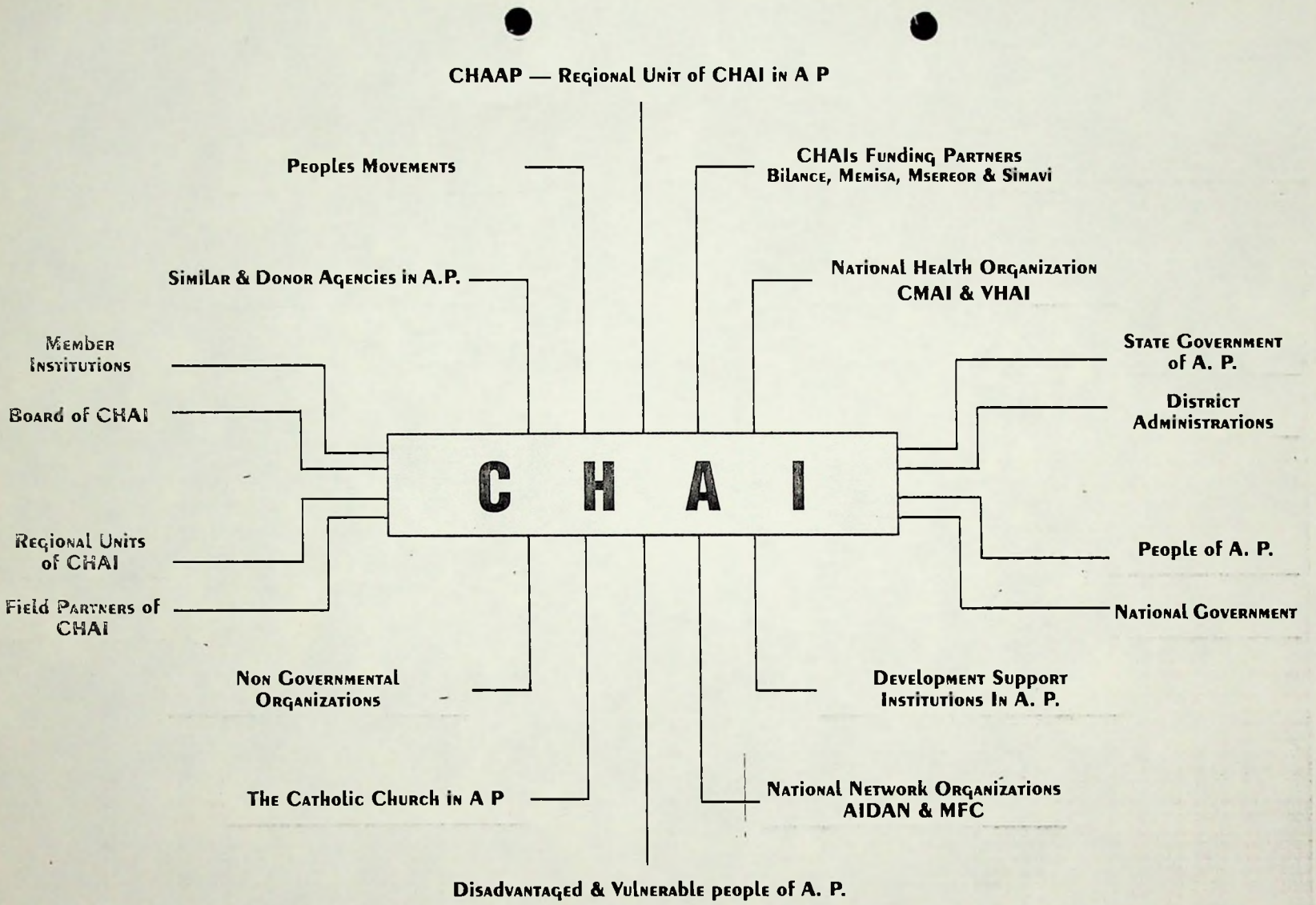

STAKE HOLDER MAP OF CHAI FOR A. P.

6. Strategic Issues

CHAI has identified the following issues for its involvement in AP.

6.1 The external environment analysis of the region brings a wide range of focus groups who are marginalised and deprived of their basic right to have a healthy life.

Some of the issues CHAI needs to reflect are

1. Should we work for all disadvangated people in AP?

2. Who among the disadvantaged are in dire need of our support and assistance. How do we identify them?

Keeping our internal analysis and the external environment, CHAI has identified the following focus groups based on the criterias low literacy, low income, low health status and high social discrimination.

* The women
* The children
* The tribals
* The dalits
* The fisherfolks
* Urban slum dwellers
* The agricultural labourers

6.2. In the analysis, we realised there are certain pockets in AP which deserve better attention compared to the rest of the places in AP. The socio-economic conditions of the people and the backwardness of the area due to drought and other reasons and the large presence of a vulnerable groups etc. call for a different strategy for AP.

1. Shouldn't we have a geo-political approach in AP?

2. Shouldn't we priorities our target areas?

3. What should be the criteria for identifying the target area?

Andhra Pradesh being so vast and an organisation like CHAI with limited resources and to make our programmes effective, it is desierable to prioritise the areas (districts) for our intensive involvement. Accordingly we have prioritised into three groups on the basis of

* High IMR

* Low female literacy and

* High incidences of poverty.

Ist group : Ananthapur, Kurnool, Mahbubnagar, Adilabad, Warangal, Nizamabad, Srikakulam, Visakhapatnam, Medak, Karimnagar.

IInd group : Chittoor, Nalgonda, Cuddapah, Khammam.

IIIrd group: Nellore, Prakasam, Krishna, West Godavari, East Godavari, Nizamabad, Ranga Reddy, Hyderabad.

6.3. Another strategic issue to be addressed is

1. Do we need to have an issue based approach?

2. Should we not take up health issues which affect the majority and the disadvantaged?

The analysis of the health status of the people shows that the following disease/health issues which affect all, but affect the poor very severely deserve our attention, particularly because there has not been any adequate response from the government. However, a vertical approach may not be the answer. Instead an integrated approach is desirable. The identified health issues are

* HIV/AIDS
* T.B.
* Malaria
* Filaria
* High prevalence of Fluorisis - content in water.
* The health problems arising out of prawn culture etc.

7. STRATEGIC AIM

7.1 To support innovative community health initiatives focussing on the socially and economically vulnerable commmunities and groups (the focus groups) in Andhra Pradesh would enable them to have control over the situations affecting their health in a sustainable manner.

7.1.1 Strategies

- Support and facilitate to get support for MIs and NGO activists and community based groups for community health programmes targetting the vulnerable and disadvantaged group.

- Provide organisational and institutional support to groups to evolve a community health programme.

- Support action-oriented research and studies.

- Assist and support groups working with the focus groups and focussed areas to integrate community health into their ongoing developmental activities.

- To play a proactive role by identifying and supporting groups/NGOs working with the vulnerable and disadvantaged people.

- Support and guide the network of peoples organisation emerging from the focus groups.

- Consciously supporting the small and medium sized NGOs and peoples organisations.

7.1.2 Focus groups

The tribals
The Dalits
The Fisherfolk
The Women
The Children
The Agricultural Lahour
The Urban Poor

7.2 To identify and support programmes which would address specific major health problems affecting majority of people.

7.2.1 **Strategies**

- Provide organisational and institutional support to MIs /NGOs, health activists in working with of people affected by the health issues.

- Facilitating interface between people, government, NGOs and other relevant groups to come together and develop appropriate interventions, strategies to the issues.

- Support or facilitate research studies or detailed situational analysis on the identified health problems as part of advocacy strategy.

- Promote network of organisations working on health issues or health related issues.

- Equip the partners with knowledge, skills and expertise to address the health issues and integrate in their ongoing activities.

7.2.2 **Focus issues**

HIV/AIDS
T.B., Malaria, Filaria
Flourosis, Health Hazards of Brarkish Water/Aqua Culture

7.3 To strengthen and develop the capacities of our field partners to develop a perspective plan based on the needs and enable them to implement the community health programmes effectively and efficiently.

7.3.1 **Strategies**

- CHAI commit itself for a long term association with the identified partners/groups for a minimum of 5 years.

- Support/recommend the projects/programmes for a shorter period (ie 18 months) as a preparatory phase.

- Assist the groups to develop a perspective plan on community based health programme on the understanding and experiences from the prepraratory phase and support/recommend it for another 3 years.

- Facilitate/Organise training programmes to equip the groups with basic skills on project management, planning, monitoring, evaluation, develop proper systems and procedures etc.

- Provide support and guidance through follow-up, visits, discussions etc.

- Organise thematic discussions/workshops for the field partners.

- Facilitate interface between other groups, forums with a view to cross programme learning and cross-country learning.

7.3.2 **Focus group**

The field partners of CHAI in A.P.

7.4 To strengthen the CHAI, its regional team and the extended teams' capacity and enhance their skills to facilitate the development process emerging from the grassroot level and develop an appropriate intervention strategies.

7.4.1 **Strategies**

- Initiate and conduct studies, analysis and workshops on emerging trends in economy, society and the situation of vulnerable and disadvantaged people in A.P.

- Develop a gender perspective into the action plan of CHAI and its regional unit.

- Gender sensitisation and enhancement of gender awareness and perspective for our team, NGO sector.

- Supporting the team with additional personnel at the central as well as regional level.

- Involving the regional team at all levels while developing programmes, perspective plans for A.P. and sharing the responsibility accordingly.

- Strengthening of the regional resource team with knowledge, skills and resources.

- To build our own internal capacity and systematise or institutional learning process so as to enhance our effectiveness in everything we do.

7.4.2 **Focus group**

CHAI team.
The regional team members of CHAAP.
The identified resource team in A.P.

7.5 To make strategic alliance with similar agencies and funding agencies to support community health programmes in the region.

7.5.1 **Strategies**

- Meetings, discussions, participatory workshops, seminars.

- Exploring the possibility of promoting a forum in the region whose health and development issues are discussed and;

- Sharing of information on various aspects.

7.5.2 **Focus group**

Similar agencies like IGSSS, Caritas India, APVHA, ISI etc. Funding agencies - OXFAM, Action-Aid, CRY, ASW etc,

7.6 To facilitate networking of NGOs, MIs, Diocesan Social Service Societies at the regional, district and national level to support each others efforts, and to develop a platform for advocacy and lobbying on the issues related to the health of the people.

7.6.1 Strategies

- Support meetings, workshop, to assess situation promoting discussion on alternative health and development strategies among the focus groups.

- Provide fellowships and non-funding supports on issues identified.

7.6.2 Focus groups

NGOs
MIs
Diocesan Social Service Societies.

ANNEXURE 1

RURAL POVERTY LINES AND PERCENTAGE OF PERSONS BELOW POVERTY LINE IN ANDHRA PRADESH

Year	NSS Rounds	Poverty line (Rs.)	% of people below the poverty line	Estimated persons below the poverty line in lakhs
1977-78	32	66.8	65.3	253.31
1983-84	38	101.8	54.5	232.07
1986-87	43	113.6	47.6	212.32

Source : Status of Women and Children - 1990

ANNEXURE - 2

RETENTION RATES IN PRIMARY SCHOOL FOR SC & ST PUPILS

(percentage)

Year	Class	Scheduled Caste Boys & Girls	Girls	Scheduled Tribes Boys & Girls	Girls
1983-84	I	100.00	100.00	100.00	100.00
1984-95	II	38.82	38.84	49.32	40.48
1985-86	III	17.11	19.67	23.59	24.46
1986-87	IV	16.42	18.63	20.72	25.40
1987-88	V	15.28	18.90	13.79	19.57

Source : Status of Women and Children - 1994

ANNEXURE - 3

ACCESS/FACILITIES WITH REGARD TO ELECTRICITY, DRINKING WATER AND SANITATION

Sl No.	District	Rural %			Urban %		
		House hold Electri-city	Safe Drinking Water	Rural Sani-tation	House hold Electri-city	Safe drinking Water	Rural Sani-tation
1.	Srikakulam	24.83	14.46	1.97	61.62	42.09	30.07
2.	Vizianagaram	24.06	19.39	2.44	61.07	70.40	33.58
3.	Visakhapatnam	25.74	30.71	3.56	69.78	65.02	48.36
4.	East Godavari	31.54	35.38	11.28	65.90	75.94	54.33
5.	West Godavari	32.86	41.09	12.71	62.37	75.95	51
6.	Krishna	33.30	22.04	11.82	69.13	82.22	63.01
7.	Guntur	32.52	45.18	9.78	58.34	77.30	44.79
8.	Prakasam	34.30	47.35	4.73	64.01	52.56	33.49
9.	Nellore	39.35	58.34	5.58	69.11	66.93	45.79
	Coastal Andhra						
10.	Kurnool	39.05	66.85	4.56	64.38	87.06	39.32
11.	Ananthapur	49.24	83.29	3.72	70.90	90.38	35.80
12.	Cuddapah	54.60	82.02	5.59	78.72	87.48	42.29
13.	Chittoor	49.14	80.87	5.30	80.68	83.44	54.55
	Rayalaseema						
14.	Ranga Reddy	41.15	60.36	10.95	80.70	72.46	63.76
15.	Hyderabad	0	0	0	90.43	86.48	87.71
16.	Nizamabad	54.20	54.45	5.28	75.70	70.15	56.43
17.	Medak	39.91	57.65	6.94	83.53	66.28	60.56
18.	Mahaboobnagar	26.21	71.83	4.71	72.06	85.23	48.45
19.	Nalgonda	40.11	57.51	5.28	78.20	61.92	51.50
20.	Warangal	41.43	37.19	5.56	80.97	59.46	61.01
21.	Khammam	31.40	46.87	5.94	69.99	63.08	47.20
22.	Karim Nagar	58.97	24.72	5.76	84.78	41.16	53.23
23.	Adilabad	31.28	31.98	5	70.82	56.31	34.45
	Telangana						
		36.89	48.89	6.62	73.3	73.82	54.60

ANNEXURE 4

COUPLE PROTECTION RATE - 1987

Sl No.	District	Couple Protection Rate %	Female age (Mean) at Marriage-1991
1.	Srikakulam	41.80	17.10
2.	Vizianagaram	41.20	17.40
3.	Visakhapatnam	38.80	16.50
4.	East Godavari	46.10	15.80
5.	West Godavari	47.10	16.10
6.	Krishna	43.30	16.10
7.	Guntur	45.70	15.80
8.	Prakasam	35.80	16.20
9.	Nellore	36.30	17
	Coastal Andhra		
10.	Kurnool	29.70	16.50
11.	Ananthapur	32	17
12.	Cuddapah	33.90	17
13.	Chittoor	35.7	17.10
	Rayalaseema		
14.	Ranga Reddy	28.60	15.70
15.	Hyderabad	43.80	17.70
16.	Nizamabad	30.60	14.50
17.	Medak	25	14.50
18.	Mahaboobnagar	24.20	14.80
19.	Nalgonda	30.20	14.60
20.	Warangal	32.30	14.50
21.	Khammam	38	15.90
22.	Karim Nagar	29.20	14.30
23.	Adilabad	21.40	15.20
	Telangana		

ANNEXURE 5

REVERSE-SURVIVAL ESTIMATES OF CRUDE BIRTH RATES AND TOTAL FERTILITY RATES DERIVED FROM 1981 & 1991 CENSUSES FOR DISTRICTS IN MAJOR STATES OF INDIA.

Districts	Crude Birth Rate per 1,000 1984-90	Total Fertility Rate 1984-90
Andhra Pradesh	28.2	3.2
1. Srikakulam	29.2	3.5
2. Vizianagaram	28.0	3.2
3. Visakhapatnam	26.8	2.9
4. East Godavari	27.5	3.2
5. West Godavari	26.4	2.9
6. Krishna	25.8	2.9
7. Guntur	24.9	2.7
8. Prakasam	26.7	3.0
9. Nellore	25.0	2.6
10. Chittoor	25.0	2.7
11. Cuddapah	25.5	2.8
12. Ananthapur	30.3	3.6
13. Kurnool	32.6	4.1
14. Mahaboobnagar	33.7	4.2
15. Ranga Reddy	33.4	4.0
16. Hyderabad	26.5	2.9
17. Medak	31.2	3.9
18. Nizamabad	28.3	3.2
19. Adilabad	32.2	4.0
20. Karim Nagar	26.5	3.2
21. Warangal	29.3	3.4
22. Khammam	29.7	3.5
23. Nalgonda	30.5	3.6

Source : Health Monitor 1995

ANNEXURE 6

SCHEDULED CASTES AND SCHEDULED TRIBES POPULATION - DISTRICT-WISE, 1991

Sl.No.	District	Scheduled Castes	Scheduled Tribes
(1)	(2)	(3)	(4)
1.	Srikakulam	2.17	1.34
2.	Vizianagaram	2.20	1.90
3.	Visakhapatnam	2.57	4.69
4.	East Godavari	8.26	1.76
5.	West Godavari	6.29	0.85
6.	Krishna	6.13	0.92
7.	Guntur	5.73	1.81
8.	Prakasam	5.53	0.99
9.	Nellore	5.23	2.14
	Coastal Andhra	44.11	16.40
10.	Kurnool	5.18	0.57
11.	Ananthapur	4.52	1.11
12.	Cuddapah	3.38	0.47
13.	Chittoor	6.00	1.05
	Rayalaseema	19.08	3.20
14.	Rangareddy	4.39	1.09
15.	Hyderabad	2.79	0.29
16.	Nizamabad	3.08	1.21
17.	Medak	4.06	0.95
18.	Mahbubnagar	5.42	2.27
19.	Nalgonda	5.04	2.76
20.	Warangal	4.85	3.85
21.	Khammam	3.60	5.59
22.	Karimnagar	5.64	0.83
23.	Adilabad	3.86	3.55
	Telangana	42.73	22.39
	Andhra Pradesh	105.92	41.99

Source : AP Statistical Abstract, Directorate of Statistics

ANNEXURE 7

DISTRICT-WISE SHARE OF CHILD WORKERS IN ANDHRA PRADESH, 1981 CENSUS

S.No.	District	% Share of all Rural Child Labour	Rank	% Share of all Rural Child Labour	Rank
1.	Mahbubnagar	6.67	1	3.75	10
2.	Karimnagar	6.37	2	3.00	15
3.	Guntur	6.14	3	8.88	3
4.	Kurnool	5.91	4	7.74	5
5.	Anantapur	5.16	5	4.49	7
6.	West Godavari	4.97	6	5.91	6
7.	East Godavari	4.91	7	7.87	4
8.	Nalgonda	4.90	8	2.24	17
9.	Warangal	4.87	9	2.86	16
10.	Chittoor	4.55	10	3.65	12
11.	Krishna	4.34	11	9.06	2
12.	Prakasam	4.29	12	3.74	11
13.	Nizamabad	4.17	13	3.59	13
14.	Visakhapatnam	4.12	14	3.24	14
15.	Khammam	4.01	15	1.61	23
16.	Srikakulam	3.93	16	1.76	22
17.	Medak	3.93	17	1.8	21
18.	Adilabad	3.78	18	2.15	18
19.	Vizianagaram	3.40	19	2.14	19
20.	Cuddapah	3.37	20	3.89	8
21.	Ranga Reddy	3.22	21	1.95	20
22.	Nellore	2.97	22	3.77	9
23.	Hyderabad	-	-	10.82	1

Source : Child Labour in AP - A Profile

ANNEXURE - 8

NUMBER AND PERCENTAGE OF CHILD WORKERS BY TYPE AND INDUSTRIAL CATEGORY IN ANDHRA PRADESH, 1981 CENSUS

S.No.	Category	Total	% of total main workers
1.	Cultivators	404540	23.06
2.	Agricultural labourers	947134	54.00
3.	Livestock, Forestry etc	143874	8.20
4.	Mining & Quarrying	4,397	0.25
5.	Manufacturing, Processing etc	1148845	8.57
6.	Construction	11084	0.63
7.	Transportation	4514	0.26
8.	Trade & Commerce	38,041	2.19
9.	Other Services	51760	2.95
	Total	1754189	100.00

3.7 Some of the questions to be answered and resolved while developing the strategies for A.P.

* What level of technical support CHAI should provide to the project holders.

* How do our partners perceive our roles in the whole process of support and guidance.

* What are the possible barriers for CHAI to be an effective partner.

* How long should we associate with a group.

* How can CHAI fulfil its responsibility as a membership organisation and at the same time make its presence felt in the mainstream.

* As a national organisation, how does CHAI perceive its role in A.P.

* In terms of promoting community health, what other roles CHAI can play in A.P.

* What should be the partnership between NGOs and NGOs; and NGOs and people.

4. The vision of CHAI

Health is the total well-being of individuals, families and communities as a whole and not merely the absence fo sickness. This demands an environment in which the basic needs are fulfilled, social well-being is ensured and psychological as well as spiritual needs are met. Accordingly, a new set of parameters will have to be considered for measuring the health of a community such as the peoples' participation in decision making, absence of social evils in the community, organising capacity of the people, the role of women and youth in the field of health and development etc., other than the traditional ones like infant mortality rate, life expectency etc.

The concept of the community health here should be understood as a process of enabling people to exercise collectively their responsibiities to maintain their health and to demand health as their right

Regarding our option : In the light of this vision and philosophy, we identify the exploited and the unorganised massess, the rural in particular as our target group. We intend to reach these groups through the existing health institutions in the country, especially through the member institutions of CHAI and other individuals and groups engaged in the field of people-oriented programes, so that our motto of "HEALTH FOR MANY MORE" would be realised. **In this process, possibilities of collaboration with other volunatry organisations which uphold similar philosophy and objectives will be explored to the maximum extent possible.**

4.1 Our Mandate

The CHAI Golden Jubilee evaluation study and the subsequent action plan have re-affirmed that promotion of community health should be our first priority in the decades to come. Other priorities identified, namely health, healing and wholeness, preferential option for the poor are in the ultimate analysis complementory to the over riding priority of community health.

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PROMOTION OF COMMUNITY HEALTH PROGRAMMES IN ANDHRA PRADESH

AN APPROACH PAPER

THE CATHOLIC HEALTH ASSOCIATION OF INDIA
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PROMOTION OF COMMUNITY HEALTH PROGRAMMES IN ANDHRA PRADESH

AN APPROACH PAPER

1. INTRODUCTION

This paper attempts to a present strategic approach for promotion of Community Health in Andhra Pradesh. It consists of :

* An analysis of External Environment covering the socio-economic and health profile of AP, NGO scenario and government responses.
* An internal analysis of CHAI.
* The mission and mandate of CHAI.
* The strategic issues and
* Strategic plans

2. EXTERNAL ENVIRONMENT ANALYSIS

2.1 Andhra Pradesh - A Profile

2.1.1 Physical Features :

Andhra Pradesh is the fifth largest state in India, in area and population. It is bounded by Madhya Pradesh and Orissa in the north, the Bay of Bengal in the east, Tamil Nadu and Karnataka in the south and Maharashtra in the west. Andhra Pradesh forms the major link between the north and the south of India. Andhra Pradesh consists of three distinct regions

(i) Coastal region made up of 9 districts generally called Andhra. This is fertile and agriculturally advanced regions.
(ii) The interior region consits of 4 districts collectively known as Rayalaseema which is a drought prone area and hence very backward and
(iii) Telangana region comprising Hyderabad and 9 adjoining districts is industrially advanced.

Table 1 : ANDHRA PRADESH AT A GLANCE

Particulars			Unit	
Area - 1991 (Census)			'000 sq. kms	275.0
Districts			No.	23
Mandals			"	1110
Village Panchayats			"	19497
Inhabited Villages	1991	(Census)	"	26613
Towns	1991	"	"	264
Population	1991	"	(Lakhs)	665.08
Males	1991	"	"	337.25
Females	1991	"	"	327.83
Rural Population	1991	"	"	486.21
Urban Population	1991	"	"	178.87
Scheduled Castes Population	1991	"	"	105.92
Scheduled Tribes Population	1991	"	"	41.99
Literacy	1991	"	(Percentage)	44.09

Source : Handbook of Statistics AP 1992-93

2.1.2 Demography

The population of Andhra Pradesh is 66304854 with 33623738 males and 32681116 females (1991 census) decadal growth rate (1981-91) is 23.82. The percentage of urban population is 26.79% as against 23.32 in 1981. The scheduled caste and scheduled tribe account for 15.9% and 8% respectively.

Rural households can be broadly classified into three categories classes. Agricultural labour is the major group accounting for 36.8% followed by cultivators (32.7%) and self-employed (30.85%).

2.1.3 Economy

Andhra Pradesh has a widely diversified farming base with a rich variety of cash crops. 74% of the states population live in villages where people live on agriculture. Nearly 40% of state domestic product comes from agriculture. Andhra Pradesh can rightly claim to be the granary of the south. The crops extensively cultivated are paddy, bajra, jawar, ragi, maize, groundnut, chillies, tobacco, cotton, sugarcane etc.

Irrigated area constitutes 34.5% (94% lakhs acres) of cultivated land, and 188 lakh acres is under-rainfed cultivation. The benifits of irrigation are confined to a small segment 1/5 rural population resulting in regional disparities. Despite the massive investments in agriculture and irrigation the growth of this sector is sluggish at 2% per annum.

There are 825 medium and large scale industries with a capital investment of Rs.11763 crore providing employment for more than 4.96 lakh persons. There are 918868 small units with investment of 1245 crore providing employment to 8.6 lakh persons.

The industries are concentrated in Telengana area like Hyderabad, Ranga Reddy, Medak and Mahabubnagar. Of late, after the liberalisation of economy, the state and central govt., is wooing the multinationals, NRIs and other industrialists to Andhra to establish industries. Though there is positive response, the power scarcity in the state is a major stumbling block in the process.

With a 970 kms coastline, AP is the largest maritime state in India. Fishing brings employment to the traditional fisherfolk and the to the groups using employees mechanised boats. Aqua-culture on brackish waters is slowly picking momentum in the coastal belt. 30% of the local shrimp production in the country comes from the state.

The forests account for 23% of the total geographical area and contributes 1% to the state domestic product. The forests are under tremendous pressure both for its produce and the land.

2.1.4 Literacy

Andhra Pradesh is one of the educationally backward states in India. The literacy rate among the population age 7 and above is 44% in the state compared with 52% in India. The literacy rates 55% for males and 33% for females in AP compared to 64 and 39% for males and females respt. for the whole of India.

Based on the overall literacy rating 11 districts come under the B category 12 under C category

Table 1A : Ranking of Districts According to GDLR Scores

Sl. No.	District	Total Lit. rate (%)	Male Lit. Rate (%)	Female Lit Rate (%)	Overall Lit. Rating
1.	Srikakulam	31.13	41.59	20.82	C2
2.	Vizianagaram	29.37	39.14	19.60	C2
3.	Visakhapatnam	39.40	48.57	30.00	B2
4.	East Godavari	41.37	46.78	35.95	B2
5.	West Godavari	45.66	50.93	40.37	B1
6.	Krishna	45.81	52.19	39.22	B1
7.	Guntur	40.70	49.11	32.04	B2
8.	Prakasam	35.10	45.71	24.19	C2
9.	Nellore	41.29	50.02	32.38	B1
10.	Kurnool	33.60	44.47	22.22	C2
11.	Ananthapur	35.69	47.23	23.50	C2
12.	Cuddapah	41.52	54.22	28.27	B1
13.	Chittoor	43.11	53.75	32.11	B1
14.	Rangareddy	41.95	50.91	32.40	B1
15.	Hyderabad	55.03	61.88	47.58	B1
16.	Nizamabad	29.13	39.77	18.69	C2
17.	Medak	27.51	37.79	16.94	C2
18.	Mahbubnagar	24.95	33.71	15.94	C2
19.	Nalgonda	32.14	43.39	21.48	C2
20.	Warangal	33.99	44.50	23.08	C2
21.	Khammam	34.10	42.06	25.81	B2
22.	Karimnagar	33.02	44.32	21.56	C2
23.	Adilabad	27.79	37.57	17.80	C2

Source : Demographic Diversity of Indian 1991 Census. State and District level data. A reference book - Ashish Book

Table 1B : Summary table for literacy rating

Category	No of Districts	Total Pop. of Districts	Percentage to Pop. of State	Name of the Districts
A (A1+A2+A3)				
B (B1+B2)	11	34 825 689	52.52	West Godavari, Hyderabad Krishna, Chittoor, East Godavari,Cuddapah, Guntur, Rangareddi, Nellore, Visakhapatnam, Khammam.
C(C1+C2+C3)	12	31 479 165	47,48	Anantapur, Nizamabad, Adilabad, Mahbubnagar, Karimnagar, Prakasam, Warangal, Kurnool, Medak, Srikakulam, Vizianagaram, & Nalongda.
TOTAL	23	66 304 854	100,00	

NB : Code for Literacy Rating A=A1+A2+A3, B=B1+B2+B3 & C=C1+C2+C3

	OLR			OLR			OLR	
	Male	Female		Male	Female		Male	Female
A1	75+	75+	B1	50-75	25-50	C1	50+	<25
A2	75+	50-75	B2	25-50	25-50	C2	25-50	<25
A3	50-75	50-75				C3	<25	<25

OLR : Overall Literacy Rate

2.1.5 Health Status of Andhra Pradesh

The health status of a population is determined by a large number of factors such as nutritional status, availability and accessibility of health services, sanitation, source of drinking water, supplies of essential goods, work pattern, incomes, housing etc. In the case of women and children, socio-cultural factors may also play a significant role. Certain indices which speak about the health status are given in the following pages.

Source : Demographic Diversity of Indian 1991 Census. State and District level data. A reference book - Ashish Book

Table 2 : Basic demographic indicators for Andhra Pradesh and India, 1981-92

Index	Andhra Pradesh	India
Population (1991)	66,5078,008	846,302,688
Percent population increase (1981-91)	24.2	23.9
Density (population/Km2) (1991)	242	273
Percent urban (1991)	26.9	26.1
Sex ratio (1991)	972	927
Percent 0-14 years old (1981)	38.6	39.6
(1991)	34.2	36.3
Percent 65+ years old (1981)	3.6	3.8
(1991)	4.0	3.8
Percent scheduled caste (1991)	15.9	16.7
Percent scheduled tribe (1991)	6.3	8.0
Percent literate (1991)'		
Male	55.1	64.1
Female	32.7	39.3
Total	44.1	52.2
Crude birth rate (1992)2	24.1	29.0
Crude death rate (1992)2	9.1	10.0
Exponential growth rate (1981-91)	2.17	2.14
Total fertility rate (1991)	3.0	3.6
Infant mortality rate (1992)2	71	79
Life expectancy (1986-91)		
Male	59.1	58.1
Female	62.2	59.1
Couple protection rate (1992)	45.3	43.5

Source: National Family Health Survey (1992)

2.1.5.1 **Health priorities and programmes**

Delivery of Health services in AP. is mainly governed by the National Health Policy. It identified certain areas which needed special attention

Nutrition for all segments of the population.
The immunisation programmes.
Maternal and child health care.
Prevention of food adulteration and maintanence of quality drugs
Water supply and sanitation.
Environmental protection.
School health programmes.
Occupational health services.
Prevention and control of locally endemic diseases.

After the Alma Alta declaration in 1978, the government started to concentrate on the development of the rural health infrastructure. This was done to provide health care services to the rural population which had by and large remained neglected. As of March 1994, AP has the following infrastructure and facilities.

Table 3 : BASIC RURAL HEALTH INFRASTURCTURE AND SOME DERIVATIONS
(As on 31.03.1994)

	No. of Functioning			Average Rural Population Served		
	Sub-Centres	P.H.C.s	C.H.C.s	Sub-Centres	P.H.C.s	C.H.C.s (in lakh)
Andhra Pradesh	7894	1342	46	6159	36230	10.05
India	131471	21214	2321	4782	296335	2.71

Table 4 : RATIO OF PHC/SCs, CHC/PHCs AND AVERAGE NUMBER OF VILLAGES SERVED BY SC, PHC AND CHC
(AS ON MARCH 1994)

	Ratio of		Average No. of Villages Served		
	PHC/Sub-Centre	CHC/PHCs	Sub-Centre	PHC	CHC
Andhra Pradesh	1: 5.8	1:29.2	3.47	20.40	575.20
India	1: 6.2	1: 9.1	4.48	27.74	253.62

Table 5 : STATEWISE AVERAGE RURAL AREAS COVERED AND MAXIMUM RADIAL DISTANCE COVERED BY SUB-CENTRE, PHC, CHC
As on 31 March 1994)

	Average Rural Area covered by			Maximum Radial Distance covered		
	Sub-Centre (Sq.km)	PHC (sq.km)	CHC (sq.km)	Sub-Centre (km)	PHC (km)	CHC (km)
Andhra Pradesh	34.33	211.95	5891.78	3.31	8.01	43.30
India	23.91	148.17	1354.26	2.76	6.87	20.75

Source : Health Monitor 1995

2.1.5.2 **Infant and Child Mortality**

Table 6 : Infant and child mortality by background characteristics

Background characteristics	Infant mortality	Child mortality	Under-five mortality
Residence			
Urban	61.9	11.8	73.Ø
Rural	77.Ø	29.Ø	1Ø3.8
Mother's education			
Illiterate	79.6	28.5	1Ø5.8
Literate,<middle complete	66.4	25.1	89.8
Middle school complete	(62.3)	(6.1)	(68.Ø)
High school and above	(36.4)	(2.8)	(39.1)
Religion			
Hindu	76.9	25.6	1ØØ.5
Muslim	15.4	22.9	59.4
Caste/tribe			
Scheduled caste	94.4	22.5	114.8
Scheduled tribe	(85.4)	(53.5)	(134.4)
Others	68.Ø	22.7	89.1
Medical maternity care			
No antenatal or delivery care	98.8	(52.7)	146.3
Either Antenatal or delivery care	69.8	(5.5)	75.Ø
Both antenatal and delivery care	51.1	(6.6)	57.3
Total	73.2	24.6	96.Ø

The above table shows infant and child mortality statistics of AP and table shows the district-wise details. The IMR of Andhra Pradesh 73 per 1ØØØ live births. The infant mortality rate is 1.2 times higher in rural areas than in urban areas ie 77 per 1ØØØ live births compared to 62 per 1ØØØ live births. The child mortality is two and half times more in rural areas than in urban areas. **Children in rural areas of AP experience a 42% higher risk of dying before their fifth birthday than urban children.**

Infant mortality declines sharply with increasing education of woman, ranging from a high of 8Ø per 1ØØØ live births for illiterate women to a low of 36 per 1ØØØ live births for women with alteast a high school eduation.

In infant and under-five mortality rates (ie 98.8 per 1000 and 114.8 per thousand are higher for scheduled castes than for non SC/ST groups. The child and under-five mortality)ie 53.5 and 134.4 respectively.) for scheduled tribes are higher than for scheduled castes and others.

The presence of medical maternity care for mothers (ante-natal and/or delivery care by a trained health personnel) is associated substantially lower mortality risks. The IMR drops from 99 per 1000 for births with no care to 70 per 1000 for births with either ante-natal or delivery care and to 51 per 1000 for births with both ante-natal and delivery care (NFHS - 1992)

Table 7 : INFANT MORTALITY RATES AND CHILD MORTALITY IN DISTRICTS OF ANDHRA PRADESH

Sl No.	District	Infant Mortality Rate	Child Mortality Rate
1.	Srikakulam	98	142
2.	Vizianagaram	109	157
3.	Visakhapatnam	78	106
4.	East Godavari	62	93
5.	West Godavari	67	97
6.	Krishna	74	101
7.	Guntur	64	93
8.	Prakasam	71	105
9.	Nellore	62	91
	Coastal Andhra		
10.	Kurnool	77	124
11.	Ananthapur	97	145
12.	Cuddapah	84	114
13.	Chittoor	92	119
	Rayalaseema		
14.	Ranga Reddy	66	97
15.	Hyderabad	N.A	N.A
16.	Nizamabad	56	84
17.	Medak	66	104
18.	Mahabub Nagar	79	124
19.	Nalgonda	72	118
20.	Warangal	79	115
21.	Khammam	70	99
22.	Karim Nagar	65	87
23.	Adilabad	73	108
	Telangana		
	Andhra Pradesh	73	105

2.1.5.3 Immunisation of children

As per the National Family Health Survey (NFHS) 1992 in AP, only 45% of children aged 12-23 months are fully vaccinated and 18% have not received any vaccinations and 37% only partly vaccinated. Andhra Pradesh thus has a long way to go to achieve the goal of Universal

Immunisation of children. Interestingly the service status published by the government claims that the state has achieved 100% coverage of child immunisation. (Ministry of Health & Family Welfare 1992 and Directorate of Health Services AP 1993).

The proportion of children fully immunised is 50% in urban areas and 40% in rural areas. The percentage of children of illiterate mothers 36.4% to 80 percent for children of mothers who have competed high school. Scheduled caste and scheduled tribe children are less likely to be fully vaccinated than children of non SC/ST mothers.

2.1.5.4 Treatment of Diarrhoea

Diarrhoea is a major killer of children, especially children under-five years of age. Deaths from acute diarrhoea are most often due to dehydration resulting from loss of water and electrolytes (Black 1984). Deaths due to dehydration can be prevented by the administration of ORS solution or by RHS (Recommend Home Solution). The govt., has been creating awareness among the public for this.

NHFS - 1992 tells that ORS is known to only 31% of mothers (52% in urban and 24% in rural areas). Knowledge is lowest in rural areas, among teenage mothers, illiterate women, scheduled caste and scheduled tribe mothers and mothers not regularly exposed to either radios, TV and cinema. ORS and RHS was not used extensively by any population subgroup and such treatment was even less common for rural children and children with illiterate mothers.

Table 8 : Knowledge and use of ORS packets

Background Characteristics	Know about ORS packets	Have used ORS packets	No. of mothers
Mother's age			
15 - 19	24.2	12.3	285
20 - 24	32.2	15.3	593
25 - 29	34.4	19.3	398
30 - 34	33.1	18.8	133
35+	27.0	18.9	74
Residence			
Urban	51.5	28.2	369
Rural	24.4	12.4	1117
Mother's education			
Illiterate	22.8	11.7	1057
Liteate < middle school complete	37.4	17.2	163
Middle school complete	51.0	31.7	104
High school and above	66.0	35.2	162
Religion			
Hindu	30.2	15.5	1303
Muslim	39.9	25.4	138
Christian	(30.0)	(10.0)	40
Caste/tribe			
Scheduled Caste	24.6	12.7	228
Scheduled tribe	26.4	13.2	106
Others	32.8	17.3	1152
Mother's exposure to media			
Exposed to media	36.0	18.1	1092
Watches T.V. weekly	47.7	23.9	511
Listens to radio weekly	39.4	19.5	870
Visits cinema/theatre weekly	36.6	17.1	754
Not exposed to any of the media	17.5	11.2	394
Total	31.1	16.3	1486

2.1.5.4.1. Availability of Health Facilities and other services

Almost two-fifths of the villages in AP have some form of health facility within the village and 36% of villages have some form fo health facility within 5 km from the village. Almost one half of the villages have a village health guide and 58% have a trained birth attendant. Table below gives the availability of other facilities in the villages.

Source : National Family Health Survey 1992

Table 9 : Availability of Health Facilities and other services in the villages of AP

Facility/Services	Percentage
Anganwadi	30.5
Adult education classes	35.2
Jana Shikshana Nilayam	6.4
Village health guide	49.0
Trained birth attendant	58.4
Mobile health unit	10.5
Electricity	76.6
Bank	12.5
Cooperative society	25.6
Post office	51.5
Market/shop	32.3
Fair price shop	66.6
Mahila mandal	23.1
Youth club	22.7
Integrated Rural Development Programme (IRDP)	41.8
National Rural Employment Programme (NREP)	12.3
Training the Youth for Self-employment (TRYSEM)	11.8

Source : NFHS 1992

2.1.5.5 **Partial and complete blindness**

The overall prevalence of partial blindness is 51 per 1000 with a higher prevalence in rural (56/1000) than in urban areas 39/1000. Partial blindness increases with age. The reported extremely high prevalence among older persons in rural areas (351/1000) is striking ie **in AP every third person aged 60 is suffering from partial blindness.**

Urban people are more prone to complete blindness (12/1000) than rural (7/1000) while the reverse is the case with regard to partial blindness. The prevalence is much higher in the age groups 0.14 (15/1000) and 60 and over (12/1000) than in the age group 15-59 (4/1000) **The complete blindness in the younger and older persons are strikingly higher in urban areas.**

2.1.5.6 **Malaria**

The ovrall occurance of malaria was 19/1000. Rural residents are twice as likely to have malaria 23/1000 as urban residents 11/1000 (NFHS Survey 1992). Though there are no statistics to support, the occurence of malaria is on the increase in AP.

Table 10 : No. of Malaria cases detected and reported - 1995-96

S.No.	District	No. of Malaria cases detected & reported	
		Month of May 1995	Month of May 1996
1.	Srikakulam	411	795
2.	Vizianagaram	255	515
3.	Visakhapatnam	2489	3721
4.	East Godavari	835	590
5.	West Godavari	7	10
6.	Krishna	1157	2167
7.	Guntur	304	232
8.	Prakasam	433	108
9.	Nellore	26	32
10.	Kurnool	95	385
11.	Ananthapur	64	204
12.	Cuddapah	78	299
13.	Chittoor	2	4
14.	Rangareddy	9	18
15.	Hyderabad	129	136
16.	Nizamabad	97	19
17.	Medak	0	1
18.	Mahbubnagar	21	38
19.	Nalgonda	2	0
20.	Warangal	111	128
21.	Khammam	124	100
22.	Karimnagar	68	158
23.	Adilabad	451	652

Source : Directorate of Health Services

2.1.5.7 Tuberculosis

The overall occurance of TB is 4/1ooo with almost the same rate in rural areas. In urban areas, the prevalence is 3/1000. TB is more prevalent among persons above age 60 and over (14/1000) than among those aged 15-59 (4/1000) and those aged 0-4 (1/1000).
(NFHS Survey 1992)

Table 10A : No. of TB cases detected and reported

S.No.	District	No. of T.B. cases detected & reported 1995 - 1996
1.	Srikakulam	4925
2.	Vizianagaram	3528
3.	Visakhapatnam	4749
4.	East Godavari	4056
5.	West Godavari	2056
6.	Krishna	3541
7.	Guntur	3144
8.	Prakasam	2185
9.	Nellore	3899
10.	Kurnool	2042
11.	Ananthapur	2427
12.	Cuddapah	2896
13.	Chittoor	2648
14.	Rangareddy	1838
15.	Hyderabad	6131
16.	Nizamabad	1792
17.	Medak	1940
18.	Mahbubnagar	2215
19.	Nalgonda	2250
20.	Warangal	4069
21.	Khammam	3618
22.	Karimnagar	2981
23.	Adilabad	1445

2.1.5.8 **HIV/AIDS**

HIV/AIDS virus has already made its way to Andhra Pradesh. Various cases have been identified and reported in variours parts of Andhra Pradesh. The total no. Elisa positives are 1233, the total AIDS cases reported is 7. The seropositivity rate is 1.9% for the groups tested, 47.2% of HIV infection is from the high risk behaviour and 15.1% is through blood transmission. The incidences of cases reported and its prevalence asked for an organised intervention for all.

Table 11 : Profile of HIV/AIDS Status (AP Scenario) as on 1-9-94

1.	Total Blood samples screened	1,44,110
2.	Total established Elisa Positives	1,233
3.	Total Western Blot positive	195
4.	Total AIDS cases as reported	7
5.	Seropositivity rate for all groups tested (1993)	1.9%
6.	Seropositivity rate in STD attenders (1993)	5.2%
7.	Seropositivity rate in Blood donors (1993)	1.2%
8.	Probable sources of HIV infection through high risk behaviour contributed	47.2%
9.	Transmission through blood	15.1%
10.	From foreigners	4.5%
11.	Others-students, hospital patients, antenatal mothers etc. contributed	33.2%

Source : Director of Health Services, AP

Table 12 : Progression of Seropostivity in all groups tested

Year	Total samples screened	No. of HIV Positive	Seropositivity rate %
1986 - 89	14,967	25	Ø.16
1990	17,848	29	Ø.16
1991	28,511	214	Ø.75
1992	34,150	249	Ø.73
1993	24,865	475	1.9Ø
1994	23,769	241	1.Ø1
Total	1,44,11Ø	1233	-

The data is as per the reported statistics on date

Table 13 : HIV Surveillance in blood donors and STD attenders in AP

Year	STD attenders Screened	No. of HIV Positive	%	Blood donors Screened	No. of HIV Positive	%
1990	2533	26	1.Ø2	15,315	3	Ø.Ø1
1991	4769	163	3.4	23,742	51	Ø.2Ø
1992	4871	184	3.7	29,279	65	Ø.24
1993	2847	149	5.2	11,829	143	1.2
Total	15Ø2Ø	522		8Ø,165	262	

Table 13 A : Sentinel Surveillance

Sentinel Site	Target group	Period of study	No. tested M	F	T	No. of positive M	F	T	% psotive M	F	T
Andhra Medical College, Visakh-apatnam	STD Clinic Attenders	1-12-93to31-1-94	324	76	4ØØ	8	2	1Ø	2%	Ø.5%	2.5%
S.V. Medical College, Tirupati	STD Clinics Attenders	1-1-94to31-5-94	387	117	5Ø4	2Ø	9	29	3.9	1.7	5.75

2.1.5.9 **Disabilities**

Andhra Pradesh is one of the states with a very high prevalence of disabilities. The state accounts for 1Ø.5% of the physicially disabled. It stands only next to Punjab in rural prevalence and Haryana and Tamil Nadu in urban prevalence.

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S.V. Medical College, Tirupati	STD Clinics Attenders	1-1-94to31-5-94	387	117	504	20	9	29	3.9	1.7	5.75

2.1.5.9 **Disabilities**

Andhra Pradesh is one of the states with a very high prevalence of disabilities. The state accounts for 10.5% of the physicially disabled. It stands only next to Punjab in rural prevalence and Haryana and Tamil Nadu in urban prevalence.

The prevalence rates of AP are higher than for all India, not only for the overall but also for each type of disability ie locomotor, visual, hearing and speech.

The reasons for high prevalence of disabilities can be understood only by examining the food habits and social and institutional, factors. The high flouride content in drinking water in many areas of AP has resulted in a high incidence of dental and skeletal flourosis in some districts.

District wise estimates of prevalence rate per lakh population is presented in the table. It is found that Mahabubnagar, Vizianagaram, Ananthapur and Prakasam are the top four district with high prevalence of disabilities. Both central and stat governments and the voluntary agencies work towards th development of disabled. But still the coverage is not adequate.

Table 14 : Prevalence of Disability according to Self Reporting Survey:1986

District	Orthopaedic	Blind	Deaf/ Dumb	Mentally Retarted	Total Disabled
Srikakulam	338	161	120	28	646
Vizianagaram	481	254	162	35	932
Visakhapatnam	362	105	122	35	613
East Godavari	341	72	83	18	514
West Godavari	429	66	100	18	613
Krishna	380	84	117	31	612
Guntur	271	60	90	24	445
Nellore	398	118	125	26	668
Prakasam	506	112	157	48	824
Chittoor	326	94	94	19	553
Cuddapah	384	122	136	20	662
Kurnool	299	102	94	20	517
Ananthapur	527	172	157	52	907
Karimnagar	435	135	106	29	705
Warangal	438	114	126	34	712
Khammam	442	94	120	33	688
Nizamabad	400	142	88	28	659
Mahbubnagar	543	209	151	36	939
Medak	430	157	112	32	731
Nalgonda	404	161	136	18	733
Adilabad	223	114	84	18	439
Hyderabad	110	23	16	6	155
Rangareddy	311	99	76	19	504
Andhra Pradesh	380	116	111	27	634

Source : Status of women and children in AP 1990

2.1.6 Water and Sanitation

The source of water and availability of sanitary facilities are important determinants of the health status of household members, particularly of children. 36% of households get piped water for drinking, 27% water from a hand pump and 32% from wells. There are large urban rural differences in the source of drinking water. Almost three fourths of households in urban areas get piped water for drinking.

The sources of water used for bathing/washing and drinking are similar in rural areas but a higher proportion of urban house holds use piped water for drinking and bathing.

Availability of sanitary facilities is poor in Andhra Pradesh. Only 17% of the households have a flush toilet, 8% have pit toilets or latrines and the substantial majority (76%) have no facility at all. Half of the house holds in urban areas and 5% in rural areas have a flush toilet.

Source - NFHS 1992

2.1.7 Vulnerable and Disadvantaged Groups

2.1.7.1 Children

The magnitude of child labour in AP standout and is very discouraging. Nearly 8.5% of all its children are workers and the state accounts for 13% of all child labourers in India.

Andhra Pradesh stands out having the highest number of child workers among,

a. Total population
b. Total workers and
c. Total child population.

In all the categories the average for AP far exceeds the national average as shown in the following table.

Table 15 : DISTRIBUTION OF CHILD WORKERS BY STATE

Region	% of child workers to total population	% of child workers to total population	% of child to total population
All India	1.68	5.03	4.26
Andhra Pradesh	3.28	7.75	8.50

92% of child labour in AP are mostly found in the rural areas. Very often, the children supplement family income. More than 80% of children primarily work as agricultural labourers and cultivators.

58% of all child workers are boys and 42% are girls. The incidence of female child labour is the highest in Andhra radesh. 7.29% of the total female child population in AP are workers. While the comparable all over India average is 2.95% only.

Nearly 60% of all children in the 5-14 years age group do not attend school., 86% of all children ie. 5-14 years age do not attend school are in the rural areas.

Adilabad and Mahbubnagar districts stand first for children not attending the schools.

Table 16 : Children not attending school by District, 1981 Census

S.No.	District	Percentage*
.	**Andhra Pradesh**	**59.18**
2.	Adilabad	73.21
3.	Mahbubnagar	72.64
4.	Nizamabad	68.36
5.	Karimnagar	67.76
6.	Medak	67.28
7.	Nalgonda	64.84
8.	Warangal	64.68
9.	Kurnool	64.15
10.	Vizianagaram	63.60
11.	Khammam	63.59
12.	Srikakulam	63.30
13.	Anantapur	61.83
14.	Visakhapatnam	61.66
15.	Ranga Reddy	58.96
16.	Cuddapah	57.93
17.	East Godavari	56.22
18.	Prakasam	56.62
19.	Nellore	53.82
20.	Guntur	53.16
21.	Chittoor	52.47
22.	West Godavari	51.69
23.	Krishna	47.17
24.	Hyderabad	29.26

Source : Child labour in AP - A profile

Table 17 : PERCENTAGE SHARE OF CHILD WORKERS TO TOTAL WORKERS BY DISTRICT, RURAL/URBAN, 1981 CENSUS

District	Rural			Urban		
	Male	Female	All children	Male	Female	All Children
Srikakulam	7.09	10.01	8.12	2.83	5.56	3.43
Vizianagaram	6.79	9.98	7.88	2.85	5.07	3.23
Visakhapatnam	7.31	11.07	8.48	1.65	3.81	1.91
East Godavari	7.60	9.30	8.12	3.70	5.51	4.03
Krishna	6.40	10.54	7.70	3.3	6.70	3.85
Guntur	6.59	11,46	8.35	3.10	6.46	3.76
Prakasam	5.76	10.66	7.56	2.89	8.35	4.15
Nellore	5.74	8.49	6.65	3.19	5.34	3.59
Chittoor	6.01	10.14	7.30	3.02	5.42	3.39
Cuddapah	6.28	12.15	8.11	3.45	7.92	4.22
Anantapur	7.68	11.40	8.99	3.04	7.68	3.74
Kurnool	9.39	13.32	10.92	4.38	9.10	5.40
Mahbubnagar	10.02	10.43	10.18	4.72	8.94	5.73
Ranga Reddy	9.43	9.16	9.33	1.97	3.35	2.19
Hyderabad	-	-	-	2.13	3.28	2.26
Medak	8.61	9.29	8.57	2.95	7.07	3.79
Nizamabad	8.33	11.4	9.6	2.95	8.06	4.31
Adilabad	8.99	11.71	9.98	2.30	7.11	3.00
Karimnagar	8.15	12.69	9.97	0.30	11.99	5.18
Warangal	8.05	10.93	9.05	1.76	9.67	3.37
Khammam	8.26	13.36	9.97	3.10	5.95	2.57
Nalgonda	7.94	9.55	8.49	3.24	6.73	3.84

Child labour face health and safety risks in their occupation. The consumption and quality of diet among them is inadequate and as a result nearly 45% of pre-school children are under-nourished with merely 8.9% suffering from severe malnutrition.

AP has high prevalence (2.3%) of disabilities among children and of this more than 80% are concentrated in rural areas. (NSS 1981)

2.1.7.2 Fisherfolk

The AP coast line is 974 kms with 407 fishing villages and a population of half a million. Marine fishing is their main source of livelihood. The men catch fish whereas the women process and market it. The marine fish production is 99,135 tonnes (1990-91) and contributes to 0.9% of SDP (Commissioner of Fisheries, AP)

Fishing is a high risk activity. This is compounded by lack of access to institutional credit which deprives them from owning boats and nets. Exploitation by money lenders, at the time of selling the produce and legislations that encourage the operation of trawlers lower their income.

Source : Child labour in AP - a profile

As part of the liberalisation policy of India, the government has allowed 40% of marine farming (prawn farms) to be operated by the private sector. This has resulted in proliferation of prawn farms, causing economic hardships to the fishermen and environmental degradation.

The increasing shrimp aquaculture activities by commercial companies in coastal AP is causing serious land degradation and health problems. The aquaculture farms require sea water which is pumped in and chemcicals and pesticides are added which after use is pumped back into the sea and the neighbouring lands. This has resulted in salinating the ground water which has led to the reductions in the availability of drinking water. A number of small farmers have sold their productive lands to private companies and have turned daily wage earners. A number of them have become unemployed because the labour requirement for prawn cultivation is very limited.

Fishing communities are gradually loosing access to the sea from their villages and marine life is being depleted due to pollution and capture of young shrimps.

2.1.7.3 Tribals

The tribal population in the state is 42 lakhs and this constitutes 6.3% of the state and the seventh largest tribal population in the country. The decadal growth rate is 32% (1981-91). There are 33 communities listed as scheduled tribes.

According to ITDA, of the total 85.87 lakh hectares of the geographical area, 53.3 (62%) lakh hectares are under forests and the actual cultivated area is 15 (18%) lakh hectares. The per capita availability of land is 1.17 hectares. Thus the livelihood system of tribals is dependent on agriculture and minor forest produce. This is subjected to various forms of exploitation.

Land alienation is a serious problem in the scheduled areas of AP inspite of the existence of land transfer regulations which clearly prohibits the non-tribals from acquiring immovable property in the scheduled area. In AP approximately 50% of agricultural land in such areas has passed on to non-tribals.

Maternal mortality among the tribals is estimated at 4.4 per 1000. The infant mortality rate is very high ie 85.4 per 1000 live births. About 25% of these deaths occur due to diarrhoea. The sex ratio is also lower (962) than the state's average (972) and there is a decline in this ratio from 977 in 1981 to 962 in 1991.

Literacy is much lower (7.8%) than the all-India average for tribals (16.4%). Female literacy is at a dismal level of 3.4%.

Nutritional deficiencies are more severe among tribal children. Calcium deficiency is common to all tribes. 89-90% of pre-school children are found to be anaemic.

The most common health disorders of tribals are enlargement of liver, soreness and the angles of mouth, opthalmic diseases, hair discoloration, moon face and dental cavities. They also suffer from many nutritional disorders.

Goitre is prevalent in tribal areas. Yaws, a tropical disease marked by skin sores which may develop into ulcers has re-occured in certain tribal areas. Measles and meningitis are other diseases prevalent among the tribals.

2.1.7.4 **Dalits**

Dalits are the worst victims of the scourge of castism. This is the community which faces the worst combination of economic exploitation and social oppression. They are mostly landless, alienated from all other productive assets, lacking skills and education and often forced to live in segregated conditions at the fringes of the mainstream society. The situation in AP also doesn't make any difference from other parts of the country. The population of Dalits (scheduled caste) in AP is 105.92 lakhs ie 15.9% of the total population.

The literacy among the scheduled caste and scheduled tribes are very low as per 1981 census report. The liteacy rate us 17.65 percent SC and 7.82 among STs. The females literacy among SC's and ST's are worse ie 10.3 and 3.5 respt. the tables are give below.

Table 18 : District-wise and Sex-wise Literacy Rates of Scheduled Castes & Scheduled Tribes Literate Population - Population Census, 1981

	District	Percentage of S.C Literates to S.C. Population			Percentage of S.T. Literates to S.T. Population		
		Total	Male	Female	Total	Male	Female
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Srkakulam	15.6	24.Ø	7.4	9.6	14.6	4.6
2.	Vizianagaram	15.2	23.Ø	7.2	8.Ø	11.9	4.Ø
3.	Visakhapatnam	24.8	33.2	16.1	6.3	1Ø.4	2.Ø
4.	East Godavari	24.3	3Ø.Ø	18.5	12.6	16.5	8.6
5.	West Godavari	23.9	28.9	18.8	11.4	14.3	8.5
6.	Krishna	28.8	35.5	21.8	14.5	2Ø.Ø	8.9
7.	Guntur	27.4	36.7	17.6	13.6	19.5	7.5
8.	Prakasam	21.3	31.7	11.2	14.7	2Ø.6	8.4
9.	Nellore	17.9	24.9	1Ø.7	8.2	11.Ø	5.2
	Coastal Andhra	23.Ø2			9.73		
1Ø.	Kurnool	17.1	25.2	8.5	14.Ø	21.1	6.5
11.	Anantapur	14.2	2Ø.Ø	5.9	12.2	18.9	5.2
12.	Cuddapah	16.3	26.3	5.8	11.1	17.6	3.9
13.	Chittoor	16.6	25.3	7.6	8.5	13.2	3.9
	Rayalaseema	15.83			11.16		
14.	Rangareddy	15.5	23.Ø	7.9	7.1	11.4	2.5
15.	Hyderabad	42.3	52.5	31.8	29.5	38.1	2Ø.Ø
16.	Nizamabad	8.9	15.1	3.Ø	4.6	8.4	Ø.7
17.	Medak	9.8	15.4	4.Ø	5.6	9.7	1.3
18.	Mahbubnagar	7.4	12.2	2.4	4.3	7.3	1.2
19.	Nalgonda	11.5	18.4	4.4	4.5	7.8	1.Ø
2Ø.	Warangal	12.7	19.4	5.7	5.1	8.5	1.4
21.	Khammam	16.5	23.4	9.2	6.3	1Ø.Ø	2.5
22.	Karimnagar	1Ø.1	16.5	3.8	5.2	8.7	1.6
23.	Adilabad	9.8	16.2	3.2	6.8	12.Ø	1.6
	Telangana	13.2			5.86		
	Andhra Pradesh	17.6	24.8	1Ø.3	7.8	12.Ø	3.5

They form the major work force in the state. 68.2% of the agriculture labourers are from the Dalit background. The dalits are prone to all kinds of exploitation and health hazards. They are exposed to all kinds of atrocities from the higher castes.

With education, political awareness and a growing sense of self-empowerment building up amongst this community, they have begun to stake their claims for their basic human rights and for the benefits of the development process. They are always at serious risk of facing from the dominant culture.

2.1.7.5 Women

The sex ratio in Andhra Pradesh is 972 per 1000 males (1991). The maternal mortality is 4 per 1000 and female literacy is 33.7%.

The women, due to the cultural and social discrimination have less access to health facilities. The girl-child has less opportunities to health, education and nutrition compared to the male child.

In AP, 25% the girls within age of 13-15 years have the first pregnancy. The singulate mean age at marriage of women in AP is 18.1 years overall. In Telangana region child marriage is still common

The dalit women are always the target of victims by the dominant group to settle the scores with the dalits in general.

Despite an increase in the number of primary schools, girl-child enrolment in classes 1-5 increased only from 37 (1956-57) to 71% (1990-91). The girls enrolled in primary schools are four times more than the boys not enrolled 7%. The dropout rate among SC/ST girls is higher being about 75%.

The economic domain is another source for gender discrimination. The inequity is manifested in the unequal wage rates and in inadequate access to the government subsidies, technologies which enhance their economic level and independence.

The attitude among the parents to have a male child still continues. The broader problems of women are same throughout AP, though they are differences between urban and rural women.

In AP, the women are capable of setting a political agenda. With the efforts of women, government has declared prohibition in the state. The state govt., has established a commission for women.

There is a reduction in the percentage of women working in the organised sectors. Women are targetted for the Family Planning Programmes.

The joggin system is very much prevalent in AP. Approximately, 30000 women from various districts ie. Karimnagar, Warangal, Mahbubnagar, Nizamabad, Chittor are forced to enter this profession.

The major health problems of a large number of pregnant women in AP are anemia and nutritional deficiencies which in turn lead to low birth weight. Mortality and infections are also common among pregnant women. Inspite of all these problems 54.2% (1991 census) of deliveries are conducted by the persons in the rural areas.

Data on prevalence of morbidity among poor women reveal that 49% of pregnant women in rural areas and 37% in urban areas have some illnesses during pregnancy.

2.1.7.6 Agricultural Labourers

A study conducted by Radhakrishna et al (1988) states that the agricultural labour households are subjected to the highest incidence of poverty ie. 65%. the very poor households agricultural labours account for 27% in the developed region and 67% in the backward region.

The agricultural labourers form 36.8% (ie 83.25 lakhs) of the total working population with regard to employment opportunities, the labour force do not find employment opportunities throughout the year. The busiest periods are at the time of sowing and at the time of harvest. They are given low wages with the women being differentiated and underpaid as compared to the men. These labourers are uneducated, unorganised and unskilled, have almost no employment opportunities elsewhere and as a result have to borrow heavily. Heavy borrowing leads them into debt traps.

The scheduled caste and scheduled tribe forms the major group among the agricultural labourers (approximately 40%). All the problems of SC/STs would also reflect among the agricultural labourers.-

Table 19 : Working Population - By Occupational Divisions, 1981 Census

in lakhs

Sl. No.	Occupational Divison	Total Working Population	Working Population among Scheduled Castes	Working Population among Scheduled Tribes
A.	Main Workers:			
1.	Cultivators	74.08 (32.7)	6.98 (17.4)	6.78 (43.20)
2.	Agricultural Labourers	83.25 (36.8)	27.35 (68.2)	6.86 (43.7)
3.	Household Industry Manufacturing, Processing, Servicing and Repairs	10.64 (4.7)	0.56 (1.4)	0.60 (3.8)
4.	Other Workers	58.32 (25.8)	5.19 (13.0)	1.45 (9.3)
5.	Total Main Workers	226.29 (100.00)	40.08 (100.00)	15.69 (100.00)
B.	Marginal Workers	18.77	3.12	1.45

2.1.7.7 Urban Slum Dwellers

The urban population has grown to 27% (1991) from 24% (1981). Nearly one-quarter of the urban population resides in slums. AP has 848 slums with about 9 lakh population and of it 26% constitute SC/ST.

Though urban areas show better performance in health than rural areas, urban slums have substandard conditions. Civic amenities and housing conditions are very poor. Only 5.3% of the slum population in AP is convered by the basic amenities against 20.6% at the national level. More than half of the slums in AP are undeclared as a result they are not entitled for civic amenities.

Employment opportunities are less, since most of them are unskilled labourers. Small cities are subjected to a greater incidence of poverty which may be due to lack of employment opportunities. Though medical facilities are available in close vicinity, their utilisation is not up to the mark.

The urban child labour consitutes 6.5% of workforce. The majority of their children are over eight years of age and have never attended school.

2.2 The NGO sector in Andhra Pradesh

The origin of the organised voluntary sector of Andhra Pradesh is due to influence of Christian Missionaries and Gandhian groups. For decades, the church has been engaged in two main areas, namely Education and Health. In both, the church has played significant role but confined insitutional to services. While welfare and relief have been the main activities of the church till the early seventies, adult education programmes, awareness programmes and community health programmes (in its elementary forms) started receiving attention, since mid-seventies. The Gandhian groups have been drawing inspiration from the Sarvodaya movement and getting involved in activities aimed at promoting that. There have been also sporadic upsurges among the people in certain areas, inspired by certain radical ideologies.

The NGO activities in the state has got expanded in the seventies. The 1977 cyclone saw mushrooming of many NGOs in the coastal region. Various NGOs came up in various parts of the state, very often as splinter groups and sometimes as off-shoots of a few major NGOs. Some of these major NGOs are Village Reconstruction Organisation (VRO). Guntur, Rayalaseema Development Trust (RDT), Ananthapur, Comprehensive Rural Organisation Society, Hyderabad, Association for Welfare and Awakening of Rural Organisations, Hyderabad.

All parts of the state is covered by the NGO. But there is a concentration of NGOs in certain pockets of AP ie in districts like Ananthapur, Cuddapah, Chittoor, Mahabubnagar and the coastal districts NGOs are less in Adilabad, Warangal, Khammam, Karimnagar, Medak, Nizamabad etc. The NGOs are involved in all the health and developmental activities.

2.2.1 NGOs - Various categories

The NGOs in AP can be categorised into 5 types, on the basis of their origin. these are -

-> The first type are NGOs started by socially concerned people, who migrated from other places and established themselves in the state over a period of time.

-> The 2nd type NGOs are initiated by those who worked with the first type of for a long period. They estahlished themselves with the support of the parent organisations and has a good credibility among the public.

-> The 3rd type belongs to the native, with a rural background. These groups are concerned about fellow brethren suffering from social discrimination and social injustice. Some of them would have also experienced the social inequalities in their life also.

-> The christian missionaries working in various parts of AP forms another brand. Their approach vary according to the personal convictions and ideologies.

-> The 5th category of NGOs are formed with varied interests.

The first two types of NGOs have urban sophistication and are professionalised or gets the services of professionals whereas the groups 3 and 4 are not managed or supported by professionals. In the present development scenario, the non-professional groups get sidelined. Presently our team supports groups belonging to the 3rd and 4th types and some selected NGOs from group 5.

Another classification of NGOs can be done based on the coverage, competency, availability of funds, no. of staff, their role etc. The groups are

* The corporate and mega NGOs : The NGO bases in one place and operates in different districts/or one district itself. Their normal coverage will be more than 100 villages. They have various projects and programmes and handle multli-million projects. eg. VRO, RDT, AWARE, RASS etc.

* Big NGOs : Operating in 50-100 villages of various mandals. Multiple programmes exists. Professionals work with the group.

* Medium size NGOs : Mostly they operate in 30-50 villages. They employ professionals and are involved in multifarious activities. Very often they have the recognition and financial assistance from government.

* Small NGOs : Small NGOs having a coverage of upto 30 villages with micro involvement and limited perspectives. Most of them including the leadership are from local areas and managed by non-professionals. Management skills and systems lack in the organisation. But the group is committed and has good rapport with the people. Some of them represent the disadvantaged group also.

* Peoples organistions : These are all small organisations emerging at the community by the involvement of intermediary organisations. These organisations come together and form a network/federation for the specific geographical area. Obviously, the leadership is from the disadvantaged, partially exposed to the development trends.

CHAI has been mostly associating and supporting the medium and small size organisations and network of peoples organisation. CHAI's Member Institutions also come under this category since most of our institutions are small dispensaries with a bed capacity of 0-6 and working in limited geographical area and managed by a sister-nurse.

2.2.3. The trends among NGOs

In all the districts, NGOs come together and form a federation of NGOs. Some of the district federations are quite active and its membership limited and is based on quality commitment etc. The inter and intra rivarly among the NGOs affect the functioning of district federations.

AP has witnessed the mushrooming of NGOs in certain pockets due to various reasons. Districts like Ananthapur, Cuddapah, Chittoor, Guntur etc. has got more than 500 NGOs in each district. Most of these are on paper and inactive organisations.

In the recent past, the NGO sector is witnessing a new development. Many NGOs get registered with the blessings of government beauracrats and other vested interest groups to mobilise the government funds especially for watershed programmes, Joint Forest Management, CAPART programme, housing, sanitation etc. These NGOs gradually get co-opted into the government network.

A silent revolution is taking place with regard to the leadership of the NGOs. Good many dalit and tribal NGOs who work exclusively for their own groups are slowly emerging. Some of the funding agencies support such a collective movement. Though such efforts has got ups and downs, the results are encouraging.

Various issue based network organisations are becoming more and more active and make their presence felt in the state. Networking of NGOs on environment, watershed, credit unions etc has made its impact in the field. These network organisations are effective in highlighting various aspects and issues related to it with the government, funding agencies etc. We can also find that the same NGO is part of several networks.

As funds availability for NGOs has increased the number of funds seeking NGOs have also mushroomed. The easy availability of funds for certain programmes eg. HIV/AIDS, watershed, child labour has accelerated this trend. Funds from govt. sources eg CAPART, social welfare dept. has become easy. Such a supply induced increase in demand has occasionally led to substandard quality, diversion of funds to fulfill political and personal aspirations and corruption among NGOs.

2.2.4 Major donors operating in AP : Action Aid, OXFAM, CRY, Christian AIDS, EZE, Memisa, Bilance, Misereor, HIVOS, TDH, Caritas India.

3 INTERNAL ENVIRONMENT ANALYSIS

At the moment a three member team as part of CHD co-ordinates and looks after the projects and evaluation activities. The team gets support from the rest of the department and the Delhi Zonal office to complete its tasks. The team also makes use of the services of the extended team members and the regional units whenever necessary. However, CHAI is on the look-out for competent personnel as full timers in the team.

3.1 Our strengths

* CHAI has been promoting community health in the region for the past 15 years through orientation and trainings. The team was set up in 1991 exclusively to support projects and programmes.

* The present CHAI team have a good understanding about the region, the needs and the NGO sector.

* Team is committed, experienced and competent to support small and medium sized NGOs.

* Regional team is slowly developing good rapport with the similar agencies and the donors in the region.

* Very positive relation with the field partners.

* Expertise on community health are available within the organisation.

3.2 Our Weaknesses

* Absence of a proper reporting system.

* Heavy workload and personnel constraints.

* Broader understanding with the regional team to be developed with regard to support and guidance to the project holders.

* Absence of gender balance in the team.

* Absence of a proper gender perspective within the team.

* Less opportunity exists for institutional learning.

* lack of expertise in advocacy and lobbying.

3.3 CHAAP - The Regional Unit of CHAI

As part of decentralisation, CHAI is in the process of strengthening regional units and gradually a resource team will be formed in each region. Along with that several of the responsibilities which CHAI now discharges for promotion of community health will be transferred to the regional units. Thus, over a period of time, regional units will play a significant role in appraisal, monitoring and evaluation of community health programmes.

3.4 CHAI - Member Institutions in AP

CHAI membership, all the health care institutions are located in all parts of the state. The total membership is 270. Most of the members are small dispensaries located in the remote areas of AP. The following table shows its strengths in each district.

Most of the member institutions are involved in community health activities at varying degrees.

The regional unit of CHAI has been in existence since 1990. With the assistance of MEMISA, CHAAP has been promoting community health in Andhra Pradesh mainly through its member institutions. The head office is in Vijayawada and has two full time staff and an active Board.

Distribution of CHAI Member Institutions in AP - District-wise

	Districts	Total Members
1.	Adilabad	10
2.	Karimnagar	3
3.	Nizamabad	7
4.	Warangal	12
5.	Medak	5
6.	Ranga Reddy	5
7.	Hyderabad	11
8.	Nalgonda	21
9.	Khammam	16
10.	Krishna	31
11.	Guntur	29
12.	Srikakulam	12
13.	East Godavari	7
14.	West Godavari	33
15.	Mahbubnagar	5
16.	Kurnool	10
17.	Prakasam	12
18.	Ananthapur	3
19.	Cuddapah	7
20.	Nellore	8
21.	Chittoor	4
22.	Vijayanagaram	6
23.	Viskhapatnam	13

3.5 CHAI and Field Partners

Since 1992, CHAI started associating with project partners at the request of our funding partners and through a policy decision. At present, CHAI associates with 23 projects in AP of which 16 are supported by MEMISA. Most of these are small and medium size NGOs involved in community health programmes.

3.6 Partnership

The involvement of CHAI in the project studies and evaluations is a recent phenomenon. CHAI, after having a lot of deliberations and discussions have decided to study, support and guide community health programmes and projects in the country. As we get involved, it was realised that a lot more interactions and involvements is needed with the field partners to translate the community health vision of CHAI in the field. Hence it became imperative to look at the role of CHAI on the process and the relations with the funding partners and field partners.

From our experiences with many projects in the past, CHAI believes that a long term association with the project holders is necessary ie to play an accompaniment role and to evolve a true partnership. However, CHAI has to address a number of questions around partnership with project holders and the funding partners and its meaning.