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PROGRAMME EVALUATION
BASIC HEALTH SERVICES INDIA
DESK STUDY

CEBEMO / ICCO / DGIS
(programme evaluation 60)

DRAFT DOCUMENT

(for internal use of evaluation mission only,
quotations and multiplication not allowed)

Public Health Consultants
Dik Roth Msc. Anth.
in collaboration with
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Overall responsibility:
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October 7 1994
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Amsterdam, October 13, 1994

Dear Ravi,

Thank you very much for your valuable contribution to the deskstudy "Evaluation basic health services India".
We have integrated your chapters in the document. I enclose a copy.
The status of the document is that of a working document for the mission. After the mission parts of it will be used in the mission report.
I would very much welcome any comments from your side on the document as it is now.
Hope everything is fine with you and hope to work with you once again.

Yours sincerely,

(M. Eerland, secretary)
Erik Heydelberg

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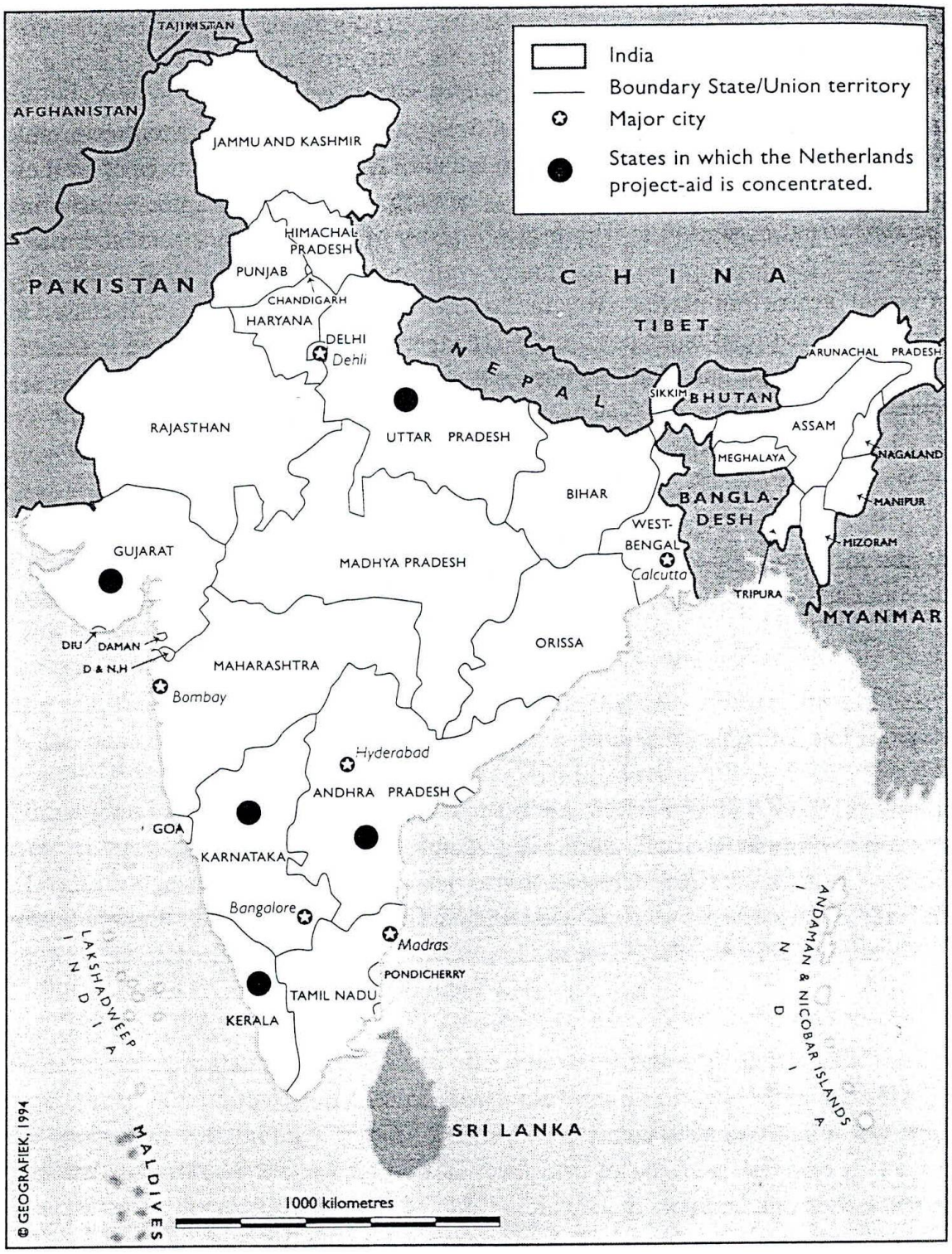
MAP OF INDIA



•Based upon Survey of India Outline Map printed in 1987.
•The territorial waters of India extend into the sea to a distance of twelve nautical miles measured from the appropriate baseline.
•The boundary of Meghalaya shown on this map is as interpreted from the North-Eastern Areas (Reorganisation) Act 1971, but has yet to be verified.
•Responsibility for correctness of internal details shown on the map rests with the publisher.

INTRODUCTION

Cebemo (Catholic Organization for Development Cooperation) and Icco (Inter-Church Organization for Development Cooperation) are two of the four Dutch Co-Financing Agencies (CFA's; the other two being Novib and Hivos). Through these organizations part of the Dutch government budget for development cooperation is channeled to non-governmental partners in developing countries. In 1965, Cebemo (actually, between 1965 and 1969 this function was fulfilled by CMC, Centraal Missie Commissariaat) and Icco were established and started to channel Dutch development funds to their counterpart organizations in developing countries (followed in the seventies by Novib and Hivos). In 1965 the Dutch Government allocated Dfl. 5 million to the co-financing programme.

Since the seventies all CFA's have experienced an enormous growth, both of the organizations themselves and the budgets allocated to them, and of their number of counterparts. In 1990 the four CFA's financed about 5.500 projects and programmes in 104 countries (Impactstudie Medefinancieringsprogramma, 1991). In 1993 a total of Dfl. 418 million (6,75% of the total budget for Dutch development cooperation) was allocated to these organizations. From 1994, 7% of the national budget for development cooperation is allocated to the CFA's (Begroting Ontwikkelingssamenwerking, 1994).

Before 1980, each project proposal had to be approved separately by the Government of the Netherlands. However, in 1980 the block grant system of the Programme Financing Agreement was introduced. This new agreement gave the CFA's greater freedom to implement their programmes, but also a greater burden of obligations related to accountability. From 1980 evaluations, inspections, financial control, annual reports and policy documents became the main instruments for (retrospective) periodical control. The Programme Financing Agreement was extended in 1984, 1988 and 1993.

One of the themes for the programme evaluations planned for the period 1993-1995 is 'basic social services' (primary health care and education). In preparing their programme evaluation in India, Cebemo and Icco have decided to concentrate on the theme of 'basic social services', and, more specifically, health care, in view of the considerable support provided to activities in this field by both organizations.

In recent years, the NGO 'sector' in India has experienced an enormous growth, both in coverage and scope of activities, and in the number of NGO's active in the field of development in general, or health care in particular. While a large number of these NGO's continue to concentrate on local implementation of projects and programmes, an increasing number of NGO's are taking up other activities not directly related to implementation: training and support, advice and evaluation, lobbying and advocacy, representation and provision of other services.

During the last few years, policy changes related to these new developments in the Indian NGO world have become visible among the Dutch CFA's. While Icco has 'scaled up' and shifted its support from implementing organizations at local level to a diversity of support organizations at higher levels of administration (federal state, national), Cebemo continues to prioritize support to local implementing organizations.

However, until now little is known about the nature of the relationships between implementing and support organizations, the quality of support and other services provided by intermediary –, support –, and umbrella organizations to implementing organizations, and their impact on the quality of the activities of the implementing organizations.

Therefore, it was decided to make the relationship between regional, state or national support organizations and local (village, block, district, diocese) implementing organizations the main theme of this programme evaluation. This relationship will have to be assessed in the light of the existing health care 'system' and the health care policy of the Government of India, the health services provided by the government and the private sector, and the changing health needs, demands and expectations of various sections of the population (including the middle and higher classes).

Key questions for this programme evaluation, as given in the concept TOR are:

1. What is the contribution of support organizations, active in the field of health care,towards the strengthening of the work of (member) organizations implementing health programmes directed towards the poor/marginalized groups, given the health policies carried out by GoI, government institutions and developments in the private sector?
2. What are, in view of providing optimal services to the poor/marginalized groups the expectations of implementing organizations regarding the role of the support organizations in improvement of the effects and impact of these activities?
3. What are, based on the above questions, recommendations to the support and implementing organizations regarding the possible improvement of the quality (i.e. efficiency and effectivity) of the services offered?
4. (sic) What are, based on the answers to the above questions, recommendations for the future support of the implementing organizations, the support organizations, (by?) Cebemo and Icco to the health sector in India?

The outcome of this programme evaluation should enable implementing organizations, support organizations and the CFA's to further specify or adjust their health care policies in India. Further, possibly the outcome of the programme evaluation will provide an input into future decisions by the CFA's regarding their health policies in India and the position of implementing and support organizations within these policies.

In the first chapter of this desk study the concept of Primary Health Care (PHC), as defined in the Alma Ata declaration of 1978, is discussed. Attention will also be paid to recent developments in the field of PHC in the light of experiences with policy implementation, and to future challenges in PHC. The second part consists of a general country profile of India. Main themes are: general characteristics of India, recent political and socioeconomic developments, some priority areas for development policy, and NGO's in India. The third chapter provides a profile of the health sector in India. In the fourth part, the general developmental policies, India policies and health care policies of the directorate General for International Cooperation of the ministry of Foreign Affairs (DGIS), Cebemo, and Icco are described. In the fifth and sixth parts short profiles are presented of a number of programmes and projects supported by Cebemo and Icco, preceded by a short introduction on the preselected programmes and organizations. In the

last part recommendations for selection will be given, preceded by some additional remarks on the (pre)selection procedure.

The third chapter of this desk study (The health sector in India) was written by Dr. Ravi Narayan of the Society for Community Health Awareness, Research and Action in Bangalore. Thanks are due to Mariëtte Wiebenga (Public Health Consultants) for writing 1.4.C. (Gender aspects of health care).

Amsterdam, September 1994

Public Health Consultants
Dik Roth

1. THE STRATEGY OF PRIMARY HEALTH CARE

1.1. Introduction

During the fifties and the sixties 'modernization' was the dominant paradigm of development. The transfer of capital, technology and scientific knowledge to 'backward' countries was generally regarded as the key to this 'modernization'. The model for planned change as well as the final destination of the process of development was, of course, modern Western industrial society. But from the sixties it was gradually realized that such modernization and 'trickle down' approaches to development did not work.

Under the influence of new analyses of the basic causes of poverty, the poor came into view of development planners. The accent shifted from macroeconomic growth to equity and income distribution. While formerly factors like 'tradition', 'backwardness', 'lack of initiative' had been identified as causes of poverty and stagnation, in the new approaches more attention was given to the socioeconomic and political determinants of poverty. Basic needs approaches gained ground and, from the seventees, target group oriented development strategies were generally acknowledged as an absolute precondition for improvement of the situation of the poorest groups, both urban and rural.

The field of health care provides a clear illustration of such changing views of development. Through the sixties, attempts to improve the health situation in developing countries had largely been based on the conventional Western model of curative, hospital-based medicine. However, gradually it became clear that the continued allocation of scarce resources to health infrastructure based on this Western model of health care was not effective, or even counterproductive. Indicators of health status like infant mortality, maternal mortality, and under-five mortality continued (and still continue) to be alarmingly high for many developing countries. Populations of rural areas and urban slums, who had no access (in a geographical or in an economic sense) to basic health facilities and essential drugs, continued to die of diseases that are preventable or treatable at low cost. At the same time, scarce resources went to the 'modern' sector of 'high-tech', urban-based, curative medicine to serve the health needs of the middle and upper classes with purchasing power living near health care facilities.

Thus, the conclusion was unavoidable that there was a fatal lack of fit between the priorities, delivery systems and services of the governments of many developing countries on one hand, and the most urgent health needs of the poor majority of the populations of these countries on the other. Diseases that made (and still make) most victims among the populations of developing countries (and especially among those groups most susceptible to them, such as infants, women, and poor and marginalized groups in general) are diseases of poverty and malnutrition. Basic causes of such diseases are often found in (socioeconomic, political or cultural) 'environmental' factors rather than in the purely biomedical sphere. Therefore, apart from its widely acknowledged preventive (e.g. immunization) and curative virtues, Western medicine, when applied in isolation from these 'environmental' factors, has little to offer in the eradication of such diseases and *long-term* improvement of the health situation.

Greater effect is to be expected from an analysis of local health needs and prevailing diseases within the context of physical, socioeconomic, political and cultural factors that strongly influence the (local/regional) health situation. Such an analysis may show that employment and income, nutrition, drinking water and sanitation should be central points of attention rather than germs or pills.

1.2. The concept of primary health care

General dissatisfaction with the limited effectiveness of the existing health services, and international recognition of the need to reorient health care in developing countries resulted in the 1978 WHO–UNICEF Alma Ata conference, known for its policy objective of 'health for all by the year 2000'.[1)] This target was to be achieved through the strategy of primary health care (PHC). In 1981, the World Health Assembly and the United Nations General Assembly adopted the 'Global Strategy' based on 'health for all'. Finally, in 1982, the World Health Assembly approved the plan of action for implementation of the 'Global Strategy' (WHO, 1993a).

In the Alma–Ata declaration a central place is accorded to the socioeconomic and cultural determinants of health. It stresses the importance of identifying, analyzing and combatting the socioeconomic causes of illness rather than propagating technical and curative solutions to the health problems of individual members of society. Inequality and poverty are identified as the main causes of the gloomy health situation in developing countries and of underdevelopment in general. The need for social justice and equity is central to the concept of PHC as defined in the Alma Ata declaration. Thus, as Macdonald (1993) stresses, PHC is *not* the same as a combination of curative and preventive primary medical care.

It should be added that PHC was not a new 'invention'. Many of its basic principles were used, for instance, in India and China. Especially the last country's 'barefoot doctors' model has laid the foundation for the Village/Community Health Workers (VHW/CHW) model central to the strategy of PHC. International acceptance of PHC as a long–term international strategy emanated from a serious concern for the enormous health problems in developing countries.

For the WHO, the strategy of PHC meant in the first place a necessary adaptation of its health policy to the economic realities of developing countries, in the light of the depressing health situation in these countries. Main instruments were prevention and a maximum of self–reliance (through VHW's providing cheap curative services) (Van der Geest *et al.*, 1990)

PHC, the central concept of the Alma Ata declaration and the key to 'reaching health for all', is defined as follows:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their

> development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (WHO/UNICEF, 1978).

PHC should be based on local needs and priorities, on 'traditional' knowledge and health systems, and make use of appropriate knowledge and technology. PHC 'reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience' (WHO/UNICEF, 1978).

The strategy of primary health care should address 'the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly' (WHO/UNICEF, 1978).

Further, in the declaration it it stated that PHC should include *at least* the following essential elements:

1. education concerning prevailing health problems and the methods of preventing and controlling them;
2. promotion of food supply and proper nutrition;
3. an adequate supply of safe water and basic sanitation;
4. maternal and child health care, including family planning;
5. immunization against the major infectious diseases;
6. prevention and control of locally endemic diseases;
7. appropriate treatment of common diseases and injuries;
8. provision of esential drugs (WHO/UNICEF, 1978).

The strategy of PHC requires a comprehensive, all-embracing approach to health. Therefore, it 'involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all these sectors' (WHO/UNICEF, 1978).

Another important characteristic of the PHC strategy is, that it 'requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate' (WHO/UNICEF, 1978).

While self-reliance is an important characteristic of PHC, this strategy cannot be successfull in isolation; it 'should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need' (WHO/UNICEF, 1978).

Finally, it is stressed that PHC should rely, both at the local and the referral levels, 'on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners
as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community' (WHO/UNICEF, 1978).

Important as they may be, policy statements like the Alma Ata declaration are sufficiently vague to allow for the identification of different 'key elements' or 'basic principles' by different authors or policy makers. Streefland and Chabot (1990), for instance, identify the basic principles of equity, participation, appropriate technology, prevention and inter-sectoral approach to public health problems. Macdonald (1993) stresses the importance of promotive aspects, partnership between health professionals and the community, and the need-orientedness of treatment and curative care. Further, this author discerns three 'pillars' of PHC: participation (community involvement), intersectoral collaboration, and equity and justice in access to facilities and resource allocation. Tarimo and Creese (1990) stress availability of essential health care according to need, involvement of communities in planning, implementation, and evaluation, and intersectoral cooperation.

Finally, some key aspects of the declaration, and their most important consequences for national health policies, strategies and activities are given below:

First, the central place accorded to the objective of equity in access to and allocation of basic health care facilities requires a fundamental reorientation of health policies and consequent allocation of resources available for health care. More specifically, the objectives of care according to need and providing a maximal coverage of the populations of developing countries can only be reached through:

- a shift from (especially urban-based) middle and upper classes to (rural and urban) poor groups in society;
- a change of priority from curative health care to preventive and promotive/educational aspects of health care;
- a shift of priority from diseases of affluence to diseases associated with poverty.

Second, participation and community involvement are important issues in development policy in general, and health care policy in particular. With reference to PHC (and especially the interaction between 'community-based' initiatives and basic health care provided by the government), one point seems to be of particular importance: attitudinal changes among health personnel with a 'traditional' (western) health education. Such a reorientation is a precondition for community involvement and participation in analyzing the local health situation, identifying major health hazards, decision-making and evaluation. Without such changes in attitude, other policy goals like making use of local skills and knowledge will probably remain hollow phrases. In such cases, the rhetoric of participation and its restriction to implementation and 'delivery' will only lead to 'collective patient compliance' (Macdonald, 1993). Therefore, 'traditional' status and power relationship between active, educated health professionals accountable to their superiors or to nobody at all, and passive, ignorant individual recipients of curative health care should make way for a new relationship. Key aspects of such a 'partnership' are active

involvement of the members of local communities, a relationship based on mutual respect, and accountability of health professionals to the members of the community. Such a partnership relation should, of course, also exist between VHW's and health professionals. Further, there is the danger of VHW's gradually alienating from 'their' communities and becoming a kind of 'extension workers' (Streefland and Chabot, 1993).

The stress on preventive and promotive (health education) aspects of health care requires a reorientation of health agencies and services, a reallocation of health resources, health personnel attitudes, skills and knowledge, and of educational curricula for the training of health professionals. Further, it requires attention to motivational and carreer development aspects of health professionals, especially those working in remote rural areas.

Orientation of health care towards local needs and priorities presupposes what Macdonald (1993) calls a 'health view' instead of a 'medical view' oriented to delivery of medical services. Attention to the socioeconomic and cultural environment and 'wider circles of disease causality' (Macdonald, 1993) should prevail over individual-oriented curative approaches common to most delivery systems (with, of course, the same consequences for health curricula as mentioned above).

The emphasis on intersectoral cooperation presupposes a 'health view' among the representatives of relevant government agencies at all levels. Health is no longer the product of vertical, top-down (curative and preventive) health interventions by one agency (the Ministry of Health), but of health-promoting horizontal 'linkages' between all government agencies relevant to public health (public works, agriculture, housing, education etc.) in the framework of an 'integrated' approach.[2)]

1.3. Between Alma Ata and the year 2000

In the past fifteen years, the Alma Ata policy statements and the objective of 'health for all' have proved to be far too ambitious and sometimes even naively idealistic. Most important, there was an enormous gap between formal policy goals formulated internationally or nationally on one hand, and the reality of their (national or local) implementation on the other. Many governments have formally accepted the recommendations of the Alma Ata declaration (there were 134 signatories of the declaration). However, in practice this often came down to a selective use of them that best suited national political or economic interests, the need for short-term successes, or the preference for a continued allocation of scarce resources to curative, intervention-oriented medicine.

But this should not blind us to the positive effects of Alma Ata. The declaration gave impetus to a radically new perspective on health, disease, and the relationship between health care and development in general. It stimulated the process of reorientation of scarce resources and facilities from curative, urban, hospital-based and vertically organized monosectoral health care for the happy few to promotive and preventive, rural, local health-centre-oriented, participative and multisectoral health care for the majority of the (rural and urban) poor. Many countries started reviewing their health systems and adapting their national policies and strategies in accordance with the PHC strategy, supported by

donor countries and organizations, and non-governmental organizations. This was increasingly reflected in plans of action in which the basic elements of the PHC strategy (see 1.2.) can easily be recognized. Some governments have recognized that health care facilities should be attuned to the needs of the majority of people rather than to those of the small, well-to-do minority with purchasing power.

In these countries priorities changed accordingly. More resources were allocated to basic health services (promotive, preventive and curative). Curricula for health professionals were adapted to the new role allocated to health workers in the PHC concept. Attention was paid to the necessary changes in attitude of health professionals towards illiterate, poor villagers and their participation in community-based health programmes. Greater respect was demanded from scientists and health professionals for locally available knowledge and local solutions to health problems.

The objectives of comprehensive, community-based PHC are, almost by definition, long-term objectives with little short-term results to boast of. On the other hand, expectations of the short-term impact of PHC have often been unrealistically high. Though not stated so clearly in the declaration, the message of Alma Ata is a political one. Its implementation implies struggle with power and interest groups at the local, regional and national levels of administration and with professional interest groups. It further necessitates a radical reorientation of health services, management (especially of district health systems), financing and cost recovery, development of PHC-oriented curricula for health professionals and training materials for VHW's, professional attitudes towards target groups of health programmes, VHW's and local knowledge and practices, research etc. It will be evident that such a reorientation is also a long-term process.

In its report of the second evaluation of the 'health for all' strategy, WHO (1993a) signals some positive trends. The majority of countries formally endorse 'health for all' as a policy objective. In many countries there is also a growing attention to the issue of equity in health. Further this political commitment is reflected in national patterns of allocation and distribution of resources for PHC.[3)] A positive trend can also be discerned, especially in Asia, in leadership development (WHO, 1993a; 40-46).

In the report some positive global trends with respect to the reorganization of health systems towards PHC are mentioned. First, many countries are in a process of reorientation towards PHC, and away from (exclusively) curative-oriented second- and third level health care. Second, in many countries there is a growing awareness of the importance of more efficient use of resources and of the need to improve access to and quality of health facilities. Third, in many countries in the Far East and the Pacific there is a clear emphasis on the comprehensive character of PHC, all eight elements of which should be represented in local programmes. Issues of special attention are decentralization, integration, district health systems, and health services in rural areas. Fourth, a growing number of countries adopt policies of decentralization in order to improve the use of resources for PHC. Some countries give special attention to the decentralization of authority and responsibility to the district level (WHO, 1993a; 47).

However, the overall conclusion by WHO is not encouraging: 'Some major programmes based on the primary health care approach have proved successful. In general, however,

disparities and inequalities in availability of national health services have remained high and have even increased in some cases. This is partly due to the fact that an intensified effort in one programme has been accompanied by a decrease in another.' (WHO 1993a; 48).

The main reasons for this continuation, or even increase of disparities, given by WHO are:

- the continued provision to some population groups of unnecessary, expensive and sophisticated health services, reducing the availability of resources for the rest of the population;
- the slow progress from a vertical to an integrated approach;
- the influence of pressure groups advocating 'glamorous' expensive second- and third-level care, supported by curative-oriented parts of the health profession;
- national economic difficulties:
    - the slow expansion of services to underserved areas;
    - the lack of trained and motivated staff;
    - the lack of supervision;
    - referral problems (WHO, 1993a; 48-49).

With reference to health care coverage, the WHO report shows that since 1985 the percentage of people covered with essential services has increased worldwide. Examples are coverage with safe water supply and sanitation, and different components of mother and child care (especially immunization; in 1990 the average global immunization rate against measles, diphteria, pertussis, tetanus, poliomyelitis, and tuberculosis was 80%) (WHO, 1993a). Improvements in coverage (but also in other determinants of health like nutrition, education etc.) are reflected in improvements in health status indicators like infant mortality rate, life expectancy at birth, and birthweight status.

At the same time it should be stressed that in many countries the total *number* of people without access to basic health care, safe water, sanitation and other services is increasing. Further, the gap between the developed (and many developing) countries and the least developed countries has widened, as have the gaps between groups within countries (between urban and rural areas, pockets of extreme poverty in urban areas, marginalized groups based on ethnicity etc.).

Data on coverage with many other elements of local health care are hard to interpret because most countries do not provide further specifications (WHO, 1993a).[4)] Another limitation of data on coverage provided to WHO by the member countries is the fact that, while data on coverage by some separate (sub)elements are provided, data on coverage by all (sub)elements of primary health care is not available (WHO, 1993; 142).

Right from its acceptance as a global strategy, PHC has been controversial. One of the main themes has been the debate about selective versus comprehensive, and vertical versus horizontal PHC (Van der Geest *et al.*, 1990; Macdonald, 1993; Rohde *et al.*, 1993). As has been said before, many countries have selectively implemented the strategy of PHC. Such lip-service paid to the Alma-Ata declaration is widely acknowledged to be a threat to the

most crucial elements of the PHC-model and the long-term survival of the model itself (Tarimo and Creese, 1990; Macdonald, 1993; Walt and Rifkin, 1990). Selective primary health care hardly differs from 'traditional' outreach programmes and delivery-oriented extension of health services through vertical health agencies.[5)]

Economic trends in the eighties and ninetees have in many respects been unfavourable for the national health policies of developing countries and the attention paid by governments to primary health care. Many developing countries were hit by economic stagnation, and involved in programmes for structural adjustment and economic stabilization. Under the influence of economic recession, structural adjustment and privatization, international donors and governments of developing countries have tended to resort to the implementation of vertical, target-oriented programmes for specific health problems: family planning, immunization, nutrition, vitamin A, ORT etc. Critics of this approach stress that such programmes tend to produce short-term results which give the illusion of progress, but have a limited sustainability.

Related to this is the assertion that certain forms of selective implementation of PHC may produce second rate health care. The policy goals of 'community participation', 'self-reliance' and 'self-help' may be misused by governments to evade their responsibilities by having carried out health care tasks in an inexpensive way by superficially trained lay persons. Thus, cutbacks in health care expenditures by the government may be presented as a radical reorientation and improvement of the quality of the health care system (Tarimo and Creese, 1990; Van der Geest *et al*, 1990).

Under the influence of the ideology of self-help and self-sufficiency, the strategy of PHC has long been too much focused on the role of community-based health care and the Village Health Worker (VHW), isolated from the larger administrative structures they are part of. Little attention was paid to linkages with basic health services provided by the government, to the detriment of referral, support, guidance, training, logistics etc. for the local level (Streefland and Chabot, 1990).

Another policy objective af Alma Ata is 'intersectoral cooperation'. In practice, realization of this objective of PHC has proved to be very difficult (as it has been in 'integrated development' in general). All too often relationships between government agencies are competitive rather than complementary or mutually supportive. Segmentation and fragmentation tend to prevail over cooperation. Sectoral bureaucratic biases against cooperation, a narrow conception of health as the responsibility of medical services, and isolated health planning create separate hierarchies rather than comprehensive programmes (WHO, 1993a; Macdonald, 1993).

Macdonald (1993) warns against such forms of forms of non-cooperation between sectors, and even within sectors. With reference to the health sector, the author gives the following examples of detrimental forms of intra-sectoral segmentation:

- between public health (promotive/preventive) and curative care;
- between health education and specific interventions (mother and child care, immunization etc.)

Finally, PHC is increasingly being criticized from a sociological point of view. Mechanistic 'systems' thinking has dominated (and still does so) the analysis of sociological aspects of PHC and of policy processes. Relationships between actors at the local level ('the community'), or between actors at the local, intermediate, national, and international levels are generally presented as relatively unproblematic and manageable through well-defined (national) policies. Thus, the practice of PHC has been too much influenced by the necessarily rather simplistic policy language of the Declaration of Alma Ata. Glimpses at the problematic nature of policy implementation are few and far between: 'Public health action may be confined to the national level and therefore limited in scope' (WHO, 1993; 139).

An example (with important policy consequences) is the concept of 'community'. Views of the 'community' in terms of commonality of interests, at the cost of attention for processes of segmentation and differentiation, are often based on political ideals and ideological premises, but seldom on sound social research. Development donors, government agencies and NGO's alike subscribe to such generalizations, though each for their own reasons (an unproblematic view on 'reaching the target group'; nationalist rhetoric and playing down socioeconomic differences; ideological assumptions about 'traditional' village society). Streefland and Chabot rightly stress that there is a need to turn away from such 'common assumptions about the fundamental unity of village society' (1990; 34).

Especially where the issues of community participation, self-help, etc. are at stake, this seems to be crucial. Many interventions are based either on the assumptions of unity and commonality of interests at the local level, or on a class model and economic classes as groups with commmon interests. Thus, other important (and often multiple, shifting and conflicting) loyalties may be lost sight of: kin group, ethno-religious, patron-client etc. And the 'target groups' may in reality have other 'real' needs and priorities than those ascribed to them by donors, governments and NGO's.

1.4. Challenges for the future

From a world economic point of view, the future for developing countries, and especially for the poorest among them and the poorest groups and regions within them, is not bright. At the same time, the populations of developing countries will continue to increase. When seen from the perspective of health care, future population growth will in many countries undo increases in coverage by health services. Even though the percentage of people covered by health services may increase, the absolute number without access to basic health care may well continue to rise (WHO, 1993a).

Especially under conditions of economic recession and structural adjustment (cuts in government spending, privatization, deregulation etc.), 'non-productive' sectors like education and health run the risk of being curtailed first. With national governments escaping from their responsibility to deliver basic health services with a high coverage, PHC may well become 'second-rate' health care for the poorest groups in society.

Thus, future challenges for PHC in developing countries are many. The continued lack of access to basic health care by the majority of rural populations and a rapidly increasing

number of urban poor and marginalized groups in developing countries necessitate a continuing process of reorientation of health expenditures from urban middle and upper class, high-tech and curative towards promotive, preventive, and basic curative services for the rural and urban poor, and other marginalized and special risk groups. Such reorientations of health care have in the past experienced much opposition from interest groups which form a strong political lobby for a curative, treatment-oriented system of health care and its related status, and will continue to do so.

Many other challenges can be identified, like sustainability of improvements in health status, AIDS, motivational and carreer aspects, health information systems, attitudinal changes among health professionals etc. Without attempting to be exhaustive, the following major future challenges will be treated below: district health care, urban health care, gender aspects of health care, intersectoral cooperation and NGO's, and future allocation of health resources.

A. District health care

A main theme in health policy in general, and PHC in particular, is decentralization of authority and responsibility to the district level of administration.[6] The district health system has become increasingly important as 'a more or less self-contained segment of the national health system' (WHO, 1988a), for the organization and provision of primary health care. This intermediate level (in between the 'first contact' local village level and provincial, federal state or national level) is supposed to play a key supportive role in (future) PHC efforts (WHO, 1988a; WHO, 1993a). At this level higher skilled and more specialized forms of care are available; treatment of more serious diseases takes place here. Though rightly priority is given to PHC and the 'first level', it should be stressed that the weakness of second- and third level care may have serious consequences for the effectiveness of health care as a whole (WHO, 1993a; 63). Therefore, specific attention will be needed for strengthening the role of the hospital and institutional care in the concept of PHC.

The district can provide logistical support and highly trained staff for the training of trainers and village health workers. However, in most countries capabilities for planning, implementation, management and support are weak. Therefore, special attention will be needed for the following 'pillars' of the district health system:

1. organization, planning and management;
2. financing and resource allocation;
3. intersectoral action;
4. community involvement;
5. development of human resources (WHO, 1988a).

Important preconditions for the effective functioning of district health systems:

- the full commitment and support from the national level;
- some degree of autonomy and authority in planning; management, decision-making and resource allocation;

- an overall national plan for PHC, in which policies and broad strategies are defined (WHO, 1988a).

At district level, special attention will have to be paid at the development of strategies for cost-recovery and the mobilization of local resources. However, in the context of privatization and structural adjustment, special care will have to be taken that ideologies of self-help and mechanisms for cost-recovery do not degenerate into new forms of exploitation of poor and marginalized groups.

B. Urban health care

Another major challenge is the struggle against the negative welfare and health effects of rapid urbanization in developing countries. In 1990, 37% of the population of developing countries (1.500 million people) lived in urban areas. In these countries, the urban growth rate during the period 1985-1990 was 4,5% . The high pace of urbanization of the last decades is expected to continue in the decades to come. By the year 2000, there will be eighteen mega-cities (cities with 10 million or more inhabitants). By the year 2025 total urban population will increase to 4.000 million or 61% of the total population (WHO, 1993a). The number of mega-cities will also increase considerably during this period.

In many developing countries the pace of urbanization is not matched by the expansion of health care and other facilities. Main victims are, of course, poor and marginalized groups without or with low-paid employment, a low educational level, and little or no access to facilities. The gloomy picture of poor housing, delapidated infrastructure, lack of safe water supply and sanitation, of facilities for basic health care and education, and the high rates of morbidity and mortality associated with it looms large. Major health hazards are malnutrition, water-borne diseases, diseases of the respiratory tract, stress, diseases causes by environmental degradation, sexually transmittable diseases (AIDS), drug and alcohol addiction, and injuries caused by violence (WHO, 1993a). The specific characteristics associated with the urban enivironment (its rapidly changing demographic and socioeconomic context) require special approaches to urban health care, based on the district health care model (WHO, 1993b)

C. Gender aspects of health care

Health services have a long tradition of focusing on women and children, especially in MCH programmes. For a long time, however, women have in this context been mainly perceived as passive beneficiaries and as mothers of their children, rather than as women in their own right, with their own needs, ideas and priorities. It was only in 1985 that the question was formulated 'Where is the M in MCH?', and in 1987, subsequently, that the Safe Motherhood Initiative was launched by the WHO, highlighting the tragedy of continuing high maternal mortality rates in many parts of the world, and indicating an even higher maternal morbidity. Since then, increasing attention has been given to these problems and their underlying causes, which undoubtedly will remain a major challenge in the near future.

In the meantime, in 'Women in Development' (WID) circles, the debate was intensified on how to increase access to and control over resources for women, how to support their empowerment and their strife for autonomy in different spheres of their lives. These issues have been relatively neglected in the context of PHC, in spite of its longstanding rhetoric on such concepts as equity and community participation. As mentioned before, however, the uncritical and too general use of these concepts has for too long left many inequities and differences within communities, including gender differentials, unspecified and unattended. Similarly, 'women' as a category can no longer be simply approached as a homogeneous group, ignoring the huge differences that can exist between women within a community (e.g. between married and unmarried women, between women with some education and those uneducated, between upper class and poor women)

In fact only recently, with the shift in emphasis from 'Women in Development' to 'Gender and Development', an increasing interest in gender issues in the context of PHC programmes is noticeable, as apparent, for example, from a mushrooming of workshops to sensitize health personnel in these matters. The former exclusive focus on women is replaced by an emphasis on gender relations and their influence on patterns of decision-making, on differential access to resources, and on different health benefits, with special attention for disadvantaged groups. A translation of these new conceptualizations into daily health practice, or, in other words, the operationalization of gender in PHC programmes, is one of the big challenges of the 1990s.

A major effort will be needed to balance gender inequities in access to and control over resources including health services. More concrete steps in actual PHC programmes are to involve women as active participants in decision-making in all matters concerning their health, be it in health committees, as individuals, or in informal groups; and, on the other hand, to ensure male involvement in programmes traditionally geared mainly towards women but in fact concerning both equally, like family planning. Changes in the underlying power relations form part of the long-term challenges in development.

D. Intersectoral cooperation and NGO's

As has been argued above, mutual relations between government agencies (sectors), and relations between government agencies and NGO's are often competitive and segmentary rather than mutually supportive and complementary. In the near future, intersectoral competition for resources may even increase in the context of economic readjustment, cuts on government spending etc. (Walt and Rifkin, 1990). Further, under conditions of a central government backing out of its responsibilities and cutting its spending on (social) programmes, while new competitors from the NGO-world fill the gap with increasing foreign donor support, cooperation between government agencies and NGO's may well become part of the problem rather than of the solution.

There is even the danger of health NGO's involved in the implementation of PHC programmes bearing the burden of what are in fact government responsibilities. In this respect a distinction is often made between *parallel* development activities by NGO's on one hand, and *complementary* activities on the other. But there is a third possibility: NGO's taking over responsibilities from a state incapable or unwilling to fulfill its

obligations towards its population. Often, it should be added, to the detriment of the NGO's concerned. They are usually unable to do on a large scale what government agencies have failed to do, lose their credibility with the population, their flexible and innovating approaches, and the motivation of their personnel.

E. Future allocation of health resources

The increase of 'lifestyle diseases' (chronic noncommunicable diseases, often associated with Western consumption patterns) like cancer, heart disease, hypertension etc. among the growing middle and upper classes of many developing countries poses a serious threat to the long-term availability of adequate public resources for PHC. Rohde *et al.* (1993) stress the importance of continued allocation of public resources to 'pre-health transition society' (the young population in general, with special attention to the control of infectious diseases and malnutrition). In a global context of economic liberalization and privatization, it is of the greatest importance that in the decades to come the private (non-voluntary, profit) sector caters to the needs of the well-to-do, while public resources and non-governmental (non-profit) resources continue to flow (and increasingly flow) to poor and marginalized groups of society. Within allocations to the health sector, priority should be given to prevention of further budget cuts for PHC, to finding new sources for funding and ways to use them more efficiently end effectively (Rohde, *et al.*, 1993; Tarimo and Creese, 1990)

However, there may be some complications here. First, it is the middle and upper classes, and not the poor, that can exert an effective demand on the health care market in developing countries. Second, these (urban-based) classes have access to political decision-making processes, and thus can influence the allocation of resources. Moreover, for governments with urban-based political clientele PHC is not a crucial issue. In such cases, short-term results and prestige may have priority over high-quality PHC (Van der Geest *et al.*, 1990).

As a 'countervailing power' in developing countries, the role of national NGO's with a policy influencing and lobbying function towards their governments, and at the same time a critical view on government health expenditures, may well be of crucial importance in the future. In this respect, the following reservation made by WHO (1993a) seems necessary: 'Although voluntary organizations are nationally organized in a number of countries, the lack of a policy framework for coordinating their efforts remains a significant obstacle to the full utilization of their skills and resources' (WHO, 1993; 78).

2. INDIA: A GENERAL COUNTRY PROFILE

2.1. General characteristics

India, with a land surface of 3.288.000km2 (approximately 100 x the area of the Netherlands) and a population of about 850 million people (1991), is demographically the second largest country in the world after China. During the 1981–1991 period average population growth was 2,1% per year. According to the 1991 census, during this period the population of India has increased by 23,5% (1971–1981: 24,6%).[7]

India is characterized by an enormous sociocultural, ethnic, linguistic, religious and ecological diversity, which makes generalizing about the country difficult, if not impossible.[8] The large majority of the population are Hindus (83%, most of which live in the Gangetic plain and central states). Other important religious groups are Muslims (11%), Christians (3%), Sikhs (2%), Buddhists (1%) and other minorities (Parsees, Jains, and others). The Christian minority is for the greater part concentrated in the southern states of Andhra Pradesh, Goa, Karnataka, Kerala and Tamil Nadu, and in some northeastern states (Nagaland, Meghalaya).

The majority of India's population (75%) lives in rural areas. Most of them are small farmers, landless, and agricultural labourers. It is estimated that between 37% and 46% of the rural population has no access to land, and fully depends on (irregular) wage labour for its daily subsistence. Their weak socioeconomic position makes the poor sections of India's rural populations very vulnerable to unfavourable external economic influences like price increases. Such economic developments and other calamities (e.g. disease) may easily set off a process of growing indebtedness to moneylenders and loss of means of production (land), often leading to 'bonded' forms of labour.

In 1991, 217 million people (25%) lived in India's cities. Urban population increases at a considerably higher rate (3,9% per year) than rural population (1,8% per year). Decadal growth of India's urban population in the period 1981–1991 was 36,19% (VHAI, 1991). India now has more than twenty cities with a population over one million. Urban population growth is increasingly becoming an autonomous process, no longer caused primarily by rural–urban migration patterns. The largest cities of India and their (1991) populations are: Bombay (12,6 million), Calcutta (10,9 million), Delhi (8,4 million), Madras (5,4 million), Hyderabad (4,3 million), and Bangalore (4,1 million).

India gained its independence from Britain in 1947. After decolonization it became a federal state based on secularism and parliamentary democracy. It comprises 25 federal states and 7 union territories. Principles of national policy, including the relationship between the state and national levels, are laid down in the constitution. While key issues like foreign affairs and defence are national responsibilities, agriculture, health, education, and other sectors are under state responsibility. Apart from national and state responsibilities, there are the joint responsibilities of the 'concurrent list' (DGIS, 1994). If national and state interest are in conflict, final decisions are taken at the national level. The latter is clearly the stronger party, as is also shown by the fact that president's rule can be proclaimed if political turmoil at state level is supposed to threaten national stability.

The state is administratively divided in the district, block (*taluk*), and village levels. In 1993, this system of decentralized local government (the '*Panchayat Raj*' system) has been revived by the central government, possiby with important consequences for developmental efforts at the local levels of administration.

State	Size (km2)	Population (million)
Madhya Pradesh	443.446	66
Rajasthan	342.239	44
Maharashtra	307.713	79
Uttar Pradesh	294.411	138
Andhra Pradesh	275.045	66
Gujarat	196.024	41

The five largest states according to size (source: DGIS, 1994)

State	Size (km2)	Population (million)
Uttar Pradesh	294.411	138
Bihar	173.877	86
Maharashtra	307.713	79
West Bengal	88.752	68
Andhra Pradesh	275.045	66
Madhya Pradesh	443.446	66

The six largest states according to population (source: DGIS, 1994)

The constitution also addressed deep-rooted aspects of social and religious life and tradition, like the caste system. In the Indian constitution (1950) the caste system was formally abolished, caste distinctions no longer recognized and discrimination of lower caste members or 'untouchables' (*harijans*, *dalits*) offically forbidden. Since then, distinctions between the major caste divisions (*Brahmans* or priests; *Kshatriyas* or warriors; *Vaishas* or merchants/big landowners; *Sudras* or craftsmen/labourers) have lost part of their significance.

However, especially in rural areas hierarchical social divisions of *jati*, endogamous kin groups based on (sub)caste divisions, remain a major determinant of Indian social life. Other determinants of (urban and rural) social life that even seem to have gained in importance during the last few years are religious and communal affiliations. In the practice of development interventions such 'traditional' loyalties, hierarchical patron-client relationships and forms of socioeconomic dependency (bonded labour) may be stronger than the unity and solidarity of 'community' or 'class'. An important aspect of Indian political life is the politicization of these bonds of identification, loyalty, and dependence down to village level under the influence of universal suffrage.

2.2. Recent political developments

India is known as 'the largest democracy in the world', and rightly so. The country has a strong tradition of parliamentary democracy and elected governments at the state and national levels, which is virtually non-existent in other Asian countries. It has a multi-party system, and general elections with voting rights for men and women. Moreover, India's parliamentary democracy is built upon a society that in its long history has become used to incorporating and tolerating a great variety of sociocultural and religious elements within its boundaries.

However, since the seventies severe threats to the democratic character of the national state have come up. In the 1975-1977 period unconstitutional rule by prime minister Indira Gandhi brought the country to the brink of civil war. At the same time, Indian democracy showed its teeth by bringing to an end a period of uninterrupted rule by Nehru's and Indira Gandhi's Congress Party: in the period between 1977 and 1980 the Janata Party was in power. However, in 1980 the old order was restored, with the Congress Party in power again through what seemed to have become a kind of hereditary rule instead of parliamentary democracy. During the past years, Indian political life was characterized by rather unstable coalition governments without absolute majority. Since 1991, the Congress Party has again become the largest party without, however, being able to gain an absolute majority in parliament.

It was also in the eighties that other political threats to India's national unity gained in momentum. First, communalism and separatist movements have become severe threats to the long-term national unity and stability of India. These problems have manifested themselves most clearly in Kashmir (Islamic separatism seeking to join politically with Pakistan or to become fully independent), Punjab (Sikhs striving for an independent Khalistan state), the Assamese separatist movement and other (separatist) political turmoil in India's northeastern states.

Further, in recent years religious cleavages have posed a new threat to the Indian state (and especially to its secular character, guaranteeing an equal position to members of all religious groups). The growth of radical Hindu fundamentalist and nationalist movements and political parties (in particular BJP), the Ayodhya affair and many other conflicts and incidents have seriously strained relations between (fundamentalist) Hindus on one hand, and Muslims and other religious minorities on the other.

The political tensions mentioned above have also negatively affected the human rights situation in India. Through a number of legal instruments, the national government has given itself greater powers for intervention in state politics considered to be dangerous to the national stability. 'President's rule' has been decreed for the states of Punjab, Assam, Kashmir and Tamil Nadu, often with negative consequences for the treatment of individuals. Violations of human rights seem to occur on a large scale, a.o. in Bihar, Uttar Pradesh and Andhra Pradesh. Some states seem to balance on the brink of a complete social breakdown.[9] While the human rights situation continues to be monitored by a number of human rights organizations, political activists and the media, human rights issues cannot be openly discussed with the national governments.

2.3. Economic development

Economically, India is a Janus-faced country. On the one hand it has become an important industrial and technological power, catering to the majority of its own needs of consumer and capital goods. During the last decades it has experienced high industrial and agricultural growth rates. India now has a middle class population of more than 150 million. On the other hand India is still among the countries with the largest number of poor and illiterate inhabitants in the world.

In the eighties, India has experienced a period of rather strong economic growth, as shown by aggregate macro-economic indicators such as GNP and industrial production. Average growth of the GNP in the period 1980-1990 was 5,3% . At the same time, from GNP per capita (US$ 330 in 1990; World Development Report 1993) it will be clear that India still belongs to the group of low income countries. There is increasing evidence that economic growth of the last decades has mainly benefited the middle and higher classes, but at the same time contributed to the further deepening of the gap between the rich and the poor.

Beginning with the rule of India's first prime minister Nehru, central state planning has played an important role in the Indian economy. The role of the central state in industrial development and production was considered crucial for the long-term development of the country. The main instrument of (economic) planning were the Five-Year Plan plans.[10] Emphasis was placed on heavy industry, mining and infrastructure. Main characteristics of this period of considerable state intervention are the (industrial) strategy of import substitution and the (agricultural) strategy of food production through 'green revolution' technology. However, protectionism, high production costs and a low quality of production were the other side of the coin.

From the seventees, and especially in the eighties, India has implemented a great diversity of programmes for poverty alleviation (PAP's), like rural (self) employment schemes, income generating programmes, wage employment programmes, backward area programmes, training programmes and integrated rural development programmes (Shah, 1991). But, generally speaking, in its industrial and agricultural policies, India has been betting on the strong, and direct alleviation of poverty has never had a clear priority. According to the 1989 World Bank report, 40% (some 350 million people) of the population is estimated to live under the poverty line, set for the period 1985-1990 at about US$ 460. While during the last three decades the percentage of people living below the poverty line has declined, absolute numbers have increased.[11]

By the end of the eighties, India entered a period of economic recession, culminating in the severe economic crisis of 1990-1991. With towering deficits and declining reserves, India became increasingly dependent on foreign aid and the conditions on which such aid is usually provided by bilateral and multilateral donors. In the eighties, during the rule of Rajiv Gandhi (who was assasinated in 1991) a beginning had been made with the restructuring and liberalization of India's economic policy. However, under the Rao government, a radical programme of structural adjustment and economic stabilization was introduced in 1991. India's economic reforms were supported by the World Bank, IMF and bilateral donor countries. As a result of the introduction of this 'New Economic Policy' (main features of which are deregulation, stimulation of foreign investment, privatization,

reduction or abolition of subsidies like those on fertilizer), international confidence in the Indian economy was restored.

As in most developing countries, the programme for structural adjustment has set off discussions about its consequences for the poor and marginalized sections of society. Especially during the last few years there is a clear trend towards widening of the gap between the rich and the poor. Poor and marginalized groups are to an increasing extent excluded from the general process of development: rural small farmers and the landless, small fishermen, urban poor and slum dwellers, the population of regional pockets of poverty, especially in areas with a majority population of scheduled castes and tribal groups, and women.

Poverty is regionally concentrated in Central and East India, where more than 400 million people live. In particular the states of Uttar Pradesh, Madhya Pradesh, Orissa, West-Bengal and Bihar show a gloomy picture: a stagnated agricultural sector, low incomes, unemployment, malnutrition and poverty diseases, a lack of adequate facilities for basic health care and education in a context of high population growth and a lack of resources for development. The position of marginalized groups (esp. scheduled castes and tribes; see below) is even worse. Poor and marginalized groups have to do without basic social services, amenities, and social rights. Thus, these groups lack access to basic health care, education, housing, safe water and sanitary facilities. Unemployment or unfavourable and unhealthy working conditions further complicate their position. Forms of bonded labour exist in a number of states, child labour is a widespread phenomenon.

2.4. Some areas of priority

In this part some priority themes will be highlighted: the position of women, urbanization and the urban poor, and scheduled tribes and castes. Within the scope of this desk study a choice has been made, so that many other important themes, as for instance environmental degradation and displacement of rural populations for large-scale infrastructural projects have been left out.

A. The position of women

Notwithstanding the full recognition of the equal rights of women in the Indian constitution, the reality of the position of women in the generally patriarchal Indian society is different. In a sociocultural and economic sense, women in many parts of India have a position inferior to that of men. They often lead a socially isolated life, are illiterate, and lack access to basic human needs and facilities. This is clearly reflected in important social and health indicators like female literacy rate, maternal mortality rate, malnutrition of female infants etc (see chapter 3).

From an economic point of view, women are generally worse off than men. Apart from their household tasks, women bear the greatest burden of agricultural labour, and play a very important part in the (urban) informal sector. If women perform wage labour, usually they get a lower payment than men for the same work. In case of restructuring of

economic activities, as for instance mechanization in agriculture, women are generally the first to be hit and lose their access to important sources of income.

The general preference for male children in combination with the use of modern medical technology to determine the sex of the foetus have led to a mushrooming of the practice of female foeticide through abortion.[12] Though in July of this year a law forbidding the use of sex determination tests for this purpose has been passed in the *Lokh Sabha* (parliament), this practice is hard to control. For the poorest sections of society, the (cheap) alternative is female infanticide shortly after birth.

Indebtedness of the relatives of the bride at best, but in the worst case mutilation or murder of the woman as a result of conflicts related to the payment of dowry further add to the social and physical burden carried by women. According to recent estimations, the total number of 'dowry deaths' in the state of Uttar Pradesh alone in 1993 amounted to at least 1952 women. Such practices cannot simply be considered 'traditional', but rather seem to be related to an increasing desire for modern consumption goods.

B. Urbanization and the urban poor

Problems related to excessive urban population growth are many. According to recent estimates, between 28% and 40% of the urban population live in conditions of absolute poverty. The number of slum dwellers was estimated at 50 million in 1981; estimations for the year 2000, when a third of the population (350 million people) will live in urban areas, are that India's cities will have 80–100 million slum dwellers. A group which is even more marginalized are the street dwellers.

Key problems in urban areas are unemployment, low wages, the lack of (low cost) housing, clean drinking water, sanitary facilities, waste disposal and other facilities and services, such as education and basic health care. The most common diseases are those diseases associated with poverty, malnutrition and unhygienic living conditions such as hepatitis, malaria, tuberculosis, worm infections, and diarrhoeal diseases.

The recent outbreak of the (lung) plague in the city of Surat (Gujarat) clearly shows what might become the scenario for many other urban agglomerations throughout India under conditions of high urban population growth (in the case of Surat clearly related to migration of low paid labourers), a provision of services lagging far behind the rate of urban growth (and, more important, neglecting the poorest sections of urban society), and a complete lack of access to basic facilities for a large group of urban poor (Surat had a 1991 population of 1,5 million. With a decadal growth rate of 87,4% in 1971–1981, and 64,2% in 1981–1991 it is the fastest growing city of India; Bose, 1993).

C. Scheduled tribes and castes

In India there are many underprivileged groups (socially marginalized, economically backward, or living in remote areas with little access to basic services for health, education etc.). Examples are small fishers, hill people and the inhabitants of urban slums.

An important underprivileged group, formally recognized by the Indian Constitution, are the so-called scheduled tribes. According to the 1981 census tribals (*adivasi*) comprise more than 400 tribal groups with a total population of 51.628.638 (excluding Assam), or 7,76% of the 1981 population. Most tribal groups live in Central and Northeast India. According to the 1981 census, Madhya Pradesh had the largest tribal population of all states (11,98 million), while Mizoram had the largest proportion of scheduled tribes relative to the whole (state) population (93,55%), followed by Nagaland (83,99%) (WHO, 1990). Members of scheduled tribes are often dependent on agriculture (shifting cultivation) for their subsistence. Encroachment on their land for forestry, mining, large infrastructural projects and other 'developmental' activities poses a severe threat to the survival of these groups.

Another important underpriviliged group, formally recognized as such by the Indian Constitution, comprises the 'scheduled castes'. Scheduled caste members still suffer all kinds of socioeconomic (e.g. occupational) and political discrimination and marginalization. Under presidential decree, some castes have been given the status of scheduled castes under the Indian Constitution. The main criterion is extreme social, educational and economic backwardness of a caste arising from 'untouchability' (WHO, 1990). Untouchables are generally known as *harijans* or *dalits*.

According to the 1981 census, 1.108 scheduled caste groups were discerned in India (15,75% of the total population). The highest percentage of scheduled castes to the total (state) population is found in Punjab (26,87%), followed by Himachal Pradesh (24,62%). The main occupation of members of scheduled castes is agricultural labour. Many of them are bonded labourers. Members of scheduled castes also perform a variety of heavy, low-income and low-status labour (leather, scavenging), or specific crafts and occupations depending on local/regional pratices: weaving, fishing, wood-, stone- and metalworkers. In north India and parts of west India, *Dai* (traditional birth attendants) belong to the scheduled casts (WHO, 1990).

Notwithstanding their formal recognition as marginalized groups needing special attention for their specific problems, marginalization, discrimination and exploitation of scheduled castes and tribes are widespread. State government attempts to increase socioeconomic and political opportunities for lower caste members often meet with resistance from groups with a higher caste background or, as recently happened in the case of Uttar Pradesh, from the central government. The recent outbreaks of violence in Uttar Pradesh show that the issue of lower caste access to government jobs still releases strong emotions. At the same time it becomes clear that the caste issue has become secondary to national and state level party politics.

The health status of schedules tribes and castes is very low. Many health hazards of these groups are related to their poverty and nutritional status, sanitary conditions and relative isolation. Poverty, malnutrition, a low literacy rate, absence of safe drinking water and of health services are characteristic of their situation. Prevalent diseases among many tribal groups are, among others, malaria, tuberculosis, influenza, dysentery, sexually transmittable diseases, and addictions. The generally low health status of these groups is reflected in indicators like morbidity and mortality (WHO, 1990).

2.5. NGO's in India

As a consequence of the – historically grown – relatively large degree of local autonomy from the central state, India has a long tradition of local–level non–governmental voluntary action.[13] Local groups have since long organized themselves for various socioeconomic activities on the basis of caste, religion, village and other identities. This is reflected in the existence of millions of non–governmental local initiatives for various purposes (Shah, 1991).

Shah estimates the total number of non–governmental development organizations (NGDO's) among them at about 15.000 (Shah, 1991). Until quite recently most of these NGO's, which often had (and still have) a Gandhian or Christian background, resticted their activities mainly to relief aid and charity, education and health care (hospitals). Since the seventies, the NGO–'sector' has grown considerably, and in the field of NGO's a greater differentiation has become visible (which is also the result of NGO's with a Marxist or other ideological backgrounds entering the arena). New priorities became, among others, target group organization and participative strategies, creating awareness and local self–reliance of target groups, economically feasible and needs–oriented development strategies (e.g. primary health care), scheduled tribes and castes, women, environmental degradation and sustainable development, human rights and advocacy. NGO's should be registered under the Societies Act of the state in which they operate. Once registered, NGO's can generate their own funds from local, regional or national private sources or receive government funding. In order to receive foreign donor funding, NGO's should possess a FCRA number (Foreign contributions Regulations Act of 1976).

Data about the geographical distribution and concentration of NGO's are not univocal. However, there is a strong presence of Indian NGO activity in the states of Tamil Nadu, Andhra Pradesh, Kerala. Orissa and West Bengal. Relatively few NGO's are found in Bihar, Haryana, Madhya Pradesh, Punjab, Rajasthan and Uttar Pradesh (Shah, 1991). A relatively high concentration of NGO–activity in the states of South India (which are *not* the poorest states) is mainly caused by religious–historical factors: the Christian background of many NGO's and the concentration of 63% of India's Christian population in the four southern states (Shah, 1991).[14]

Shah distinguishes three types of NGO's, on the basis of their approaches and ideological positions:

- the *'welfare'* type: mainly oriented to service delivery (women, children, the disabled, the poor; rehabilitation, income, education); absence of empowerment strategies;
- the *'development'* type: oriented towards the provision of infrastructure, basic amenities, health, education, production, income and local self–reliance; capitalist or Gandhian ideology;
- the *'empowerment'* type: attention to political context, mobilization and participation, conscientization and empowerment, structural change.

Shah concluded that most NGO's follow the welfare and development approaches, and do not relate poverty and exploitation with broader societal and political processes, even

though many of them claim to follow 'empowerment' strategies (1991; 12).[15)]

According to Shah, about 30% of Indian (developmental) NGO's receive foreign donor funding. Many of these NGO's are funded by more than one foreign donor. The total number of foreign donor organizations amounts to more than 130, contributing an estimated Rp. 7.000 million in 1990 (Shah, 1991).

In its seventh Five-Year Plan, the Indian government for the first time explicitly recognized the necessity of involving NGO's in implementing rural development and poverty alleviation programmes of the government (Cebemo, 1989). On the positive side, an increasing amount of government funds is channeled through NGO's, new forms of government-NGO cooperation can develop, and doors are opened for NGO's to influence government policy. On the negative side such recognition and cooperation may easily degenerate into cooption, and restrict the room of manoeuvre for NGO's, reduce their flexibility and capability to adapt to local circumstances, and undermine their useful position as critical observers of government policy.

While the role NGO's play in the development process in India (and in general) should not be over-estimated, contributions that NGO's can make to the development process are many and thematically important. As actors in between the (national) state and civil society they can play an important part in building a heterogeneous and democratic society. For instance, by tackling problems and issues not taken up by the state and its agencies (e.g. the environment, human rights, the position of women etc.); by taking an innovative, creative and experimental approach and being committed; by standing up for poor and marginalized groups in society (Cebemo, 1989; Shah, 1991).
but the dangers of organizational growth and professionalization associated with the increasing availability of donor funds are clearly present:

- bureaucratization and routinization;
- the prevalence of vested (institutional) interests;
- self-preservation;
- the establishment of hierarchical NGO 'kingdoms' (depending too much on one leader), and increasing competition in the NGO sector instead of cooperation and coordination;
- increasing awareness and instrumental use of donor conditions, fashions of the day and 'policy speak';
- increasing distance between NGO and target group; excessive preoccupation with (upward) accountability towards the donor, at the cost of (downward) accountability towards the 'target group';
- loss of their innovative and flexible character; loss of distinction from 'traditional' government delivery systems.

3. THE HEALTH SECTOR IN INDIA

3.1. Introduction

This chapter aims at providing a bird's eye–view of the health and health care situation in India, to help to contextualize the programme evaluation to the broader health care realities in India. By its very nature and the inevitable constraint on size, the report touches upon various topics, sectors and issues only briefly, highlighting some key indicators or available data, wherever possible and relevant. While the focus is on the Indian situation as a whole, an effort has been made to give some understanding of the regional diversities and the emerging pluralities in the health situation as well as in the responses by the central and state governments. An attempt has been made to draw information from some key resource documents, both published and unpublished, which pertain to data of the early 1990s so that the document presents a realistic view of the current situation.

In the last few years the Government of India, after many years of a protected socialist economy, has initiated steps towards a new economic policy to become integrated with an open global market economy. This has led to an intense public debate on the whole issue of privatization, structural adjustment and the inevitable effects on state investments in welfare and health. A variety of political, social, cultural and economic factors have played a very important role in the development of the country and have shaped the strategies that evolved to organize health care services to meet the health needs of the people. The same factors, especially the new economic policy will probably also be a major determinant of strategies and responses in health care that are evolving in the 1990s.

India is a country of stark contrasts. On the one hand it is a rapidly industrializing country that today can boast of a pool of locally trained scientific manpower among the top ten in the world and with a recent experience of relatively successful 'green revolution' (technological agricultural development) that made us self–sufficient in food. On the other hand these technological successes have yet to affect the life of the large majority of our rural population. This dichotomy means that we may reach the end of the decade with the rather dubious distinction of also being among the countries with the large majority of the poorest and the most illiterate citizens of the world. States like Kerala, Pondicherry, Goa and some of the districts in other states have already reached or exceeded norms laid down by the government as goals for the 'Health For All by the year 2000' strategy and they compare well with some of the developed countries in the world. In contrast the whole Gangetic belt, desert regions and northern–central region comprising Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Orissa have health statuses and indicators far below the national average and among the lowest in the world.

With one sixth of the world's population and nearly 2,4% of the world's area, the regional diversity and health status plurality of the country remain a great challenge to health care policy makers and planners. The growing number of international (bilateral and multilateral) collaborative efforts in partnership with the Indian government and the voluntary sector also need to keep this in mind, so that their initiatives will help to achieve acceptable health norms and standards by the year 2000, throughout the country.

3.2. Recent political-administrative developments relevant to the health sector

The constitution has laid down directive priciples of state policy which cover the relationship between the national government and the state governments, as well as local self-government. The constitution brings Defence, Foreign Affairs under the Central List. Health, Education and other sectors under the State List. Finally, some areas of national life under a joint or concurrent list making it a collaborative responsibility of the centre and states. In the health sector this covers areas such as drug manufacture and control, pricing, medical education, prevention of food and drug adulteration.

The political and administrative structure therefore means that, while the central government can sponsor and promote national health programmes, the organization and delivery of health care services is primarily the responsibility of each state. Thus, while there are prescribed national norms, there is also a great diversity in the actual situation in the various states, availability and quality of health care services and programmes in the country.

India has an ancient tradition of local self-government at the village level which explains to some extent how the social systems have maintained such an unbroken continuity over centuries. Legislations in the 1950s sought to strengthen these local institutions. State Acts were passed, but in practice there were hardly any decentralized finances available to them. In addition, the tradition of self-government was deeply affected by the caste divisions of society and did not cater adequately for the participation of women and many disadvantaged sections of traditional society. Local vested interest were well entrenched.

In 1993 constitutional amendments have been brought in by the government with two major new features that are hoped to make the concept of local self-government and decentralization an effective instrument of national development. Firstly, greater financial and other powers and responsibilities have been devolved to the elected village bodies at village, block and district levels. Secondly there is a 33% reservation for women and reservations for scheduled castes and tribes (disadvantaged and marginalized sections of Indian society) in proportion to their population. The eleventh schedule of the Act lays down all the areas of development that will be under the purview of local village-based elected bodies. These include public health, water and sanitation, and supervision of the functioning of the Government primary health centres.

The implications of these new developments are yet to be fully realized by the government health sector (the professionals and the bureaucracy) and even by the elected village leaders, and the detailed modalities and strategies are still being worked upon. Some states have initiated or completed the election process. Massive training and orientation programmes are under way by the government and the voluntary (NGO) sector to equip elected village (*Panchayat*) leaders to carry out their new responsibilities including those related to health care. It is expected that the re-emergence of the concept and the new commitment to *'Panchayat Raj'* will be a crucial factor in the evolution of health care strategies in the 1990s.

3.3. Health and the voluntary sector

The 1980s was marked by the emergence of alternative trainers, networkers, researchers and issue raisers in the voluntary sector. Moving away from the earlier role of alternative service providers, many NGOs began to get involved with community organization and empowerment. The 1990s is seeing a rapid professionalization of the voluntary sector and perhaps the increasing emphasis on market economy values because of the increased availability of funds. The 'alternative development dimension' is giving way to 'social entrepreneurship' that may shift emphasis (like the profit/private sector), to those who can afford rather than those who need!

After many years of relatively ignoring the voluntary sector, the 1982 National Health Policy set a new trend. Not only was the voluntary sector recognized as a partner in development, but, since the enunciation of policy, the Government has sought to direct more of its funds to support projects run by this sector. Increased availability of funds and resources and associated services while being a good indicator of the recognition of the role of the voluntary sector, has also led to increasing concerns in the sector of, firstly, cooption. Secondly, and perhaps more significantly, (in the context of the new economic policy) there is the possibility of the government offloading its welfare responsibility onto the voluntary sector. Some indications of this are directly evident.

There is a growing concern in India also about the use of the terminology 'NGO Sector'. There is a feeling, that the 'for profit' private sector and the 'not for profit voluntary sector' are two distinct sectors needing space, support and linkages, but that these should not be clubbed together through the terminology of NGOs in government policy. Some groups are convinced that this is a 'back door' measure to support privatization of welfare, education and health services, as part of structural adjustments.

3.4. The population profile

The total population of India in the 1991 census was 846,3 million, with 74,3% of this population based in rural areas and 25,7% of it in urban areas. This makes India the second largest country in the world with an average annual exponential growth rate of 2,14% in the decade 1981-91. The latest data from the sample registration scheme shows a natural increase rate of 1,90% in 1992.

The crude birth rate (CBR) was 29 and the crude death rate (CDR) was 10 in SRS 1992. The decrease in CDR over the decades has been significant (in 1951 it was 27,4). The CBR has also fallen significantly (in 1951 it was 39,9) but not fast enough to offset the CDR and hence there has been a larger overall growth. India is currently in the third stage of demographic transition.

The sex ratio has been a matter of concern. This indicator of women's health status has shown a worsening over the decades. In 1981 it was 934 while in 1991 it was 929 (females per 1.000 males). Males form 51,7% of the population and females 48% . The percentage of the population belonging to schedule castes and tribes (marginalized and underdeveloped sections of society) is around 24,6% .

The density of population (persons per km2) was 216 in 1981 and is now 267 in 1991. It varies from 200 in the rural areas to 4.092 in the urban areas. Urban migration from disadvantaged rural areas and inter-rural migration from disadvantaged to advantaged areas is high. It is estimated that at the present urban growth rates 40 percent of the population may become urban by the year 2000, putting a great stress on urban health and welfare services.

The population distribution by age is a typical population pyramid, characteristic of developing countries with nearly 40% under 14 years. The proportion of the elderly population was 6,2% in 1981 and in 1991 it was 6,6% . Although the family structure is still strong there are indications that care of the old is an emerging problem. The sociocultural tradition has stressed universality of marriage and early marriage for women, but the age at marriage has shown an increase over the years - and the increasing opportunities for education and economic opportunity have contributed to this trend.

Life expectancy has shown improvement over the decades. For males from 41,9 years in 1951-60 it has reached 58,1 in 1986-91 while for females the rise has been from 40,6 to 59,1 in the same period. Here again the trends show a regional diversity. For the period 1976-80 Kerala showed a combined average of males and females at 65,5 while Uttar Pradesh was down to 46,2 years.

The literacy rate for those over 7 years of age in the country has shown an increase from 43,7% in 1981 to 52,2 in 1991 (as a percentage of total population). Male literacy has risen from 56,6 to 64,2 but female literacy is still rather low, the change being only from 29,8 to 39,2. Rural-urban literacy differentials are quite wide. In the 1991 census for urban it was 73% , while for rural it was 44,5%. The male-female differential is even greater. In urban areas it was 81,1% for males and 63,9% for females. In rural areas it was 57,8% for males and 30,4% for females. The government has now initiated a literacy programme aiming to tackle this major obstacle as a high priority matter.

The population of India is expected to cross the one billion mark by 2.000 AD as per projections of expert committees. The implications of this trend on education, employment and health services and opportunities are major and will remain the key challenge for the decade.

3.5. Health status and health problems

A. Some general data

In the previous section the changes in CBR, CDR and life expectancy gave an initial overview of the health status of the Indian population. Now we will continue with a number of other indicators of the health status and health problems of the population.

The Infant Mortality Rates went down from 129 in 1971 to 80 in 1991. While urban IMR has decreased from 82 to 53, rural IMR has come down from 138 to 87 (which is still fairly high). However, the regional differences are very large, with states like Kerala

having a rural IMR of 32 and states like Uttar Pradesh having a rural IMR of 152.

The under-five child mortality has shown a gradual decline from 21,2 (per 1.000 children) in 1984 to 13.3 in 1988 and the goal for the year 2000 is to bring it down to 6,3. Preventable deaths are being tackled by a massive programme of universal immunization, control of diarrhoeal diseases and ARI's, and various types of nutritional supplementation. However, much remains to be done.

In 1985 (Register General Newsletter - July 1987) the ten key diseases as main causes of death were asthma and bronchitis (8,7%), TB (5,8%), pneumonia (5,7%), heart attacks (5,2%), anaemia (3.5%), cancer (3.0%), gastroenteritis (2.5%), typhoid (1.9%), malaria (1.9%) and dysentery (1.6%). This shows that along with the diseases of underdevelopment due to poor nutrition, inadequate water supply and sanitation, the diseases of development (cancer, heart disease) are also beginning to become significant, putting a double burden on the evolving health services.

In 1981-85 (Register General Newsletter in 1987) the major causes of death in rural areas were senility (22,4%), respiratory diseases (20,3%) including TB, infancy-related causes (11,2%), fevers (9,5%), diseases of circulatory system (9,3%), digestive disorders (7,5%), accidents and injuries (5,8%) and others (14%). Due to inadequacy of reporting and high level of illiteracy, data on causes of death are not very reliable but some indications are available of the types of problems from these statistics.

The maternal mortality rate is 500/100.000 births (UNICEF, 1983). This is still very high and the statistics become significant when it is understood that more maternal deaths occur in India in one week than in all of Europe in one year. The main causes in 1986 (Register General Survey, 1987) was bleeding of pregnancy and puerperium (21,6%), anaemia (17,0%), puerperium sepsis (13,1%), toxaemic (11,9%), abortion (8%), malposition of the child (6,2%) and others not classifiable (22,2%). These indicate the continuing challenge of providing trained birth attendants at the time of the delivery, nutritional supplementation and basic ante-natal care which is already the focus of a major national programme. However, the relative overemphasis on family planning aspects rather than on maternal health and child health is a cause of continuing concern.

Malnutrition continues to be an important public health problem. Data from the National Nutritional Monitoring Bureau have continued to show the extent of the problem, though there are changes in qualitative trends. Prevalence of severe malnutrition among slum dwellers and rural children is a major problem. The larger problem of mild to moderate malnutrition affecting nearly 40% of the population has also to be kept in mind. Studies by the Indian Council of Medical Research (1986) show that 7% of preschool children have severe malnutrition, 47% moderate, 47% mild and only 7% are normal. A study by National Institute of Nutrition (1980) shows that 65% of adult women, 75% of pregnant women, 77% of preschool children and nearly 45% of adult men in rural communities have iron deficiency anaemia, one of the most extensive nutritional deficiency disorders in the country.

Vitamin A deficiency is very high among preschoolers especially in rural areas and slum dwellers and over 54.3 million people are estimated to be affected by iodine deficiency

disorders including goitre in more recent surveys. While food production has gone up and we are now self-sufficient maldistribution continues to be a major problem. Micro studies have shown that diets of female children and women are still inadequate because of discrimination in Indian household food allocation. Nutritional problems thus remain a major health challenge linked closely to factors in the socio-economic and cultural milieu of the country.

B. Communicable diseases

Various communicable diseases continue to contribute to the mortality and morbidity of the population in India. These include the following:

- *Malaria* has shown a drastic decline since the 1970s as a result of a national control programme. In 1971, there were 1.322.000 cases of malaria which rose to 6.467.000 in 1975-'76 and has presently declined to 1.744.000 cases in 1985, causing much continuing concern. There are around 2 million cases per year since 1985.
- *Tuberculosis* continues to be a major problem. It is estimated that 1.5 % of the population is infected (12.7 millions infected and diseased). In 1992-'93 1.539 million cases were detected.
- *Leprosy*: it is estimated that there are 1-3 million cases of Leprosy with a prevalence rate of over 5/1.000 in around 201 districts. The states which have the largest reported numbers are Tamil Nadu, Andhra Pradesh, West Bengal, Uttar Pradesh, and Maharashtra.
- *Filaria* occurs in 175 known epidemic districts and estimates vary.
- *STD's* affect 20-30 million people according to expert estimates.
- *Kala Azar* (Visceral Leishmaniasis) has shown a resurgence in some endemic districts of Bihar and West Bengal. 77.101 cases and 1.419 deaths were reported in 1992.
- *Cholera* is also showing a resurgence especially in some endemic urban pockets, while diarrhoea and dysenteric diseases continue to take a heavy toll, especially in children.
- *HIV-Infection* has now been reported from as many as 23 states and union territories in the country with the highest incidence from Maharashtra, Tamil Nadu and Manipur. In the former two states the pattern of infection is through sexual transmission while in the northeastern states it is probably linked to drug abuse. Of 1.898.670 persons screened for HIV by september 1993, 13.294 were found to be seropositive. According to expert estimates the number of infected persons by end of 1990-92 was about 1 million.

C. Non-communicable diseases

Cancer, heart disease, mental health and occupational health problems are increasingly recognized as important public health problems. Blindness is a major disability with estimates of around two million cases of cataract induced blindness annually though preventable causes like vitamin A deficiency and injuries continue to be significant as

well. Accidents and injuries, particularly occupational, are another major cause of morbidity in the working age-groups. While the earlier decades saw a major emphasis on national communicable disease control programmes, the last two decades have seen the evolution of many national programmes for these non-communicable diseases as well.

D. Other major problems

According to the 1981 census there were 11,2 lakh cases of disabled and handicapped persons in 1980 (about 171 per 1.000 population). 87% are in rural areas. Of these 171 per lakh of population, 73 were blind, 42 dumb and 56 physically handicapped. Other estimates here suggested that 18% of the population are disabled.

Another major problem is access to safe water and sanitation. The 1981 census showed the following state of water supply and sanitation in the country:

Population	Rural	Urban	Combined
With water supply (%)	30.9	77.8	41.3
With sanitary facilities (%)	0.5	26.9	6.4

While the rural areas are still very bad off, the urban areas do not reflect properly the inadequacy of water supplies and sanitation facilities for the urban poor who live in slums and shanty towns. Due to their low paying capacity and to the problems regarding legality of settlement patterns a large percentage are deprived of basic amenities.

In 1980 a government survey identified 2.31 Lakh problem villages. The problems were of three types:

1. villages which do not have a source within a distance of 1,6 km. (criterium 1);
2. villages where existing water sources contain excess salinity from fluorides, and other toxic elements (criterium 2);
3. villages where existing water sources were prone to cause diseases like cholera and guinea worm (criterium 3).

In response to this high-priority problem the government declared the decade 1981-'91 as the water and sanitation decade. A National water supply mission was then established to provide safe drinking water supply to rural areas. By 1992-'93, out of a total of 583.000 villages in the country 582.250 were provided with drinking water facilities fully or partially. During 1992-'93, 2.218 no source villages were provided with safe drinking water and 32.157 partially covered villages were also given additional sources.

The Eighth Five Year Plan (1992-'97) aims at covering the no-source villages, providing sustainable supply of safe water to the no-source habitations, completing eradication of water borne diseases, enhancing quantum of supply and quickly, securing scientific inputs into rural water supply programmes and improving the operation and maintenance of water supply sources. The master plan also aims to get urban water supply to 100% and urban

sanitation to 80% soon.

In summary: while statistics on morbidity patterns are increasingly available and improving in quality and validity, what is emerging is that the health status in India shows all the major problems related to poor nutrition, poverty and poor environment continuing as major public health challenges. These are however co-existing with most of the non-communicable- diseases of the developed world increasing the overall burden on the health services.

3.6. Primary health care services and national programmes

A. Primary health care services

Based on two expert reports (The Bhore committee report, 1946 and the Sokhey Committee Report; both pre-independence), the Government of Independent India launched a massive programme for the establishment of Primary Health Centres (PHC's) from 1952, covering initially 100.000 population with sub-centres at 10.000 population level.

The primary health centres were envisaged to have doctors, nurses, lady health visitors, auxiliary nurse midwives, sanitary inspectors, block extension educators and basic health workers. This pattern was adopted all over the country and adapted by each state in terms of levels of coverage by PHC's and subcentres, according to local needs and resource availability.

Initially, the health workers, especially the male workers were unipurpose focusing on special problems like malaria, filaria, trachoma etc. In the early '70s, the whole PHC concept was reviewed and all unipurpose workers were retrained as multipurpose workers and the whole distribution and function and supervision was rationalized.

Now primary health centres range between coverage of 50.000 and 80.000 population and subcentres from 5.000 to 10.000. At least three doctors are posted to the centres - one senior medical officer, one lady medical officer especially in charge of mother and child health and family planning, and one other medical officer who may be involved with training of health workers or may be of an alternative system of medicine. The subcentres have at least one male and one female multipurpose worker and groups of subcentres are supervised by male and female health supervisors. This is the basic pattern but there are variations and diversities in the different states.

In 1977, the government launched the community health guide scheme which was aimed at identifying and training at least one community-based volunteer for every 1.000 population in basic health care needs. This scheme was taken up by some states only. Training of traditional birth attendants was also adopted as a programme in the 1960s, but it got greater emphasis in the later decades. In recent years the CHG scheme has been somewhat neglected.

In the early 80s, the government has initiated a plan to upgrade every 4th PHC to a 30-bed hospital with some specialists in the basic disciplines of medicine, surgery, obs. and gyn. and paediatrics, but this scheme is progressing very slowly.

B. National programmes

Over the years the government of India at the centre has launched a number of national programmes to deal with specific diseases and health problems. While these are vertical at the centre and state ministry level they integrate into the primary health centre system as multiple functions of the centres and staff at each level.

The programme planning, organization and implementation and evaluation is carried out by experts both at the central and state directorate levels and the specialized National Training and Research institutions. The special national programmes sponsored by the Central Health Ministry include among others programmes for eradication of malaria and leprosy, control of tuberculosis, filaria, kala-azar, STD, AIDS, control of blindness, goitre, cancer, guineaworms and mental health programmes. In addition, family welfare, universal programme of immunization against six vaccine-preventable diseases, vit. A and iron and folic acid supplementation programme, ORT and diarrhoea control, ARI control and training of TBA's programme have been more recently grouped under the CSSM group - child survival and safe motherhood programmes.

There are growing concerns in India that some programmes like the expanded programme of immunization (supported by UNICEF) and family planning programme (supported by USAID and other agencies) are promoted with a zeal, overriding focus and target-oriented, top down and vertical process that affects the other programmes and diverts the attention of the health team. Apart from raising concern about the abilities of international bilateral and multilateral funding agencies to skew priorities by funding decisions and selectivizing primary health care, this trend also causes various management problems affecting other programmes and priorities. The World Bank supported AIDS Programme is a new one and is beginning to show the same trend and potentiality.

3.7. Population, development and family welfare

A. Population and development programmes

The development process in India has tried to gradually reduce the proportion of people living below the poverty line, with different degrees of success and failures in various regions (poverty line: annual income of Rs 11.000 or less). Since over 40% of the world's absolute poor live in India, special efforts have been initiated to provide a social safety net. These include:

1. A public distribution system (PDS) providing subsidized food for the poor;
2. The Integrated Child Development Services (ICDS), which provide basic health, nutrition and education packages to mothers and children, (it now reaches 15

million children and 3 million mothers);

3. The Integrated Rural Development Programmes (IRDP) providing subsidies and loans to low-income rural households to get productive assets;
4. The Jawahor Rozgar Yojana (JRY) a wage employment programme for disadvantaged groups;

50% of IRDP programmes are expected to be weaker sections of society (scheduled castes and tribes) and 40% is earmarked for women. Two additional sub-schemes complement the effort. Training of rural youth for self-employment (TRYSEM) and development of women and children in rural areas (DWCRA). TRYSEM trains 2-3 lakh youth each year and DWCRA has formed 57.000 groups (987.000 members) of women for income generating activities.

These programmes are supplemented by additional schemes focused on the more difficult districts. The Employment Assurance Scheme (EAS) seeks to provide assured wage employment for 100 days a year during the agricultural season; the National Water Supply Mission to provide water supply to 'no source' villages, eradicate water-borne disease and enhance quality and quantity of supply; The National Education policy which includes among other steps priority for rural schools and motivation centres programmes for promoting self-confidence and self sufficiency among women.

The progress of these programmes has shown varied successes as well as the identification of operational problems. Poverty has however diminished, in spite of population growth. Incidence of rural poverty fell from 51,2% (1977-'78) to 33% (1987-'88) and urban poverty from 41% (1977-'78) to 20% (1987-'88).

National level statistics about poverty and the economic situation, the levels of agricultural development and the levels of infrastructural development hide the glaring disparities and regional diversities that occur in the country. Land use patterns are diverse reflecting a diversity of agricultural incomes. This is further complicated by differences in rainfall patterns and drought and desert proneness of regions.

State governments have invested in infrastructure development to varying extents. Complicating the 'poverty problem' are other social issues of marginalization, like variations in percentage of scheduled castes and tribes, levels of urbanization and levels of labour bondage. Poverty alleviation programmes therefore cannot be just economic and technological packages, but need to be deeply rooted in the local sociocultural and development diversities.

These gains in development are bound to have their effect on population growth and health status which will become more evident in the years to come. However, close monitoring and supportive supervision and continuous orientation of government functionaries will be required to ensure that the gains are not in paper but in actual 'on the ground realities'.

B. Family planning (welfare) programme

Family Planning and population issues have been a high priority concern of planners in India since independence. In 1951, India launched the first official Family Planning Programme in the world. The objective was to 'reduce the birth rate and to stabilize the population at a level consistent with the requirement of the national economy'. The programme evolved in phases starting with the clinical approach, then the extension education approach and the 'cafeteria' or 'choice of alternatives' approach. A national policy statement in 1976 affirmed the priority and commitment of the Government to this important issue. The National Health Policy (1981–'83) set the demographic goal to achieve a net reproduction rate of UNITY (NRR–1) by the year 2000 AD. This means a crude birth rate of 21 per 1.000, a crude death rate of 9 per 1000 and a natural increase rate of 1,2% . The policy also aims at reducing IMR to below 60 per 1.000 live births. More recently this date has been shifted to the year 2011. Recently the National Development council, an apex planning body chaired by the Prime Minister, has set up an expert committee to formulate a national policy reviewing the past, assessing the present and planning effectively for the future.

Family Welfare Programme aims to provide family planning services within the broader context of MHC care. It disseminates information and organizes services to enable couples to make voluntary and informed choices regarding size of family, spacing and contraception. Links are establishes with other development programmes in the areas of education, nutrition, poverty alleviation and minimum needs. The programme includes primarily the provision of MHC and FP services through the large network of PHCs and subcentres, supplemented by training of personnel and infrastructural development. The methods promoted are sterilization, condoms, IUDS and oral pills. Recently injectables and inplants have also been introduced. The supplement gives as idea of the couple protection rates and level of acceptance of methods.

As part of an overall strategy to reduce IMR and MMR and complement the programme, the Universal Immunization Programme for six vaccine preventable diseases in children and tetanus toxoid for pregnant women has been introduced. A new child survival and safe motherhood project (CSSM) is under implementation since 1992–'93. Apart from sustaining high coverage of UIP it also provides ORT, prophylaxis schemes for control of anaemia in children and pregnant women, control of blindness in children by vitamin A, supplementation and control of ARI in children.

Training of traditional birth attendants and provision of aseptic delivery sets, and strengthening of first referral units to deal with high–risk pregnancies and obstetrical emergencies are also components. Medical termination of pregnancies on health grounds is now legally permissible and provided for as a safeguard against clandestine abortion under unhygienic conditions. The whole programme is also linked to a massive information, education and communication strategy that includes both modern media and traditional media.

3.8. Supportive services and structures, and additional sectors

A. Human power planning and health team training

A large country like India needs a massive human power training programme, and since independence a very large number of medical colleges, nursing colleges, dental and pharmacy colleges and rural health and family planning training centres have been established (to train health workers). The country has around 140 medical colleges, about 10 percent of the 1.400 medical colleges in the world. It produces annually over 14.000 doctors and the present doctor population ratio is 1:2412 (1986).

Though there is a large rural–urban differential with the large majority of doctors preferring urban practice of all types, there is growing concern that we are producing more than we can absorb and much of this is at the cost of investment in training of other members of the health team. There has been a large gap in the investments in nursing colleges (nursing education), and both staff nurses and nurse midwives are inadequate in numbers. Some efforts are underway to remedy the situation in the next plan period.

Continuing education of the health team is another major lacuna, and the present efforts are inadequate. The government has evolved good training manuals for all categories of the health team which reflect primary health care priorities. However, the quality of training is very variable at the state levels, and at all levels of training this quality differential exists.

National councils regulating standards exists. These include the Medical Council, the Nursing Council, the Dental Council, and the Pharmacy Council.

B. General Practice

India has a very large number of doctors trained in different systems of medicine, providing service to the community as primary level general practitioners. In 1984 there were about 702.000 registered medical practitioners, of which 42,3 percent were allopaths, 40,3 percent were trained in Indian systems of medicine and 17,4 percent were homeopaths.

All these practitioners do not come under any organized National Health Service, and private practice is totally unregulated. There are professional associations, with the allopaths being more organized than the other systems but these tend to be more 'pressure groups' rather than self regulatory associations or forums for continuing education and maintenance of standards of care.

The health policy makers gave inadequate attention to this sector till the 1982 health policy, though even now their involvement in primary health care priorities and national programmes is still relatively marginal. They are mainly involved, if at all, in immunization and family planning work. Unregulated practice also makes this sector open to irrational practices in prescribing and investigation. The ICSSR/ICMR expert study

group on Health for All – an Alternative Strategy – has noted that 'Eternal vigilance is required to ensure that the doctor–drug producer axis does not exploit the people' and the abundance of drugs does not become a vested interest in ill health'.

C. Secondary Care Services

The large number of primary health centres are linked to secondary level hospitals at district levels and in all major towns and cities for medical care referrals and to district level referral centres and resource teams/units coordinated by the district medical officer. Plans to upgrade every 4th PHC to a small 30–bed hospital (community health centres) with four doctors – a surgeon, obstetrician, physicians and pediatricians – have been initiated but they are progressing very slowly because of the reluctance of clinicians to work at the primary level.

At the secondary level there is also a large network of private hospitals and an increasing number of nursing homes and polyclinics, though they too show an urban bias and do not go beyond the district headquarters. The mission hospital sector was initially a response to the lack of health and medical care in the more disadvantaged areas of the country but this is fast changing with the mission network in a financial crisis and unable to handle the evolving pressures of the medical market economy.

D. Tertiary Care

The government has also invested gradually in a large number of specialized centres offering specialist services and tertiary care referral support to the health centres and hospitals. These are all city–based, mostly in state capitals and – as in many parts of the world – tend to draw much more of the support required from an overall limited health budget.

While many of these are of good quality and provide very good facilities for postgraduate training many if not most of them tend to 'transplant ideas' from Western hospitals and are not adequately focused on priority health problems or on the evolution of appropriate technological responses that would cater better to the socioeconomic, cultural, geographical and logistical challenges of primary health care in the country.

E. The private sector

Apart from the army of general practitioners most of them outside the government health systems mentioned earlier, the country has a very large number of private hospitals, dispensaries, nursing homes and polyclinics (already mentioned in secondary care). In recent years there has been a mushrooming of high–tech diagnostic centres and super specialist hospitals supported by the corporate sector and massive NRI (Non–resident Indian) initiatives. Medical business is booming, and while the country can now boast of having every type of high technology and super specialist care, this is not accessible to the large majority, and the costs are increasing.

The private sector is estimated to include over 55,5 percent of the hospitals and 55,3 percent of the dispensaries in the country as of January 1990.

Considering that private sector health is totally unregulated and has till very recently been totally ignored by national health planners, there is a growing concern that this unregulated sector will grow even more significantly because of the new economic policy and its commitment to market economy and privatization. The concern is not so much against the private sector per se, but about what importance it will give in the future to preventive medicine, public health priorities and primary health care, which it has totally ignored so far.

F. Research institutes

The country has established a network of national research and training centres linked to the Indian Council of Medical Research (ICMR). These include the National Institute of Health and Family Welfare, Nutrition, Tuberculosis, Communicable disease, Environmental Health, Occupational Health, Reproductive Health, Vector Control, Mental Health and Neurological sciences, Leprosy, Immunobiological research, Speech and Hearing and Cancer. The ICMR also supports research in many other institutions, primarily medical colleges. The quality of research in many of these institutions is of a high standard and good contributions, especially applied aspects in the field have been made, including field guidelines for various national programme and orientation training for health teams at different levels.

Health practices research, epidemiological research and health policy research however have not received the important emphasis they should have been given, considering the health care challenges and problems in a country with phenomenal regional diversities and disparities.

G. University linkages in Health team training

Education is a state level responsibility and the central government can only lay down standards and norms for training institutions and curricula. All medical, nursing, pharmacy and dental colleges are affiliated to various universities in each state. Recognition by the National level councils however ensure that qualifications are recognized in all parts of the country. Paramedical training may or may not be affiliated to universities. There are plans to evolve a National education council that will plan for human power needs and set guidelines for training in the future.

H. National Health Service

While the Health Ministry at Central and state level through the health directorates organizes and maintains the network of subcentres, primary health centres, dispensaries and hospitals there is no National health service in the European (UK) sense covering all the population and bringing all services under a single planning and regulating authority.

Like the general economy in India, Health care is a mix between the government and the private sector, and a small voluntary sector as well (NGOs).

All Central government employees all over the country are covered by the CGH Scheme (Contributory Government Health Scheme) provided by a network of dispensaries and hospitals, and affiliated institutions and recognised practitioners. Similarly all factory workers, especially in the public sector and in the medium to larger private sector are covered by the Employment State Insurance Scheme (ESI Scheme). Both these schemes are like the UK–NHS but cover only smaller sections of the population. The agricultural sector and most of the other unorganized sectors like constructions workers and small scale establishments are not covered by any specific schemes. They have to utilise the services of the general government hospitals and dispensaries.

I. Occupational health

The ESI scheme, though occupational in focus, does not provide adequate occupational hazard–related services though some prevention and protection measures are provided. The National Safety Council and Central and regional labour institutes and the labour inspectorate do recommend and supervise some occupational health measures but much more needs to be done.

An important area of priority concern is the continuing situation of child labour. In the 1981 census there were over 11,2 million children who were involved in employment. While the large majority were in the agricultural sector there were other areas of special focus like the match/firework industry in Sivakasi (Tamil Nadu), the carpet weaving and brass industry in Uttar Pradesh and others which have a larger child labour and are dependent on it. The recently enunciated national policy for children has now identified it as an important goal that 'no child under 14 years shall be permitted to be engaged in any hazardous occupational or be made to undertake heavy work'.

J. School health

The Primary Health Centres and the government dispensary medical offices are supposed to provide a school health service for the government schools in their area. This usually means an annual check–up and some immunizations. In the voluntary sector there has been some interesting attempts to enhance the educational aspects of school health programme and bring in child to child concepts and some state governments have shown an increasing interest in these as well. In Andhra Pradesh there is a better organized School Health programme supported by ODA (UK).

3.9. Health finance

This is an area that is beginning to receive much more attention in recent years and policy planners and researchers are beginning to focus more specifically on financial systems, costing of health care, cost recovery, low cost alternatives and studies of patterns of

expenditure on health care at individual family and community levels. Only some salient points will be outlined in this review:

1. Allotment for health care including medical care, family welfare, public health programmes, water and sanitation etc have gone up progressively in each plan period with the present expenditure being over 8.200 crores in 1991–92 (Per person Rs. 95,81).
2. The estimates for private expenditure on health, based on various indirect estimates for the same year 1991–'92 was 9.022 crores (per person Rs. 105,40).
3. The 7th plan outlay for health, family welfare and water supply and sanitation is about ten times the 4th plan outlay showing increasing investment by the government (to approximately 3+ percent of total plan outlay). However, it is still not as high a percentage of total development expenditure as is seen in some of the other Asian countries who have shown a major priority expenditure on health and education service.
4. The per capita state incomes are quite variable but some states like Tamil Nadu, Kerala, Karnataka, show greater per capita state expenditure on health, with better dividends in health status indicators.
5. Levels and patterns of household expenditure on health care are being studied, and in recent studies the major role that the private sector plays as a health provider is being documented. While government health care is estimated to cover 13–15 percent, people are using the varied alternatives in the private sector to about 77 percent. The study also showed that 5,75 percent of the total annual household income was spent on health–related expenditure or an estimated Rs 183 per person per year; and much of this on consultation fees and drugs (66 percent).
6. While the voluntary sector serves or covers only 5 percent of the population, some recent studies done by VHAI/Ford Foundation have shown that they tend to provide low–cost services as compared to the public and private sector. Studies have also shown that this sector taps a number of different sources of revenue to fund health activity – government grants, foreign donations and community and self–financing funds and usually also tap more than one source. This was the only sector that has also some experience in innovative financing methods that include fee for services, prepayment schemes, health cooperatives and running commercial activities to support health care. Realizing that self–financing initiatives can often exclude the poor and marginalized, many voluntary organizations have been experimenting with innovative ways to protect or subsidize poor patients. Further studies of these innovative experiments need to be done. Financial recovery schemes, supported by greater initial investments and built in social safety nets for the poor need to be further researched in the years ahead.
7. While financing health care is receiving greater attention the new economic policy with its focus on privatization and liberalization may convert health care into medical business at the cost of primary health care and public health services to the detriment of the needs the large majority who are marginalized in the country. This will remain a major challenge to health planners in the 1990's (see later section).

3.10. Traditional systems of health care/ISM

India has a number of systems of medicine and folk health practices that have developed over the centuries, as people tried to alleviate the sicknesses that they fell prey to. The foremost among the classical Indian Systems is "Ayurveda" – The Science of Life. This is a well-developed body of knowledge which has many specialities including an extensive pharmacoepoea, surgery, care of children, women etc. It requires a formal course of study for which there are several existing colleges even today. The principles and practice of health lifestyles was also considered very important and responded to the prevailing circumstances. Elaborate details regarding types of diet during different seasons and in different physiological conditions, during pregnancy etc., have been prescribed.

"Yoga" which harmonises physical, mental and spiritual health and is used to promote and maintain good health, is also an ancient science. It is getting better known both in the country and elsewhere. The other classical systems are "Siddha" medicine practised particularly in the South Indian State of Tamilnadu, and "Unani". Unani developed from the Arabic System of Medicine which was introduced by the Moghuls but which interacted closely with Ayurveda.

Homeopathy is fairly widely practised in India today and acupuncture, accupressure etc. are also gaining wider popularity. Several other forms of healing are being used particularly by the richer urban groups eg., magnetotherapy, naturopathy, holistic health etc.

Having links with Ayurveda, but responding to local situations and disease patterns are what are known as Lok Swasthya Paramparas' or folk health practices. These are extremely widespread and used commonly even today. Their practitioners would include the more informal healers like bone-setters, traditional birth attendants, specialists in snake and insect bites, herbalists etc. They acquire skills through oral handing down of traditions and through experience. These are really our front line primary care workers. Of course, even earlier come the grandmothers' remedies or home-remedies used widely by people for minor ailments. There is fairly widespread knowledge regarding these remedies, being spread between persons and generations by word of mouth.

Increasing recognition is more recently being given to the contribution of this entire traditional indigenous health care sector. During the later period of colonialism, this group was looked down upon and their practitioners were considered as quacks and even banned. After Independence also they were not taken seriously and Indian Systems of Medicine (ISM) were allotted only 5% of the total health budget. However, studies have shown that 80-85% of the population actually use the services of this sector. They are more accessible to people, available where people live, cheaper and culturally acceptable. Indian Systems of Medicine and Homeopathy will have to be taken more seriously in this decade, because the quantity and quality of the infrastructure and human resources available is now better known and the ground realities can no longer be ignored by the health planners.

At the grass root levels, there are an estimated 7 lakh midwives, 60.000 village home setters and 60.000 herbal medical healers apart from millions of housewives with knowledge of home remedies and therapeutic diets. Non-governmental ISM centres and

clinics are present all over the country but no clear estimates at all–India level are available on their extent, types and structure. But there is evidence that states such as Tamil Nadu Kerala and Gujarat have a fairly good tradition.

Official institutions for ISM set up by Government/Private (1987) include 225 colleges of which 95 are Ayurvedic; 17– Unani; 1–Siddha and 112–Homeopathic colleges. There are 25 postgraduate institutes as well of these Ayurveda has 22, Unani have two and Siddha system has 1. The government has also set up Central Research Councils for all the systems; thirteen state run pharmacies; and a network of small rural dispensaries are present in some states.

The network of practitioners of ISM is a very large one. The Ministry of Health and Family Welfare has estimated in 1987 that there were 404.856 registered practitioners of which Ayurveda doctors were 243.153; Unani 28.021; Siddha had 11.500; Homeopathy has 122.173. Professional associations of ISM practitioners also exist.

It has also been estimated that there are 1.776 hospitals of ISM with 21.116 beds (in 1987), and about 14.434 dispensaries.

More recently a national network of medical professionals and others who believe in the integration of ISM with the National Health Care System has evolved entitled LSPSS (Lok Swrasthya Parampara Samvardhan Samiti).

State government allotments for ISM show the same regional disparities as in many other aspects of Indian health care. Kerala allocates 13 percent of the medical budget while West Bengal allocates less than one percent. The States most responsive to ISM's are Punjab, Gujarat and Maharashtra.

3.11. Voluntarism and health care alternatives

Since several decades there has been the phenomenon of non–governmental organizations (NGOs) or voluntary groups working in the field of health care. The traditional sector already mentioned has been the mainstay of health care in the villages. They are part voluntary, being extremely low–cost, often taking payment in kind whenever it is available. This tradition continues and functions in a decentralized fashion, being part of rural life. The system is breaking down or is non–existent today in urban areas including urban slums. The urban population is estimated to increase to 40% by the turn of the century. This is therefore an important lacuna which has no ready replacement.

More institutionalized forms of voluntarism or voluntary work have also developed. These are often linked to religious groupings, e.g. Buddhist, Jain, Muslim, Sikh, Hindu and Christian. Gandhian groups and several charitable trusts and societies also are involved in a range of health work. To give an indication of the quantum, 20% of the total hospital bedstrength of the country is run by the voluntary sector. This sector essentially runs on a not–for–profit basis and provides fairly good quality service that is available to the poor. If one considers out–patient medical services, community health and development work, health education and awareness raising, the contribution of the voluntary sector is even

greater. There are estimated to be about 7.000 voluntary agencies/groups in the country working in the field of health.

Interestingly, the government looks rather favourably to the work of the voluntary sector. During the past decade it is providing increasing scope for participation of the voluntary sector in various capacities. It even channels funds to the voluntary sector.
Among the strengths of the voluntary groups are that they are flexible, innovative, committed and they identify fairly strongly with the poor. They are involved with a very wide range of involvements. These include:

1. Provision of curative and preventive health care accessible to the poor especially in remote areas/difficult terrains. In this area there has been very successful experimentation with the training of community health workers, who can provide treatment for minor ailments. They also undertake health education, follow-up patients with TB and leprosy, make use of facilities provided by the government and organize peoples' groups. Training by dais (traditional birth attendants) to improve the quality of their servies and to link up with referral services of the government and voluntary sector has also been done. The government has taken up the above concepts and introduced them on a nation-wide level even before the famous Alma Ata conference.
2. Evolving innovative health financing schemes eg., health insurance, linking to cooperatives etc.
3. Building on local health knowledge and skills - using herbal remedies, studying folk health practices and strengthening those found to be beneficial.
4. Promoting low-cost, appropriate health technologies, e.g. the use of home made oral rehydration solution, use of nutritious supplements using locally available foods, use of nutrition bangles for assessment of malnutrition.
5. Focus on mother and child health and of late on women's health. Child to Child health programmes are also being tried out.
6. Use of folk media/low-cost media for communication of health messages, e.g. dance dramas, puppetry, harikathas, songs, nachnas, street plays etc.
7. Some groups work in specific areas like leprosy control, TB control, provision of sanitation/water supply. The current trend however is to integrate activities.
8. Working with the disabled, working in the area of mental health, working with street children, focusing on alcoholism, drug addition, AIDS etc., are all areas in which NGOs make a small but significant pioneering contribution.
9. Many groups working at the grass roots realise that health work cannot be done in isolation from other aspects of life. Also that medical work alone brings about only a minimal improvement in the lives and health of people. Therefore, several programmes which have a health component have also introduced other aspects e.g. promotion of kitchen gardens with plants whose products have good nutritional value, promotion of smokeless chullas (cooking places) which prevent a number of respiratory problems, gobar gas plants in which cowdung and organic refuse is used to generate energy in the form of gas which is used for cooking/lighting etc.
10. Others are involved with a variety of educational programmes like non-formal and adult education, vocational training etc. Still others have agricultural programmes or other income generation schemes, small saving schemes etc.
11. Yet other groups focus primarily on community organization - formation of mahila

mandals or women groups, youth groups, farmers groups, fishermen's groups etc. From this has evolved an understanding and respect for the peoples' own knowledge systems and the evolution of participatory training programmes, where there is mutual learning and growth. Building further on this are participatory methods of evaluation and research.

12. Issue raising groups among the voluntary sector raise critical issues regarding the national health policy. They attempt to bring into focus the need for a rational drug policy, women's health issues, needs of tribal groups, urban slum populations etc.

13. Thus in more recent years the voluntary sector has began to search for and experiment with alternative approaches to health care. These attempt to evolve initiatives relevant to our own sociocultural, political and ecological milieu.

3.12. National level voluntary organizations

At the national level there are many coordinating, networking associations providing linkages between voluntary efforts. The key ones include:

1. The Christian Medical Association of India (CMAI) was formed in 1921 and links the personnel in institutions related to the Protestant and Orthodox Churches in fellowship and professional growth. This is provided through workshops, meetings, consultancies and publications. It promotes all the components of Primary Health Care. It is involved with emerging health problems of AIDS, substance abuse etc.

2. The Catholic Hospital Association of India (CHAI) formed in 1943, today has 2304 institutional members spread across the country. These are primarily health centres, dispensaries, hospitals, social welfare centres with health programmes or and social services societies. CHAI provides continuing education to members through workshops, seminars, annual conventions and a publication section. It promotes community health in its broadest sense. In recent years the focus has been on use of herbal and non-drug therapies and health work among the urban poor. It provides assistance (with partner agencies) for supply of medicines, equipment etc. to all voluntary organizations.

3. The Voluntary Health Associations of India (VHAI) was formed in 1974. It grew from the efforts of the above two associations. It is a federation of 18 state level voluntary health associations. It is secular in character. Approximately 3.000 voluntary health institutions/groups are members of the state level associations. It focuses on community health and on interaction with government. During the past decade it has been lobbying and doing advocacy work on various public policy issues like need for a rational drug policy, against pesticides and tobacco, against commercialized high-cost baby foods etc. It has also initiated lobbying with parliamentarians and political parties regarding health issues. It organizes training programmes in community - and school health and focuses on use of traditional medicine. It has a creative publication division producing materials in different Indian languages.

4. The Medico Friend Circle (MFC) is a national group of individuals who share a common concern and interest in reshaping the health system in India to meet the needs of the majority who are the poor of the country. The groups is primarily a thought-current. Individual members give shape to and internalize the perspectives

in their own work and in other groupings to which they belong. A few of the common actions undertaken by the group included community based research in the aftermath of the Bhopal disaster and lobbying for a rational drug policy.

5. There are many other associations at the national level which focus on specific health problems eg, family planning Association of India (FPAI), National Tuberculosis Association etc.

3.13. International funding agencies

India receives external assistance both from multilateral and bilateral agencies for strengthening the Family Welfare programme primarily and many aspects of other national health programmes complementarily. UNFPA assistance is utilized for three area project in the states of Rajasthan, Himachal Pradesh and Maharashtra. WHO assistance is utilized for purchase of supplies and equipment, and training of manpower and related consultancies. UNICEF assists the Child Survival and Safe Motherhood Programme (CSSM). World Bank assists India population projects in 11 states and 2 cities (Service delivery enhancement, infrastructure development, training) and CSSM. NORAD supports post partum programmes at subdistrict level (1012 centres) and innovative intervention programmes in Orissa and Karnataka. DANIDA supports Integrated Development projects in districts of Madhya Pradesh and 2 districts of Tamil Nadu. ODA (UK) supports area development projects in 5 backward districts of Orissa. World Bank supports development of services in the urban slums of Delhi, Calcutta, Bangalore and Hyderabad, in entire Assam and 10 lagging districts of Karnataka and 10 desert districts of Rajasthan, and a special social safety net scheme in 90 demographically poor performing districts (involves upgradation of MHC/FW services) are also in various stages of evolution.

In the health programme sector, World Bank supports MDI for Leprosy Control Programmes, supports national blindness control programmes; the development of secondary level hospitals in Andhra Pradesh; and more recently a massive project for prevention and control of HIV infection. Other agencies like DANIDA support leprosy eradication and blindness control; SIDA supports leprosy eradication and TB control and NORAD supports MDT activities in leprosy control. ODA (UK) supports six research projects in area like cervical cancer, haemoglobinopathy control, Rotavirus infection, chlamydial lab project, viral hepatitis and study of gene products of mycobacterium leprae. It also supports the Andhra Pradesh government school health programme.

The multilateral and bilateral agencies support to health and family welfare programmes is appreciated as a partnership in the country's efforts to tackle challenging health and population problems. However, there are growing concerns that these agencies thrust agendas, experience, models and market economy solutions that are not always in touch with local realities or suited to the local milieu. In some cases they are also based on rather inadequate epidemiological evidence and extrapolations from experience in other parts of the world not necessarily relevant to the Indian situation. Foreign experts and academics often use these funding opportunities to try out ideas and methods not rooted in Indian analysis and field experience. Funding 'muscle' also ensures that local expertise is not adequately tapped. The problems of partnership need constant review and dialogue. The challenge of the 1990s is to find 'spaces' and 'fora' for this sort of partnership evaluation.

India has a very large network of voluntary agencies (NGOs) which are also supported by both local funds and charities and foreign funding agencies. Among these there are a large number of groups, big and small, from all parts of the world. The most well known are Oxfam, Action Aid, Care. In the Mission sector MISEREOR, Cebemo, EZE, Bread for the world, MEMISA, HIVOS and numerous European agencies are important partners. More recently support from North American sources has increased. The support process in this sector has shown a gradual shift from infrastructural development to programme support aid, human resource development (training) and more recently to community organization and empowerment activities. Some support to networking, continuing education, alternative research and issue raising/lobbying activities have also been available.

The project orientation of most of these funding partners (rather than social process orientation), the scaling-up pressures on NGOs (to reduce administrative costs of funding agencies) and the professionalization and perhaps market economy related competition and other factors are bringing about changes in the ideology and orientation of NGOs in the country. These are therefore now, not necessarily always focused on a more poor or pro-marginalized group related problems. Funding agencies need to constantly monitor and review their support to ensure that they fund processes and initiatives rooted in a deeper sociocultural, political, economic and ecological assessment of the country's or region's needs and potentialities.

Focusing on quality rather than quantity; regional long-term initiatives rather than multiple micro-short term projects inputs all over India and supporting continuing education and measures toward sustainability will be the challenges in the 1990s. All regional and local and national partnerships in health care and community health action will have to emphasize and facilitate this aspect further without getting pre-occupied or side tracked by the market economy factors of competition, institutional development or sectoral politics.

3.14. Issues and challenges in health policy development

A. Recent developments in health policy

At the Silver Jubilee of India's independence in 1972, the government initiated a process of review and retrospection of the first 25 years of development planning, since 1947. Various aspects of the health care system were reviewed, particularly the policies on human power development. The Srivastava Report (1974) an expert committee on Medical Education and Support Manpower while making some far-reaching recommendations on reorientation of medical education, training of village based health workers (Community Health Guides) and the building up of referral services complex between peripheral and district level hospitals, also raised some serious misgiving about the model of health care that had been adopted from the West. It noted that health was wrongly defined as consumption of specific goods and services; that overprofessionalization increased costs; and that autonomy of individuals was getting reduced. It was therefore recommended that we should 'strive to create a viable and economic alternative suited to our conditions needs and aspirations'.

India was a co-signatory of the Alma Ata declaration and in 1981 an expert study group jointly facilitated by the Indian Council of Social Sciences Research and the Indian Council of Medical Research was requested to recommend an alternative strategy for the 'Health for All' goal. This group was also highly critical of the system that had been developed since Independence. The model of health care was found to be 'topheavy, overcentralized, heavily curative, costly, urban, elite-oriented, dependency creating and inappropriate'. It warned against small and well-meant reforms and suggested a radically different alterative community health strategy. Its prescription included:

1. a mass movement to reduce poverty, inequality and spread education;
2. an effort to organize poor and underprivileged to fight for their basic rights;
3. A concerted effort to move away from the counterproductive Western model of health care and replace it by an alternative based in the community - which it outlined in some detail. The model in brief was an integration of promotive, preventive and curative services through a process that was democratic decentralized and participatory; oriented to vulnerable groups, economical, involving the people and increasing their capacity to solve their own problems. In principle it was an endorsement of the Primary Health care approach evolving out of grass roots experience in India particularly in the voluntary sector in that phase - the 1970s.

In 1982, inspired by both these expert committee documents the Government enunciated a National Health Policy which called for a review of "the entire basis and approach towards medical and health education at all levels in terms of national needs and priorities". It also suggested a restructuring of curricular and training programmes "to produce personnel of various grades and competence who are professionally equipped and socially motivated to effectively deal with day to day problems within the existing constraints". The policy was focused on the development of Primary Health Care as a priority, and intersectoral coordination as well as the involvement of the voluntary sector and NGOs in these efforts. This policy was followed up with a National Education Policy for Health Sciences in 1989.

The late 1980s saw a convergence and increasing intersectoral complementarity in India's planning efforts, especially in the linkages established in health care planning with areas such as women's development, integrated child development, anti poverty programmes and minimum needs programmes, water technology mission, family planning, literacy programmes and housing programmes. National policy on education, initiatives to promote gender equality, and more emphasis on rehabilitation of disabled, AIDS control and newer priority problems. By the end of the 1980s all these efforts have however run into a new obstacle caused by political changes in the country and the development of a new economic policy as part of the global pressure on India to make structural adjustments and integrate with the global economy. The new primary health care focused shift in health planning and health service development had hardly got of the ground and begun to make headway when the larger socioeconomic and political crisis overtook the country. The future of health care services development is now very largely linked to the direction, emphasis and priority this broader economic policy effort will give to health and health care issues.

B. Two continuing challenges

First, there is a great regional disparity in health. Development indices and data from the last decade highlight this feature effectively. The overall population profile based on all-India rates and projections tends to mask this disparity. Health planners and policy makers are increasingly recognizing this disparity and the whole concept of more decentralized health planning and health policy making is seen as an urgent need. In this context a new focus on the "BIMARU" area of India is gaining ground. (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh). The acronym also means "ill" in Hindi – reflecting the growing concerns about the backwardness in health and social indicators of these states when compared to the all-India data or to the more advanced/developed states of Kerala, Tamil Nadu, Maharashtra and Punjab.

Second, urban-rural differences in all aspects of development are well-established facts and these are not showing much improvement in spite of all the emphasis about minimum needs. Urban areas continue to draw the major share of development efforts and when rural areas do get some benefits and services, it is the top ten % of the rural rich who get most of it.

This continuing differential leads to two key policy matters that need emphasis. First, continuous monitoring of this difference in developmental effort is needed to provide some stimulus to concerted efforts to reduce the disparity. Second, there is growing evidence that urban models of development built primarily on an institutional, high technology framework borrowed from the west or transplanted through neo-colonialism will have to be discarded in favour of more low-cost, human resource developing alternatives. Health care will be no exception.

There is also an increasing recognition that urban statistics and indicators, thourgh definitely better than rural, also mask the growing disparity in health indicators of the urban slum populations from the rest of their urban counterparts. This calls for a concerted effort to obtain disaggregated statistics by social classes and other forms of classification of marginalization so that initiatives are focussed on those who need them most – both in rural and urban areas.

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4. DUTCH DEVELOPMENT POLICY AND INDIA

4.1. Dutch bilateral development cooperation with India

Bilateral development cooperation between the Netherlands and India on a structural (yearly) basis started in the beginning of the sixties.[16] While in the first years Dutch aid mainly consisted of the supply of goods and financial assistance, gradually (and especially in the eighties) development policy changed to technical assistance and project aid. While in 1980 the share of non-project aid still amounted to 98%, in the period 1987-1992 this percentage had decreased to 50% (DGIS, 1994). Dutch development aid to India has for a long time been strongly influenced by commercial interests, particularly in the fields of water transport, dredging, and fertilizer production.

In 1969, India was granted the status of priority country (countries on which Dutch development assistance was to be concentrated). After a period of continuous growth of the cash ceiling for the regular programme (from Dfl. 150 million in 1975 to Dfl. 234 million in 1981), after 1981 the cash ceiling stabilized around Dfl. 200 million (with additional funds from other sources, e.g. the sector programmes).[17] While in the beginning the cash ceiling consisted entirely of loans, from 1975 the share of grants gradually increased from 20% in the late seventies to 50% in later years.

Dutch development assistance to India during the 1980-1992 period (both regular and non-regular) amounted to a total of Dfl. 3.538 million (more than 80% of which was channeled through the regular programme). In this period, India was the country that received the largest amount of Dutch development aid. The Netherlands was the fifth largest bilateral donor (providing 10,5% of all bilateral aid; 5,2% of total aid) (DGIS, 1994). To put this amount within a proper perspective: on a per capita basis, the net annual flow amounted to only Dfl. 0,25 (US$ 0,10) per year.

Activities of the CFA's in India are financed through the non-regular programme (disbursements of which are included in the total of Dfl. 3.538 mentioned above). From 1980 until 1990, the four Dutch CFA's together received a 6% share (yearly) of the overall development budget. In the programme financing agreement recently (1993) concluded between the Government of the Netherlands and the CFA's, this share was raised to 7% . As the CFA' have also access to funds from the 'special programmes' of the category of non-regular funds, their total share in the disbursement of Dutch development assistance is estimated to be 10% for the period 1980-1992 (DGIS, 1994).

Recently, in the light of policy changes associated with the policy document for Dutch development cooperation 'A world of difference' (1990), a new policy plan for India (1992-1995) had to be prepared. Some of the main points relevant as background material to this study are summarized below. Possibly, the conclusions and recommendations of the 1994 evaluation of Dutch development assistance to India will lead to new policy changes in the near future.

Main general point of departure for Dutch development policy is 'sustainable development' defined as 'development which provides for the needs of the present generation without

jeopardising the opportunities for future generations to provide for their needs' (DGIS, 1992). Another important policy priority is the struggle against poverty and its socioeconomic and ecological aspects. In 'A World of Difference' the need is stressed to combat poverty in a direct way.

An important policy change for development cooperation with India (and other developing countries as well) is the decision to reduce the volume of loans for development activities. This meant that the cash ceiling for India was reduced from an average of Dfl. 200 million per year (in the eighties) to Dfl. 160 million in 1992. As a result of this policy change, Dutch development assistance to India now wholly consists of grants, and no longer contributes to the increase of India's debt burden.

The policy changes described above have necessitated a gradual change in the composition of Dutch development assistance to India, without doing damage to the continuity of certain programmes (e.g. drinking water supply). All new activities will have to be reassessed in the light of their expected effects on the environment (sustainability), the position of the target group of the poorest, and the position of women (the policy priorities of Dutch development assistance).

For reasons of efficiency and managability, from 1985–1986 Dutch project aid became in principle limited to the states of Andhra Pradesh, Gujarat, Karnataka, Kerala, and Uttar Pradesh (the states where most Dutch assistance had been concentrated before).[18] Further, four priority sectors were determined: rural drinking water, land and water management, environment, and water transport. In special cases (e.g. programmes that have relevance for India as a whole, and urban poverty programmes), exceptions to these restrictions were possible (see DGIS, 1992).

The states mentioned above have not been selected on the basis of poverty criteria (almost two thirds of the poorest people in India live in the states of Bihar, Orissa, West Bengal, Assam, Madhya Pradesh, Uttar Pradesh and Rajastan; DGIS, 1994). Rather, their choice reflects a historically grown situation. In the policy plan 1992–1995 it is stated that a revision of this relationship based on aggregate (state–level) data about the poverty situation is not opportune. Given the enormous local and regional diversity and the importance of paying attention of vulnerable groups like tribals and scheduled castes, inhabitants of slums, selection of regions is a more effective instrument than selection of states on the basis of aggregate data on the poverty situation in those states. The five states in which Netherlands development assistance is concentrated together cover an area of about 1 million square kilometres, with a total number of 320 million inhabitants (DGIS, 1994).

In the 1992–1995 policy period, 60% of the cash ceiling will be reserved for the four core activities mentioned above (within this category, expenditure on the water transport sector will be restricted to a maximum of 15%, while minimally 35% will be allocated to activities in the rural development sector). The remaining 40% will be reserved for programme aid. Within this category, the share of import support will be gradually reduced to 15%, while 25% will be reserved for budgetary support for poverty alleviation programmes.

Sectors and activities receiving special attention are rural development, land and water, rural drinking water supply, credit facilities, non-formal education, employment, the environment, women and development, combating urban poverty, infrastructure (water and transport), and education and research.

4.2. General development policy of Cebemo

Cebemo (Central Agency for the Co-Financing of Development Programmes) is one of the four co-financing agencies (CFA's) of Dutch development assistance, through which development aid is channelled to non-governmental partners in developing countries. Cebemo was established in 1965 at the initiative of the Central Missionary Council (CMC) and the missionary movement in the Netherlands. Cebemo's development policy is rooted in and draws its inspiration from its (Catholic) religious background.

Main objective of Cebemo's development policy is the long-term (sustainable) improvement and strengthening of the position (emancipation) of poor, deprived and neglected groups in developing countries, allowing these groups a greater access to knowledge, income and political influence.

Implementation of this policy takes place by giving support to the following activities:

- activities of/for deprived and neglected groups at grassroots level (basic amenities and services like education, health care, housing, water, income generation, and group formation);
- activities aimed at the strengthening of social organizations, related to activities by/for deprived and neglected groups at grassroots level;
- initiatives aimed at influencing policy, both in the Netherlands and internationally, particularly if these are related to activities by/for deprived and neglected groups at grassroots level (Cebemo, 1993a).

The main ('natural') partners of Cebemo are organizations of the Catholic church or related to the church, dedicated to the improvement of the situation of the poor. But Cebemo does not restrict itself to its 'natural partners'. For specific issues, alliance is sought with other partners (NGO's).

Cebemo receives its funds from 3 sources:

- the co-financing programme (CFP);
- additional funds from the Government of the Netherlands (DGIS);
- additional funds from the European Union (EU).

In 1993, the co-financing programme of the Dutch government and the four co-financieng agencies was extended for a period of four years (1993-1997) by the conclusion of a new co-financing agreement between the CFA's and the Government of the Netherlands. In that year, 92% of Cebemo's total financial resources originated from the first source (CFP).

Recently the decision has been taken to intensively cooperate with Vastenactie Nederland. Further cooperation and integration is expected to materialize by the end of 1994. Further, Cebemo and Mensen in Nood have decided to establish a common desk for emergency aid. Cebemo will also coordinate its assistance to Eastern Europe with this organization. Mensen in Nood, MEMISA, Vastenactie and Cebemo also intend to expand their collaboration. Regular contacts with the other CFA's (Hivos, Icco and Novib) are maintained through the common forum of GOM (Gemeenschappelijk Overleg Medefinanciering). On the basis of recommendations made in the impact study, the GOM-partners have decided to cooperate on the following issues:

- the formulation/compilation of NGO-country documents;
- developing instruments to stimulate cost-consciousness among the CFA's and their partners;
- further elaboration of the concept of the concept of 'structural combat of poverty'.

Cebemo cooperates with Icco in the field of professional guidance and support of programmes.

Internationally, Cebemo actively participates in CIDSE (Cooperation Internationale pour le Développement et la Solidarité). In Europe, Cebemo cooperates with euro-CIDSE, over which Cebemo presides. Within the framework of CIDSE, Cebemo intensively cooperates with (German) MISEREOR in particular. In the future, cooperation with like-minded organizations in the Netherlands, Europe and the United States will receive full attention (consortia, agreements on geographic concentration etc.).

In 1993, 1.000 commitments of more than one year were concluded for a total amount of more than Dfl. 160 million.
Specific attention was paid to a number of special themes and issues: women in development, sustainable land use, income improvement, human rights, indigenous people, and the population problem.

Region	Number of projects	Commitment (Dfl.)
Africa	320	58.018.150
Asia	372	34.175.305
Latin America	291	65.557.998
Other projects	17	2.670.107
Total	1.000	160.421.560

Cebemo commitments in 1993 (source: Cebemo, 1993b)

In Asia, Cebemo supported 372 projects for a total amount of Dfl. 34.175.305 in 1993. Most important fields of attention in 1993 were:

primary production : 10%
health care : 11%
institut. development : 29%

education : 17%
strengthening of
counterpart organizations: 10%
human rights : 10%

Other important priority themes in Asia are: the combat of urban poverty; small-scale economic and income generating projects; women and development; the environment and strategies for sustainable development; indigenous people.

For Cebemo, India is by far the most important partner in Asia. Almost sixty percent of the total number of Cebemo projects is located in India.

Location	Number of projects	Commitment (Dfl.)	% total
India	200	15.761.097	46,1
Other Asian countries	156	14.942.747	43,7
General projects	16	3.471.461	10,2
Total	372	34.175.305	100

Distribution of Cebemo commitments in Asia (source: Cebemo, 1993b)

4.3. Cebemo in India

More than half of the new commitments made in India in 1993 belong to the sectors 'institutional development' (28,9%) and (formal and non-formal) education (25,1%). Other important sectors are health care (12,8%) and primary production (9,9%) (Cebemo, India 1993).

As far as possible, in India Cebemo supports initiatives that are complementary to activities of the government and non-governmental organizations. An important objective is to create access for the target group to both governmental and non-governmental programmes. Often the target group lacks access to these programmes, due to ignorance or lack of political influence. Therefore,the second important policy objective is creating awareness among the target group.

Cebemo's target group orientation is aimed at the direct combat of poverty. Special attention is given to:

- landless and marginal farmer households in the rural sector;
- the urban poor;
- traditional fishers and migrants from Sri Lanka;
- *dalits*, *adivasis*, and backward castes;

Cebemo recognizes the special position and role of women in Indian society. This factor is taken into account in the assessment of and decision-making of project proposals.

Cebemo intends to gradually shift its attention from South India to North India. Therefore, due attention is given to the extension of its network of partners and advisory organizations. Other important themes are environment and ecology, communalism, caste discrimination, relations between the government and NGO's, labour issues, women in development, social justice, peace and human rights, and interreligious cooperation.

Cebemo builds its partner network by stimulating the extension of regional resource centres. Apart from these, national partners like ISI, Caritas India, CHAI and PRIA are important partners.

4.4. Health policy of Cebemo

Cebemo currently has no policy paper specifically stating its health policy in India. However, the 1994 position paper on basic health care in the Philippines (Cebemo, 1994) may serve as a guideline for health policy in general. The following description of Cebemo's health policy is based on this policy document.

For more than twenty years Cebemo has supported the concept of primary health care, and especially its community-based health care component. More than fifteen years after 'Alma Ata' the concept retains its validity, but adaptations have become necessary. Health policy should be able to react flexibly to important political, socioeconomic, and other changes like the spread of AIDS, urbanization, and population growth.

When appraising a project proposal in the health sector, special consideration will be given to the health situation of the population of the particular area in comparison with the national average. In the light of important processes like the high pace of urbanization in many developing countries, areas of concentration of Cebemo support might be redefined and lead to new geographic and thematic priorities.

Priority will be given to programmes in the health sector 'which take into consideration the existing traditional health system and promote genuine traditional medicine' (Cebemo 1994; 12). Moreover, Cebemo gives special consideration to 'traditional lifestyle groups', like tribal groups, who tend to occupy a marginal position in society. In general, the appropriateness of existing approaches will have to be the object of continuous assessment, while innovative approaches and new activities will have to be taken into consideration.

Cebemo remains committed to Primary Health Care (PHC) at the 'first' (community) level. It is stressed that the PHC approach is a political choice for a new approach to health care at grassroots level. Cebemo considers operationalization of PHC through its component parts of Basic Health Services (BHS) and CBHC (Community-Based Health Care) to be an appropriate approach towards improving the health situation of the population.

Cebemo uses the concept of Basic Health Care (BHC) to operationalize the PHC concept. Its contents will have to be formulated in accordance with local needs in specific situations, and consist of a number of health and health-related activities for the improvement of health, and for prevention and promotion.

Within BHC, programmes which show the following characteristics will be emphasized:

- qualitative rather than quantitative aspects;
- integrity, stability and professional competence of the organization rather than its size;
- lasting effects on basic health care rather than quick results;
- a measurable indication of a gradual improvement of the health situation of the target population.

The main criteria for Cebemo to support health programmes are the degree to which a community can be effectively reached, can actively participate and can benefit from the programme. In this respect, capacities, programmes, services and activities of organizations in the health sector rather than structures (apex organizations, support organizations, implementing agencies) are important.

Cebemo distinguishes between the following important actors and partners in the field of health care:

- government: health care is and remains primarily a responsibility of the government. NGO's should not duplicate government efforts or replace them, but have a complementary or supportive role;
- health professionals: the need of ongoing training for staff working at community level is stressed;
- the Catholic church: in view of the potentially positive role of the church, its activities for the poor in the spirit of PHC will be promoted;
- NGO's: "Support for NGO's, especially those implementing the PHC concept at grassroots level, the BHC, will be continued. Without dismissing the role of intermediary organisations, their added value to the NGO's working in the field will have to be substantiated. National bodies and networks are the prime responsibility of their members" (Cebemo, 1994; 13).

Cebemo is in favour of cooperation between the church, NGO's and the government, provided that each retains its autonomy. Support of programmes in collaboration with the national or local government will be given priority. A major priority is the support of organizations working at the grassroots level, in close relationship with the target population. The strengthening of such people's organization will be fostered.

A number of themes receive special attention in Cebemo's health policy: AIDS, industrial health hazards, urban health problems, and increasing population pressure. It is expected that the churches and NGO's can play a positive role in addressing these problems, in view of their commitment, their innovative approach, and proximity to the community. Activities and services addressing the problems mentioned above will have to be part of a comprehensive health programme. Activities for the prevention and control of AIDS will be stimulated. Here, an adequate response to the threat of AIDS is needed rather than academic and theological discussions.
Another theme that receives attention is the development of a health financing system at community level. In this respect, NGO's can play an important role in testing out different possibilities for such a financing system.

4.5. General development policy of Icco

Icco (Inter-church Coordination Committee for Development Cooperation), one of the four Dutch co-financing agencies (CFA's), was established in 1964 by churches and Christian social organizations, inspired by their religious background to combat poverty and strive for social justice and equity for the poor in developing countries.

The organization has set itself three main tasks:

1. financing (non-governmental) developmental activities in developing countries and in Middle/Eastern Europe;
2. providing information, both in the north and the south, about the poverty problem and Icco's acitivities;
3. Influencing policy that has a bearing on the poverty problem, both in the north and the south (Icco, 1993a).

Icco receives the greater part of its financial resources from the Ministry of Foreign Affairs, Directorate General for International Cooperation (DGIS) of the Government of the Netherlands, which channels part of its development budget through the CFA's (Cebemo, Hivos, Icco and Novib) in the framework of the co-financing programme. Apart from this yearly block grant, Icco receives additional funds from the Government of the Netherlands (special programmes) and from the European Community. In 1993, Icco has concluded new financial agreements for a total amount of Dfl. 162 million (Icco, 1993c).

Through its policy, Icco supports local and national initiatives aimed at the structural improvement of the position of poor and marginalized groups in society. At the same time, Icco provides information to the general public and tries to influence policy in the north, realizing that our affluence is part of the problem of the poor in developing countries.

To use its scarce resources as effectively and efficiently as possible, Icco has to make policy choices between countries, partners, target groups and sectors. Icco's policy is further elaborated in the country policy documents, which provide updated information about the countries in which Icco cooperates with partner organizations. Icco has partner organizations in about fifty countries.

Icco gives priority to the support of developmental initiatives at the local level. Its partner organizations have the knowledge and provide the information necessary for Icco to base its country policy on. In its relations with partners, Icco stresses the need to give priority to initiatives that reach poor and marginalized groups, such as ethnic minorities, the handicapped, and women. Priority is given to conscientization and organization, basic social services, income generation, and rural development.

In Icco's development policy, three themes are of crucial importance: human rights, women, and environment. These themes function as the yard stick for developmental activities at all stages (Icco, 1993a).

Icco's contribution to health care aims at providing adequate basic health care facilities. A central place is accorded to prevention, esssential drugs, AIDS, family planning, and peri-

natal and mother and child care. Preferably, health initiatives are part of a more comprehensive approach to health and development.

Icco actively seeks national and internation cooperation with Protestant Christian organizations, but also with the other CFA's. Recently, an agreement was reached with (Catholic) Cebemo about far-reaching cooperation between these organizations. Internationally, Icco closely cooperates with like-minded foreign Protestant agencies, active in the field of development. In this respect, Brot für die Welt, Christian Aid, and Evangelische Zentralstelle für Entwicklungshilfe (EZE) are important international partners. All agencies mentioned are members of the Association of Protestant Development Organizations in Europe (APRODEV), and maintain close relations with the Geneva-based World Council of Churches.

In 1993, Icco concluded funding agreements for a total amount of Dfl. 162.210.980. In Category IV (the co-financing programme) 518 contracts were concluded for an amount of Dfl. 142.154.753 (the remaining Dfl. 20.056.227 originating from the categories of special programmes and from European Union funds). Category IV funds were divided over the continents as follows:

Region	Number of contracts	Total amount (Dfl.)
Africa	190	49.673.573
Asia	118	42.812.208
Latin America	190	41.283.001
Other contracts	20	8.385.971
Total	518	142.154.753

Icco: category IV contracts concluded in 1993 (source: Icco, 1993c)

As can be seen from the following table, India is an important Asian partner for Icco:

Country	Number of projects	Total amount (Dfl.)
India	42	10.892.673
Philippines	23	9.499.190
Vietnam	6	4.778.326
Cambodja	7	3.910.025
Thailand	8	2.605.058
Bangladesh	7	2.483.482
Other countries and continental programmes	25	8.643.454
Total	118	42.812.208

Icco: number of projects and contributions in 1993 for important partner countries in Asia and the Pacific (source: Icco, 1993c).

4.6. Icco in India

Icco has recently issued its new policy profile India for the period 1993–1995 (Icco, 1993b). Icco has been active in India from 1971. In the past period a gradual shift can be seen in Icco's development policy in India. In the first period (1971–1975) Icco restricted itself to material support (infrastructure, equipment) for 14 projects in the fields of health care and education implemented by the Protestant and Orthodox churches.

From 1975, Icco's policy shifted to the co–financing of programmes not necessarily related to the churches. In the same year it was decided to give special attention to India, in view of the magnitude of the poverty problem in this country, the increase of funds for the CFA's, and the decision to follow a target group policy.

From 1976, priority was given to community development projects. More attention was paid to specific target–groups (poor and marginal farmers, landless, tribals, untouchables) and their active participation. In the eighties, the contribution of supported activities to a process of structural change became an important criterium. In addition, from 1985 Icco systematically contributes funds for large integrated rural development projects.

The total contribution of Icco to partners in India during the period 1971–1990 amounts to Dfl. 150 million, comprising 790 projects of 272 organizations (9% of which were national organizations) throughout India. Total funds available per year for India (including additional funds from the Government of the Netherland and the EC) amount to Hfl. 14–15 million. In the period 1989–1991, total allocation to counterparts was considerably reduced, mainly for financial reasons. After 1991, allocations to India have increased again. Main reasons for this are the recognition of the magnitude of the poverty problem in this country, and the availability of a large number of NGO's in India, both in rural and urban areas (Schulpen and van der Velden, 1992).

Regional spearheads of Icco support during this period were the states of Tamil Nadu, Andhra Pradesh and West Bengal (53% of all financing). Ther northern states of Haryana, Punjab and Himachal Pradesh are under–represented.

The policy shift mentioned above (from construction projects to community development) is clearly illustrated by an analysis of the types of projects supported. While construction projects represented 87% of Icco–supported projects in 1971–'75, 46% of the projects supported in the 1986–'90 period were community development projects. A breakdown for the period 1971–'90 shows the following distribution:

community development	39%	refugees	4%
health care	12%	alternative media	4%
education and training	9%	emergency aid	4%
training	5%	legal aid	1%

Target group of Icco are 'the poor'. In practice this general category consists of a great variety of poor and marginalized groups in Indian society, like tribals (*adivasi*), untouchables (*harijans*), and lower castes and classes. The majority (68%) of projects and programmes supported by Icco are rural. Urban projects and programmes account for 9%,

while the remainder (23%) have a mixed character.

While in the first period of Icco's involvement in India (1971–'75) only Christian organizations were supported, in the period 1975–1990 gradually the share of secular, Gandhian, Hindu and Muslim organizations increased. At the moment, some fifty percent of the total number of projects/programmes supported by Icco concern activities by Christian organizations or by secular organizations with a Christian background (Icco, 1993b).

In 1989–'90 the India desk of Icco executed an internal evaluation of the relevance, efficiency and effectiveness of Icco–supported organizations and projects. The evaluation showed that about fifty percent of Icco–supported activities in India was efficient and effective, for the remainder the precise effects are unclear or lacking.

4.7. Health policy of Icco in India

In the field of health and health care, Icco gives priority to the support of organizations that advocate an integrated approach to health care, in which full attention is given to social, economic and political factors that have an impact on the health situation. Monosectoral approaches will no longer be supported. Icco promotes a combination of community–based health care (CBHC) and basic health services (BHS), supported by baseline surveys. Active participation of the target communities in planning, organization and implementation is considered of central importance. Other points of priority are:

- promotion and support of alternative health training and training institutes;
- the support of organizations and networks which promote community–based health care and/or basic health services, are innovative and/or act as political advocacy organizations;
- the financial sustainability of programmes (adequate planning and management, use of local resources, appropriate technology, essential drugs etc.;
- the position of women and girls;
- sex education and information about reproduction that contribute to the empowerment of women;
- AIDS;
- integrated approach to the rehabilitation of disabled people (Icco, 1993b).

5. PROFILES OF ORGANIZATIONS, PROJECTS AND PROGRAMMES FUNDED BY CEBEMO

5.1. Introduction

According to the most recent overview Cebemo presently supports 109 projects with a substantial health component in India, amounting to a total contribution of more than Dfl. 10 million. Total Cebemo contribution to these projects amounts to more than Dfl. 10 million (Cebemo: overview of health projects, september 1994; see Annex 1).

Out of the total number of projects and programmes supported by Cebemo, a preliminary selection has been made by the Cebemo staff, based on the following criteria:

- candidate programmes should be larger programmes (in terms of Cebemo's commitment), and have a substantial health component (at least 25%–30%);
- implementation (funding) should, in principle, have been going on for at least three years;
- they should be comprehensive projects/programmes rather than specifically addressing one theme only;
- they should be of some (potential) relevance to the current and future activities of Cebemo in india (e.g. innovative approaches).
- (a more practical criterium) geographical location of projects and programmes chosen should make inclusion in the mission schedule feasible without taking up too much of the relatively short time available.

On the basis of these preliminary criteria, the following organizations/programmes were selected as possible candidates for evaluation:

1. Bengal Rural Welfare Service (BRWS), Calcutta, West Bengal: Programme for Rural Basic Health Care (5.2.)
2. Village Health Workers Scheme, Diocese of Berhampur, Orissa: Diocesan Training Centre and Programme of Rural Health Workers, Jaganathpur village (5.3.)
3. St. Thomas Mission Society, Mandya, Karnataka: Community Based Health and Development Programme (5.4.)
4. Karuna Social Service Society (KSSS), Diocese of Bijnor: Community Health Programme (5.5.)
5. Peermade Development Society (PDS), Kerala, India: Integrated Health and Development Programme (5.6.)
6. Trust for Reaching the Unreached (TRU), diocese of Ahmedabad, Gujarat: Comprehensive Primary Health Care, Panch Mahals, Gujarat. Diocese of Ahmedabad (5.7.)
7. Christian Council for Rural Development and Research (CCOORR), MAGR District (Vengal), Tamil Nadu: Rural Health Training Centre and Extension of Field Activities (5.8.)

5.2. Bengal Rural Welfare Service (BRWS), Calcutta, West Bengal: Programme for Rural Basic Health Care

Organization	:	Bengal Rural Welfare Service (BRWS)
Project/programme	:	Programme for Rural Basic Health Care, Calcutta.
Rural/urban	:	rural and urban
Organization type	:	implementing and intermediary
File number	:	C317-1105(F)
Commitment	:	three years (1992-1995)
Financing	:	total : Dfl. 173.655
		own contribution : Dfl. 48.000
		contribution Cebemo: Dfl. 125.655

The Bengal Rural Welfare Service (BRWS) is a secular voluntary organization based in West Bengal. Area of operation of BRWS are the rural areas around the city of Calcutta and some urban districts of this city. BRWS has been active for more than fifteen years in the districts of south 24 Parganas, Nadia, Midnapur, Hooghly and Howrah in West Bengal. BRWS centres are located in Garia and Patuli (two urban districts in Calcutta), and in the villages of Balarampur, Jeadergot, Balakhali, Hogolkuria, Andharmanik and Majdia. These centres serve a total population of 240.000 people (see below).

BRWS originates in a small group of volunteers who in 1978 took up the initiative of providing low-cost curative health services for the rural poor through homoeopathic clinics in Sonarpur Block of 24 Parganas district. The first centre was established at Nanah, Howrah district, West Bengal. In the wake of the success of this first centre, a number of others were established in the area. However, due to lack of organisatory skills, funding, and other causes these new centres had to be closed down again.

After the districts of Hooghly and Midnapore had been hit by floods in 1978, the group provided emergency medical care for 22.000 victims in the area. In 1980, BRWS was formally established as an organization. Recognition and registration by the government of West Bengal followed in 1981. In the years after, the scope of the BRWS programme widened from a curative approach into a more 'integrated' approach to health care. More attention was given to the needs of the people and their active participation. Preventive health care became increasingly important. Thus, the scope of activities of BRWS gradually became much broader than curative health care alone. Activities added to the programme were: mother and child care (ante-/post-natal), immunization, hygiene, family planning, child care, growth monitoring (through the GOBI-programme) and preparation of nutritious food, an economic assistance programme, training of community health workers, pre-primary school education, and environmental and sanitation programmes. In the BRWS approach, improvement of the health situation in the area is considered a precondition for further development. Therefore, in BRWS programmes health has become an entry point for other - social and economic - developmental activities. Main target groups of these activities are women and children, the most vulnerable groups with respect to health. Improving their health status and socioeconomic position has become the main general objective of the programme. Some of the main health problems in the area are: gastro-intestinal infections, respiratory diseases, gynaecological disaeses, deficiency

diseases, trauma or injury, eye diseases and skin diseases. BRWS is actively involved in the prevention of communicable diseases through its immunization programme, in cooperation with the government.

Short term objectives of BRWS became low cost curative and preventive medical care for the poor and socially vulnerable groups. Long term objectives comprise (apart from low cost health care, including homoeopathy) information and education, organization of women, creating awareness among the target population (health hazards, people's rights etc.), and health training camps for other organizations.

BRWS gradually expanded its activities to new villages by following a step-by-step strategy. First, BRWS provided curative and other health services in a 'new' village. Then, around these activities a community centre was built-up. After BRWS presence and the activities mentioned above had been accepted by the village population, health workers started to organize *balwadi* (nurseries) and *mahila mandal* (women's groups). After a limited period, usually when most of the target population has been immunized, the clinic was moved to another (central) place. While from this moment group organization (*balwadi, mahila mandal*) and involving local people were stressed, regular home visits at the old centres for health purposes continued.

In the field of curative and preventive health care, priority is given to mother and child care. Among the more general developmental activities, a central place is accorded to organizing women in local women's organizations (*mahila samiti*). These organizations participate in programmes for the improvement of hygiene and nutrition. In cooperation with the government, programmes for family planning and vaccination are carried out. BRWS has a solid relationship with its main target group of women from poor families in the area covered by BRWS activities. The women's groups are involved in planning and implementation of the programme activities.

Main target groups of the current programme are the population surrounding the health centres run by BRWS (the direct target group) and the population covered by the activities of 58 NGO's reached by the BRWS training unit (the indirect target group). The target group consists mainly of Muslims and *harijans* that belong to the lowest income groups, and work as agricultural labourers, day-labourers, rickshaw pullers, domestic servants etc. The total target groups amounts to 240.000 people, both directly and indirectly reached (by BRWS health services and services provided by other NGO personnel who participated in the BRWS training programme). The majority of the total target group belong to low-income families in Calcutta and the rural areas of West Bengal. Another target group are the various categories of health workers (TBA's, VHW's, medical doctors, and NGO staff) involved in community health work. It should be added that little is known about the size of the direct target group of BRWS programmes. Probably this does not exceed 10.000 people.

Through the activities organized in the training unit, a network of some ten voluntary agencies (NGO's) in the working area of BRWS now exists. Once a year network meetings are held, apart from smaller and informal meetings, to exchange experiences and ideas. For workers of these NGO's BRWS provides training, information and other support.

Through the training unit, the organization has also extended its services to organizations in West Bengal and other states Bihar, Orissa and Madhya Pradesh (Bhopal; community health workers among the victims of the Bhopal disaster). BRWS provides training for health workers from these states.
Further, BRWS did relief work after floods and cyclones. Often, relief work by BRWS is followed up by long-term development programmes, such as rehabilitative activities among victim groups and preventive measures against damage caused by new calamities.

BRWS has built up a network of 100 trained local volunteers and 6 women's groups. It has six centres (BRWS mentions ten centres in its project proposal for the last funding period) from which various activities are initiated and monitored. All centres are run by local volunteers. The new Garia centre in Calcutta, established with funding from Cebemo (C317/1105C), has a referral service for the other centres. It is also the site of the BRWS training unit, and serves as a family planning centre (in cooperation with the government) and a clinic for TB, dentistry and eye diseases.

In phased-out areas, BRWS only provides non-financial support (guidance and other forms of cooperation), as people in the areas concerned are supposed to be able to meet their own needs. In these areas, trained VHW's maintain contacts between the population of their working area and the government. The women's organizations in these areas decide on their own priorities and plan their own programmes.

Local (village) health workers trained by BRWS and working in the target areas are paid for their services by the target group itself, which also contributes to the running costs of the different programmes. BRWS tries to reduce its dependence on foreign donor support by paying much attention to the long-term self sufficiency of its programmes and gradual reduction of donor contributions.

The core team of the organization consists of project officers (one homeopathic doctor, a training coordinator, a doctor for mother and child care, a family lawyer and an administrator). The core team is assisted by a team of multi-disciplinary experts, some of which are government health personnel. Further, more than one hundred volunteers are involved in the various programmes undertaken by BRWS.

From 1989 onward, the working area of BRWS has been divided into three zones:

Zone A: this zone covers Andharmanik, located in a remote area without health services. First activities in this area took place under 1105D. More than 10.000 people are served through mobile health services and local health workers.

Zone B: this zone covers Majdia, a remote village with a 3.000 population, and Patuli (1.000 pop.). In both areas, people had access to government services, but the results were unsatisfactory. Though the ICDS (Integrated Child Development Service programme) was implemented, health status and immunization coverage continued to be low.

Zone C: this zone covers the old centres of Balakhali, Balarampur, Hogolkuria and Jeadergot.

The main current activities of BRBS are:

- integrated health care programmes based on the GOBI/FFF programme (growth monitoring, oral rehydration, promotion of breast feeding, immunization, nutrition education, and family planning);
- running of a polyclinic laboratory in Garia, which serves as a referral clinic for all centres;
- a training centre in Garia, which provides training for grassroot health workers and rural doctors, both from the BRWS staff and from the staff of other NGO's (e.g. in 1990 64 staff members from 29 NGO's participated in the training courses). Through this training unit, BRWS has been able to extend its services to other states;
- ante-natal clinic in Julpia;
- programme for the development of women: 6 *mahila samitis*, with a total membership of approx. 375 women. Main activities are adult education, vocational trianing, weekly meetings, reforestation, social awareness, cultural activities, smokeless *chullas*, and sanitation;
- education: three 'pre-primary' schools.

BRWS has received financial support from Cebemo since 1983 (C317/1105,B,C,D,E). The current contribution by Cebemo concerns a continuation of ongoing activities from the last funding period. Cebemo provides funds for health care, promotional activities for women, education and training, and administration.

Main activities carried out in the current phase of the programme to reach the objective described above are:

- continuation of mother and child health services in the different areas, through trained local health workers and with assistance from Government Health Centres in order to maintain at least 80% immunization coverage;
- at least 80% of the children under five years will be immunized against the six basic killer diseases. On a yearly basis, 800 children will be vaccinated;
- permanent family planning work through motivation and organization of monthly operation camps, in which 12-15 women are sterilized (150 women per year). Another 500 women per year are brought under the temporary family planning programme;
- antenatal care services to 200 pregnant mothers through weekly clinics (with the help of trained gynaecologists, nurses and midwifes);
- pre-primary education for approx. 90 children per year (30 children in each of the three schools). In the schools two health camps per year and monthly mothers' meetings will be organized (to create awareness and provide health education);
- *mahila samiti* activities, to improve the socioeconomic condition of women in the slums (50 new members per year, three awareness camps per year, handling of cases related to the oppression of women, construction of smokeless *chullas*, loans in the income-generating programme);
- sanitation and drinking water programme, to control water-borne diseases. Construction of about fifty low-cost latrines per year through the women's

organizations
- provision of training and fruit saplings for the reforestation programme;
- material assistance to village-based community organizations for village-level developmental activities;
- continuation of the existing training programme for village health workers and community doctors (two 21 day training courses for village health workers, and one course for rural medical practitioners).

In 1991 BRWS was evaluated, at the request of Cebemo, by the Gujarat-based NGO Trust for Reaching the Unreached (TRU). Above all, the evaluation revealed some fundamental differences of opinion, orientation and approach between the two organizations. Some points of criticism made by the evaluators of TRU were:

A. general:

- programmes are phased-out at a too early stage (after a few years);
- BRWS provides selective primary health care through a limited number of vertical programmes, e.g. GOBI/FFF
- BRWS should work in a more scientific way, and should pay much more attention to the collection of reliable statistical data, necessary for designing programmes and monitoring their impact;
- need for more systematic research, identification of patients and problems, and the development of specific criteria for treatment and follow-up.

B. specific programmes:

- inadequate adminstration of medical records in the mother and child health (MCH) programme, especially with regard to immunization (identification of children, calculation of actual coverage);
- shortcomings of statistical record keeping in growth monitoring. Further, as protein energy malnutrition (PEM) did not seem to be a problem in the area of the programme, it was advised to reconsider the position of growth monitoring;
- family planning: TRU was very critical of the 'camp approach' and over-emphasis on female sterilization;

Whereever BRWS can partake in and contribute to government programmes, it tries to cooperate with the government. Examples of cooperation with the government are the immunization programme and activities in the field of family planning. Health services in the Garia centre are provided at the request of the government, which lacks health infrastructure in the area. If cooperation is not possible, BRWS looks for other NGO's or takes the initiatives on its own.

5.3. Village Health Workers Scheme, Diocese of Berhampur, Orissa: Diocesan Training Centre and Programme of Rural Health Workers, Jaganathpur village

Organization	: Diocese of Berhampur	
Project/programme	: Diocesan Training Centre and Programme of Rural Health Workers	
Rural/urban	: rural	
Organization type	: implementing and intermediary	
File number	: C317-1130A	
Commitment	: three years (1990-1993)	
Financing	: total	: Dfl. 165.708
	own contribution	: Dfl. 55.700
	contribution Cebemo	: Dfl. 110.008

The diocese of Berhampur exists as a religious-administrative unit since 1974. In 1978, the diocese of Berhampur in Orissa was the first church organization in India to start with a programme for primary health care. It was realized that the heavy work load for health personnel, the many and increasing needs of the population, and the isolated position of their villages necessitated a training programme on health and hygiene for village health workers (especially women).

The Mobile Orientation and Training Team (MOTT) of the Indian Social Institute (ISI) played a central role in these first experiments with primary health care. Financial support was provided by Cebemo (K317-0917; 1979-1982), for the training of 90 women to work as VHW's around 9 health centres (training, guidance, follow-up, and refresher courses were provided by MOTT-ISI). Activities were continued in C317-1130R (1982-1990; village health workers training) and C317-1130A1130A (1990-1993; extension of activities beyond this year was caused by exchange rate developments during the funding period).

The state of Orissa covers a total area of 155.707km2 and has a population of 32 million (1991). It consists fore more than 60% of hills, mountains and forests. Orissa is one of the states with the severest poverty problem and the lowest per capita incomes in India (with Uttar Pradesh, Madhya Pradesh, Bihar, and West-Bengal). Fourty percent of its inhabitants belong to the marginalized groups of scheduled tribes and castes (*harijan*).

The diocese of Berhampur comprises 20 parishes with a total area of 51.025km2, spread over the districts of Ganjam, Koraput, Kalahandi, Gajapati, Nowrangpur, Malkangiri and Rayagada in the southern part of the state of Orissa. The town of Berhampur is the diocesan headquarters. It is the second biggest town in Orissa and harbours a variety of educational institutions, including a medical college. Jaganathpur village, the location of the training centre, is situated at a distance of 11 kilometres from Berhampur. The diocese of Berhampur is registrated under the Societies Registration Act and has a FCRA number. Thus, it fulfills the conditions for receiving foreign donor funds for its programme. The programme is supported by Cebemo from 1979.

The diocese has a population of 7 million. Tribals and scheduled castes make up an large part of the population (Koraput: 70%; Kalahandi: 50%, Ganjam: 60%). The majority of the population depend for their living on agriculture. Agricultural yields are uncertain due to climatic circumstances (erratic rainfall patterns, drought periods, floods, storms). Tribal groups (a.o. Khonds, Sauras, Porjas, Kayas and Bondas) seek a meagre subsistence in small farming; members of the scheduled castes (a.o. Panos, Doms, Reles) often work as marginal farmers, petty hawkers, and (landless) agricultural wage labourers. A basic socioeconomic problem is dependency on and exploitation by landowners, middlemen, and moneylenders.

The poor sections of the population in general, and members of tribal groups and scheduled castes in particular, have little or no access to basic facilities for health, hygiene, sanitation and education. They live in small, isolated settlements without basic health care facilities, and can only be reached by foot. Prevalent diseases are water-borne and diarroeal diseases, respiratory infections, diseases related to malnutrition, and skin and eye diseases. Literacy among the marginalized groups mentioned above is low: 15 per cent for males, and 5 per cent for females. The needs of these groups are hardly attended to by government institutions. Diocesan facilities in the area of health care include: 18 health centres and 15 mobile clinics. Social facilities include training facilities, hostels and orphanages, old people's homes, and *balwadi* programmes.

The main (general) objective of the diocesan programme is the improvement of health conditions of the rural population of the diocese of Berhampur. A specific objective is to bring about attitudinal change among the target group population, in particular women, and to 'help them to better understand, appreciate and accept the modern concept of health'. To reach this objective, stress is laid on health education and community health, preventive aspects of health care, and integration with socioeconomic, political and other aspects of village life.

Three main points of attention can be discerned. First, to provide preventive and curative health care to the rural masses through their own people and at low costs, and thus to enable them to take care of their own health. Second, to build up a three-tier system that can function as a referral system providing basic health care to the rural masses (linking up the health centres with a promotional middle level team and the level of the VHW's). Third, (by linking the health programme to the non-formal education programme) to go beyond health and enable the target communities to regain their self-confidence and develop means to improve their own social, economic and contextual situation.

The direct target group of the current (training) programme are the 252 VHW's already active and 100 new trainees in community health in Berhampur diocese. The indirect target group is the rural population of the diocese, with special attention to the marginalized groups of tribals and scheduled castes.

Health care has since long been a priority in the diocesan programmes. While initially a curative approach to health care was taken, gradually the influence of new concepts, methods and approaches became felt: community health, health education, an integrated approach and prevention became new points of attention, next to ongoing basic curative services.

One of the main assets of the approach in Berhampur was its innovative character, which made it an example for other diocesan organizations in India. However, in the history of this project supervision and guidance by MOTT seems to have played a crucial role. After MOTT involvement had come to an end in the eighties, the project suffered from a lack of follow-up support in the isolated villages, and from the paternalistic attitude of the health staff. Frequent changes of personnel further added to the problems. As a result, completion of the second phase of the programme (1130R) took eight years instead of the originally planned three years.

In view of the vastness of the diocesan area, it has been subdivided into two zones for the purpose of programme planning and implementation Each zone has its own core team members for the training programme:

1. Ganjam/Gajapati zone, with a training centre at Mohana
2. Koraput/Nowrangpur/Malkangiri/Rayagada/Kalahandi zone, with a training centre at Rayagada

(For quantitative data on the number of courses given in these two centres: see progress report 1130A; 1992).

When support for the Diocesan Training Centre and Programme of Rural Health Workers, Jaganathpur village (C317-1130A) started, an active network of village health workers (VHW's had already been built up and consolidated. A total of 252 VHW's (40 males and 212 females) worked full-time in about 252 villages of Berhampur diocese. Every year between forty and fifty selected rural women receive the basic training for CHW's. Expenses for the basic training and the first three years of VHW-activity are paid by the diocese. In this period, VHW's receive a monthly salary of Rp.50. After three years, VHW-activities will have to be paid by the community for which they perform health care activities. (According to the most recent progress report of february 1993, a total of 318 Village Health Workers are attached to 15 main health centres). Bigger villages have two CHW's, while small villages have one each.

The main functions of the VHW are:

1. treatment of minor illnesses, cuts, burns etc.;
2. referral of serious cases to one of the government or diocese health centres;
3. administering of preventive medicine (polio, triple antigen, BCG etc.);
4. main task: community health through health education;

Selection of (women) trainees takes place by the villagers in cooperation with the sister in charge of the nearest diocesan health centre, parish priests and village elders. Some VHW's are selected form tribal groups and scheduled castes. The training is built up as follows:

1. basic training on health and hygiene (22 days);
2. trainees receive their medical kits for basic health care and are placed back in their villages (mainly interior tribal areas, where no other health facilities are available),

under supervision of the sister in charge, to take care of 100 households each;

3. monthly meetings/reporting at the health centre (with the opportunity for guidance and replenishment of medical kits);
4. After 6 months and 12 months: a fifteen days refresher and leadership course; during a five years' period: a ten-days' refresher course (sharing experiences, updating of knowledge, learning new techniques, solving problems etc.).

By 1990 some 700 VHW's had been trained in the Ganjam zone. However, only 252 of them funcioned as full-time VHW (Brief report Community Health Programme, Berhampur). The training centre will be utilized for the following main activities:

- two basic training courses a year (20 days each for twenty persons);
- four refresher training courses (10 days each for tweny persons);
- the monthly one-day meetings of VHW's (2-3 meetings a month for 15-20 VHW's);
- seminars and meetings;
- regional meetings in the field of health, training etc.;
- trainer courses and refresher courses;

The training centre is staffed by two diocesan health coordinators assisted by competent resource personnel, under the overall guidance of the diocesan director of social work. At the regional/district level two core teams of three trained staff runs the training and follow-up programmes. At the local (village) level the staff of the nearest health centre provides monitoring and guidance to the 252 active VHW's.

The diocese has a capable and professional health staff at the diocesan and the district levels, consisting of nurses trained in public health, nutrition and social work. The 18 local diocesan health centres have a professional staff as well. Relationships with government personnel and institutions exist from the beginning. District medical officers were asked to contribute to the training programmes. Moreover, these officers provided trainees with certificates allowing them to work as VHW's. Vaccines and other material medical support were given to the health centres involved in the programme by the district medical officer.

Difficulties encountered, as mentioned in the February 1993 progress report are: the large area of the diocese; the isolated interior location of many target villages combined with difficult communication; the poverty, exploitation and oppression of the marginalized groups in Berhampur diocese, which makes the collection of funds to meet running costs very difficult; the bad functioning of government medical and health facilities (inefficiency, insensitivity to the needs of the villagers).

Attempts in 1986 to have a participatory evaluation executed by ISI-ES failed due to opposition from the diocese of Berhampur, as well as internal problems in ISI-ES. Later, relations between the diocese and the ISI were broken off. Since then a working relationship with CHAI has been built up. At the request of Cebemo, CHAI has evaluated the programme in 1991 and 1992 (CHAI, September 1991 and July 1992). Some important observations made in the 1991 report are:

- sometimes there seems to be a preference for 'Christian' villages among the sisters working in the Ganjam zone;
- sisters and diocesan authorities restrict their work to medical (curative) remedies, 'softer options'; in some activities (e.g. immunization) they tend to take over the work that should be done by government PHC officials, instead of representing the villagers and their claim to health care toward the authorities (the same problem can be seen in primary education). In short: there is a general lack of critical analysis of 'the root causes of the ills of society'.

Some of the remarks made in the 1992 report:

- superficial, inefficient and ineffective implementation of the programme due to the vastness of the area. It is recommended that the programme focuses on a limited number of 'model' villages, and will be gradually expanded;
- there is a need to collect base-line data about these core villages; to critically reconsider the curriculum, which concentrates on diseases, symptoms, remedies and prevention, with little attention to social analysis, conscientization etc.; to have more trained personnel at the core team and middle levels, more planning at the central and regional levels, and more motivation and guidance to middle level workers (the sisters).

5.4. St. Thomas Mission Society, Mandya, Karnataka: Community-Based Health and Development Programme

Organization	: St. Thomas Mission Society
Project/programme	: Community-Based Health and Development Programme
Rural/urban	: rural and (recently) urban
Organization type	: implementing and intermediary
File number	: C317-1505(D)
Commitment	: three years (1992-1995)
Financing	: total : Dfl. 591.589
	own contribution : Dfl. 177.400
	contribution Cebemo : Dfl. 414.189

St. Thomas Mission Society (STMS), the social branch of pastoral work in the district, started its activities in the field of health care in Mandya district in 1980. Projects were started from six centres in different parts of Mandya district, concentrating on (curative) health care and some economic activities, with hardly any coordination and coherence between the project activities on the different locations.

After an evaluation of the activities of these centres it was decided that the organization should more concentrate on community development, with health as one point of attention. Under the guidance of a.o. CHAI (which gives guidance to the programme from 1986), in the field of health care STMS has gradually evolved from a selective, disease oriented approach to more comprehensive, promotion and prevention oriented approach. After 1986, activities in the six villages were integrated and gradually other activities were added: nursery centres, education for school drop-outs, adult education, farmer extension, leadership training, training of village health workers, mother and child care, school health, promotion of herbal medicines people's organizations, conscientization, and income generating activities. Financial support for this integrated programme came from Cebemo (C317-1505B).

Mandya district is situated in the southern part of the state of Karnataka. The district covers an area of 12.886km2. District capital is the city of Mandya, at a distance of 40kms. north of the city of Mysore, and 100kms. southeast of the state capital of Bangalore. According to the 1981 census, Mandya district had a population of 1.418.109 (rural: 1.198.084, urban: 220.025; scheduled castes: 182.807, scheduled tribes: 11.653), and a population density of 286/km2. Mandya district is subdivided into 7 *taluk*, together consisting of 406 *panchayat*. Mandya district has 10 towns and 1354 villages.

The great majority of Mandya population (90%) is economically dependent on agriculture. Most agriculture is rainfed; less than 25% of the total agricultural area irrigated. Important irrigated crops are paddy, sugar cane and ragi. Rainfed crops are oil seed, jowar, ragi and others. A relatively small group of landowners have been able to profit from the the Green Revolution and associated agricultural technology and irrigation. The socioeconomic position of the majority of poor people dependent on agricultural wage labour, however, has further deteriorated as a result of decreasing employment opportunities.

Factors like religion, caste divisions and tribal origin continue to exert a great influence on social life and socio-economic relations in the rural areas. Caste consciousness of the higher castes is an important factor in the process of marginalization of lower-caste people. They are the victims of various kinds of segregation, oppression and exploitation (e.g. by moneylenders). Main religions are Hinduism (90%) and Islam (8%). Christians and other minority religions make up 2% of the population (STMS, 1986).

A major social problem is the low status of women in society. The female literacy rate in rural areas is very low (less than 10% in 1986). Girls marry at an early age, usually before the age of 17. Most marriages are arranged by the family; often great expenses are involved for payment of the dowry. Another social problem in the area is the occurrence of child labour and bonded labour. Main victims are the economically backward and marginalized groups, esp. scheduled castes and tribes.

Oppressive social relations are perpetuated by the influence of traditional power structures, with power in the hands of rich, influential, landowning, usually upper caste members of society. Usually they exert effective control over government welfare programmes entering village society (STMS, 1986).

Mandya city has a slum area with a population of more than 10.000 (mostly settlers). Most of them subsist on manual labour in the city. Health conditions in these slums are very poor. Main problems are the lack of basic services and amenities, a great diversity of communicable diseases, and social problems like theft, drugs, alcohol etc.

The main target group of the programme are the weak and marginalized sections of society in Mandya district, Karnataka, with special attention to women and children, and those with a *harijan* (*dalit*) or tribal (*adivasi*) background. Members of scheduled castes and tribes are usually landless, and subsist on agricultural wage labour for the landowning elite.

Main general objective of the community-based health and development programme of STMS is the integral development of the people in the district, or 'to create awareness among people, enabling them to critically analyse their life situation and to explore ways and means to help themselves for their liberation from the entaglement of underdevelopment, from the clutches of poverty, ill health, illiteracy, unemployment, casteism and oppression of every sort' (progress report, 1992).

Main activities developed to reach this general objective are: the establishment and strengthening of organizations, and empowering the target group. Main areas of concern in organization building are: the formation of youth groups (men/women) and women's groups (*mahila mandals*); encouragement to these groups to work independently and on their own initiative; stimulation to the target group to create new organizations and tap government resources for amenities, services, infrastructure etc. Other important topics are: health programmes, educational programmes, and governmental programmes (creches, night shelter for rag pickers and street children in Mandya city, vocational training).

In developing these activities, special attention will be given to the target groups of scheduled tribes and scheduled castes 'so they can be brought to the main stream of

society'. At Shikkaripura, a tribal colony, main objective has been to settle the tribal population by providing permanent jobs.

Relatively new are the slum development programmes in Mandya city. STMS is intensively involved in these developmental activities from 1993. Some of the achievements:

- 14 slums have been identified;
- 50 motivation programmes have been conducted (with a total participation of 1131 people);
- 15 health motivation seminars have been held (for a total of 576 persons);
- 78 youths have received training on health and leadership;
- youth organizations have been formed;

The current programme is implemented from 6 centres, each of which is staffed by two priests and a group of religious sisters and dedicated lay persons (together forming a core staff of 37 persons). At district level ten volunteer organizations (four of which exclusively for women) function as umbrella organizations for a growing number of village organizations. These district organizations are fully recognized by the government and have a total membership of 230 persons. They are responsible for programme implementation, in consultation with the core staff members. Members have been trained in health promotion, infant care, leadership, mobilization, and adult education. (In the progress report, 1992, other data on personnel involved in the Community–Based Health and Development programme are given: 47 core team members (priests and nuns), 34 field workers, 311 animators, and 32 nursery teachers).

In 1990, main attention was focused on consolidation of existing activities. Further, there was a growing awareness that even greater priority should be given to scheduled castes and tribes. From 1992, policy changes have made such a reorientation possible. During this new period, next to continuation of the existing programme, further extension of the programme to 4 other centres is foreseen. Extension takes place after careful research in the areas concerned, and after regular contacts have been established with the local population, and discussions have been held with village leaders and voluntary organizations.

Cooperation with the government has been good during the last period. Relationships have been further strengthened as a result of the cooperation between STMS and the government in the 1991 literacy campaign in Mandya district, the programmes for organization and mobilization of women, and those directed at scheduled castes and tribes. Thus greater confidence has been built among district government personnel and administrators as well as the general public. At the same time, voluntary organizations are increasingly able to demand government resources for various facilities (creches, night shelters, destitute homes, tailoring centres, vocational training programmes, youth development programmes, educational programmes for women). The main constraint in the relationship with government institutions is the fact that 'the government machinery is often insensitive to the needs of the people. People are sceptic about government schemes' (STMS, progress report, 1992).

Strengthening of the network of voluntary organizations (NGO's) in Mandya district is another point of attention of STMS. Attempts at greater coordination are made at the Taluk, district, state and national levels:

- at taluk level meetings are organized for voluntary organizations operating in these taluks (coordination, discussion, action plans);
- at the district level, STMS is a member of a federation of voluntary organizations, as well as another forum for lik-minded voluntary organizations (social change, community health, awareness). Specific issues are addressed (alcoholism, addictions, and environmental pollution);
- at state level: collaboration with the Federation of Voluntary Organizations for Rural Development of Karnataka (FEVORD-K), Catholic Hospital Association of India, Karnataka Region (CHAI-K), and Community Health Cell (CHC), Bangalore. Main activities are sharing of views and experiences, training, exposure and exchange, evaluation;
- at the national level: collaboration with like-minded organizations and individuals, e.g. CHAI, National Health Workers Forum, LSPSS (organization for development of traditional health care and promotion of herbal medicines). Main fields: exchange of views, experiences, ideology, facilities, skills etc. Regular 'self-evaluation' of STMS takes place in cooperation with the community health care team of CHAI.

Quantitative data on the programme are scarce, due to the extent of the programme, the great diversity of activities and the adaptation to local needs and priorities. Some quantitative data are available for the 1989-1992(?) period: During this period more than 30.000 patients have been treated in the five village clinics. Immunization programmes have been implemented in 90 villages, providing vaccination to about 2.000 children. In these villages, weekly educational meetings are held. There are 34 *balwadis* (creches) for which 34 leaders have been trained, receiving a total of 2.000 children. In 75 villages weekly motivational meetings were held. A leadership training was held 30 times for 1821 persons. In 1990, 50.000 volunteers were trained for adult education. Each of those trainees have weekly educated groups of adults in 1991. In 42 centres, education is provided to early school leavers.

A number of problems and constraints confront the various programmes of STMS. First, there is a large turnover of core team members and a great degree of inconsistence among field workers. Moreover, personnel are often discouraged by the lack of tangible results. Second, people of the target groups do not seem to show great interest in educational programmes offered by STMS: 'They, especially the target group, always ask for something that is immediately advantageous and of economic benefit'. Other problems recently mentioned are the negative impact of village politics and the role of village leaders, and of communal-religious riots, as well as the insensitivity of the government to the needs and priorities of the people.

Main objectives for the (current) second phase of the programme are:

- awareness-building among the weaker sections of the community;
- creation of political awareness among the people to enhance meaningfull

participation in the political process and their use of their right to self-determination; thus they can easier mobilize the government apparatus for their development;
- to foster collective action;
- to enhance a harmonious coexistence between various castes and groups;
- greater awareness in the field of health;
- promotion and strengthening of regional and district level networking of different groups;
- ensure people's participation in the process of establishing a healthy society.

These objectives are to be achieved through training programmes, coordinated action programmes, strengthening and promotion of organizations, integral development programmes etc. A major concern is involvement of the people's organizations among the target group. In this period priority will be given to creation of awareness, which should lead to organization building in the villages.

In this phase of the programme, main concern and area of activities will be 'health'. Activities during the second phase undertaken at village level are:

1. health education seminars and camps, to create health awareness among the people (including awareness of aspects of exploitation in the existing health care system, commercialization and mystification);
2. health volunteers training: training of volunteer cadre in each village, to conscienticize the people and facilitate the process of awareness-building;
3. health exhibition, to create awareness about diverse aspects of health (e.g. sanitation, hygiene, nutrition, prevention etc.);
4. school health programme: education of school children on health;
5. mother and child health programme, to create health awareness among women, and organize them to struggle for their rights;
6. mental camps: to educate people on diseases, their causes and prevention;
7. nursery centres: an entry point to new villages; creation of awareness and interest among parents and children
8. non-formal education centres: for school dropouts and illiterates;
9. leadership camps: for orientation and training of youths identified by STMS for future leadership roles in the villages;
10. youth festivals: general goals like interaction, encouragement etc.;
11. exposure programmes: interaction and sharing of experiences;

Other activities and points of attention during this period are cultural troop training; organizations and awareness building; vocational (handicraft) training and production centres; cooperative societies (for marketing etc.); small savings and self-help; cattle and poultry; irrigation; seed bank.

5.5. Karuna Social Service Society (KSSS), Diocese of Bijnor: Community Health Programme

Organization	: Karuna social Service society (KSSS), Diocese of Bijnor, Garhwal, Uttar Pradesh
Project/programme	: Community Health Programme
Rural/urban	: rural
Organization type	: implementing and intermediary
File number	: C317-1918
Commitment	: three years (1989-1992)
Financing	: total : Dfl. 134.178,-
	own contribution : Dfl. 20.025,-
	contribution Cebemo : Dfl. 114.153,-

The diocese of Bijnor consists of the five districts of Western Uttar Pradesh. Of these districts, the district of Bijnor is located in the plains; Pauri (Garhwal), Tehri, Chamoli and Uttarkashi are located in the hills. The project area consists of the districts of Bijnor and Pauri (Garhwal). Health conditions in the area are poor. Uttar Pradesh has a 25% infant mortality rate. Main causes of death are birth-related diseases, diarrhoea, tetanus, pneumonia, measles, typhoid and tuberculosis.

The district of Bijnor covers a total area of 4.852km2 and had a (1981) population of 1.925.637 people. It is a poorly developed, isolated district. Six district towns have primary health care facilties. Main activities of these centres are curative work and a variety of extension services to the surrounding villages (immunization, malaria control, sanitation programmes). Main disease in the area is malaria. Other common diseases are tuberculosis, leprosy, and childhood diseases caused by malnutrition. Diseases are mainly caused by a combination of poverty and unhygienic living conditions.

The district of Pauri (Garhwal) covers an area of 5.440km2, with a (1981) population of 623.617. It is situated in the hills of Western Uttar Pradesh. There are four centres for basic health care in the area. In the hilly area agricultural yields are low. Damage to the environment due to the collection of firewood is a major problem. One of the major diseases in the area is tuberculosis, caused by a combination of poor living conditions, smoking, and hard work under difficult climatic circumstances.

From 1987 the diocese has implemented a programme for training and upgrading of village animators, the Awareness Training and Motivation for Action (ATMA) programme. Village animators are considered the catalysts of development in the villages. By 1989, 20 village animators worked in 20 villages, under the guidance of coordinators of the health centres. To ensure people's participation, *mahila mandals* (women's organizations) are established in the villages. In each village there are village level organizations with decision-making capacity with respect to community decisions and people's involvement. The *mahila mandals* in particular are considered an important forum for people's participation. In the project area, 12 centres have been established to coordinate and give guidance to programme activities, each comprising 3-4 villages. The project holder, Karuna Social Service Society has been formally registered by the government and has a FCRA number.

The target group of the programme financed by CEBEMO consists of the tribal population of 36 villages in the districts of Bijnor and Pauri (Garhwal). The majority of the target population are seasonal agricultural labourers, depending for their daily wages on a small, non-tribal landowning elite. Wages paid to irregular agricultural labourers are very low, and not sufficient to meet subsistence needs. Tribals are the victims of a gradual process of marginalization, due to the loss of control over forests and agricultural land.

The general objective of the programme is to improve the health and general living conditions of the tribal target group. Through active participation in the community health programme, the target group are made to realize that:

- health care encompasses more than merely curative intervention, and can be adequately provided only in the context of total human development;
- the target group makes a legitimate claim to the minimally necessary health facilities and means of development.

KSSS stresses that development should be growth from within, self-growth. Therefore, a primary role is attributed to self-help and self-sustained programmes. The role of outside assistance is a facilitating one: coordination, encouragement, etc.
In the approach chosen to reach the objectives mentioned above, health (especially the preventive aspects of health, and mother and child care) functions as an entry point to total development. Central to the approach are community development and community decision-making, the mobilization of local resources (personnel, financial, government and local social structures) for self-help and self-sustained programmes, and (non-formal) education. The following main activities can be discerned:

1. orientation and training of health teams:

   - training and exposure programmes for the central team, health coordinators, and animators;
   - health education for mothers (through the *mahila mandals*);
   - care of mothers: special care during pregnancy;
   - care of the under-five children, including regular check-ups, nutrition and immunization, deworming, supplementary feeding, vitamin prophylaxis, and an integrated child development programme (in cooperation with the government);
   - day care centres for children of female workers;
   - development programmes: socioeconomic development activities like small-scale industries, cattle rearing, poultry farming, housing (in collaboration with a government programme), saving and loan schemes.

2. training and courses:

   - orientation for the central team;
   - awareness and motivation for the mother and child health coordinators of the area;
   - training for the village level health animators
   - training for *ayas* (child care worker);

- training for women (economic, income-generating activities);
- study on the nutritional status of the target group;
- assessment and evaluation of training programmes;
- follow-up training and orientation programmes for animators;

The staff consists of:

- the central team (six persons: a health coordinator, non-formal education director, director of social work, MCH coordinator, health visitor, and an extension health worker);
- 12 health coordinators from each centre;
- 30 health animators, selected from the target villages, accepted by the villagers and able te read and write, as well as to motivate their communities. Their main tasks:

  - giving regular health education classes;
  - organizing health care activities in the villages;
  - dispensing basic medicine for common diseases;
  - family visits, and study of the health situation;
  - giving non-formal education to children.

- 36 ayas trained in child care, to take care of the day care centres. In cooperation with the balwadi teachers, they will monitor the under-five children;
- *mahila mandals*: to organize the women in the villages. Motivation of the mothers to become active in the fields of health and general developmental activities. They are expected to become a powerful forum for people's participation.

5.6. Peermade Development Society (PDS), Kerala, India: Integrated Health and Development Programme

Organization	:	Peermade Development Society (PDS), Peermade, Idukki district, Kerala
Project/programme	:	Integrated Health and Development Programme
Rural/urban	:	rural
Organization type	:	implementing and intermediary
File number	:	C316-2027(B)
Commitment	:	three years (1993-1996)
Financing	:	total : Dfl. 240.060,-
		own contribution : Dfl. 22.408,-
		contribution Cebemo: Dfl. 217.652,-

Peermade Development Society (PDS) is an intermediate Catholic organization active in the district of Idukki in the state of Kerala. PDS is related to the Syrian diocese of Kanjirapalli, Kerala. From 1981, PDS has been active in two *taluk* of Idukki district (Udumpanchola and Peermade). Main points of attention were improvement of public health, agricultural methods, and education of girls and women. In the course of the years, PDS has gradually switched its activities from provision of services to the target group to stimulating organization building and self-reliance among the target group.

Idukki district, covering an area of 5087km2, is the largest district of Kerala. At the same time, from a developmental point of view, Idukki is one of its most backward areas. Until recently the area was scarcely populated. However, from the fifties a process of colonization by migrants from the lowlands of Kerala and Tamil Nadu started. In 1991, Idukki had a total population of about 972.000.

More than eighty per cent of the district population are small farmers, agricultural workers (wage labourers), or estate workers. Most vulnerable groups are the tribals (mostly agricultural wage labourers) and Tamil estate workers. Landownership is predominantly small, between 0,25 and 2 hectares. Main crops cultivated are pepper, cardamom, coffee, bananas, yams, cassava and other tubers. In Idukki there are hardly any industrial activities.

The level of basic facilities for health care and education in Idukki district lies below the average for Kerala. Important threats to food production and consumption, the general health situation, and ecology are harmfull agricultural practices (land clearing, deforestation), and the increasing use of fertilizer and agricultural chemicals.

From 1984, Cebemo provided financial support for a programme for community development in twelve villages (C317-1288/1288A) and for community health care in 24 villages (C317-1200A/B; people's organization, agricultural training, *grihini* (girls) training, income-generating activities including mobilization of government funds, and a health programme).

In 1990, suppletion funds were provided by Cebemo awaiting a proposal for a new integrated programme. In the new proposal this 'integrated approach' of health and

community development was worked out. From 1991, both programmes in 36 villages were combined into one 'integrated' programme, for which Cebemo support was continued (2027A). As a result, combined attention was paid to health care and general socioeconomic development. But a long-term vision on strengthening of local organizations and the role of PDS was still found lacking. Therefore this funding period was used for further dialogue with PDS, in cooperation with ISI/ES.

The current programme (2027B) is a continuation of the last mentioned programme. Cebemo funding of the ecological programme (2241R) has been included in C317/2027B, with a Cebemo contribution of Dfl. 60.180,-.

Target group of the current programme are the poorest segments of 36 villages in the taluks of Udumpanchola and Peermade in Idukki district. The programme is, more specifically, directed at the 100 poorest families in each of the 36 villages. These are divided into 5 units, the leaders of these subgroups forming the core-group in the village. The programme includes special activities directed at men, women, and youth. The majority of the village population consists of tribals and *harijans* who make a living as estate workers and small farmers.

In the field of health, some data on coverage of the activities of the community health programme are given in a report on the 1990 staff development programme and evaluation:

- immunization: 95% of the children were reached (a.o. 852 BCG, 926 triple, 1035 polio, 259 TT);
- nutritional education and demonstrations: executed in 24 villages; promotion led to adoption by 1200 families;
- environmental sanitation: educational and supportive programmes, leading to 153 families building sanitary latrines and 793 new users of smokeless *chullah*;
- group meeting with discussion of vital developmental issues: 205 sessions in 24 villages (with an attendance between 70% and 80%);
- health education: in all villages; 170 sessions;
- detection and referral of serious cases: the need for more hospital involvement;

The general objective of the programme is integrated development and creation of a sustainable and just society using health or other programmes as entry points. Main points of attention are: organization of the people (through a.o. *sangham*, *grihini* and youth organizations), improvement of hygiene and nutrition, use of indigenous medicines, immunization, savings schemes, health insurance, self-help programmes etc.
In general, the approach taken aims at the gradual strengthening of the target group organizations in such a way that they will be self-reliant in a 5-6 years period.

Priorities for the current period include further strengthening of the self-reliance of the target group organizations (*Paraspara Sahaya Sangham*; 'mutual aid societies'). Further, a survey will be held to serve as a basis for further support to these organizations in undertaking various socioeconomic (developmental) activities. The system of primary health care will be further elaborated, with a.o. mother & child care and vaccination of all children under five years.

The main objective of organization building is gradually (in a 5–6 years period) to create a viable organizational structure for the target groups in the 36 target villages, contributing to the sustainablility of the work of PDS. After creation of a local structure through local organization building, further strengthening of these organizations will have to take place.

An important forum for local decision–making is the *sangham*. Administratively, sanghams consist of a general body, which has final authority and elects the executive body (a president and secretary nominated by the president of the general body, and 5 elected members). All development–related activities are discussed in, and priorities are decided upon by the executive body. As the groups acquire the necessary management skills through training, they are gradually given more responsibility for managing their own affairs without outside control and intervention.

Main objective of the community health programme is the establishment of a health care system in 36 villages linked with 6 hospitals. In this system, Village Health Workers (VHW) are responsible for health education and basic curative services. Hospital nurses provide training, coordination, and more complex curative services. The community health programme was started in 1984 in 12 villages, linked with 3 hospitals. Twelve more villages, linked with three more hospitals, were added in 1986. Thus, the programme became active in a total of 24 villages. In 1991, another twelve villages were added. In the long run, the health system should be able to function independently, in close cooperation with the target group organizations. In the objectives for the community health development programme 1992–1993 a specific health objective mentioned is 'to check the spread of communicable diseases, especially TB and STD's, by screening all the people in the area. Early detection of cancer is also envisaged' (PDS, community health development programme 1992–1993).

The main objectives of the community development programme are organization of the people and implementation of small income–generating projects (rubber, cattle rearing, bee keeping, improvement of agricultural techniques). Further support to these activities is provided by activities in the field of non–formal education and a savings and credit programme. In the long run (after 5–6 years) the programme should enable the target group members to have access to basic needs like housing and employment.

The main objectives of the ecological programme are to develop and spread the application of alternative ecological farming methods in the area, incorporating useful traditional methods used by the farmers.

Main activities in organization–building:

- strengthening of the target group organizations and making them more independent from PDS (management, decision–making, financial responsibility);
- health activities: primary health care, health and hygiene, education, and improvement of environment;
- developmental activities;
- ecological activities;
- extension work;

For the health programme (primary health care, health and hygiene, education and improvement of the environment) the following activities are foreseen for the 1991–1993 period:

- completion of a socioeconomic survey of target families;
- distribution of a health card to each family;
- identification of individuals or groups that require special attention from paramedicals or extension workers;
- listing of children under five years to reach a 100% immunuzation rate;
- organizing pre- and post-natal care for mothers;
- primary health care to the families (house visits);
- encouragement of home deliveries and training of those willing to assist in home deliveries;
- cultivation of essential herbs;
- maintenance of kitchen gardens;
- the construction of at least 10 latrines and 110 compost pits per village every year;

Specific developmental activities are:

- providing basic needs to every family in the target area (employment, education, basic health care, drinking water, housing);
- further organization of sanghams and starting a programme for debt reduction/redemption;
- optimal development of available land ('Whoever owns the land should develop it in the proper and optimum way');
- alternatives to agricultural work: self-employment schemes, small joint ventures etc.;
- non-formal and supportive education;
- housing: the construction of durable houses in collaboration with government schemes;
- other vital issues: drinking water, pricing of agricultural products, roads etc.;

Activities of the ecological programme:

- research and development (a.o. agricultural base-line studies, trials on crop varieties, development of low-cost technology, assessment of soil improvement through ecological farming, demonstration and trials);
- extension work (demonstration plots, contact farmers, volunteer farmers, training);

In 1991 the programme of PDS was evaluated by ISI/ES. The changes brought about in the area are called impressive, as shown for instance in the fields of health care, employment and income generation, education, WID, environmental sanitation, and resource mobilization. Positive results are reported in the attitudinal sphere: cleanliness, cultivation of herbal plants, health consciousness, agricultural methods, initiatives of the population towards the government, banks etc.

But the evaluation report stresses the fact that these achievements (which by the way can hardly be measured or quantified due to the lack of baseline data) were the result of 7 years' work by a large team. The evaluators have the impression that more could have been reached under conditions of better management.

One of the points of critique emanating from the evaluation is that the groups that have been formed seem to have above all a supportive function, with PDS continuing to take the important decisions. Therefore, according to the evaluators, a main point of attention should be the further strengthening of the self-reliance of the target group organizations and of the health care programme.

ISI/ES also observed that, due to a number of causes, gradually the original objectives and strategies of the health programme became less important, and focus shifted to a great variety of other programmes. Activities suffered from compartmentalization, and common goals gave way to segmentation between the programmes, each with its own targets. They concluded: 'The original idea of evolving an alternative system of primary health care is forgotten.... What is seen at the moment is a number of activities, without a common thrust or common goal. Each one has its own merit. But, in their isolated fashion, they cannot achieve the objective of creating a sustainable society' (p.13-14).

ISI/ES concluded that there was a need for a redefinition of goals, and a new strategy to orient activities towards a common goal. It was suggested that special attention should be paid to the following points:

- assessment of the type of services required, and the type of system needed to implement it;
- the village health programme should be under the control of the village core groups, with the hospitals as partners and not as masters;
- development of a long-term plan to run the health programme without external aid within 2-5 years;

Other important points of attention for the health programme as identified by ISI/ES are:

- the need for better tools for planning, improvement and evaluation of health programmes for the poor;
- the need for a base-line survey (with data on infant mortality, maternal mortality, male-female ratio, malnutrition, protein-caloric deficiency, sanitation and hygiene, health awareness);
- the need for monitoring and evaluation, and applying new insights in preventive and promotive measures and approaches.

5.7. Trust for Reaching the Unreached (TRU), diocese of Ahmedabad, Gujarat: Comprehensive Primary Health Care, Panch Mahals, Gujarat. Diocese of Ahmedabad

Organization	: Trust for Reaching the Unreached (TRU), Vadodara (Dioc. of Ahmedabad), Gujarat
Project/programme	: Comprehensive Primary Health Care in a Tribal Area, Panch Mahals, Gujarat
Rural/urban	: rural
Organization type	: implementing and intermediary
File number	: C316-2195(A)
Commitment	: three years (1993-1996)
Financing	: total : Dfl. 304.096,-
	own contribution : Dfl. 11.735,-
	contribution Cebemo : Dfl. 292.361,-

Trust for Reaching the Unreached (TRU) is a Gujarat-based secular non-governmental organization. TRU was established in 1987 by four professionals with a long-standing experience in rural development, and particularly in programmes for rural health care. TRU concentrates on activities aimed at improving the health situation in Panch Mahals, a poor, isolated and economically backward area in the eastern part of Gujarat, bordering on Madhya Pradesh.

The majority of the inhabitants of the project area are of *adivasi* (tribal) origin or belong to the 'backward classes' (non-tribal, marginalized caste communities). Many of them work as small farmers and landless labourers. The project area is located at a distance of 65 kilometres from Baroda, which harbours a medical college and a hospital.

The present programme has as its primary objective the training and education of Village Health Workers (VHW's) in sixteen villages in Panch Mahal district, Gujarat. The project area has a total population of about 30.000 people. During this funding period activities among the original target group of 15.000 will be consolidated, while the target group will be expanded with another 15.000 people. The target group consists for the larger part of tribals and members of vulnerable groups in general ('backward classes').

Choice of the current project area is based on a number socio-economic and health-related criteria:

- the majority of the population belong to the groups of tribals and 'backward classes';
- the prevalence of contagious diseases like skin diseases, leprosy, malaria, respiratory infections (especially among children), tuberculosis, STD's, diarrhoeal diseases and malnutrition;
- high infant - and pre-school mortality rates; high protein energy malnutrition and vitamin A deficiency (five per cent of the children under the age of five suffer from serious malnutrition);
- a low (aggregate) literacy rate of 28% (for men: 50%, for women: 18%);
- the majority of the population (66%) has no regular work/income, and live under

the poverty line as defined by the Indian government;
- the geographically isolated character of the area.

Government health facilities are few and far between (situation 1990). At Shivrajpur there is a government primary health centre, which spends most of its time and energy on the programme for population control. Apart from some irregular immunization activities, preventive and promotive health services do not exist. No use is made of community health workers or traditional birth attendants. Other important activities, like health education, care of children under five years, control of communicable diseases, nutritional education, women's health care, are also lacking. Private practitioners and drug stores are concentrated in the local towns, further restricting access of the rural population to health care.

TRU has a core staff of ten qualified medical and social workers, working under the guidance of of three medical doctors and three qualified and experienced social workers. Field staff consists of 30 trained VHW's/organizers, recruited from the target group and trained by the core staff. Their main tasks are the formation of women's and youth groups, health education, mother and child care, savings and credit programme promotion, *balwadi*, promotion and stimulation of hygiene and sanitation, and non-formal education.

The activities supported by Cebemo during this funding period are a continuation of the previous period (C317/2195R). The main objectives of the current programme are:

a. to improve the health status of the target group (through a combination of curative, preventive, promotive and rehabilitative services); reduction of morbidity and mortality (specifically directed at malnutrition of women and children);
b. basic epidemiological research to gain more knowledge on health problems in the local socioeconomic and cultural context (especially: malnutrition);
c. networking with like-minded organizations and persons, to develop a health-for-all strategy;
d. continuing education programmes for health personnel at various levels, appropriate to local conditions and experiences (for both project personnel and for personnel of member institutions of Gujarat-VHA);
e. to stimulate and create conditions for people's participation, so that in the long term they will be in charge of their own health (by establishing and working with village level groups).

In order to realize the objectives mentioned above, a great variety of activities are carried out:

1. curative services at various levels (30 village health workers at village level, each serving a group of 100 families or about 500 people; three multi-purpose workers at mobile team level; a doctor and laboratory facilities at centre/dispensary level in Shivrajpur);
2. preventive services, including health education and disease prevention (regular health education sessions and other educational activities; a special programme for school children; education as part of preventive programmes like (a.o.) growth

monitoring, identification of at-risk children under five years and immunization, women's clinics, and a training programme for traditional birth attendants);

3. promotive programmes concerning the health behaviour of local people (identification of local determinants of 'positive health', promotion of positive practices, and health education action through community organizations);
4. training programmes (focus group camps for women, youth, teachers, community leaders etc.; training camps for village health workers; in-service training and continuing education programmes for staff and health workers);
5. information gathering and field research (data information system; basic epidemiological research);
6. community organization (formation of formal and informal groups of the target population and their involvement in all stages of the project);
7. networking with other NGO's (network; resource base; link-up of the network with Gujarat-VHA, Medico Friend circle etc.; coordination of project activities through three units/centres in Talawadi, Shivrajpur and Waghbod; Shivrajpur, having a dispensary and laboratory facilities, will act as the referral point and training centre for VHW's. The Baroda office maintains relationships with the hospital and medical college).

TRU gives priority to prevention and promotion, and to a comprehensive approach to health care in which community participation plays an important role, without neglecting curative aspects of health care (in 1991, 11.933 persons were treated in the three clinics run by TRU).

In the TRU proposal for the period 1993-1996 a number of problems, experiences and major challenges for the future period are mentioned, the most important of which are:

Most local resources are concentrated in the hands of a few regional traders, with vested interests in the existing socioeconomic relations and little sympathy for initiatives aiming at the improvement of the socioeconomic position of the poor. The situation of the poor target group of TRU has even worsened during the last years. They have been hit by price rises and inflation, and can hardly meet their subsistence needs. Under the influence of these developments, motivation to spend time and energy on common goals has decreased, generally leading to an absence of participation in the project activities. Increasing seasonal migration is another threat to participation in the programmes.

Sometimes an adequate choice of village health workers is very difficult. While in principle priority is given to the training of women, in practice they are hard to find, especially because of the low rate of (semi)literacy among them and the weight of household and other tasks. Other obstacles to the functioning of women as VHW's are their lack of mobility in the village and its surroundings (especially in the case of widely scattered village populations). In villages with mixed caste populations, their role as VHW is seriously hampered due to problems of acceptance among different groups.

Organizing women has also proved very difficult. They are
still subject to male domination and decision-making, and exploited. Moreover, in the villages concerned there is no culture of women's gathering except for death and marriage ceremonies. As women are not very mobile in the village surroundings, services related to

the TRU-programmes have to be delivered from house to house.

Another difficulty are expectations among the target group about the role of outside agencies or organizations. People have become used to a culture of charity and material incentives. There is, as a result, a very low rate of acceptance of TRU's theory of self-help and self-support: 'This has made it extremely difficult to persuade people to participate in a public activity without material gains. This is a major inhibitory factor to people's organization and mass mobilization'.

5.8. Christian Council for Rural Development and Research (CCOORR), MAGR District (Vengal), Tamil Nadu: Rural Health Training Centre and Extension of Field Activities

Organization	:	Christian Council for Rural Development and Research (CCOORR), MAGR District (Vengal), Dioceses of Madras and Milapore, Tamil Nadu
Project/programme	:	Rural Health Training Centre and Extension of Field Activities
Rural/urban	:	rural
Organization type	:	implementing and intermediary
File number	:	C316-3840
Commitment	:	three years (1994-1997)
Financing	:	total : Dfl. 411.754,-
		own contribution : Dfl. 141.299,-
		other donors : Dfl. 131.861,-
		contribution Cebemo: Dfl. 156.639,-

The Christian Council for Rural Development and Research (CCOORR)is a secular organization, established in 1986 by a number of committed Christian leaders, and local leaders from the target area. After its establishment, CCOORR became a secular organization. The eight board members of the organization have a background in the medical, social and educational sectors. Training staff consists of qualified medical personnel and a social scientist. Specialized resource persons are available for additional advice.

CCOORR has extensive experience with various approaches to health care. Initial experiments with mobile clinics were too much concentrated on medical (curative) intervention, while preventive and promotive aspects of health care came in the second place. Later experiments with community health workers gave problems with selection, training, follow-up and financial support. Now, in the approach taken in Vengal, new directions have become visible. Characteristics of this approach are among others: a small working area; organizing inhabitants into groups and inquiring into their needs; integration with local practices and available skills (e.g.: TBA's); making use of locally available people (VHW's); representation of people's organizations in the board.

Headquarters of CCOORR is at Tiruninravur, Chengalpattu, MGR district, in the state of Tamil Nadu. The town of Tiruninranvur is located at a distance of 34 kms. west of the state capital Madras. The training centre established during the current funding period is located at Vengal village, 16 kilometres from Tiruninranvur.

The original target area for the programme that was started after 1986 comprises 31 villages and hamlets, with a total target population of 32.000. Direct beneficiaries among the target population are 16.000 inhabitants of these villages (the 'old area'), some 70% of which are socially and economically disadvantaged and have a lower caste or tribal background, with little access to health care facilities. All villages are located within a distance of eight kilometres from Tiruninranvur.

Main points of attention in the approach taken by CCOORR are people's organizations (the erection of elders', women's and youth councils) and health. By organizing the village population in councils, a local structure is created for the planning and implementation of programmes, according to local needs and priorities.

Health activities are based on a two-tier system of so-called 'micro centres' and 'macro centres'. While there is one micro centre for each 150 families (1.000 persons), the macro centre is a local headquarters provided with a small hospital.

Two priorities stand out in the CCOORR-approach to health care. The first is integration of programme activities with the local traditional medical system. In this respect the central role of the traditional birth attendant deserves mentioning. These birth attendants have been scientifically trained and appointed as Village Health Worker (VHW). The VHW is the manager of the micro centre at village level (in the VHW's house). In the project area there are 15 micro centres and one macro centre. From the macro centre supervision by trained health personnel is provided to the VHW's at micro level.

A second priority is a multisectoral approach to health development. Points of attention in the socioeconomic field are creation of awareness through (non-formal) education, providing know-how, training and other support to programmes for development initiated by the micro centre councils. Socio-economic development is considered a precondition for health development.

Through the diverse groups at micro level, a great number of socioeconomic activities have been initiated in the fields of irrigation, agriculture, cattle rearing, adult education (for the elders' groups), a dairy programme for family nutrition, training and employment, small industry, creation of awareness for leaders, community banking, child development centres, and a library (for the women and children groups), poultry, fishery, sports and games, mental development and community banking (for the youth groups), a goat bank, formation and operation of a banking association, vending consumer needs (for the handicapped).

For the health care programme, some statistical data are given in the CCOORR proposal (1992), comparing the base-line data with the 1992 situation on a number of indicators:

	base line (1989)	report (1992)
births (per 1.000 pop.)	28	18
deaths (per 1.000 pop.)	9	5
maternal mortality (per 1.000 life births)	3	2,5
infant mortality (per 1.000 life births)	72	26
family planning acceptor rate	10%	17%

Now this successfull approach used for the 'old area' has been extended to the 'new area', with a target population of 20.000, living within a radius of 8 kilometres from Vengal. Experiences gained in the 'old area' can be used for implementing this programme in the 'new area'. In the meantime, the old area is on the verge of attaining self-reliance. The new area is situated at a 14 kms. distance from the 'old area', and has a predominantly tribal population.

Target groups of the programme (Vengal) are, first, the lower and middle cadres of NGO's working in the field of rural health care and, second, the inhabitants of the villages around Vengal, most of which are poor, have a tribal background, and have little or no access to basic health care facilities.

The first objective of the programme supported by Cebemo is the establishment of a primary health care training centre in an area which until now is characterized by a very simple health infrastructure. The training centre will primarily be used for sharing and disseminating knowledge and experiences on primary health care by middle level and grass root level personnel of voluntary organizations (NGO's) in South India. Such a forum for periodical meetings will facilitate the establishment of a network of NGO's in the region.

The second objective is the improvement of the living conditions of 20.000 people around the training centre by primary health care outreach programmes and training.

The third objective is to provide a forum for other NGO's to periodically meet, share experiences in rural health development and establish a network.

In the proposal, a number of 180 direct beneficiaries, and 91.500 indirect beneficiaries after five years are mentioned. For the three-years period of Cebemo support a number of 110 direct, and 54.900 indirect beneficiaries are foreseen.

Main activities of the programme are:

- building a training centre at Vengal;
- establishing contact with NGO's to participate in the training programmes;
- organizing training programmes in the training centre for:

    = village health workers (traditional birth attendants, TBA's: women who conduct home deliveries); integration of existing practices with scientific knowledge and skills; emphasis on the preventive and promotional aspects of health. Each year three one month-training courses are held for 10 trainees each;
    = rural health extension workers (RHEW): supervisory staff of VHW's, who operate from the macro-centres in monitoring, guidance, assistance and advice of the VHW's; coordinating role between micro- and macro levels, and between NGO and government apparatus. Training with a duration of 18 months.
    = medical technologists: "This training aims at bringing science and

technology to village level..." by training rural persons with ten years of schooling in x-ray, lab., ECG recording and building up medical records for rural hospitals; a one-year training phased in two semesters;

= continuing education programme (envisaged): for ex-trainees (VHW's and RHEW's) on a monthly basis;

- establishment of 15-20 new micro centres in the villages around Vengal, with a target population of 20.000. The macro-centre for this area is to be located in the training centre. Micro centres will function as demonstration areas for trainees.
- stimulate networking among like-minded NGO's, cooperation and sharing of experiences.

As becomes clear from the proposal, target groups, criteria for eligibility, and level of skills and knowledge reached through the training programmes have been formulated in such a way as to minimize the risk of migration of trainees to urban areas or other countries.

CCOORR is registered with the Tamil Nadu government under the Societies Registration Act, and thus recognized as a charitable social organization entitled to receive funding from the state government and from abroad. Central staff consists of a director, a secretary, an accountant, a typist, an office helper and a driver. For the training programme and community programme there are three qualified training staff members, a community nurse two cooks and an audiovisual assistant.

This programme has been recently (1994) adopted for financial support by Cebemo. Though Cebemo has a restrictive policy towards new requests for financial support originating from the southern part of India, in some cases exceptions to this general rule are made. Such exceptions are the special priority areas of women, environment, urban poverty and rural development, as well as projects or programmes that stand out by their innovative approach. As the CCOORR takes a comprehensive approach (participative, multisectoral, and integrated with local practices), which is considered both successfull and innovative, can be further spread through training programmes for lower and middle NGO personnel, and explicitly pays attention to networking among like-minded NGO's, Cebemo has decided to give financial support to this activity (construction of the training centre and initial expenses of the training programme).

CCOORR makes use of and cooperates with diverse government programmes in the fields of health and development. Relationships with the government agencies are good. The government is very interested in the training programme, and provides part of the necessary financial support. Within five years, running costs of the training centre are expected to be covered by local resources (both governmental and non-governmental).

6. PROFILES OF ORGANIZATIONS, PROJECTS AND PROGRAMMES FUNDED BY ICCO

6.1. Introduction

According to the most recent overview, Icco presently supports 45 health-related projects and programmes in India. Out of these projects and programmes a preliminary selection has been prepared by the Icco staff. Selection took place according to the following criteria:

1. in view of the key questions of the evaluation (see concept TOR) and the increased support by Icco of intermediary organizations, the organizations selected should be intermediary rather than implementing;
2. the organizations selected should be relatively large organizations with a considerable health component;
3. they should be of some (potential) relevance to the current and future activities of Icco in india.

On the basis of these preliminary criteria, the following organizations/programmes were selected as possible candidates for evaluation:

1. Child In Need Institute (CINI), Calcutta, West Bengal: Integrated Development Programme for the Women and Child in Need
2. Ashish Gram Rachna Trust/Institute of Health Management Pachod (AGRT/IHMP), Aurangabad District, Maharashtra: consortium project
3. Voluntary Health Association of India (VHAI), New Delhi: programme financing 1992-1995
4. Christian Medical Association of India (CMAI), New Delhi: Consortium Financing 1993-1996
5. Rajasthan Voluntary Health Association (RVHA), Jaipur, Rajasthan: support to RVHA programme 1993-1997
6. International Nursing Service Association (INSA), Bangalore, Karnataka: Rural Health and Development Trainers Programme 1991-1994 (---> March 1995)
7. Asian Community Health Action Network (ACHAN), Madras, Tamil Nadu: Community-Based Action for Transformation in Asia (proposed)
8. Association of Sarva Seva Farms (ASSEFA) (IN 057041)

On some of these organizations, preliminary remarks can be made (some of which are based on data gathered from the files of the organizations concerned and on informal discussions with Icco personnel) that are relevant for a decision on the evaluandum:

INSA has been (externally) evaluated during the period 1988-1991. INSA has planned another external evaluation for 1994. Whether this evaluation has already been carried out or will take place in the near future, is not clear. A possible danger of over-evaluation is clearly present.

ACHAN is in some respects an 'outsider'. First, ACHAN is an all-Asia umbrella organization, operating from Madras and Bangkok. There is a lack of clarity about the precise value of ACHAN for the *Indian* health sector. This could in itself be a useful main point of attention for the evaluation mission. Second, and related to the first remark, ACHAN seems to have few regular contacts with other NGO's in India. Currently, a new ACHAN proposal for the period 1994-1997 is being assessed by a consortium of EZE, Icco and Miserior. In the profiles, ACHAN has been included under the name of its new programme, currently under consideration of the donor consortium mentioned above.

ASSEFA is a special programme funded with DGIS funds. An evaluation by DGIS is planned for the near future. Another reason for *not* including ASSEFA in the evaluandum is the fact that it is far from representative for the kind of organizations generally supported by Icco (ASSEFA is a real multinational, supported by 15-20 'ASSEFA groups' in different countries. It has offices in Europe, a.o. in Italy. Developmental activities are not *primarily* concentrated in the field of health and health-related activities. In the light of, especially, the first point, ASSEFA has not been included in the desk study.

6.2. Child in Need Institute (CINI), Calcutta, West Bengal: Integrated Development Programme for the Women and Child in Need (phase II)

Organization	:	Child in Need Institute (CINI), Calcutta, West Bengal
Project/programme	:	Integrated Development Programme for the Women and Child in Need (phase II)
level	:	local/regional
urban/rural	:	rural
Organization type	:	intermediate
File number	:	ZA 15493 (934319)
Commitment	:	three years (1993-1996)
Financing	:	total : Dfl. 545.835,-
		local contribution : Dfl. 93.828,-
		other donors : Dfl. 179.089,-
		contribution Icco : Dfl. 272.918,-

The Child in Need Institute (CINI) is a secular organization active in the fields of health and development. CINI was formally established in 1975. Initially, CINI was primarily concerned with relief and welfare. Later, more comprehensive approaches to village development were taken, resulting in the current programme. CINI has been supported by ICCO from 1990.

CINI has been registered under the Societies Registration Act. Currently CINI has a total staff of 183 people, the majority of which are women. The board is made up of seven persons, with an academical and medical background. CINI has a system of decentralized decision-making through the CINI-parliament, consisting of all project officers responsible for the implementation of CINI programmes. Decisions of this parliament are submitted to the Governing Body, which meets every 2-3 months. In accordance with its objective of promoting communal harmony, CINI personnel are drawn from all sections of society and all religious groups (Hindu, Muslim, Christian, Sikh).

In the recent past CINI claims to have achieved considerable improvements in the local health situation (infant mortality rate, crude death rate, crude birth rate; note however that the data given by CINI in its proposal for phase II provide an interesting general comparison with the national averages and targets for the year 2.000 for the indicators chosen, but do *not* allow for an assessment of trends in the CINI target area itself and of the impact of intervention by CINI).

Yet, the CINI approach is not restricted to health care alone. CINI considers health as part of overall development and an entry point for other developmental activities. In the field of health care, priority is given to preventive and promotive rather than curative aspects. CINI fully supports the primary health care approach, and has developed a model for health care which is appropriate, low-cost and replicable. Emphasis is laid on participation by mothers and family members.

Initially CINI experimented with decentralization of health care through *mahila mandals*.

These women's organizations carried out activities in the fields of health care, pre-school education, income-generation for women, and girl child programmes. Later, it was realized that, with respect to other important issues, there is a great need of broader village involvement and representation. Therefore, CINI decided to start working through so-called 'village development forums' (VDF). This new approach is now tried out on a trial-and-error basis. The *mahila mandals* play an important role in the VDF's, and continue to do so in village development.

Main programmes implemented by the organization are: health service programmes; community development; environmental change; training; research; publication; referral services; consultancy work. All CINI programmes are related to health and development. The current programme (phase II) falls under the CINI community development programme.

The programme currently funded by Icco aims at improving the health situation of women and children through an integrated programme in 65 villages in Bishnupur Block I and II, and villages in different blocks of Diamond Harbour subdivision of South 24 Parganas District, West Bengal. While during the first period the programme concentrated on health, later attention was also paid to income-generating activities for women. The 65 villages are located in a rural area with low accessability to nearby towns. The majority of the population are landless and daily wage labourers, many of them illiterate, unskilled, and belonging to a scheduled caste.

For the purpose of programme implementation and gradual phasing-out, the villages ('village units') have been subdivided into three distinct areas ('sets' A, B and C). The sets A and B are part of the existing project area. Set C consists of villages which have not yet received any assistance from CINI and are not (yet) served by any government agency. Villages in this last group have requested CINI to start their programmes in the villages concerned. In these last villages CINI implements its new approach and strategy of the current programme. Target villages can be subdivided as follows:

- set A (15 villages): in these villages the village development forum (VDF) will probably be operative. VDF will be responsible for a population of about 25.000 people, with only minimal technical and clinical support from CINI;
- set B (35 villages): in these villages CINI facilitators will phase out within the next three years. The total population of these villages is about 51.000. Villages in this category require more regular support;
- set C (15 villages): these villages have not yet received assistance from CINI, nor are there any government services. Here, the new CINI approach will be tried out.

The general objectives of the programme is to improve the prospects for better living conditions of women and children
in the target villages. As the so-called 'Village Development Forum' will play a central role in the programme, specific objectives are:

1. establishing and strengthening the concept of village Development Forum (VDF) to

run village development activities in a sustainable manner;
2. identification of village problems through the VDF;
3. collective analysis of and reflection on existing problems;
4. implementation of the collective solution to the problems identified above in an appropriate manner;
5. facilitation of this process by CINI-personnel.

Specific activities to reach these general objectives are:

1. field-based activities: CINI's involvement should enable the village communities to better identify their needs. This should allow them to target their activities. CINI does not concentrate on health only; the major thrust of its activities will be on general developmental issues. Health activities in the field will be carried out either through home visits or in *mahila mandal*/VDF centre or camp:

   - children (0-6): preventive, promotive and curative activities;
   - mothers: antenatal services; health and nutrition education; post-natal care; motivation for family-spacing; referral services to the institution-based activities;

2. institution-based activities: emergency ward; nutritional rehabilitation centre; thursday clinic; daily OPD;

3. support services: support on a regular basis to the areas A, B and C in the fields of health care, public awareness and income-generating activities from the monitoring team For technical and clinical support institution-based referral services, training and exposure will provided:

   - training exposure for trainees from government and non-government organizations;
   - action research programme for further programme development;
   - clinical services;
   - referral centre for child care;
   - in-service training for CINI personnel;
   - family spacing programme.

Other support services which should facilitate the integrated character of the programme are:

- public awareness team
- women credit groups
- girl child programme
- regular monitoring team

The target group of the programme comprise the women, and children under the age of six years in 65 village units. The target group totals around 106.000 people. The major part of programme activities are carried out by the members of the target group (community

members, women's organizations and the village development forum). The existence of these groups at village level are expected to ensure sustainability of the benefits of the CINI programme.

The distinction between three areas of target villages (areas A, B and C; see above) is reflected in a differentiation between activities and health care objectives for each of these areas.

Activities:

Set A: – encouraging the process that has already been initiated to establish VDF's;
- formalizing the formation of five VDF's in the first year, and ten in the second year;
- follow–up of the evolving VDF's in the third year;

Set B: – strengthening the well–established and the newly–formed women's groups;
- initiating the formation of VDF's;
- formalizing at least twenty VDF's by the end of the third year;

Set C: – identifying local group leaders;
- initiating the process of community organization (*mahila mandal*, VDF, etc.);
- formalizing the formation of fifteen VDF's by the end of the third year.

Health care objectives:

Set A: – sustaining and improving the current levels of health and nutrition achieved in CINI's target population in the last three years;

Set B: – sustaining and improving the current levels of health and nutrition achieved in CINI's target population in the last three years;

Set C: – improving the nutritional and health status of children under five years in communities served by women's groups/VDF's;
- increasing the knowledge and improving health related practices among members of communities served by these groups;
- increasing the acceptance of home and community sanitation;
- providing family planning education and services to eligible couples (esp. spacing);
- increasing the total number of trained personnel in the community;

To monitor and maintain the quality of CINI activities, the following instruments have been developed:

1. keeping and following–up reports, proceedings of meetings and survey results of the monitoring team;
2. early identification of gaps and shortcomings in the programme, and the implementation of appropriate modifications;
3. the formation of subgroups of CINI personnel from various levels, to debate and decide on developmental plans and strategies;

At the local level CINI collaborates with the state government and participates in the government programme for Development of Women and Children in Rural Areas (DWCRA). In the eastern part of India (e.g. in Bihar) in general, and West Bengal in particular, CINI cooperates with a great number of (smaller) NGO's active in the field of community health and development. Among the larger NGO's, CINI is an active member of the West Bengal Voluntary Health Association (WBVHA). CINI has been one of the driving forces behind the recent establishment of the Voluntary Action Network India (VANI), New Delhi.

6.3. Ashish Gram Rachna Trust/Institute of Health Management Pachod (AGRT/IHMP), Pachod, Maharashtra: consortium project

Organization	:	Ashish Gram Rachna Trust/Institute of Health Management Pachod (AGRT/IHMP), Aurangabad District, Maharashtra
Project/programme	:	consortium project AGRT/IHMP
level	:	national (through the training component)
urban/rural	:	rural
Organization type	:	intermediate (service and support)
File number	:	IN 074051 (933068)
Commitment	:	three years (1993-1996)
Financing	:	total : Dfl. 1.724.511,-
		other donors : Dfl. 1.149.674,-
		Icco (EC funds) : Dfl. 316.160,-
		Icco (Dutch gov't): Dfl. 258.677,-

The Ashish Gram Rachna Trust (AGRT) in Aurangabad District, Maharashtra is a secular organization that was established in 1977. It has been formally registered under the Bombay Public Trusts Act in 1979, and possesses a FCRA number. During the first years of its existence, the organization concentrated on hospital-based activities (in an old mission hospital) and the development of a programme for basic health care in the rural area around Pachod. In the eighties, other (more general) developmental activities were added to the original health care programme: biogas, reforestation, safe water supply. In 1986, AGRT established a training institute, the Institute of Health Management Pachod (IHMP). Here, training for staff of other NGO's active in the field of basic health care are organized.

AGRT used its health programme to systematically try out alternative methods and strategies for basic health care. As a result of testing and research by IHMP, new insights were developed and applied in the programme. These new insights also form the basis of, among others, the training programme on health management.

In 1991 AGRT was invited by the Government of Maharashtra to test on a larger scale (at the *taluk* level) a number of government programmes: the drinking water programme (SDW), the health and sanitation education programme, the child health programme (ICDS), and a primary health care programme (PHCP). The target area for these experiments on macro-level, *Paithan Taluka*, has been chosen because it is a drought-prone region with poor health care services. The majority of its population consists of landless labourers and small subsistence farmers.

AGRT stresses that, due to misallocation of scarce resources, poor social targetting and lack of participation, the health programmes of the Indian Government have only little effect on the health situation of the poorest and most needy groups. NGO's, on the other hand, have not very successfully responded to this situation. According to the analysis made by AGRT, their activities are usually based on anecdotal evidence or emotive appeal rather than on analysis and empirical research. In the few cases that they were successful, they had little impact on government or NGO's.

Therefore, the general objective of AGRT is to improve the primary health care programmes and health-related programmes of the government and NGO's through:

1. the provision of health facilities;
2. micro-experiments with alternative strategies to implement health and health-related development programmes;
3. research;
4. sharing innovative experiences and research findings with other NGO's through training programmes;
5. upscaling of innovative systems and strategies to the *taluk* or district level;
6. influencing the policies of, and networking with other NGO's.

Currently, the main activities of AGRT/IHMP are, in short:

1. research on and testing of new methods, approaches and strategies with respect to basic health care in the target area;
2. transmitting these new methods and strategies through the organization of training courses and through consultancy assignments.

As the old organizational structure, centreed round the hospital and the CHDP, did no longer fit the recent developments in AGRT/IHMP, IHMP has recently become the core of the organization, stressing the fact that research and training are gradually replacing implementation of community health care programmes as its core activities.

From 1993, responsibility for the organization rests with the Board of Trustees, which consists of seven people (five of which are women). The organization is headed by a director and an associate director. Different projects are headed by coordinators, under which resort supervisors, support staff and fieldworkers. The total personnel of AGRT consists of 147 people, a large part of which are women (also in higher functions).

Since 1988, at the request of Christian Aid and Oxfam, Icco has funded the AGRT/IHMP training programme and the Community Health and Development Programme in 52 villages (AZ 4378/88, 1988-1989, partyly with EC-funds; AZ 903314, 1990-1991; AZ 903079, 1990-1992). In 1991, Icco has contributed to the training costs of IHMP personnel (913298).

During this funding period Icco contributes to the running costs of the current programme. As has been decided during two consortium meetings in 1992, this programme is funded by a donor consortium, in which Icco cooperates with CA (Christian Aid) and EZE (Evangelische Zentralstellung für Entwicklungshilfe). Instead of funding specific projects, each of these three organizations finances one third of the total consortium budget. Icco support is composed of funds from the Government of the Netherlands (45%) and from the EEC (55%).

Apart from the activities carried out under the consortium programma, the following donor-funded projects are being implemented: a Mother and Child Care programme funded by WHO; a research programme by IHMP, funded by Ford Foundation; CA funds

the safe drinking water programme; CAPART finances tubewells and pumps. The hospital (run by AGRT) with 40 beds is self-supporting.

Expansion of AGRT/IHMP took place from 1991 as a result of the request by the Government of Maharashtra to participate in testing out the government programmes mentioned above. These new developments have led to new forms of cooperation between the donors of AGRT/IHMP, resulting in the consortium agreement in which Icco takes part.

Target area and target group of the current programme are:

a. the primary health care programme of AGRT serves a population of about 250.000 people in 186 villages in Paithan Taluka in Aurangabad district;
b. the trainees from IHMP, who mainly work in the NGO-sector. There are two major courses, one for senior level health managers, and the other for health supervisors who have a minimum educational qualification (SSC) and at least one year experience;
c. the Information, Education and Communication programme: 1000 schoolchildren, 250 teachers and 225 kindergarten teachers will be trained;
d. the safe drinking water programme: the inhabitants of about 700 villages in the Aurangabad district will benefit from this programme.

Most of the beneficiaries are involved in the project at the implementation- and monitoring stage. Comments of the beneficiaries, made during evaluations, are used as a base for future project design. Women are activily involved in project activities. AGRT makes a gender analysis, and some of its activities are especially directed to women.

Main activities carried out during the funding period are:

1. Institute of Health Management Pachod (IHMP) training programme:
   a. senior level health management course (7 weeks);
   b. health supervisors course (1 month);
2. Information, Education and Communication project (IEC): upscaling of the nutrition programme to 186 villages of Paithan Taluka; upscaling of water awareness camps; formation of women's groups for the maintenance of watersources; upscaling of schoolchildren programme to all Paithan Taluka villages.
3. Safe Drinking Water programme (SDW): improved maintenance programme of handpumps, education on waste water management, sanitation and afforestation programmes (in cooperation with UNICEF and the Maharashtra government). During this period a further refinement of the model and further training of government and NGO personnel in the 10 districts of Maharashtra where the World Bank-sponsored programme is implemented, are foreseen.
4. Innovative Integrated Child Development Scheme (ICDS): AGRT has found out that, while most of the malnourished children are under 4 years, 80% of the food supplies under the government ICDS goes to children between 3 and 6 years old.

Girls suffer three times more from malnutrition than boys, but only 50% of the food supplies goes to girls. Therefore, AGRT has developed an alternative scheme, with attention to: training of VHW's in nutrition and growth monitoring; emphasis on prevention of diarrhoea and infections; a better monitoring of food supply to malnourished children; and better social targetting for children under four years and girls. During the current period, the new method will be tried out at macro (*taluk*) level by training government personnel. AGRT will provide supervision and training, while the government will remain responsible for implementation.

5. Sanitation programme: a pilot programme for ten community latrines combined with a biogas programme.
6. Primary Health Care programme (PHC): maternal health care, child health care, TB control, family planning, health education and school health. The programme will be carried out in the entire Taluka (40 'old' CHDP villages, and 146 'new' villages where health workers and TBA's will be trained).

6.4. Voluntary Health Association of India (VHAI), New Delhi: programme financing 1992-1995

Organization	:	Voluntary Health Association of India (VHAI), New Delhi
Project/programme	:	programme financing 1992-1995
level	:	national
urban/rural	:	urban and rural
Organization type	:	intermediairy (service and support)
File number	:	IN 123041 (923350)
Commitment	:	three years (1992-1995)
Financing	:	total : Dfl. 2.691.597,-
		own contribution : Dfl. 479.520,-
		private contrib. : Dfl. 1.883.577,-
		contribution Icco : Dfl. 328.500,-

VHAI (Voluntary Health Association of India) is a national, secular non-profit non-governmental organization. VHAI was established in 1969, at the initiative of the medical commission of the World Council of Churches. Its establishment was a response to the need for the promotion of community health as an alternative to the existing curative, hospital-based and expensive health system. Most important general objectives of VHAI are promotion of health care in India, with special attention to the poorest groups in society. VHAI stresses the interconnection of health issues with socioeconomic and political factors. The organization tries to reach its objectives and influence health policy through active lobbying activities (government, parliament).

Since its establishment, VHAI has become one of the largest and most important national support/umbrella organizations active in the field of health in India. VHAI has now more than 3.000 member organizations. VHAI has 83 staff members and four consultants. The organization has recently embarked on a process of decentralization by stimulating the establishment of state-VHA's and strengthening these organizations at state level. State-VHA's have been established in 19 states. Recognizing the importance of further growth at the level of the state-VHA, from 1991, VHAI has consolidated its position and given priority to the expansion of state-VHA's.

VHAI has a 'general body' which consists of 19 VHA-representatives. Board members should be women for at least 30 percent, and should also be composed of people with different religious and professional backgrounds. Changes in the composition of the board take place every two years, while the maximal duration of board membership is four years. The 'executive board' has 11 members. VHAI is registrated under the 'Societies Registration Act' and has a FCRA-number, which makes it possible for VHAI to receive funding from foreign donors. VHAI is known to be a stable organization with a clearly outlined and consistent policy.

A major general aim of VHAI is the promotion of social justice in access to and the provision of health care. In order to reach that goal, health issues are analysed in the context of socioeconomic and political issues that have an impact on the health situation. The following major objectives can be discerned:

- creating the conditions for building up a people's health movement through networking, lobbying, campaigning and activities related to public affairs;
- assisting in the development of low cost, appropriate and people-oriented health programmes in harmony with locally available knowledge and skills;
- providing support services to community health programmes of members and associate organizations;
- research of various aspects of primary health care.

The short-term objectives are to plan and implement a wide range of programmes and activities, and to create an adequate decentralized organizational structure which are instrumental to reach the long-term objectives. Specific aims for the current period (1992-1995) are:

- to develop a more broadly-based health movement in the country through active state-VHA's and their expanded memberships, particularly in the neediest parts of the country;
- to develop and further strengthen the support function in VHAI, to ensure that members and associate organizations receive prompt and appropriate training and information;
- to build up a strong research base on important health and health-related issues like nutrition, clean and safe environment, education, health care systems and services, health research, and AIDS;
- more systematic public education on major health issues and effective campaigning and lobbying on these issues with the policy-making bodies;
- to build up active links with similar apex bodies in health care in India, South Asia, and Southeast Asia, and with PHC resource centres throughout the world;
- to make systematic efforts towards self-sufficiency through local fund-raising and more widespread distribution of VHAI publications.

The target group of VHAI consists in the first place of those people who have no sufficient access to basic health care facilities, especially poor and marginalized groups in society. It should be stressed that these can only be reached indirectly, because VHAI is not an implementing organization. Direct target group(s) of VHAI are those institutions, officials, NGO staff members and health workers reached by training, information, lobbying and other VHAI activities.

VHAI is organizationally subdivided into the following departments, created to carry out the activities mentioned above:

1. Promotion of Community Health

Main task of this department is to build up and strengthen the professional and managerial skills in health programmes based on the principles of community health and development. Training programmes should be need-based and participatory. The programme covers health functionaries at different levels.
The following programmes can be discerned: a school health programme; traditional systems of medicine; health orientation for development groups; child to child programmes; diploma course in community health planning and management (DCHM);

training of trainers; correspondence course in community health and management; training programmes on special request; publication of newsletters; preparation of training modules and educational materials.

2. Public Policy

Main objective of this department is 'to create awareness on health policy programmes and issues related to social justice in health care. It also tries to mobilise people's opinions and activities with a view to influence policies and legislations at different levels so that right, power and basic amenities can be assured to the poorest of the poor.' Related objectives are:

- creating awareness among the people, professionals and policy makers with a view to influence policies related to health;
- network development among organizations and activists with similar objectives;
- activating and involving health personnel and academic circles in health-related issues;
- advocacy, lobbying, networking ang campaigning activities at different levels;

Main issues taken up are: rational drug use and drug policy; women and health; rational use of drugs (traditional systems of medicine) and rational TSM policy; prevention and control of AIDS (Currently VHAI is implementing a three-year project for prevention and control of AIDS in the states of Manipur and Tamil Nadu, started in 1991-1992 and funded by the Ford foundation); national health programmes (e.g. iodine deficiency, diarrhoeal disease control, TB control, malaria, kala azar; pesticides; addictions.

Activities undertaken for these issues are: collection and compilation of policy documents and scientific papers from diverse sources; analysis of the collected information; preparation of basic material; dissemination of information to organizations and personnel active in the field; workshops, seminars, training programmes etc.; meetings and group discussions to facilitate networking among like-minded organizations; advocacy and lobbying at different levels.

3. Communications

Main points of attention in the field of health education are the provision of information material on health and health-related issues. Of particular importance is the provision of low-cost materials accessible to voluntary groups in India (e.g. flip charts, flash cards, books and posters in Hindi, English and other Indian languages).

The department provides support to VHAI programmes (educational material for target groups in urban and rural setting: policy makers, the general public, middle level workers, village health workers, school children etc.)

4. Information and Documentation

This department provides information support to VHAI-programmes and staff, state-VHA members and affiliated groups, and serves as a referral centre for other users from 'outside' the VHAI network. Priority themes are, among others, communal issues, health finance, alcoholism, violence and health.

5. State VHA's

The network of 19 state VHA's which VHAI has built up forms an important instrument for linking-up with voluntary organizations active in the field of health care throughout India (totalling some 3.000 organizations now). The State VHA Unit has the following functions:

1. liaison with and support to all State VHA's (staff orientation and training; planning and implementation of programmes; relations with funding agencies, government and non-government forums; and diverse other activities);
2. contacts with NGO's that are not (yet) members of State VHA's, motivating them to join;
3. contacts with union and state governments, and seeking their cooperation;
4. getting together VO's in those states where State VHA's do not yet exist;
5. common action programmes;
6. identification and development of new relevant concepts;
7. personnel motivation and placement, as well as receiving inputs from experienced personnel.

Recently VHAI has prepared and issued an extensive report on the health situation, the existing health system and health services in India, with special attention to sociocultural and socioeconomic determinants of the health status of the population (VHAI, 1992). In 1991-1992 VHAI has been (internally) evaluated. The evaluation committee has made a number of recommendations to make VHAI a more effective and efficient organization able to face the many challenges as identified in the report 'State of India's Health'.

While until recently the relationship between the government and VHAI was characterized by some government distrust regarding the objectives and activities of VHAI, during the last few years this relationship has much improved. The government now fully recognizes the important role that VHAI plays in the health sector, to such an extent that VHAI has produced the health care section of the eighth five-year plan of the Government of India.

Icco has a funding relationship with VHAI since 1983. From 1987 support was concentrated on the VHAI/PEHA (Public Education and Health Action) programme for health campaigns, research on health issues, and production of information materials. At the request of VHAI, in 1991 Icco shifted its policy of project/department financing to programme financing. From 1992, Icco-funding takes place through a consortium. Icco provides funding not only to VHAI, but to a number of state VHA's as well (e.g. Rajasthan VHA; see this chapter).

For Icco, VHAI is an important partner for a number of reasons:

- VHAI has a network of which many regional and local NGO's are part;
- it is an important resource organization for Indian NGO's (information, expertise, statistical material);
- it is a large producer of material for information, training and conscientization (a.o. for NGO's in the health sector);
- VHAI implements many programmes and activities in the field of public health and equity in health care;
- because of their lobbying activities towards the government and critical appraisal of government policies;
- as an advisor to Icco.

Apart from Icco, VHAI receives contributions from other donors (EZE, Brot für die Welt, Christian Aid and other donor organizations). But the organization itself makes a considerable financial contribution gained by its publications section. In the near future VHAI's own contribution could possibly be further enlarged throught the collection of 'service fees' from government sectors and NGO's (and possible also MFO's) to which special services (consultancies, data collection, publications etc.) have been delivered. In the future, large NGO's like VHAI can be expected to receive increasing amounts of funding, both from the Indian government and from national and international donors.

An important future policy issue for Icco is the reconsideration of its relationship with VHAI in the light of the growing importance and more intensive contacts and funding relationship with the state–VHA's. The relationship between the national and state organizations will remain an important issue for VHAI as well.

6.5. Christian Medical Association of India (CMAI), New Delhi: consortium financing 1993–1996

Organization	:	Christian Medical Association of India (CMAI), New Delhi
Project/programme	:	Consortium Financing 1993-1996
level	:	national
urban/rural	:	urban and rural
Organization type	:	intermediairy (service and support)
File number	:	IN 142021 (934062)
Commitment	:	three years (1993-1996)
Financing	:	total : Dfl. 3.788.567,-
		own contribution : Dfl. 792.665,-
		other donors : Dfl. 2.070.900,-
		other local contr. : Dfl. 406.699,-
		contribution Icco : Dfl. 518.303,-

CMAI is a Christian (Protestant) intermediary (support, networking) organization. It was established in 1905 as an organization for Christian doctors (which did not allow Indian members). CMAI has been registered and formally recognized for more than eighty years, and during this period has functioned as the umbrella organization in the field of health care for the Protestant churches in India. It has a membership of more than 300 institutes for health care and some 3.000 individual members, like medical specialists and other health personnel. CMAI is the official health care organization of the National Council of Churches in India (NCCI).

CMAI is a national organization with field secretaries in 11 states all over the country. A large part of its membership, however, is concentrated in the southern states of India. Recently, CMAI has recognized that, in order remain true to its own priorities, objectives, and Christian inspiration, it should give special attention to the BIMAROU states (Bihar, Madya Pradesh, Rajasthan, Orissa en Uttar Pradesh). About 45% of the population of India is concentrated in these states, where according to health –, socioeconomic –, and welfare indicators the poverty situation is most acute. These mainly Hindi–speaking states have large tribal populations, the social status of women is very low, and feudal practices are still common. Therefore, CMAI has decided gradually to shift attention from the south to these northern areas. CMAI headquarters have already been moved from Nagpur to New Delhi.

Cooperation between Icco and CMAI dates from 1979, and focused on programmes in the fields of family planning, mother and child care, and infrastructural support when recently CMAI moved its headquarters from Nagpur to New Delhi. In 1991 it was decided that from 1993 onwards the majority of CMAI's activities will be financed within the framework of a consortium. During the 1993–1996 period Icco supports CMAI through a consortium agreement for the first time. The consortium is made up of eight donors (among which: Brot für die Welt, Christian Aid and EZE).

Apart from its funding relationship with the consortium mentioned above, CMAI maintains (bilateral) relations with the World Health Organization (WHO) and the American organi–

zation Lutheran World Relief (concerning AIDS prevention and starting a programme for field hospitals/basic health centres after the 'Jamkhed model').

According to the analysis made by CMAI of the Indian health care system and contributions made to it by the church, the Indian health situation can be characterized by the following main problems:

- high mortality and morbidity rates among children, usually caused by preventable diseases;
- a severe lack of attention to the health situation of women; many women die in childbirth;
- little attention is paid to the relationship between environmental factors, poverty, a low rate of literacy and the health situation;
- health services, when available, are predominantly curative-oriented, hospital-biased and too much stressing the role of medical doctors. Another problem is the low quality of planning;
- the factors mentioned above are further reinforced by the increasing population pressure;
- new problems with a clearly social dimension like alcohol and drug addiction, AIDS, and negative effects of the gradual individualization of Indian society;
- the lack of attention paid to the above-mentioned problems in educational curricula for doctors and nurses, and the lack of motivation among health personnel to work in rural areas.

According to CMAI, the church response to these problems has in the past proved to be inadequate. This is due mainly to a lack of vision, a lack of motivated staff, conflicts between churches and institutes, a lack of (updated) knowledge of the basic causes of disease, weak leadership and bad management, inadequate systems for supervision and control, out-of-date infrastructure and financial problems of many institutes, as well as to a lack of vision on the role that the church and its institutes should play in a more holistic approach to health care.

CMAI intends to play an active role in the process of transformation necessary to tackle the problems described above. Moreover, CMAI stresses the need for paying more attention to preventive and basic health care, which have until recently been undervalued. In this way, health care should become more accessible to the poor.

In this respect, the strong religious affiliation of CMAI is not always an assett. Especially in the case of issues that are not acceptable to the conservative segments of CMAI membership (e.g. the socially isolated and oppressed position of women; family planning; AIDS), wide differences of opinion may arise among the membership about the question whether, or how CMAI should tackle these issues.

The general long-term objective of CMAI is 'to serve the Church in India so as to equip, assist and encourage it in its ministry of healing, health and wholeness focused on the prevention and relief of human suffering irrespective of caste, creed, community, religion and economic status'. This general objective can be operationalized as follows:

- promoting the better functioning of Christian institutes for health care in India, and improvement of health care in general;
- making India's health care more accessible for the poor groups in Indian society;
- introducing, whereever possible, preventive health care and basic health care into existing, usually curative-oriented Christian institutes for health care;
- advising on how to improve the services of existing institutes for health care, and how to make/keep them cost-effective;

Main short-term objectives are:

- the promotion and spread of knowledge of the factors governing the health situation;
- the coordination of activities for the training of doctors, nurses, paramedics and others involved in the ministry of healing (human resource development);
- the implementation of schemes for comprehensive health care, family planning and community welfare.

In implementing its policy, CMAI concentrates on a number of fields of activity:

- community health (training, advise and support to community programmes);
- human resources development (some 1.000 formal courses per year, for a variety of health personnel like doctors, nurses, paramedics, laboratory workers, VHW's, DAI's etc.). A new activity is CAMS a three-years postgraduate training on management, leadership, and health work in the setting of rural hospitals with good community health programmes. Cooperation exists with other centres like Rusha and Pachod;
- regional and membership development (to promote membership and stimulate commitment of local churches to CMAI;
- communications, advocacy and networking (especially in the fields of healing ministry, health and development, women, community health, and drug abuse);
- administration.

Recently, CMAI has become very active in the field of AIDS prevention. As mentioned above, CMAI has concluded an agreement with WHO, NORAD and the Government of India for training 1.200-1.500 doctors in HIV control and AIDS prevention within one year. In its general AIDS policy, CMAI will focus on the following issues:

- establishing safe blood banks;
- developing protocols in hospitals for controlling HIV infection caused by hospital work;
- the combat of drug abuse in northeast India;
- information and education;
- a condoms 'undercover' programme (the spreading of condoms as part of the family planning programme);

Target groups for the activities of CMAI are the following:

- the members of the association (300 institutions and 3.000 individual members); main point of entry for this group is capacity building;
- the churches (as far as their health-related activities are concerned);
- in collaboration with other health networks (e.g. CHAI, VHAI) CMAI tries to influence health professionals, the central and state government officials, and politicians;

Indirectly (through health education publications and local activities of individual CMAI members) CMAI reaches a population of about 5 million. CMAI knowledge and expertise is spread and shared on the international level through networking and connections with the World Council of Churches.

CMAI has a well-qualified board consisting mainly of leading persons in the field of Indian curative and preventive health care. It has a competent, professionally skilled staff of 86 persons (about one third of the members of board and staff are women). Largest divisions of CMAI are: community health department, general administration, and department for human resources. Before 1985, CMAI had twelve offices apart from its head office. In 1985, the number of offices was reduced to four. It is the intention of CMAI to further reduce this to two offices (Delhi and Bangalore).

CMAI maintains a good working relationship with other NGO's, especially with the Catholic Health Association of India (CHAI) and the Voluntary Health Association of India (VHAI). In cooperation with the first, CMAI organizes health ministry work in Christian churches, carries out research and study programmes, and is engaged in establishing a community health cell in Bangalore. CMAI advises VHAI members to become members of the state-VHA in their state. Working relationships are good, and CMAI avoids duplication of activities carried out by the state-VHA's (like, for instance, the publication of health periodicals). The directors of CHAI, VHAI and CMAI have regular (4 monthly) meetings.

6.6. Rajasthan Voluntary Health Association, Jaipur, Rajasthan (RVHA): support to RVHA programme 1993-1997

Organization	:	Rajasthan Voluntary Health Association (RVHA), Jaipur, Rajasthan
Project/programme	:	Support to RVHA programme, 1993-1997
level	:	state level
urban/rural	:	urban and rural
Organization type	:	intermediairy (service and support)
File number	:	IN 145011 934061
Commitment	:	four years (1993-1997)
Financing	:	total : Dfl. 425.185,-
		own contribution : -
		contribution Icco : Dfl. 425.185,-

RVHA is a secular intermediary (support) organization with a large membership of NGO's operative in Rajasthan. RVHA was established in 1991 as an independent organization, in close cooperation with its national umbrella organization, VHAI. It has in the first place a platform-, training-, motivational and lobbying function. RVHA originates from the cooperation between NGO's in the wake of research done by VHAI during 1985-1987 drought period in Rajasthan. More than 100 NGO's were involved in the preparations for the establishment of RVHA in 1991. In 1992, RVHA was formally recognized by the government and has received a FCRA number.

The state of Rajasthan covers a total area of 342.239 km2. It is characterized by a generally low level of socioeconomic development. Nearly eighty percent of the population live in rural areas and depend on agriculture for their subsistence. In 1990, almost half of the total land area was brought under cultivation. However, only one fifth of the cultivated land is irrigated, the remainder is rainfed. The health situation of the majority of the population (particularly of women and children) is bad. Mortality and morbidity indicators for Rajasthan are higher than the Indian national averages of these indicators. Another major problem is environmental degradation (a.o. desertization and shrinking reserves of drinking water). Women find themselves in a socially inferior and isolated position. The bad health position of women is clearly illustrated by a sex ratio of 912/1000 (for an extensive overview of the health situation, see: Status of Health in Rajasthan, RVHA 1993). There is a great need of good NGO's to address these problems. As RVHA has developed an adequate programme which is in keeping with Icco policy priorities, Icco has decided to finance RVHA.

From 1983, Icco has supported VHAI, a secular organization with a platform function at the national level. During the last few years, a gradual process of decentralization and delegation of activities to the state-level (state VHA's) has set in. In this process skills, knowledge and experience of VHAI can be optimally used in establishing state VHA's. VHAI consolidates its position as a national support and umbrella organization, continues to function as a national forum and retains its lobbying function at this level. But for the near future priority will be given to the establishment and growth of the state-level organizations (state-VHA's), which are in a better position to concentrate their objectives and activities on state-specific organizations, issues and health problems.

Icco has started financing state VHA's in the eighties. It has sponsored the state VHA of West Bengal until 1990. In 1991, funding of Rajasthan VHA and Assam VHA began. Later, in 1994, Tripura VHA was added. In 1991, Icco supported the VHA's of Rajasthan and Assam with a one-year starting subsidy (project 913059). In Rajasthan, during this period the organization and its network was built-up, policy priorities were set, staff was attracted and a number of specific activities started (eye diseases, medicine use, youths and women). In 1992, a one-year continuation of Icco support was granted (project 923326; Dfl. 122.482,-). Next to ongoing activities, RVHA concentrated on campaigning, training, lobbying and further strengthening of NGO networks. In 1993, RVHA had a total membership of some 50 NGO's. The contribution of Icco to the current programme (1994-1997) concerns a continuation of the main activities of RVHA during the preceding period.

The general objective of RVHA is to develop a broad-based health movement which strives for a better health care in Rajasthan, greater access to health facilities and a better health status for the poor segments of Indian society. RVHA supports NGO's involved in the implementation of health programmes. It provides training, information, education and training of village health workers (VHW's). Specific points of attention are: environmental issues; strengthening of the position and improvement of the health situation of women; information to the general public; training of VHW's; information on over-use of medicines; prevention of exploitation by quacks; quality and availability of drinking water; and common occupational diseases (e.g. tuberculosis and silicosis).

The main short-term and mid-term objectives of RVHA are:

- strengthening the common forum of voluntary organizations in Rajasthan, to focus on shared concerns and undertake joint action programmes;
- to improve the functioning of government state health services via liaison with voluntary organizations and interaction with the state government, the medical and health department, the IEC bureau and public health engineering department (PHED);
- to improve, via training, supply of information and interaction, the functioning of medical professionals and traditional health practitioners;
- to mobilize public opinion against irrational health care, unnecessary drugs, unqualified sex determination tests, abortions and the malpractices of quacks;
- to increase the level of knowledge among the public about health and health-related issues through campaigns, exhibitions and the distribution of documentation materials;
- to improve the status of women's health through research, development of information material, and activities in the field of advocacy;
- to execute relevant studies and research in order to collect proper information and a solid basis for the planning and action of RVHA activities and interventions.

Important points of attention are:

- stimulating the further strengthening of primary health care activities of member organizations;
- the interaction between factors influencing health and the prevention of diseases;

- stressing the importance of the role of other sectors;
- paying attention to state-specific problems (main problems in Rajasthan are: child mortality, nutrition, safe water supply and water-borne diseases, occupational diseases (TB, silicosis) women's diseases, diseases caused by ecological degradation, and addictions (alcohol, opium).

The main activities of RVHA to reach the objectives described above are:

A. research activities on environmental problems, preventable communicable diseases, occupational health hazards, women health workers, primary health centres, AIDS, privatization, the voluntary sector in Rajasthan, and the evaluation of national health programmes;
B. campaign and lobbying activities on the impact of pesticides on health, water-related health problems, occupational health hazards, rational drug use and other issues;
C. training activities on various subjects for diverse target groups as, for instance, TBA's, VHW's, school teachers, women's health and adolescent girls;
D. communication activities, through a communications team, exhibitions, and the production of RVHA publications in local language;

Direct target groups of RVHA are:

1. the partner organizations which are involved in a variety of activities, including health, education, research, environmental rehabilitation, water conservation, income generation, safe water supply etc. RVHA plays a facilitating role through the motivation, training and improvement of the total functioning and performance of these organizations;
2. the general public;
3. the members of the State Legislative Assembly (for lobbying activities);
4. government health functionaries (for liaison work with NGO's);

Indirect target groups are the poor and neglected sections of the population of Rajasthan (including tribals and *dalits* in the Aravalli hills and Thar desert).

Recently RVHA has internally evaluated its own performance, achievements and constraints. It was concluded that results were satisfactory form the point of view of the amount of response and activities of the member-NGO's. On the other hand, activities were found to have too much an ad-hoc character, and not to be based on systematic research and analysis of the health situation in Rajasthan. RVHA then decided to execute a rapid health survey. The proposal for the current programme (1993-1997), supported by Icco is based on the outcome of this study.

RVHA gives much attention to the quality of its relationship with the government and its representatives. RVHA systematically tries to expand and improve these relations, in order to be able to strengthen its intermediary role between NGO's and government agencies. Increasing presence of government functionaries in training courses, meetings and workshops forms a sound basis for the further expansion of future cooperation.

RVHA has a board consisting of competent and experienced members of NGO's with a long working experience in Rajasthan. A minority of the board members are women. RVHA staff comprises an executive secretary, an administrator, a researcher, a campaign leader, a communications coordinator, a publicity coordinator, and a support/administrative staff of five persons. The majority of personnel in all staff segments are women. A large turnover of qualified staff has been a major constraint during the first years of RVHA's existence.

6.7. International Nursing Service Association (INSA), Bangalore, Karnataka: Rural Health and Development Trainers Programme 1991–1994 (1995)

Organization	:	International Nursing Service Association (INSA), Bangalore, Karnataka
Project/programme	:	Rural Health and Development Trainers Programme 1991-1994 (---> March 1995)
level	:	national
urban/rural	:	predominantly rural
Organization type	:	intermediate (service and support)
File number	:	IN 15991 (913043)
Commitment	:	three years (1991-1994)
Financing	:	total : Dfl. 193.175,-
		own contribution : Dfl. 5.217,-
		private contrib. : Dfl. 77.901,-
		contribution Icco : Dfl. 110.057,-

INSA is a secular organization, based in Bangalore, Karnataka. In 1982 INSA was established as an independent organization, but with affiliations to the USA–based International Service Association for Health. Since 1972 INSA–USA organizes health education programmes for health workers and community leaders from Third World countries. The INSA network comprises 42 countries (of which INSA–India is the only independent division). INSA is formally recognized by the government, and has a FCRA number.

The objective of INSA–India is to train staff involved in carrying out health care activities to improve their activities so that they can play a more effective role in the promotion of community–based health care programmes related to community development initiatives. Special attention will be paid to train the staff to become good trainers of local VHW's

Main activity of INSA is organizing training in the fields of basic health care and development for nurses and other health personnel from various NGO's in India. These (10 weeks') courses are held twice a year. Much attention is paid to the follow–up of these courses. trainees are at least once visited in the field, and special workshops are organized for former trainees. Next to that, INSA organizes small workshops in which certain aspects of health care are dealt with. More specific:

- to conduct every year at least two rural health and development training courses of ten weeks' duration, with a minimum of 15 participants;
- to conduct follow–up visits by INSA staff to assess the effectiveness of the training and to offer further help to the participants, if required. Contact with all graduates will be maintained through a newsletter and an update;
- participants from each course, on completing one year of work in the field, will be invited by INSA for a two or three days' regional workshop to share and evaluate their performance in the field;
- to build up the core group members to at least 85 persons, and to conduct one workshop with the core group every year;
- to conduct AIDS education in high schools/junior colleges in Bangalore;

- specialized training programmes for various organizations on request, and consultancy work.

The first target group are participants (nurses, paramedical workers etc.) of the courses from institutions or organizations all over India involved in rural community health care, especially from the southern states. Some eighty percent of the trainees are women. The second target group are the organizations to which to trainees are affiliated. The third (indirect) target group are the (rural) communities in which trainees will apply their skills and knowledge.

Icco has supported INSA since 1983. Between 1983 and 1987 Insa was supported on a yearly basis. As experiences in these years were very positive, in 1988 the first three years' agreement was concluded (1988–1991). The programme currently funded by Icco is a continuation of the activities carried out in the period 1988–1991. The decision by Icco to continue financial support to INSA is based on the consideration that, in view of the general shortage of qualified and motivated health care staff, there is a great need for programmes like the one implemented by INSA.

Apart from the activities mentioned above, INSA carries out no other programmes or activities. It is financially supported by Icco and INSA–USA. For a new (3 years) programme on AIDS education, INSA receives Rs. 7,5 lakh from Ford Foundation. INSA raises its own funds on a small scale, through consultancies and the organization of workshops.

INSA has a board consisting of six members (four of which are women), all of which have extensive working experience with all kinds of social work (law, management, health care). INSA staff consists of six qualified people, who are all women.

In 1989, INSA has been evaluated (on its own initiative). Special attention was paid to the following items: organization and management; quality and methodology of the training; impact of the training on other programmes and 'community change and awareness'. The outcome of this evaluation was very positive for the training programme of INSA and its impact on other organizations and communities.

Some recent (1993) critical remarks made about the organization:

- in 1993 there was a stagnation in the number of registrations for the training, while among health personnel there is a continuing demand for the kind of training offered by INSA. What about INSA's networking and P.R. activities?
- it is not clear whether INSA is successful in its objective of stimulating other NGO's to give the kind of training provided by INSA;
- all training courses are in English. Are there any possibilities to organize them in other languages like Hindi or Tamil in the near future?

During a recent visit it became clear that the low number of registrations is partly caused by the fact that the number of trainees is restricted as a matter of policy (to maintain the high quality of the courses). However, another reason is that for many women it is still difficult (regarded as socially unacceptable) to follow a training course. As to the problem of language: the issues of regionalization and the organization of training courses in local languages are main points of attention in future INSA policy.

6.8. ACHAN (Asian Community Health Action Network), Madras, Tamil Nadu: Community-Based Action for Transformation in Asia

Organization	:	ACHAN (Asian Community Health Action Network), Madras, Tamil Nadu
Project/programme	:	Community-Based Action for Transformation in Asia (proposed)
level	:	Asia/India
urban/rural	:	urban and rural
Organization type	:	intermediary/umbrella organization
File number	:	AZ 893228
Commitment	:	three years (1994-1997) (proposal currently under consideration)
Financing	:	total : Dfl. 2.100.000,-
		other donors : 60% (EZE)
		contribution Icco : Dfl. 850.000,- (under consideration)

ACHAN is an international, secular non-governmental umbrella organization active in the health sector. ACHAN was established in 1980 by a group of health activists with extensive experience in basic health care in Asia. Since its establishment ACHAN functions as the meeting point of a large number of organizations active in the field of primary health care in various countries in Asia. Within Asia, priority is given to Nepal, Bhutan, Kampuchea, Burma, Bangladesh and Indonesia. ACHAN is registered in Hong Kong, with offices in Madras and Bangkok.

A focal point in ACHAN's analysis of the health situation in Asia is, that the main causes of the bad health situation in Asia can be found in the sociopolitical and economic spheres. Nutritional deficiencies (nutritional blindness, retarded growth), water-borne diseases (infective hepatitis, cholera, typhoid, amoebiasis etc.), and many other poverty-related diseases continue to make many victims among the Asian poor.

At the same time, access to education is primarily restricted to the ruling classes. Growth-oriented development has become a major threat to the environment, and further added to the plight of the poorest groups in society. Under the existing national and international sociopolitical and economic structures, the majority of poor people are denied basic human needs and basic human rights.

According to the analysis made by ACHAN, the voluntary sector (NGO's) has, generally speaking, not been able to change this situation. Usually NGO's have become part of mainstream development practices and helped to increase the existing social disparities. ACHAN tries to be an alternative network which aims at bringing about a fundamental change in the thinking and practice of NGO's, enabling them to see the vision of an alternative society, and capacitating them in achieving it. In the field of health care, ACHAN promotes an integrated approach with a high local level of participation by the target group in planning, implementation, monitoring and evaluation.

The general objectives of ACHAN are to promote and improve community-based health care programmes and rational drugs policies in Asian countries to bring people's health in people's hands. More specifically:

- to facilitate the formation of national grass-roots networks and task forces on community-based health care;
- to strengthen programmes aimed at training, motivation and orientation of mid-level health workers;
- to influence policy makers in favour of community-based health care;
- to improve the effectiveness of health care programmes from the point of view of women;
- to make educational institutes like universities more supportive to community-based health care;
- to increase the use of community resources like indigenous drugs and practices;

Main activities carried out by ACHAN to achieve these objectives are:

- organizing exchange and training programmes for management and staff of organizations active in primary health care through participatory training methodologies (PTM). Special attention is given to the role of women in health care, and to the strengthening of this role;
- research on the effects of the much criticized large-scale programmes of international (multilateral) organizations;
- the improvement of government programmes through lobbying activities, training for government personnel, and direct cooperation with the Ministries of Health;
- involvement in the establishment of a health care programme in Kampuchea, in collaboration with the World Council of Churches.

In the project description for the ACHAN programme 1990-1992 the following specific activities are mentioned: training for mid-level workers; promotion of community-based health care programmes; mid-level curriculum formation; herbal medicines; women in health; alternative medical education; Asian apex bodies; follow-up; participatory action research; special initiatives (Kampuchea); publication (the quarterly magazine LINK, and handbooks on various topics).

The main target group are mid-level health workers and health trainers of organizations involved in promoting and implementing community-based health care programmes. Another target group are the coordinators and managers of community-based health care programmes and government officials responsible for the preparation of decision-making on health care and for the implementation of health care policies. Special attention is paid to the involvement of women in all programmes.

Icco supports ACHAN since 1983. All foregoing Icco commitments comprised a limited number of activities out of the total ACHAN-programme. Other donors of ACHAN are EZE, Misereor, Brot für die Welt, CIDA and UCC-USA. In the last few years, EZE has been the major donor of ACHAN.

ACHAN differs from most organizations active in the field of health care supported by Icco. First, it is an international organization with Asia as its area of operation rather than India. as its area of operation. Second, the ACHAN approach and organization differ somewhat from the pattern generally found, in that its networking and training activities and seminars seem to be rather loosely structured and to lack any follow-up.

Therefore, there are doubts about the precise significance of ACHAN for the health sector in India. It is not very clear whether ACHAN has a great impact as an innovating and alternative network in the Indian health sector.However, in the (international) Asian context of health NGO's ACHAN seems to play an important role as a promotor of equity in health, community-based health care, rational drug use, and radical reorientation of curricula.

Recently, ACHAN has developed plans for decentralization of activities through 'core groups', 'country coordinators' and country profiles. Thus, the strategy of ACHAN can be more intensively and effectively oriented towards specific countries. At the same time, the regional office will be able to concentrate on coordinating regional (Asian) activities (workshops, training, exchange programmes etc.), facilitation, stimulation and support.

Neither progress reports nor the external evaluation (1992-1993) recently carried out throw more light on the scope and impact of the ACHAN programme in India. Moreover, in the wake of the evaluation, new questions were asked and even doubts were raised about the importance of ACHAN as a network organization, both in India and in the international context.

7. RECOMMENDATIONS FOR SELECTION OF THE EVALUANDUM

7.1. Introduction

As has been shown in the above chapters on the projects and programmes of Cebemo and Icco, a preselection has been carried out by these organizations in preparation of the choice of the evaluandum.

In this final chapter the recommendations for choice of the evaluandum as have been presented to the team, as well as the definitive choice agreed upon by the team are rendered. While choice was limited due to the fact that a preselection had already been made out of a total of more than 109 projects and programmes, it has been tried to base this further choice as much as possible on the following elements:

1. relevance in the light of the research questions in the preliminary terms of reference (TOR);
2. relevance in the light of a number of thematic points of attention and further operationalizations as presented in the preliminary terms of reference.
3. relevance against the background of societal developments in India and, more specifically, of important developments in the NGO–world and the position of NGO–actors in society.

7.2. Recommendations: Cebemo

With respect to the preselection of programmes eligible for evaluation, some remarks seem appropriate. We feel that the element of choice in determining the evaluandum was in practice very limited. Of the seven programmes that were preselected, two (KSSS and TRU) fell off for logistical reasons (accessibility and location in relation to the main clusters of preselected programmes). Thus, in practice, four programmes had to be chosen out of five.

The first criterium used for preselection (larger projects or programmes) may be understandable from the point of view of efficiency of an evaluation mission that has to be carried out within severe time constraints, but there remain some questions when considered from the point of view of the composition of the total package of health–related activities of Cebemo.

From the data given below it can be seen that 66% of the total number of health–related projects and programmes belong to the two lowest categories (cat. A and B), with the great majority in category A. Moreover, total amounts of funding per category do not significantly differ. However, none of the preselected programmes belong to one of the 'small' categories (A or B).

	I	II	III
A	0- 50	53 (48,6%)	1.127.308 (10,9%)
B	> 50-100	19 (17,5%)	1.467.718 (14,2%)
C	>100-150	14 (12,8%)	1.682.059 (16,2%)
D	>150-200	7 (6,5%)	1.261.341 (12,2%)
E	>200-250	7 (6,5%)	1.570.438 (15,2%)
F	>250-300	4 (3,6%)	1.119.667 (10,8%)
G	>300	5 (4,5%)	2.100.534 (20,3%)
Total		109 (100 %)	10.329.065 (99,8%)

Source: Cebemo; list of projects with health component currently in implementation (5-9-1994)
I : commitment by Cebemo (x Dfl. 1.000)
II : number of projects (and percentage of total number)
III: total amount per category (and percentage of total)

Apart from the fact that the criteria for distinguishing 'larger' projects are rather vague, some other observations can be made. First, while small 'grassroots' and directly target-group oriented activities are part of the 'trade mark' of Cebemo, the numerically important category of smaller projects (A/B) is not represented in the evaluandum. Unless the ultimate criterium for selection is 'money moved per project', their exclusion is questionable.

Second, and related to the first remark, in the light of the TOR and (key) research questions of the mission the position of small projects might even be very important indeed. How do such small interventions relate to their institutional environment? Are they isolated 'islands' or are there forms of cooperation with government agencies and NGO's? Particularly, how do they relate to health services and infrastructure at the local level (e.g. district) These and other questions have a direct bearing on the TOR questions.

Further, and important against the background of the TOR, could it not be the case that the smallest interventions are institutionally the most isolated ones, and the ones most in need of support? In that case their inclusion would seem essential. The more so, if it is realized that most of the projects that have been (pre)selected have *not* a purely implementing, but also an (in some cases rapidly developing) intermediary/supportive function.

Finally, it should be stressed here that future policy decisions by the CFA's on the kind of implementing organizations to be funded or on the 'level' to concentrate support on may well be based on considerations of the limited CFA-capacity to 'manage' a large number of small projects and on the need for more local partners at a higher institutional level (concentrating on intermediary, support, lobbying and networking functions) that can take over 'decentralized' CFA-functions and responsibilities, rather than on answers to the key questions of the TOR.

From the programmes preselected by Cebemo, we propose to select the following evaluandum (note that many points of attention mentioned for each programme are important issues in other programmes as well):

1. Bengal Rural Welfare Service (BRWS), Calcutta, West Bengal: Programme for Rural Basic Health Care.

Important points of attention which may throw light on the long-term effectiveness and sustainability of BRWS, and on the question of its possible needs for support are:

- aspects of cost recovery (payment for sevices by the target group);
- (related to the above point) the precise function and target group of the (urban) Garia health center; is it a 'cash cow' among the urban middle class population for financing other (rural) activities? Does it complement or replace government services?
- BRWS shows some characteristics relevant to the discussion about selective and comprehensive PHC (family planning, growth monitoring);
- in programmes in which BRWS cooperates with government services/programmes like family planning: is BRWS an independent, innovative organization operating complementary to, or an instrument of target-oriented government programmes? What about other important BRWS-government relations (health services, referral)?
- what is the size of direct/indirect target groups? How do health service targets (e.g. vaccination) relate to the size of the direct target group?

2. Village Health Workers Scheme, Diocese of Berhampur, Orissa: Diocesan Training Center and Programme of Rural Health Workers, Jaganathpur village

In this project, the following points of attention might contribute to a further operationalization of the TOR into research questions:

- what are, in this particular case, the main causes of the high drop out rate of VHW's? Is there any direct relation with the issue of payment of VHW's?
- to what extent has the programme in fact taken over health care responsibilities of government agencies rather than complementing them?
- (relating to the discussion about comprehensive/selective PHC and the long-term effectiveness of intervention): do the training course and the programme surpass curative approaches to health care? Is the programme responsive to recent developments in the field of health (AIDS; STD's in general), and are such issues reflected in the curriculum for VHW's?
- are there signs that the programme is biased towards Christian segments of the target group? At the institutional level, how does a programme within a diocesan administrativer like Berhampur

3. St. Thomas Mission Society, Mandya, Karnataka:
Community-Based Health and Development Programme

With reference to this programme, the following points of attention might be relevant to the mission:

- the urban component of the programme. Though Mandya is a small town, it might be useful to pay attention to a directly target-group oriented programme like the slum development programme, especially in view of the weak representation of urban activities in the preselected programmes.
- to what extent have group formation and education among the target group become an end in themselves? Especially in the field of education there seems to be a gap between felt priorities and needs of the target group and the ideological preoccupations of the programme.
- to what extent has the programme succeeded in maintaining and strengthening its comprehensive orientation? Are the various activities well-integrated, or segmented and unconnected, each with its own targets?

4. Christian Council for Rural Development and Research (CCOORR), MAGR District (Vengal), Tamil Nadu: Rural Health Training Center and Extension of Field Activities

Some possible points of attention are:

- innovative approaches visible in the training programme;
- aspects of 'self-reliance'; under what conditions are (parts of) the target groups supposed to have become self-reliant? Are there any criteria for cost-recovery, the position of VHW's etc.?
- how does the two tier-system of micro and macro centers relate to government health institutions at the local and district levels? The proximity of local town centers seems to create a favourable condition for cooperation in health care programmes. How do representatives of the traditional local system, like TBA's, relate to the government structure of health care, if present?

- Karuna Social Service Society (KSSS), Diocese of Bijnor: Community Health Programme: not selected for logistical reasons.
- Trust for Reaching the Unreached (TRU), diocese of Ahmedabad, Gujarat: Comprehensive Primary Health Care, Panch Mahals, Gujarat. Diocese of Ahmedabad: not selected for logistical reasons.
- Peermade Development Society (PDS), Kerala, India: Integrated Health and Development Programme: this programme shows many of the characteristics that are also found in Mandya. In view of the fact that Mandya contains an urban (slum development) component, this programme has been chosen instead of PDS.

7.3. Recommendations: Icco

With respect to the preselection of programmes, the same remarks can be made as for Cebemo. In particular, the criteria used for preselecting the programmes/organizations mentioned in chapter 6 have not been made explicit.

Further, the remarks made above (chapter 6) on part of the preselected organizations (INSA, ACHAN and ASSEFA) make clear that the choice of the evaluandum was in fact more restricted than suggested by the number of preselected organizations. Further, at the request of ICCO, CMAI was also excluded from the proposed evaluandum, and will be visited as a 'resource organization'.

Considering the above, from the programmes preselected by Icco we propose to select the following evaluandum:

1. Child In Need Institute (CINI) (IN 019021)

Points of special interest are:

- experiments with a new strategy for decentralizing health care through the Village Development Forum (instead of exclusively through women's organizations);
- attention to the gradual phasing-out of activities, through a distinction between the A, B and C villages;
- cooperation with the government programme for Development of Women and Children (DWCRA);

2. Ashish Gram Rachna Trust/Institute of Health Management Pachod (AGRT/IHMP) (IN 074051).

The following points might be of special interests for the mission:

- the combination of fieldwork, research, training and the running of a hospital;
- cooperation with government programmes and agencies at the *taluk* level;
  systematic attempts at application of new approaches on a larger scale;
- Alternative approaches to the governmental Integrated Child Development Scheme;
- extension of activities and processes of 'scaling up'; what are the consequences for the quality of AGRT programmes?

3. Voluntary Health Association of India (VHAI) (IN 123041)

- Being one of the most important health-NGO's in India and, moreover, the umbrella organization of state-level organizations like RVHA, VHAI has been included in the evaluandum (to replace CMAI; see above).

4. Rajasthan Voluntary Health Association (RVHA) (IN 145011)

- In our opinion RVHA should be included in the evaluandum because this state level organization is the exponent of an important process of decentralization started by the national organization VHAI, and now covering most states.

Not selected as part of the evaluandum for reasons mentioned above:

- Christian Medical Association of India (CMAI) (IN 142021)
- International Nursing Service Association (INSA) (IN 073011)
- Asian Community Health Action Network (ACHAN) (AZ 893228)
- Association of Sarva Seva Farms (ASSEFA) (IN 057041)

1). The WHO defines health as '..a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity'; a state unknown to ordinary mortals. The main social target of 'health for all' was the attainment by all citizens of the world of a level of health permitting them to lead a socially and economically productive life (WHO/UNICEF, 1978).

2). A major obstacle is the artificiality of 'sector thinking' through which interrelated problems like health and nutrition are separated. There is still a tendency both among donors and receiving governments and organizations to call any activity carried out a 'sector' and fund them accordingly.

3). However, on a per capita basis, central government expenditure in many developing countries shows a decrease in real spending. Moreover, data on the percentage of national expenditure allocated to local health services are scarce. If available, these data show stagnation in developing countries and a decrease in the least developed countries (WHO, 1993; 139-140).

4). According to WHO (1993a) one of the major constraints in the second evaluation of the 'health for all' strategy, is the lack of information about the achievements of member states in implementing their national strategies (WHO, 1993a; 138).

5). Rohde et al. (1993; 507-509) relativate the dichotomy between 'selective' and 'comprehensive', 'vertical' and 'horizontal' approaches. At the level of implementation, they argue, such a polarization has never existed. All programmes are the product of choices and compromises, and the outcome is never exclusively 'selective' or 'comprehensive'. 'Selective' programmes even tend to produce more 'horizontal' results than 'comprehensive' programmes.

6). While such decentralized health systems are generally called 'district health care', the optimal level of decentralization will of course depend upon specific circumstances in the country concerned (WHO, 1988a; 9).

7). The 'Operation Research Group' (ORG) of Baroda University gives higher population estimates, amounting to 908 million in 1991, and an estimate for 2021 of 1,4 billion. Only by the year 2025 will population growth have decreased to a level below 1% per year, according to ORG (DGIS, 1992).

8). Linguistic differences are the foundation of many of the present states.

9). For the state of Bihar, see Das, 1992.

10). Currently, India is implementing its eighth Five-Year Plan (1992-1997).

11). For further remarks on the determination of the poverty line, see Shah, 1991 (footnote 36).

12). see, a.o. VHAI, 1991, and a recent article in NRC Handelsblad (van Straaten, 1994).

13). Such autonomy and room for manoeuvre for NGO's may even increase in situations of decreasing state capabilities and responsibilities associated with structural adjustment programmes and the consequent drawing back of national states.

14). These same factors account for the large degree of concentration of Cebemo's NGO-partners ('preferential partners') in South India (Tamil Nadu, Karnataka, Andhra Pradesh, and Kerala) (Cebemo, 1989).

15). Shah estimates that only about five percent of the Indian NGO's (the 'social action groups', often with a Marxist background) do not wholly subscribe to the government's development perspective (1991; 16).

16). This section is mainly based on two recents publications on Dutch development assistance to India (DGIS, 1992 and DGIS, 1994). For an extensive account of the history of Dutch development assistance to India, and especially the role of Dutch commercial interests in determining the composition of the aid package, see DGIS, 1994.

17). Dutch development assistance consists of a regular programme (annual allocations to the priority countries involved), and a non-regular programme (involving other programmes, like the sector programmes and the allocations to the four co-financing agencies).

18). See DGIS, 1994. According to DGIS, 1992 this 'streamlining' of development assistance was introduced in the 1988-1992 policy plan.

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ANNEX 1.

Projektnummer	Nederlandse titel	Plaats van Uitvoering	Bj	Aanvrager	Bijdrage Cebemo
M 317 00149 B	Gezondheidszorgprogramma	Devikapuram	92	ST.J.D.	5.000,00
C 317 01033 C	Basisgezondheidszorg en ontwikkelingsprogramma	Hyderabad	93	CHAI	275.379,00
C 317 01130 A	Gezondheidszorgprogramma	Berhampur	90	DIOC.BERHA	110.008,00
C 317 01148 A	Basisgezondheidszorgprogramma	Siripuram	87	SOC.ST.ANN	25.234,00
C 317 01157 C C	Basisgezondheidsprogramma	Raisen District	90	A.B.H.C.	26.593,00
C 317 01182 C	Gemeenschapsontwikkelingsprogramma	Gudipalli, Gollahalli	92	SUNANDA	211.236,00
C 317 01185 A	Consolidatieprogr. groepsgewijs ondernemersschap	Lapung Block	93	X.I.S.S.	140.847,00
C 317 01216 A CE	Opleiding gezondheidswerkers	Vejendla	88	J.M.J.PROV	290.333,00
E 317 01216 A EC	Opleiding gezondheidswerkers	Vejendla	89	J.M.J.PROV	104.220,00
C 317 01227 A	Ontwikkelingsprogr.t.b.v. krottenwijkbewoners	Poona	90	C.D.S.A.	190.578,00
C 317 01239 E	Vernieuwing van informeel onderwijs	Manvi	93	GOOD.SH.S.	90.368,00
C 317 01260 A	Programma voor geestelijke gezondheidszorg	Delhi	90	SANJIVINI	100.000,00
C 317 01271 B	Vrouwen-ontwikkelingsprogramma in slums	Ghaziabad	90	G.N.K.	88.270,00
C 317 01280 D	Geïntegreerde plattelandsontwikkeling	Tumkur	94	R.E.D.S.	364.404,00
C 317 01292 A	Kodaikanal streekontwikkelingsprogramma	Kodaikanal	90	M.M.S.S.S.	170.717,00
C 317 01293 A	Schoolgezondheidsprogramma	Mananthavady	90	JANA SAUKH	106.898,00
C 317 01294	Gemeenschaps-gezondheidszorg	Dhamola	87	D.C.D.P.	19.057,00
C 317 01430 A	Gemeenschapsontwikkelingsprogramma	Rajkot	90	DIOCESE RAJKOT	233.461,00
C 317 01498 A	Gezondheidszorgprogramma	North-East India	91	NECHA	74.768,00
C 317 01505 D	Gemeenschapsontwikkelings- en gezondheidsprogramma	Mandya	92	S.TH.M.S.	414.189,00
C 317 01575	Gezondheidszorgprogramma	Mokama/Patna	87	M.N.H.S.	90.368,00
M 317 01610 A	Gezondheidsvoorlichting	Khedbrahma	92	N.L.R.D.F.	6.975,00
M 317 01632 A	Vervoermiddel voor ruraal gezondheidszorgprogramma	Bamhori	94	R.D.S.S.	15.000,00
C 317 01673 D	Programma voor gezondheidsz. en gemeenschapsontw.	Udumalpet Block	94	C.H.D.P.	21.865,00
C 317 01776	Gezondheidsprogramma	Chilakaluripet	88	ST.CH.CON.	33.300,00
C 317 01786	Ontwikkelingsprogramma voor slumbewoners	Ramarajvanagar	89	VIJ.S.S.C.	21.007,00
C 317 01893 R	Gemeensch. ontwik. & niet-formeel onderwijsprogr.	Balasore diocese	89	MARSHAL D.	139.877,00
C 317 01918	Gezondheidsprogramma Bijnor Diocees	Bijgnor Diocees	89	KSSS	114.153,00
C 317 01954 CT	Opleiding voor gezondheidswerkers	Narasaraopet	89	SASSS	68.250,00
C 317 02027 B	Geintegreerd ontwikkelingsprogramma	Peermade	93	P.D.S.	217.652,00
C 317 02047 A	Gezondheids- en educatieprogramma	Varusanadu	92	S.A.M.	30.514,00
M 317 02047 B	Programma voor gezondheidszorg en educatie	Varusanadu	94	VSSS	8.877,00
C 317 02060 C	Basisgezondheidsprogramma	Ganjam	90	U.A.A.	205.003,00
M 317 02183	Gezondheidszorgprogramma	Idappadi	91	ARAISE	11.302,00
C 317 02195 A	Basisgezondheidsprogramma voor tribalen	Panchmahals	93	T.R.U.	292.361,00
C 317 02195 R	Basisgezondheidsprogramma voor tribalen	Panchmahals district	90	T.R.U.	104.958,00
C 317 02209	Jakkalli streekontwikkelingsproject	Jakkalli	90	O.D.P.	565.219,00
C 317 02283 R	Vrouwenontwikkelingsprogramma	5 distrikten in Andhra Pradesh	90	SASSS	192.764,00

Projektnummer	Nederlandse titel	Plaats van Uitvoering	Bj	Aanvrager	Bijdrage Cebemo
C 317 02317 A	Geïntegr. ontwikkeling voor vrouwen en kinderen	Bagalkot	93	SEEDA	127.935,00
C 317 02407	Geïntegreerd gezondheidsprogramma	Faizabad district	91	PANI	66.028,00
C 317 02525	Ruraal trainingscentrum voor gezondheidszorg	Bangalore	93	S.J.M.C.	52.640,00
C 317 02580	Gezondheidszorgprogramma	Samastipur district	91	JPSSA	16.870,00
M 317 02612 R	Haalbaarheidsstudie medisch test-laboratorium	Secundarabad	91	CHAI	9.867,00
C 317 02613	Ruraal gezondheidszorgprogramma	Chamba district	91	ARPANA	120.004,00
C 317 02636	Educatief ontwikkelingsprogramma	Chintamani	91	MANUSH	129.990,00
M 317 02644	Bewustwordingsprogramma voor tribalen	Garla Mandal	92	C.M. GARLA	13.400,00
M 317 02646	Verbetering onderwijs/gezondheidssituatie tribalen	Warangal district	93	CAFP	13.568,00
C 317 02683 A	Gemeenschapsopbouwprogramma	Kankadahad Block	94	ASHA	41.830,00
C 317 02727 R	Tribaal gezondheidscentrum	Gudalur	92	ASHWINI	241.152,00
C 317 02737 A	CHAI Evaluatie	Hyderabad	93	CHAI	108.571,00
C 317 02776	Basisgezondheidszorgprogramma	Gangaloor	92	TERA PREM	27.834,00
C 317 02822	Vrouwen- en jeugdontwikkeling	Virar	91	VHDS	82.052,00
C 317 02839 R	Trainingsprogramma in gezondheidszorg	Saran district	92	SZSVSS	26.270,00
M 317 02851	Geintegr. ontwikkelingsprogramma	Kulithalai	92	SEVAI	9.912,00
C 317 02880	Bewustwordingsprogramma voor sloppenwijkbewoners	Bangalore	92	JANODAYA B	79.583,00
C 317 02940 R	Woningherstelprogramma	Guntur	92	DIOC. GUNT	191.609,00
C 317 02941 A	Plattelands-ontwikkelingsprogramma	Yeraganahally	93	SUMANA	72.994,00
C 317 02967 R	Basisgezondheidszorgprogramma	Mayurbhanj district	92	DULAL	33.501,00
C 317 02982 R	Gemeenschapsontwikkeling in Jyothinagar	Mangalore	92	A.C.E.S.	74.900,00
C 317 02983	Gezondheidsprogramma op het platteland	Moodbidri	92	MRCI	31.330,00
M 317 03004 R	T.B. controleprogramma	Changanacherry	92	CH.S.S.S.	15.000,00
C 317 03006 R	Gezondheidszorgprogramma	Manapparai Taluk en Pudukottai	93	TMSSS	80.505,00
C 317 03023 A	Alfabetisering en gemeenschapsopbouw progr.	Anandapuram & Yedehalli	93	S.N.S.	138.422,00
C 317 03024 R	Geïntegr. gezondheidszorgprogramma voor platteland	Honavar	92	B.P.K.	171.635,00
C 317 03061	AIDS-preventie	Manipur	92	RDO	334.217,00
M 317 03065	Programma voor rurale gezondheidszorg	Dhenkanal	92	MLM	5.965,00
M 317 03084	Gezondheidszorg- en bewustmakingsprogramma	Jaisinagar	92	MVSS	6.965,00
C 317 03120 R	Beurs voor coördinator gezondheidsprogramma's	Secunderabad	92	CHAI	36.245,00
C 317 03146	Trainingsprogramma voor sociale werkers	Dakshina Kannada Dt.	92	PRAJNA CC	79.138,00
M 317 03197	Heruitgave van gezondheidsposters	Andhra Pradesh	92	APVHA	6.600,00
M 317 03198	Volwassenenonderwijs t.b.v. Savara Tribalen	Koraput Dt.	93	VINCENT'S	6.531,00
C 317 03208	Ontwikkelingsprogramma voor tribalen	Singrauli region	93	SLS	117.472,00
C 317 03255	Documentatiecentrum basisgezondheidszorg	Bangalore	92	COM HEALTH CELL	75.855,00
C 317 03268 R	Basisgezondheidszorgprogramma	Nationaal	93	CHAI	39.522,00
C 317 03276	Gezondheidszorgprogramma	Uchkagaon Block	93	KARUNALAYA	22.156,00
M 317 03366 A	Geintegr. plattelandsontw. programma	Bilkisganj	94	SHANTI BH.	15.000,00

Projektnummer	Nederlandse titel	Plaats van Uitvoering	Bj	Aanvrager	Bijdrage Cebemo
C 317 03401	Geïntegreerde stedelijke ontwikkeling	Ahmedabad	93	SAATH	118.704,00
C 317 03411	Aids bewustwordingsprogramma	Madras	93	DESH	90.146,00
C 317 03412	Gemeenschapsopbouw	Urutur	93	ST.J.CH.	31.257,00
H 317 03413	Gemeenschapsontwikkelingsprogramma	Singhbhum dist.	94	S.L.A.D.S.	5.253,00
M 317 03433	Gezondheidszorg en educatie programma	Dhenkanal dist.	93	ABAJ	6.903,00
C 317 03458	Preventieve en curatieve gezondheidszorgprogramma	Nilgiri, Wayanad, Calicut	93	MSMI	41.738,00
C 317 03470	Aids preventie	Gujarat	93	GAP	241.542,00
C 317 03590	Volksgezondheidsprogr. voor sloppenwijkbewoners	Bombay	93	FRCH	48.544,00
C 317 03591	Onderzoeksprogr. gemeentegezondheidszorg	Bombay	93	FRCH	42.323,00
M 317 03613	Gezondheidsprogramma	Patia/Bandhamunda Gramapanchy.	94	PYS	6.680,00
C 317 03648	Aids preventie via bewustwordingsprogramma	Dindigul-Anna District	93	SARADADEVI	34.882,00
C 317 03661	Geïntegreerd gezondheidszorgprogramma	Faizabad Dt.	94	ISWRDES	21.425,00
C 317 03677	School gezondheidsprogramma	Mananthavady	93	MANANTHAVADY	48.764,00
C 317 03701	Gemeenschapsopbouw via juridische assistentie	Nagpur	93	L.A.C.	28.238,00
M 317 03710	Moeder en Kindzorg programma	Pratapgarh	93	MVSS	13.591,00
M 317 03726	Gezondheidsprogramma	Pattamundai Block	94	GARRVO	7.225,00
C 317 03734	Gemeenschapsgezondheidszorg	Bombay	93	ALERT INDIA	261.594,00
C 317 03741	Geïntegreerd ontwikkelingsprogr. voor slumbewoners	Bangalore	94	ST. MICHAEL'S	422.505,00
M 317 03754	Gezondheidsprogramma	Derabish block	94	CCD.	5.676,00
C 317 03778	Gemeensch. ontw. via sociale woningbouw	Peddavadlapudi	94	GDSS&WS	187.399,00
C 317 03799	Gezondheidsprogrammaambalpur Action Group	Rengali Block	94	MASS	17.899,00
C 317 03802	Vrouwenprogramma	Baliapal & Jaleswar Blocks	94	SBP	19.477,00
C 317 03805	Geïnt. gemeenschapsontwikkeling t.b.v. tribalen	Barrack Valley	94	SKS	63.993,00
C 317 03840	Trainingscentrum voor rurale gezondheidszorg	Vengal, M.G.R. District	94	CCOORR	156.639,00
C 317 03875	Ontwikkelingsprogramma t.b.v. vrouwen	Chotanagpur	94	HCSSC	220.392,00
H 317 03885	Programma voor vrouwen en kinderen	Gajwel Taluk	94	SAID	57.832,00
H 317 03889	Verbetering v.d. positie van tribale vrouwen	Bihar/Madhupur	94	V.A.K.S.	17.344,00
H 317 03892	Geïntegreerde plattelandsontwikkeling	Sunghbum	94	SLAC	14.496,00
M 317 03893	Gemeenschapsontwikkeling	Awandapur Block	94	SAWP	5.963,00
H 317 03909	Wederopbouw rampgebied via gemeenschapsontwik.	Latur	94	S.A.K.	80.028,00
H 317 03912	Sociaal opbouwwerk door org. onderwijs en voorl.	Medak District, Andhra Pradesh	94	PRAGATHI	29.736,00
C 317 03913	Gezondheids-en onderwijsprogramma t.b.v. slumbew.	Bhubaneswar	94	SJA	49.996,00
C 317 03962	Mobiele gezondheidszorg centrum	Gania Block	94	GUC	26.808,00
					(109) 10.329.065,00

Gezondheidszorg [ESPVS]

6.1

Clustercode: alle; Land van uitvoering: IN; Behandelaar: alle; Naam aanvraag: alle.

Cluster	Projectnr.	Prjr	LvU	Afkorting org.	Beh.	Naam aanvraag	Bedrag financ.	Fin. per.	Omschrijving aard organisatie	Percentage
INDIA	IN142021	93	IN	CMAI	AVDM	CMAI - ROUND TABLE FINANCING 1993-1996	518.303,00	9304-9603	Netwerkorganisatie	80,00
	IN095041	93	IN	CNI/SBSS	AVDM	CNI/SBSS People's Plan 1993-1996	1.251.141,00	9304-9603	Dienstverlenende organisatie	10,00
	IN106031	94	IN	CTVT	AVDM	Integrated Community Dev. Pr. Kanumolu	147.859,00	9404-9803	Dienstverlenende organisatie	10,00
	IN123031	92	IN	VHAI	AVDM	Interim Support to VHAI-Programme	78.100,00	9204-9209	Netwerkorganisatie	100,00
	IN122021	93	IN	SEDS	AVDM	SEDS - socio-eco. dev. of the poor in mi	111.575,00	9307-9403	Intermediaire organisatie	40,00
	IN145011	92	IN	RVHA	AVDM	Steun aan Rajasthan Voluntary Health Ass	122.482,00	9204-9303	Dienstverlenende organisatie	70,00
	IN123041	92	IN	VHAI	AVDM	VHAI PROGRAMME FINANCING 1992-1995	328.500,00	9210-9503	Netwerkorganisatie	100,00
	IN152011	94	IN	VHAT	BR	Community Health Programme 1994 - 1997	38.965,00	9404-9703	Netwerkorganisatie	40,00
	IN077061	93	IN	DEEPALAYA	BR	Deepalaya Fund Raising 1993-1995	118.525,00	9301-9512	Intermediaire organisatie	15,00
	IN077071	94	IN	DEEPALAYA	BR	Interim South Delhi/Phase-in/Core 94-95	243.167,00	9401-9503	Intermediaire organisatie	10,00
	IN151051	93	IN	VHAA	BR	Vhaa Community Health Programme 1993-199	132.620,00	9310-9609	Dienstverlenende organisatie	100,00
	IN083021	91	IN	SUCHI	MV	Community Development Programme	93.648,00	9201-9412	*	50,00
	IN101031	92	IN	VSA	MV	Community Health Programme 1992-1993	10.568,00	9207-9307	Dienstverlenende organisatie	30,00
	IN092031	94	IN	EHA/TUSHAR	MV	Community health, education & dev. pro.	78.544,00	9406-9605	Dienstverlenende organisatie	60,00
	IN043031	94	IN	CEDMA	MV	Community organization and dev. pro. 94-	154.579,00	-	Intermediaire organisatie	35,00
	IN087021	92	IN	JCSS	MV	Comprehensive Dev. Project of Weaker Sec	23.426,00	9208-9303	Doelgroep/Basisorganisatie	20,00
	IN074051	93	IN	AGRT	MV	Consortium Project 1993-1996	574.837,00	9304-9603	Dienstverlenende organisatie	100,00
	IN081021	93	IN	CRDS/CHITTOOR	MV	CRDS Community Development Project 1993-	212.810,00	9302-9601	Dienstverlenende organisatie	20,00
	IN087011	93	IN	JCSS	MV	Interim Development Project 1993/94	34.143,00	9304-9403	Doelgroep/Basisorganisatie	30,00
	IN110031	94	IN	CDT/ASHA KENDRA	MV	Interim health and education programme 9	177.208,00	9404-9503	Intermediaire organisatie	50,00
	IN111021	93	IN	KASSAR	MV	Kassar Trust People's Water, Sanitation	158.885,00	9304-9603	Dienstverlenende organisatie	10,00
	IN097021	93	IN	SARVODAYA	MV	SA Integrated Development Programme	138.760,00	9307-9606	Intermediaire organisatie	30,00
	IN101041	93	IN	VSA	MV	VSA Community Health Programme 1993-1996	175.877,00	9307-9607	Dienstverlenende organisatie	90,00
	IN050021	92	IN	CRTDP	NOG_	Comprehensive Tribal Dev.Project - Inter	42.163,00	9208-9307	Dienstverlenende organisatie	30,00
	IN128011	93	IN	SNEHAKUNJA	PG	Rural Health and Development Programme 1	134.275,00	9304-9603	Intermediaire organisatie	100,00
	IN096031	93	IN	TBS	PG	TBS/IREDP Integrated Rural Education and	219.398,00	9306-9605	Doelgroep/Basisorganisatie	30,00
	IN060031	93	IN	CORD	PG	Tribal Socio Economic Development 1993-1	1.196.115,00	9304-9603	Intermediaire organisatie	15,00
Z-AZIE	IN022041	94	IN	CCD	HVDH	CCD-Community Dvpt Programme in Rural Ar	161.163,00	9404-9703	Doelgroep/Basisorganisatie	38,00
	IN154011	94	IN	CSD	HVDH	CSD-Urban Development Project, April 94-	98.794,00	9404-9603	*	35,00
	IN020011	92	IN	CUS	HVDH	CUS - Urban Programme, 1992-1995	143.626,00	9207-9506	*	40,00
	IN018021	92	IN	RHDC	HVDH	RHDC - Rural Health & Development Projec	6.344,00	9207-9306	*	40,00
	IN015021	92	IN	TGBK	HVDH	TGBK-Comm. Health & Women Development Pr	23.960,00	9207-9306	*	60,00
	IN009051	92	IN	ANTARA	NVDV	AANKOOP GROND T.B.V. UITBREIDING PSYCH.C	59.265,00	9208-9303	Intermediaire organisatie	100,00
	IN009061	93	IN	ANTARA	NVDV	ANTARA - SUPPLETIE ONDERHOUDSKOSTEN	59.000,00	9206-9306	Intermediaire organisatie	100,00
	IN019021	93	IN	CINI	NVDV	CINI-SUPPORT TO THE INT.DEV.PROGR.FOR WO	179.089,00	9309-9608	Intermediaire organisatie	100,00
	IN008051	94	IN	TSRD	NVDV	TSRD - Patamda Interim 1994	187.212,00	9403-9506	Intermediaire organisatie	18,00

ANNEX 2.

Kluster	Pro.nr.	Pr.jr.	LvU	Afk. org	beh.	Naam aanvr.	bedr. fin.	Fin.per	Om.aard.org	%
Z.Azië	IN 008	93	IN	TSRD	NvdV	TSRD-Core Pro. 93-96	731.600,-	93.12	Inter mediair	10
India	IN 157	89	IN	ACHAN	BR	ACHAN Pro. 89-92	269.240,-	89.10	Netwerk org	100
India	IN 040	91	IN	AF	BR	AF Eco-employment programme 91-93	2.273.798,-	91.07	Inter mediair	10
India	IN 057	91	IN	ASSEFA	BR	ASSEFA Integrated Rural Devt. Projects	4.195.145,-	91.04	Inter mediair	5
India	IN 035	92	IN	AWARE	BR	AWARE Interim Perspective Plan	5.46.997,-	92.10	Inter mediair	10
India	IN 094	92	IN	DDS	BR	ADATS/DDS Extension Prog. Phase II	1.594.125,-	92.07	Inter mediair	10
India	IN 055	91	IN	GV	BR	Gram Vikas Gezondheidszorg + Milieu	3.781.900,-	92.01	Inter mediair	10
India	IN 073	94/91	IN	INSA	BR	Rural Health + Dev. Trainees Pro.	1.10.057,-	91.03/ 95.03	Inter mediair	100
India	IN 101031	92	IN	VSA	MV	Community Health Programme 92-93	10.568,-	92.07/ 93.06	Inter mediair	90

ANNEX 3: SELECTED STATISTICAL DATA ON INDIA

A. General geographic and demographic indicators

Total land area:	3.288.000km2
Population (1991):	846,3 million
- Male population:	439,2 million (51,7%)
- Female population:	407,1 million (48,3%)
- Rural:	628,7 million (74,3%)
- Urban:	217,6 million (25,7%)
Sex ratio (females per 1000 males):	929
- rural:	941
- urban:	893
Population under 14 years (as a percentage of the total population):	40%
Average growth rate (1981-1991):	2,1%
Decadal growth rate (1981-1991):	23,6%
Density of population (1991):	267 persons per km2
Population projection (year 2001):	1.003.000.000
Religions (percentage of population):	
- Hindus:	82,6%
- Muslims:	11,4%
- Christians:	2,4%
- Sikhs:	2,0%
- Buddhists:	0,7%
- Jains:	0,5%
Scheduled castes and tribes (as a percentage of the total population):	24,6%
Total literacy rate (1991):	52,2%
- Male literacy rate:	64,2%
- Female literacy rate:	39,2%
- Rural, for males:	57,8%
- Rural, for females:	30,4%
- Urban, for males:	81,1%
- Urban, for females:	63,9%

B. Some health indicators

Crude birth rate (per 1000 pop.):	
- 1951:	39,9
- 1992:	29
Crude death rate (per 1000 pop.):	
- 1951:	27,4
- 1992:	10
Life expectancy at birth (1986-1991):	
- Male:	58,1
- Female:	59,1
Infant mortality rate (per 1000 life births):	
- 1971:	129
- 1991:	80
- Urban:	53
- Rural:	87

Under five child mortality (per 1000 children):	
- 1984:	21,2
- 1988:	13,3
Maternal mortality rate (per 100.000 births, 1983):	500

C. Urban population

The four largest cities:	
- Bombay:	12,6 million
- Calcutta:	10,9 million
- Delhi:	8,4 million
- Madras:	5,4 million
Total urban population (1991):	217 million
Urban population as % of total:	25,7%
Decadal growth rate (1981-1991):	36,19%
Average annual growth rate:	3,09%
Number of million-plus cities:	23

D. Economic indicators

GDP per capita:	US $330
Growth of GDP 1980-1991:	5,4%
Share of the three major sectors in GDP:	
- Agriculture:	30%
- Industry:	30%
- Services:	40%
Number of middle class population:	150 million
Average annual inflation 1980-1991:	8,2%
Total external debt (millions US $):	
- 1980:	20.611
- 1991:	71.557

ANNEX 4.

Glimpses of the Health Situation in Asia

TABLE - 2 : HEALTH STATUS IN THE ASIAN REGION - 1990

Countries	IMR 1990	Under 5 Mortality Rate	Life Expec-tancy at birth (years) 1990	Crude Death Rate	Crude Birth Rate	Maternal Mortality Rate	Total popu-lation (Milli
1. Afghanistan	167	292	43	23	51	640	16.6
2. Cambodia	123	193	50	16	39	500	8.2
3. Bhutan	123	189	49	16	38	1310	1.5
4. Nepal	123	189	52	14	38	830	19.1
5. Bangladesh	114	180	52	15	41	600	115.6
6. Pakistan	104	158	58	12	44	500	122.6
7. Laos	104	152	50	16	45	-	4.1
8. India	94	142	59	11	32	460	853.1
9. Indonesia	71	97	61	9	28	450	184.3
10.Myanmar	65	88	61	9	30	460	41.7
11.Mongolia	64	84	63	8	35	140	2.2
12.Philippines	43	69	64	7	32	100	62.4
13.Vietnam	49	65	63	9	31	120	66.7
14.China	30	42	70	7	21	95	1139.1
15.Korea, Dem	26	35	70	5	24	41	21.8
16.Sri Lanka	26	35	71	6	22	80	17.2
17.Thailand	26	34	66	7	21	-	55.7
18.Korea, Rep	23	30	70	6	16	26	42.8
19.Malaysia	22	29	70	5	30	59	17.9
20.Singapore	8	9	74	5	17	10	2.7
21.Hongkong	7	7	77	6	13	6	5.9
22.Japan	5	6	79	7	11	11	123.5

Source: WHO 1991 World Health Statistics Annual, Genera, 1992

Table 1.13

Birth Rate and Death Rate
(Three-year moving average)

Birth rates (per '000)						Death rates (per '000)				
1971-73	1974-76	1979-81	1984-86	1989-91		1971-73	1974-76	1979-81	1984-86	1989-91
					States					
34.1	34.2	31.6	30.9	25.8	Andhra Pradesh	15.8	14.9	11.7	10.4	9.3
35.8	32.2	33.1	36.7	32.1	Arunachal Pradesh	20.9	22.8	15.4	15.3	13.9
36.0	31.9	32.9	34.7	29.3	Assam	17.3	16.2	11.5	13.0	11.0
32.3	29.3	38.4	38.1	32.6	Bihar	15.7	13.5	14.7	14.4	10.8
25.4	24.0	17.7	20.5	16.0	Goa	8.8	9.3	7.1	8.0	7.7
38.6	37.6	35.1	32.9	28.6	Gujarat	15.7	14.6	12.4	10.7	9.0
40.6	37.9	36.8	36.0	33.4	Haryana	11.3	12.6	11.0	9.6	8.4
36.0	33.3	31.6	30.5	27.7	Himachal Pradesh	14.6	13.0	10.8	9.8	8.8
32.3	31.2	31.3	33.5	30.8	Jammu & Kashmir	10.5	11.5	9.3	9.3	7.6
30.7	28.4	28.0	29.6	27.5	Karnataka	12.4	11.2	9.7	9.0	8.6
30.5	27.6	26.0	22.9	19.1	Kerala	8.9	8.1	6.8	6.3	6.0
38.6	38.9	37.5	37.9	36.1	Madhya Pradesh	17.1	16.9	15.7	14.0	13.1
31.1	29.3	28.3	30.0	27.4	Maharashtra	12.9	11.4	10.0	8.7	7.8
31.0	25.0	28.7	27.7	21.1	Manipur	7.9	7.0	6.5	6.9	6.2
na	na	32.3	37.5	31.8	Meghalaya	na	na	10.5	11.5	10.1
na	21.3	22.4	23.7	18.1	Nagaland	na	9.0	6.9	6.7	3.7
34.7	31.2	31.9	32.0	29.7	Orissa	17.9	15.1	14.0	13.8	12.3
34.1	31.8	29.6	29.1	28.2	Punjab	11.7	10.8	9.2	8.7	8.0
40.9	35.5	37.1	38.6	33.9	Rajasthan	16.2	15.0	13.5	13.1	10.0
na	na	na	32.3	28.1	Sikkim	na	na	na	10.9	9.0
31.3	30.2	28.3	25.5	22.1	Tamil Nadu	14.5	14.5	11.7	9.9	8.7
33.8	32.0	26.9	27.5	24.9	Tripura	13.4	10.5	9.1	9.9	7.7
43.2	41.7	39.5	38.0	35.9	Uttar Pradesh	21.7	20.9	16.4	16.1	11.9
na	29.6	32.5	29.8	27.1	West Bengal	na	12.4	11.3	9.7	8.3
					Union Territories					
35.2	36.8	33.8	28.1	20.5	Andaman	8.0	8.4	8.1	7.8	5.8
na	34.7	26.7	23.9	18.1	Chandigarh		4.3	2.6	4.4	4.0
	Included under Goa			34.0	Dadra & Nagar		Included under Goa			10.1
38.7	38.9	34.6	42.1	27.7	Daman & Diu	14.8	13.5	15.4	12.3	8.7
31.1	28.9	27.3	31.1	24.7	Delhi	7.8	7.6	6.9	8.0	6.3
35.9	37.7	31.0	34.9	27.2	Lakshadweep	14.5	11.6	9.8	7.1	5.4
29.2	28.9	24.8	23.3	20.0	Pondicherry	9.5	10.5	8.3	8.0	7.1
36.3	34.4	33.8	33.2	29.9	All-India	15.9	15.0	12.7	11.8	10.1
35.3	33.0	31.6	31.7	29.6	Relatively rich States	12.0	11.6	10.1	9.0	8.1
37.9	35.3	36.9	36.9	33.6	Relatively poor States	17.7	16.3	14.9	14.3	11.6

LIST OF 90 DISTRICTS WITH POOR DEMOGRAPHIC PROFILE

State	District	State	District
BIHAR			
	1 NAWADA		44 SIROHI
	2 SAHARSA		45 GANGANAGAR
	3 SAMASTIPUR		46 JAIPUR
	4 KATIHAR		47 SIKAR
	5 GAYA		48 BIKANER
GUJARAT			49 PALI
	6 KACHCHH		50 BARMER
	7 BANASKANTHA		51 ALWAR
HARYANA			52 BUNDI
	8 BHIWANI		53 NAGAUR
KERALA			54 JHUNJHUNUN
	9 MALAPPURAM		55 TONK
MADHYA PR.			56 CHURU
	10 SEHORE	UTTAR PR.	
	11 REWA		57 FARRUKHABAD
	12 GUNA		58 PRATAPGARH
	13 DAMOH		59 MAINPURI
	14 GWALIOR		60 BANDA
	15 PANNA		61 AZAMGARH
	16 RAISEN		62 SHAHAJAPUR
	17 HOSHANGABAD		63 TEHRI GARHWAL
	18 VIDISHA		64 HARDOI
	19 TIKAMGARH		65 MORADABAD
	20 BHIND		66 ALIGARH
	21 WEST NIMAR		67 LALITPUR
	22 SAGAR		68 PILIPHIT
	23 JHABUA		69 DEORIA
	24 BHOPAL		70 BULANDSHAR
	25 SHIVPURI		71 GORAKHPUR
	26 BETUL		72 BUDAUN
	27 CHHATARPUR		73 SHARANPUR
	28 MORENA		74 SITAPUR
	29 EAST NIMAR		75 BASTI
	30 DATIA		76 SULTANPUR
	31 DHAR		77 ETAH
	32 SATNA		78 JAUNPUR
ORISSA			79 AGRA
	33 BALESHWAR		80 BAREILLY
RAJASTHAN			81 GONDA
	34 JODHPUR		82 ALLAHABAD
	35 UDAIPUR		83 NAINITAL
	36 SAWAI MADHOPUR		84 MEERUT
	37 KOTA		85 BIJNOR
	38 JHALAWAR		86 RAEBERELI
	39 JALOR		87 GHAZIABAD
	40 DUNGARPUR		88 RAMPUR
	41 BHARATPUR	WEST BENGAL	
	42 BANSWARA		89 MALDAH
	43 AJMER		90 MURSHIDABAD

Table 2.3

Expenditure on Health: 1950-51 to 1992-93

(Rs. crores)

	Private final consumption expenditure		Combined Government Expenditure					
			Medical, Public Health Sanitation, etc.		Family Welfare		Total Expenditure	Per person (Rs.)
	Rs. crore	Per capita	Revenue	Capital	Revenue	Capital		
1950-51			27.9	0.3			28.2	0.79
1955-56			50.9	2.1			52.9	1.35
1960-61	205	4.81	88.9	8.8			97.7	2.29
1961-62	227	5.11						
1962-63	253	5.57						
1963-64	296	6.38						
1964-65	345	7.28						
1965-66	390	8.04	168.5	11.2			179.7	3.70
1966-67	472	9.54						
1967-68	505	9.98						
1968-69	536	10.35						
1969-70	565	10.68	305.4	15.5			320.9	6.07
1970-71	618	11.42	330.1	19.7			349.8	6.47
1971-72	727	13.12	391.0	27.9			418.9	7.56
1972-73	854	15.06	477.1	38.7			515.8	9.10
1973-74	1,004	17.31	490.1	41.7			531.8	9.17
1974-75	1,180	19.90	555.2	63.7	65.7	3.0	687.5	11.59
1975-76	1,386	22.83	628.2	78.5	85.9	3.5	796.1	13.11
1976-77	1,629	26.27	715.8	104.1	171.0	1.8	992.7	16.01
1977-78	1,915	30.21	831.1	119.1	95.8	1.2	1,047.2	16.52
1978-79	2,221	34.27	973.1	132.3	107.8	2.7	1,215.8	18.76
1979-80	2,577	38.81	1,154.6	166.3	119.1	2.8	1,442.7	21.73
1980-81	2,970	43.74	1,389.9	227.8	141.9	4.4	1,764.0	25.98
1981-82	3,453	49.76	1,652.3	276.1	183.2	9.0	2,120.5	30.55
1982-83	4,014	56.61	1,925.8	318.2	273.1	21.4	2,538.5	35.80
1983-84	4,666	64.45	2,306.1	396.4	359.5	32.7	3,094.5	42.74
1984-85	4,829	65.35	2,624.7	402.9	392.3	36.6	3,456.5	46.77
1985-86	5,089	67.40	3,042.5	426.4	484.5	52.0	4,005.5	53.05
1986-87	5,355	69.46	3,580.2	487.8	529.0	41.3	4,638.2	60.16
1987-88	5,923	75.16	4,148.9	595.1	601.1	41.1	5,386.2	68.35
1988-89	7,264	90.24	4,674.5	599.9	676.1	36.8	5,987.4	74.38
1989-90	7,604	92.51	5,282.1	512.0	803.1	64.2	6,661.5	81.04
1990-91	8,242	98.35	5,705.0	617.4	859.0	102.8	7,284.2	86.92
1991-92	9,022	105.40					8,201.1	95.81
1992-93							8,878.0	101.70

Table 2.1

Health Services: 1960 to 1990

	Registered doctors		Hospitals	Dispensaries	Primary health centres (a)	Sub-centres (a)	Beds(b)	
	Lakh	Per lakh persons					'000	Per lakh population
1960	0.76	17.6	4,011	9,874	2,800		200	46
1965	1.00	20.7	3,900	9,486	4,481		295	61
1970	1.39	25.8	4,239	10,508	5,112	28,489	326	60
1975	1.98	33.0	4,023	11,295	5,328	34,088	404	66
1980	2.55	37.2	6,670	15,968	5,740	51,405	561	82
1981	2.69	39.2	6,804	16,751	5,851	57,975	569	81
1982	2.72	39.6	6,897	17,409	5,959	65,643	584	82
1983	2.84	41.5	7,189	21,777	6,375	77,236	599	82
1984	2.97	43.2	7,369	21,872	7,284	84,590	625	84
1985	3.08	44.8	7,474	25,584	12,934	92,483	657	86
1986	3.20	46.6	8,067	26,943	14,281	101,549	695	90
1987	3.31	48.2	9,834	27,728	16,449	109,644	719	93
1988			10,156	28,841	18,811	120,767	741	92
1989			10,157	28,565	20,531	129,291	750	93
1990	3.65				22,229	131,379		
Compound annual rate of increase (%) between 1960 & 1990	5.6	3.8	3.1	3.6	7.1	7.9	4.7	2.5

(a) Relates to financial year e.g. 1960 refers to 1960-61.

(b) Includes all types of beds in hospitals, dispensaries, PHCs and voluntary organisations.

Distribution of Hospitals and Dispensaries: 1 January 1990

	Hospitals		Dispensaries		Hospital beds		Dispensary beds	
	Number	%	Number	%	Number	%	Number	%
Government	4,178	41.1	9,702	34.3	403,577	67.0	15,191	66.3
Local bodies	348	3.4	2,937	10.4	21,830	3.6	1,772	7.7
Pvt. & voluntary	5,646	55.5	15,665	55.3	177,083	29.4	5,965	26.0
Total	10,172	100.0	28,304	100.0	602,490	100.0	22,928	100.0
Rural	3,167	31.1	12,747	45.0	95,722	15.9	13,642	59.5
Urban	7,005	68.9	15,557	55.0	506,768	84.1	9,286	40.5
Per lakh population								
Rural	0.51		2.03		15.26		2.18	
Urban	3.23		7.16		233.32		4.28	

NATIONAL NORMS

1. Atleast one trained dai.....for each village.

2. One trained Village Health Guide.....for each village/ 1000 population.

3. One Sub-Centre.....for every 5000 population in plain area & for 3000 population in tribal,and hilly areas.

4. One Primary Health Centre(PHC).....for every 30,000 population in plain area & 20,000 population in hilly, and tribal areas.

5. One Community Health Centre(CHC).....for every 80,000 to 1.20 lakh population, serving as a referral institution for four Primary Health Centres.

6. Sub-Centres Covered by a PHC..... 6 Sub-Centres

7. PHCs Covered by a CHC..... 4 PHCs

8. Population covered by a Health Worker (Male & Female)..... i) 5000 in Plain area
   ii) 3000 in tribal and hilly areas.

9. Population covered by a Health Asstt. (Male & Female)..... i) 30,000 in Plain area
   ii) 20,000 in tribal and hilly areas.

10. One Health Asstt.(Male/Female) Provides supportive supervision to 6 Health workers.....6 health Workers (Male/Female) (Male / Female)

3.3 (a) PHCs with & without Doctors

PHCs with 4 or more Docts.	PHCs with 3 Docts.	PHCs with 2 Docts.	PHCs with 1 Docts.	PHCs without Docts.
(1)	(2)	(3)	(4)	(5)
408	716	4059	6874	1115

3.3 (b) PHCs without Lab. Tech/Pharmacist

PHCs without Lab. Tech.	PHCs without Pharmacist
(6)	(7)
6045	750

4.0 ANM/HW(F) as on 31.3.94

1. Total number of ANM Schools	466
2. Annual admission capacity	20291
3. Average Annual admission capacity per School	43 (Approx.)

4.1 LHV/HA(F) AS ON 31.3.94

1. LHV/HA(F) promotional schools	44
2. Annual admission capacity	2758
3. Average Annual admission capacity per School	63 (Approx.)

5.0 HEALTH MAN POWER IN RURAL AREAS As on 31.3.94

Category	No. Sanctioned	No. In Position	% Vacant
1. Surgeons	1053	725	31.1
2. Obst. & Gynaecologists	816	421	48.4
3. Physicians	667	464	30.4
4. Paediatricians	628	340	45.9
5. Doctors at PHCs	27621	23672	14.3
6. Block Extension Educators	6246	5782	7.4
7. Health Assistants (Male)	20108	18564	7.7
8. Health Workers (Male)	70259	62200	12.8
9. Health Assistants (Female)/LHV	21629	20127	6.9
10. Health Workers (Female)/ANMs	131904	124365	5.7
11. Pharmacists	20438	18644	8.8
12. Lab Technicians	12233	9804	19.9
13. Nurse Mid-wives	14915	11583	22.3
14. Radiographer	1185	972	17.9
Actual Total of catagories (1)-(4)	S= 3891	P = 2598	% V= 33.2

PRIMARY HEALTH CENTRES

STAFFING PATTERN

A. STAFF FOR SUB-CENTRE		No. of Posts
1. Health Worker(Female)/ANM	-	1
2. Health Worker(Male)	-	1
3. Voluntary Worker (Paid @ Rs.50/-p.m.as honorarium)		1
		3

B. STAFF FOR NEW PRIMARY HEALTH CENTRE. *		
1. Medical Officer	-	1
2. Pharmacist	-	1
3. Nurse Mid-wife (Staff Nurse)	-	1
4. Health Worker (Female)/ANM	-	1
5. Health Educator	-	1
6. Health Assistant (Male)	-	1
7. Health Assistant (Female)/LHV	-	1
8. U.D.C.	-	1
9. L.D.C.	-	1
10. Lab. Technician	-	1
11. Driver (Subject to availability of vehicle)	-	1
12. Class IV	-	4
		15

* for every 30,000 population in plain area & 20,000 population in tribal and hilly areas.

Table 2.1

Family Planning Programme during 1991-92

('000 numbers)

Couple protection rates (%) (31.3.91)	Cumulative Acceptors since inception		Per '000 population			Number of Acceptors during 1991-92			
	Sterilisation	IUD insertions	Sterilisation	IUD insertions		Sterilisation	IUD insertions	Conventional contraceptive users	Oral pill users
					States				
44.3	8,088	1,914	121.6	100.8	Andhra Pradesh	483.5	290.1	790.9	196.1
10.5	11	21	13.1	7.8	Arunachal Pradesh	1.8	2.2	1.2	1.2
28.2	1,585	445	70.7	62.2	Assam	66.3	28.3	38.5	11.8
26.0	5,877	2,130	68.0	58.6	Bihar	212.6	134.3	105.3	35.7
34.0	77	33	65.7	54.6	Goa	4.1	3.5	14.7	2.2
57.8	5,146	3,280	124.6	106.8	Gujarat	257.3	348.8	776.6	114.2
56.6	1,605	2,114	97.5	80.5	Haryana	100.8	147.0	487.8	36.6
52.1	572	383	110.6	90.6	Himachal Pradesh	38.1	47.4	73.5	14.9
21.1	421	222	54.6	43.6	Jammu & Kashmir	38.1	10.5	10.8	3.8
46.9	4,840	2,253	107.6	88.2	Karnataka	301.6	233.4	255.3	83.4
55.6	3,574	1,234	122.8	103.2	Kerala	173.6	115.4	296.4	39.0
40.3	6,084	2,833	91.9	79.2	Madhya Pradesh	316.6	322.6	1,028.6	262.9
56.2	11,234	4,976	142.3	121.8	Maharashtra	538.1	467.9	1,089.5	379.8
41.0	71	80	38.4	31.8	Manipur	4.0	5.5	2.7	0.1
5.0	20	20	11.0	10.1	Meghalaya	0.6	1.8	1.4	1.2
41.4	41	22	59.1	41.5	Mizoram	4.5	2.0	2.4	1.1
4.8	8	7	6.8	4.1	Nagaland	1.0	0.6	0.0	0.1
41.0	3,259	1,525	102.9	89.2	Orissa	137.3	149.3	267.9	61.5
75.8	1,971	3,760	97.2	81.6	Punjab	85.5	358.6	537.8	72.1
29.0	2,875	1,486	65.3	55.2	Rajasthan	173.3	158.6	375.5	60.2
20.6	10	14	25.2	17.4	Sikkim	1.3	0.9	0.4	2.1
57.3	7,835	3,470	140.3	120.0	Tamil Nadu	364.5	431.8	290.9	157.2
17.6	113	22	40.9	32.5	Tripura	7.6	2.5	2.7	3.5
35.5	7,784	11,352	56.0	46.6	Uttar Pradesh	375.8	833.5	1,609.5	251.9
33.7	5,926	1,412	87.0	72.8	West Bengal	327.1	168.2	342.6	131.0
					Union Territories				
42.3	21	17	75.8	54.6	Andaman	1.9	1.8	2.4	0.6
41.8	47	92	73.7	61.7	Chandigarh	3.0	6.0	18.6	0.3
47.5	16	2	114.1	96.8	Dadra & Nagar	0.8	0.3	0.5	0.1
30.2	4	1	40.1	28.4	Daman & Diu	0.4	0.2	0.9	0.1
40.4	632	877	67.1	56.2	Delhi	37.2	78.1	363.2	8.0
8.6	1	1	17.7	16.4	Lakshadweep	0.0	0.1	0.2	0.1
60.6	113	60	139.6	110.5	Pondicherry	8.2	4.2	11.8	1.0
44.1	80,873	46,435	95.6	80.9	All-India	4,116	4,384	14,019	3,369
62.9	14,810	10,851	128.0	108.9	Relatively rich States	724	973	705.0	488
34.4	25,879	19,326	70.5	60.0	Relatively poor States	1,216	1,598	677.3	672

All-India includes acceptors in defence & railways and oral pills and CC distributed commercially.

APPENDIX-III

TARGETS AND ACHIEVEMENTS UNDER MCH PROGRAMME DURING 1992-93

(Figures in 000's)

Activity	*Target for 1992-93*	*Achievement* 1992-93*	*%Achvt. of Annual target of 1992-93*
1.	2.	3.	4.
A. Immunisation			
i. Tetanus Immunisation for expectant mothers	27008	21444	79.4
ii. DPT Immunisation for children	24290	21907	90.2
iii. Polio	24290	22058	90.8
iv. B.C.G.	24290	23430	96.5
v. Measles	24290	20830	85.8
vi. DT Immunisation for children	17552	12906	73.5#
vii. T.T. (10 years)	16054	10448	73.1#
viii. T.T. (16 years)	16102	8249	57.5#
B. Prophylaxis against Nutritional Anaemia among:			
(a) Total women	27008	16296	60.3#
(b) Children	24290	13889	57.2#
C. Prophylaxis against Blindness due to Vit.A deficiency	24290	28429 (doses)	66.4#K

* Figures provisional.

K % of achievement of target was worked out by taking half of the total doses given to the first time initiated continuing and completed dosed beneficiaries as annual target of Vitamin 'A' solution are two dosed beneficiaries.

Worked out after excluding targets for States/UTs for which achievement figures were not received.

TABLE NO. 5.01 : TARGETS FOR MAJOR SCHEMES UNDER CONTROL OF COMMUNICABLE DISEASES PROGRAMME DURING SEVENTH PLAN 1985 - 90

SL. NO.	NAME OF THE SCHEME	INDEX	CURRENT POSITION	TARGET SET FOR 1985-90 PLAN
1	2	3	4	5
1.	Malaria Control Programme	(a) Annual parasite Index	2.16 (1990)	1.9
		(b) Deaths recorded and verified	222 (1990)	Nil
2.	National Leprosy Eradication Programme.	(a) Cases detected	24.46 lakhs	19.62 lakhs
		(b) Cases put on treatment	23.72 lakhs	19.62 lakhs
		(c) Cases discharged	27.98 lakhs	24.47 lakhs
3.	Control of Blindness.	(a) % of Blindness	1.4 %	0.5 %
4.	T.B. Control Programme.	(a) Total No. of cases detected as % to total estimated cases.	42 %	50 %
		(b) Disease arrested cases.	66 %	70 %
5.	Filaria Control Programme	Population under Protection.	42.60 million	45 million

Source : Respective Programme Officers.

TABLE 1

Current stock, Annual otturn, supply, total stock, projcted requirements and gap regarding health manpower at Primary and intermediate level of care i.e. upto level of Community Health Centre.

S.No.	Category of Manpower	Stock in		Annual outturn	Supply by		Total Stock		Requirement		Gap	
		1986 IAN	1991	2000	1983	1981	2000	1991	2000	1991	2000	1991	2000
1	2	3	4	5	6	7	8	9(4+7)	10(5+8)	11	12	13	14
1.	Community Health Officer									22,305	26,439	—	—
2.	Block Extension Educator/ Health Educator	4,915	2,902	1,124	35	175	490	3,077	1,614	28,578	33,875	25,501	32,261
3.	Opthalmic Asstts.	951*	505	196	617	3,702	9,255	4,207	9,451	6,273	7,436	2,066	(—)2,015
4.	Staff Nurses †	162,875*	61,428	14,228	8,533*	51,198	127,995	112,626	142,223	409,246	664,623	296,620	522,400
5.	Pharmacist	24,449	14,437	5,593	4,063	20,315	56,882	34,752	62,475	34,851	41,511	99	(—)20,964
6.	Lab. Technician	8,336*	4,922	1,907	1,558	9,348	23,377	14,270	25,277	34,851	41,511	20,581	16,234
7.	X-Ray Technician/ Radiogrpher	INA	—	—	609	4,872	10,353	4,872	10,353	6,273	7,436	1,401	(—)3,117
8.	Nurse Midwife	9,395	5,548	2,149	627	3,135	8,778	8,683	10,927	66,216	78,491	57,533	87,564
9.	Dreasser	651	—	—	—	—	—	—	—	6,273	7,436	—	—
10.	Health Asstt. (M)	15,989	9,441	3,658	1,538	7,690	21,532	17,131	25,190	34,155	40,485	17,024	15,295
11.	Health Asstt. (F)	26,105	15,415	5,972	3,095	15,475	43,330	30,890	49,302	34,155	40,485	3,265	(—)8,817
12.	Health Worker (M)	84,122	49,673	19,244	819	4,095	11,466	53,768	30,710	136,620	161,941	82,852	131,231
13.	Health Worker (F)	95,615	56,460	21,874	15,296	76,480	214,144	132,940	236,018	158,925	188,380	25,985	(—)47,638
14.	Health Gnide**	385,572	—	—	—	—	—	—	—	627,337	743,610	—	—
15.	Traditional Birth** Attendant (TBA)	515,691	—	—	—	—	—	—	—	627,337	743,610	—	—

* Figures pertain to the year 1985.

** Being Voluntary workers, calculations cannot be done in the same manner as is applicable for other workers.

† Calculations are based on manpower requirement for hospital nursing services.

INA Information Not Available.

‡ The gaps indicated above are only in relation to the need of Primry and Intermedite Health care services. These will become much wider when viewed in the perspective of comprehensive health care system including tertiary care services, as also the needs of organized sector and private sector.

§ The requirements indicated above are only in relation to the needs of primary and intermediate health care services. A large number of the surplus will be absorbed by the organised sector and the private sector.