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AN APPROACH TO TRIBAL HEALTH PLAN

TRIBAL WELFARE DEPARTMENT
GOVERNMENT OF ANDHRA PRADESH
HYDERABAD
MAY, 1997.

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AN APPROACH TO TRIBAL HEALTH PLAN

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TRIBAL HEALTH PROJECT

In A.P.P.T.D.P. Areas of Andhra Pradesh

Towards a Reproductive and

Child Health Approach

(A Project proposal for improvement

of Health among Women & Children)

TRIBAL WELFARE DEPARTMENT

Government of Andhra Pradesh

Hyderabad

ABBREVIATIONS & ACRONYMS

ANM	=	Auxilliary Nurse Midwife
ARI	=	Acute Respiratory Infection
CHC	=	Community Health Centre
CHW	=	Community Health Worker
GOI	=	Government of India
ICDS	=	Integrated Child Development Services
IEC	=	Information, Education and Communication
MCH	=	Mother and Child Health
MTP	=	Medical Termination of Pregnancy
PEM	=	Protein - Energy Malnutrition
PMP	=	Private Medical Practitioner
PHC	=	Primary Health Centre
RCH	=	Reproductive and Child Health Approach
SC	=	Sub - Centre
TBA	=	Traditional Birth Attendant
TT	=	Tetanus Toxoid

C O N T E N T S

SL. No.	SUBJECT	PAGE No.
I.	INTRODUCTION	1
II.	PRESENT SCENARIO	4
III.	OBJECTIVES & APPROACH	12
IV.	STRATEGY	13
V.	PROJECT AREA	15
VI.	PROJECT INTERVENTIONS	16
VII.	INFORMATION, EDUCATION & COMMUNICATION ACTIVITIES (I.E.C)	24
VIII.	MONITORING & EVALUATION	26
IX.	PROPOSED ACTIVITIES	27
X.	BUDGET	37
XI.	ANNEXURES	40

INTRODUCTION

I. PROFILE OF TRIBAL AREAS :

Andhra Pradesh has a relatively high concentration of tribal population (41.99 lakhs) with about 33 Scheduled Tribes. They constitute about 6.31% to the total population of Andhra Pradesh. Of these more than 50% live in a contiguous belt of inaccessible, hilly forest areas extending from Adilabad district in North Telangana to Srikakulam District in North Coastal Andhra. The largest concentrations of tribal population is in Khammam District, followed by Adilabad and Vishakapatnam. Vast tracts of these areas are inaccessible, especially in the rainy season, which is also the time when the population is most susceptible to many illnesses like gastro-enteritis and malaria which need medical attention.

Tribals now occupy the more remote and mountainous areas and are characterised by small, close-knit communities. Most of them live in single tribal villages and there is little social stratification. They have a lifestyle with little or no concept of planning, money management and savings and live in what is predominantly a subsistence economy.

Tribals fare badly when compared to the rest of society on health indicators (See Table) such as life expectancy, infant mortality, crude death rate, under five mortality, maternal mortality, population growth rate, ante-natal care for pregnant women, immunisation coverage and births attended by trained staff. They also fare poorly in comparison on general indicators which have a bearing on their health status like income levels, food security and nutritional status, literacy and education, drinking water and sanitation, housing, roads and communication network.

B. PRESENT SITUATION :

A study of the health infrastructure and staffing in the tribal areas revealed that :

- **Though numerous PHC's have been established they are facing many problems. Infrastructure like buildings (quality), electricity, water, toilets, transport are lacking in a significant number of cases. The PHC's also lack facilities like a lab., cold storage, supply of essential drugs, operation theatre and labour room.**

A further problem which needs to be addressed is the reluctance of staff to work in tribal areas due to their remoteness, inaccessibility and lack of facilities.

> * **Living conditions in many of the locations do not seem to be conducive to the staff posted there and it is an open secret that in many PHC's the staff, including the Medical Officer, do not stay in their place of posting. The position in the sub-centres is the same.**

The combination of the lack of medical facilities at these centres and the absence of the concerned staff has led to a situation of near non-functionality of the Government health care system. This has been clearly brought out during the PRAs conducted during 1995 on the perceptions of people in the tribal areas about the health delivery system.

C. HEALTH CARE POLICY :

Health planning in the state of Andhra Pradesh is guided by the policy of Government of India, which is committed to attaining the goal of 'Health for All' by the year 2000 AD through the primary health care approach. The Government is concentrating its efforts on the development of a rural health infrastructure so as to provide health care services to about 80% of the rural population which, by and large have been neglected. There are no specific guidelines for the organisation of health care in the tribal areas, except where they form part of the general policy.

The rural primary health care delivery system has been developed and strengthened based on the principle of Minimum Needs Approach. Rural primary health infrastructure has been created on population norms and is founded on a three-tier system of sub-centres, primary health centres and community health centres. For delivery of health and family welfare services to the tribal population, the operation of the three-tier system is based on following standards.

> **Sub-Centres** are established on the basis of one sub-center for every 3000 population in hilly, tribal and backward areas. Each sub-center is required to be staffed by a trained Female Health Worker or Auxiliary Nurse Midwife [ANM] and a trained Male Health Worker ;

Primary Health Centres [PHC] are established for an average of every 20000 population in hilly, tribal and backward areas. The PHC is staffed by a Medical Officer with supportive para-medical staff ; and

Community Health Centres [CHC] are established for every four Primary Health Centres so as to serve as a referral institution, having a minimum of 30 beds and four specialists.

The delivery of health and family welfare services to the rural communities by this three-tier system can be divided into the following components :

Maternal and Child Health Programme [MCH] : The care of mothers and children is a top priority of the health care system. The major MCH programmes are prophylaxis against nutritional anaemia and against Vitamin A deficiency, acute respiratory infection control, immunisation, and control of diarrhoeal diseases; (* what about identification of high risk mothers and safe deliveries ?)

Major Diseases Control Programme : The control and eradication of endemic and communicable diseases is the other area of priority and specific programmes exist to combat malaria, filaria, leprosy, blindness, tuberculosis, goitre, STD and AIDS.

The State Government has diligently followed the guidelines of the Government of India and expanded its health delivery system and opened requisite number of PHC's and sub-centres in tribal areas, but is unable to either maintain and operate them effectively or succeed in providing satisfactory reproductive or general health care. There are a number of conceptual and practical inadequacies which are contributing to this situation and a specific strategy has to be developed to improve the situation.

D. WOMEN IN DEVELOPMENT (WID) ISSUES :

The essence of tribal family health is around the health of the mother, who is also the economic support for the family. One of the issues which can reduce her drudgery is ensuring support for the establishment of healthy home environment. Due to logistic reasons and lack of infrastructure, presently the tribal women is not able to receive the medical care and attention. Only when the medical services are closest to the door steps of the tribal households, there will be a scope for reducing the above drudgery of the tribal women. In A.P.P.T.D.P., it is proposed to address the Women in Development (WID)., issues in health through an integrated approach of health, education, IEC, CHW scheme and referral system for needy patients.

II. PRESENT SCENARIO :

A. HEALTH STATUS

Reproductive Health and Child Care

The status of tribal women is generally higher than in non-tribal societies. Economically they are the mainstay of the tribal economy. Tribal women, in addition to their domestic and child care duties contribute the major part of the labour in agriculture whilst also freely accepting wage labour when opportunities are available. However they generally play minor part in village decision making although they have a major influence in household affairs, being responsible in many communities for managing household finances.

Despite the best efforts of the Government, the MCH services coverage in the tribal areas is abysmally low as revealed from the studies conducted in the tribal areas in 1995, through a survey of 2000 tribal mothers and also PRA exercises conducted by teams of resource personnel.

The literacy rate amongst tribal women is 8.60% and the drop out rates amongst girls who enrol in schools is 70.38%. The average age at marriage of the tribal women is around 14 years and the average age at the birth of the first child is 16.8 according to the studies conducted by the TCR & TI. This study also revealed that pregnancy wastage was more than 2.5 per married woman and that the total marital fertility rate is around 5.25.

Studies revealed a high incidence of protein/vitamin/caloric under nutrition among tribal women in general and more so in pregnant and lactating mothers. Traditional customs like 'korra kotha' festival coupled with strong food taboos regarding consumption of certain nutritious and protein rich foods are responsible for high incidence of gross anaemia in mothers resulting in low birth weight babies. These babies have greater vulnerability to risk of death from common childhood illnesses.

Of 1781 mothers interviewed about 1316 (73.89%) worked (both domestic and agricultural work) until delivery and 317 (17.8%) up to eight months and 103 (5.78%) upto seven months and 45 (2.53%) less than six months. The above data shows that the pregnant women are not taking adequate rest. Their economic situation warrants manual labour till advanced stages of pregnancy and hence higher incidence of mortality and morbidity and consequential in the fields itself. So there is a great need for provision of maternity assistance to these women.

Of 1855 mothers only 1260 (67.92%) received TT prophylaxis and only 934 (50.35%) Iron and Folic Acid prophylaxies. About 426 (22.96%) had ante-natal complication and 619 (33.37%) had intra-natal complications. Of these 119 (19.22%) received medical attention either from ANMs or Doctors.

Of 1855 mothers 1527 (82.32%) had home deliveries of which 415 (27.18%) were conducted by trained Dais and 941 (61.62%) by untrained Dais, only 19 (1%) were conducted by ANMs - the rest were attended to by relatives or had to manage by themselves. Some of the practices during deliveries such as traditional way of cutting the umbilical cord with a sickle or bamboo; application of ash, juices from leaves or other substances to the umbilicus are common and the practice of 'five cleans' while performing deliveries is not followed.

Most of the tribes lack of awareness of the need for child immunisation and special care of the diets of infants and children. Of 4659 children sampled only 1208 (25.93%) received immunisation. Although tribal women often breast milk to children for a period of three years, they do not start weaning their children until after a year.

The infant mortality rate for Andhra Pradesh is 73 per 1,000 live births per year. A study conducted in the East Godavari District among various tribes including Konda Dora, Konda Reddy, Konda Kapu, KOnda Kammara and Valmikis has shown an infant mortality rate of 120/1000 live births. However, other studies indicate that the infant mortality rate is around 150. Infant deaths expressed as a percentage of total deaths amounts to 50%, which is highly significant.

Age specific mortality rates among children (1-14 years) indicate that around 49% of child deaths occur in the 1-3 years age group and 64% of deaths occur among 1-6 year olds. This emphasises not only the need for intensive natal and post-natal care but also for pre-school child survival measures, particularly during the weaning and post weaning periods.

Complications during child birth are responsible for a large number of deaths among tribal women in the reproductive age. This is because they have no access to essential health care during this period much less sophisticated emergency equipment so that even minor problems can lead to death. Maternal mortality rate (MMR) is 7 per thousand when compared to the general figure of 4 per thousand for Andhra Pradesh.

The major elicitable causes of maternal mortality are anaemia, medical complications arising from improperly performed abortions, eclampsia, haemorrhage (pregnancy bleeding), obstructed labour, and puerperal sepsis. These together account for more than 50% of the deaths among the tribal mothers associated with child bearing. These deaths can be prevented and occur because tribal women have no access to minimal health care during this period leave alone sophisticated emergency equipment.

Quite apart from these problems, women suffer from gynaecological disorders like cervical and vaginal infections, prolapse, and backaches, for which medical attention is not readily available. The scope of MCH needs to be expanded to include these concerns which are part of Reproductive Health Care.

Even today despite the expansion of medical facilities to the rural areas only a small percentage of deliveries take place in hospitals or are attended by trained personnel. The greater burden of providing obstetric care continues to be shouldered by traditional village dias, more so in tribal areas. What is required is to train and deploy a cadre of village based community supported tribal women development organisers who would be responsible for providing integrated health and nutrition support to 50 - 100 families and a large number of tribal women to function as trained birth attendants so that they are available in every village. There is a strong case for measures to prevent premature births, low birth weight and prenatal mortality on the one hand, and maternal mortality on the other.

MORBIDITY :

Among adults respiratory infections (many including tuberculosis) and fevers (including malaria) are the most common diseases, followed by alimentary diseases (including peptic ulcer and dysentery) and various aches and pains. These are mostly the result of infection - bacterial or parasitic - except that dyspepsia and peptic ulcer could be the result of the smoking, drinking and of irregular eating habits.

In contrast to the adults, fevers, acute respiratory infections and gastro-enteritis (diarrhoea) are the most common diseases among children followed by scabies and skin infections. These are essentially infections possibly aggravated by malnutrition and lack of protected drinking water and sanitation facilities.

MORTALITY :

Less is known about the causes of death than about the diseases from which the tribals suffer. Hospital figures as well as enquiries indicate that the major causes of death are malnutrition - and/or infection-associated, both in the case of adults and children. Studies conducted among various tribals have revealed crude death rates varying from 15 per 1,000 for Savaras, 16.5 for Konda Doras, 17.5 for Gadabas and 19.48 for Jatapus. These are much higher than the averages for Andhra Pradesh which is less than 10 (9.9/1,000/year) and for India (12.6/1,000/year in 1986).

B. HEALTH SERVICE COVERAGE IN TRIBAL AREAS

The scheduled Tribe population in the State are served by 29 Mobile Medical Units, 120 Primary Health Centres and 1110 Sub Centres spread over nine ITDAs. The average population coverage per PHC is about 19,000 which is within the norms for tribal area. The variation is from a coverage of 9,000 in ITDA, Eturunagaram to 25,000 in ITDA, Bhadrachalam. Each PHC has an average of 10 Sub Centres which cover a population of 2600. The range is from 1150 in K.R.Puram to 4050 in Bhardachalam.

COVERAGE OF HEALTH SERVICES IN APPTDP AREA:

Out of 120 PHC's in the sub plan area of Andhra Pradesh, 77 PHC's are in APPTDP area serving to a total population of 71,024 excluding Chenchu project area. The population coverage ranges from 8,928 in Eturungaram, ITDA., to 25,096 in Bhadrachalam, ITDA., which is higher than the specified norms. Out of 891 sub centres, 502 sub centres are in the project area and the population coverage ranges from 1142 to 4052. The area of operation for the sub centre is more even though the population coverage of each sub centre is within the norms.

Coverage and Location of Primary Health Centres

I.T.D.A	POPN. in Lakhs	PHC's	COVERAGE @ 20000 PER PHC	SC's	COVERAGE @ 3000/- PER SC
S'PETA	1.05	8	13125	41	2560
P'PURAM	1.53	11	12909	66	2318
PADERU	3.55	15	23667	189	1878
R.C.VARAM	1.74	9	19333	93	1871
K.R.PURAM	0.64	4	16000	56	1142
B'CHALAM	7.78	31	25096	192	4052
E'NAGARAM	1.25	14	8928	64	1953
UTNOOR	3.99	19	21000	123	3243
SRISAILAM	0.35	9	NA	67	NA
[1]TOTAL :	21.88	120	19396	891	2612

1 (Separate details are given in the annexure regarding Chenchu area)

Coverage of Sub-Centres

I.T.D.A	ITDA AREA Sq.Kms	PHC's	COVERAGE Sq.Kms	SC's	COVERAGE Sq.Kms
S'PETA	1289.32	8	161.16	41	31.44
P'PURAM	1740.98	11	158.27	66	26.37
PADERU	5904.51	15	393.63	189	31.24
R.C.VARAM	4191.65	9	465.74	93	45.07
K.R.PURAM	1006.10	4	251.53	56	17.96
B'CHALAM	6899.92	31	222.58	192	35.93
E'NAGARAM	3122.46	14	223.03	64	48.78
UTNOOR	6138.50	19	323.07	123	49.90
TOTAL :	30293.44	111	272.91	824	36.76

Though the number of PHCs and sub-centres are within the population norms defined by the Government of India for hilly, backward and tribal areas there is, however, an opinion that geographical area could be a better criteria given the low population density which makes outreach services difficult and access to the centres a major problem for the people. This is specially true for the Sub-centres. Though the average service area of 36 Sq.Kms.per sub-centre is not very large, there are many areas with hostile terrain, lack of roads etc., which render effective service delivery impossible. Further there are instances where sub-centres are expected to serve far greater areas. An exhaustive survey was conducted in 1995 of the 120 PHCs and 1110 sub-centres situated in the agency areas. The survey revealed the following situation.

Infrastructure Facilities in PHC's

Name	No.of PHCs	Major Repairs	M.O.Quarter		No Power	Water Shortage	Toilets	
			Abs.	Reps.			Abs.	Uns.
S'pet	14 [10]	2	0	2	2	8	4	5
P'puram	18 [9]	3	4	6	2	11	5	4
Paderu	15 [14]	5	6	7	5	11	5	8
R.C.Varam	10 [9]	3	2	4	1	3	3	3
K.R.Puram	4 [4]	2	0	2	0	1	1	2
B'chalam	32 [20]	5	23	5	6	14	16	7
E'nagaram	15 [5]	1	10	3	2	9	6	4
Utnoor	17 [12]	4	8	3	3	15	10	3
Total :	121 [83]	25	53	32	21	72	50	36

Figures in brackets indicate number of PHC's which responded about the state of the buildings.

Buildings : Around 80% of the PHC's are situated in Government buildings and 26 in privately owned ones. It is not clear how many of these buildings were constructed with the express intention of locating a PHC because there is no definite pattern in the type and design of the buildings. Of the 120 PHC's surveyed 25 are located in semi-pucca structures, whereas 2 are thatched buildings. 67 of the PHCs have quarters for the Medical Officer and 43 have staff quarters.

Of the 120 PHC's, 89% require repairs, 40 (ie., a third) of the PHC's are in a dilapidated condition and need major repairs. A similar percentage of Medical Officer's quarters and staff quarters also require repairs. About 30% of the PHCs are located in places without electrical supply. 40% of them have no water supply, 20% have open wells, 30% borewells and only 8% have a tap facility.

Nearly 81% of PHC's are having Government accommodation in the project area. The remaining 19% of the PHC's are located in private, thatched or sub centre buildings. Nearly 30% of the buildings require major repairs while 70% of them require minor repairs. Nearly 60% of PHC's are having quarters for Medical Officers. Nearly 23% of the PHC's are not having the electricity supply and about 3/4 of the PHC's are not having the water supply facility.

MCH and Other Facilities : 94 of the 120 (80%) PHC's have Blood Pressure apparatus. However facilities for weighing, urine, blood and foetal examination are abysmal with 6,4,2 and 5 PHC's having the necessary equipment.

Sterilisation and MP Facilities Available

Name	No.of PHCs	Sterilisation	MTP Facilities
S'peta	14	13	3
P'puram	13	10	3
Paderu	15	12	1
R.C.Varam	10	8	3
K.R.Puram	4	4	1
B'chalam	32	19	8
E'nagaram	15	13	2
Utnoor	17	11	6
Total :	120	90	27

62% of the PHC's have no labour rooms and of the 46 which have them only 20 are properly equipped. MTP facilities, a vital component of MCH services, are absent in 85.8% of PHC's which is quite distressing. On the other hand over 60% of the PHC's have sterilisation facilities. 30 PHC's are reported to be conducting tubectomies and 40 vasectomies.

Infrastructure in PHCs

Name	No.of PHCs	Pont Op.Ward		Op.Theatre		Labout Room		Waiting Hall	
		Abs.	N.Eqpd.	Abs.	N.Eqpd.	Abs.	N.Eqpd.	Abs.	N.Eqpd.
S'peta	14	8	1	3	5	5	5	5	4
P'puram	13	6	3	5	5	8	4	7	1
Paderu	15	9	3	6	6	8	5	7	4
R.C.Varam	10	4	2	3	0	2	2	3	2
K.R.Puram	4	0	1	0	1	0	1	0	1
B'chalam	32	18	5	16	6	19	3	13	11
R'nagaram	15	4	2	8	2	9	3	11	3
Utnoor	17	5	4	12	1	10	3	9	2
Total :	120	54	21	53	26	61	26	55	28

Refrigerators and thermocol boxes are essential parts of the cold chain which is required for the immunisation programme. In this regard 70% of the PHC's have refrigerators and only 8 of them are not in working condition. In another analysis only 28 PHC's have working refrigerators. The position of thermocol boxes is also good but some PHC's complain that there is no provision for ice. Such a scenario, seriously compromises the cold chain facility, thus adversely affecting the immunisation programme.

About half the PHCs have an operation theatre, but half of these do not have equipment. Facilities for post operative care are available in only 17 PHC's.

SUB CENTRES :

The situation of the sub-centres can be judged by the fact that information could not be obtained about their status in a significant number of instances. Out of a total of 1110 sub centres supposed to be in existence, the PHC's reported only 962. Information could not be obtained about the situation in the sub-centre in many cases. Responses were obtained about the building condition in 374 cases, power supply in 639 cases, water supply 116 cases,

toilet conditions 633 cases. An analysis of the responses show that 2/3rd of the buildings require repairs, about half are located in places without electricity supply, and a vast majority of them do not have any toilets. Only about a tenth of the sub-centres have quarters for the ANMs. Only a few sub-centres have furniture like tables, chairs, examining tables, delivery tables etc., though most of them had drugkits and delivery kits.

Staff Position in PHCs

Name	No.of PHCs	M.Officers		P.H.Nurse		MPHW(F)		MPHW(M)		S.Nurse	
		S	V	S	V	S	V	S	V	S	V
S'peta	14	22	4	5	0	92	6	74	11	14	6
P'puram	13	18	4	7	2	104	19	60	9	14	8
Paderu	15	27	10	9	2	189	55	165	35	15	11
R.C.Varam	10	19	4	9	0	133	35	72	41	14	1
K.R.Puram	4	5	1	2	0	28	6	7	1	3	1
B'chalam	32	40	10	14	0	306	139	143	31	29	9
E'nagaram	15	16	6	5	0	91	18	58	7	10	7
Utnoor	17	22	13	7	4	81	19	46	6	13	7
Total :	120	169	52	58	8	1024	297	625	141	112	50
% of Vacancies			31 %		14 %		29 %		23 %		45 %

The health delivery system is understaffed (vacancies) in crucial areas namely the posts of Medical Officers at the PHC's and the functionaries in the sub-centre. 52 of the 187 sanctioned posts of Medical Officer are vacant and about a third of the MPHA(F). An interesting aspect to be noted is that though the sub-centres are meant to be run by a male and a female health assistance there are 1024 posts of MPHA(F) and only 625 posts of MPHA(M). This means that the health system is functioning at present without 50% of its male health workers and this shortage of paramedical staff at the basic level is clearly excessive.

III. OBJECTIVES AND APPROACH :

IMPROVED ACCESS TO HEALTH FACILITIES

* By re-locating and re-organising health infrastructure facilities so that they are easily accessible to tribal people.
* Establishing new sub-centres with qualified ANMs and increasing the number of PHCs if necessary.
* Drawing up fixed day schedule of movement for each PHC and sub centre so that comprehensive health camps are held on predetermined days at sub-centres and other nodal points located in interior and inaccessible tribal areas.
* Increasing investments in laboratory and diagnostic facilities and also in infrastructure so that each PHC is well equipped to deliver effective health care.
* Ensuring mobility by providing transport to each PHC and also to paramedical staff if possible.

COMMUNITY PARTICIPATION AND CONTROL

* Training of tribal women as "Community Health Workers" [Development Organiser] and birth attendants so that each village has a person responsible for the health needs of the community.
* Constituting "Women's Health Committees" in each village with powers to administer a Village Health Fund [as part of village development fund] and supervise the functioning of the Sub-centres and Anganwadis.

IV. STRATEGY :

The health status of the tribal communities would be improved through a three pronged strategy of improving MCH services, reduction of mortality and morbidity and enhancement of the technical skills of the personnel, involved in health care delivery. It will be implemented by the co-ordinated efforts of both the formal and community based health systems. The strategy would include the following activities.

1. IMPROVED MCH SERVICES

a). The village based, community supported village Health Workers (Development Organiser) would be networked with a rationalised, expanded and trained battery of paramedical functionaries whose focus would be zeroed on more effective MCH services.

b). The functions of the health delivery system would be sharply defined with thrust on MCH services to be delivered through well trained ANMs and more efficient outreach services through better Mobile Medical and Para Medical functionaries.

c). Providing 100% ante-natal services to all pregnant women and arranging institutional deliveries for high risk mothers and arranging intra-natal services through trained birth attendants.

d). The Health Committees will ensure that comprehensive promotive services are made available to all the pregnant women, lactating mothers and children and strive to strengthen linkages between the health care delivery system and the ICDS programme.

e). 100% immunisation of children with involvement of local communities and improvements to the cold chain.

f). Provision of maternity assistance and improved nutritional delivery through ICDS to all pregnant women.

g). Involving women groups in administration and supervision of Health care delivery.

2. REDUCTION IN MORBIDITY AND MORTALITY :

a). A comprehensive survey of all families to prepare a profile of the morbidity burden of the tribal society which would facilitate more scientific and long term planning for more effective health care delivery.

b). Generating consciousness regarding promotive and preventive dimensions of 'Health' and stimulating demand for effective health service delivery.

c). Measures to improve general sanitation and habitat hygience and general consciousness regarding personal and environmental hygiene and sanitation.

d). Ensuring sufficient supplies of ORS packets and drugs for treating ARI.

e). Deworming of children and treatment for skin ailments and effective School Health Services.

f). Universal administration of anti-malaria drugs at 15 day intervals during peak malarial season and effective surveillance through community participation and prompt treatment through village based 'Drug Depots'.

g). Early identification and complete therapy for T.B. by adopting new strategies, if required.

h). Provision of health fund with every Village Tribal Development Association and adequate support for referral services and for extending loans for emergency health support.

i). Strengthening Diagnostic infrastructure available at the PHCs and to strengthen the referral services by establishing clear and well delineated linkages from village level to the referral hospital.

j). Involving the Non-Governmental Organisations (NGOs) and the Community Development Co-ordinators in more efficient health care delivery.

k). Upgradation of skills, knowledge and measures to enhance motivation of the functionaries involved in the health care delivery system and to provide greater mobility to all those involved in the implementation of the project.

3. IMPROVE TECHNICAL SKILLS OF THE PERSONNEL : BY

a). Providing training to all the traditional Birth Attendants/ Dais (TBA) for better delivery systems.

b). Technical Training to Community Health Workers - to raise provide skills in preventive aspects to a demonstrated standard of competence.

c). Establishing effective monitoring and retrieval system from village level to apex level

V. PROJECT AREA :

The Project will be implemented in 5 Integrated Tribal Development Agencies viz., K.R.Puram (West Godavari District), Eturunagaram (Warangal District), Bhadrachalam (Khammam District), Utnoor (Adilabad District) & Srisailam (Kurnool District). Chenchus are recognised as primitive tribal group in the year 1976 and a separate (exclusive) ITDA was established in the same year for their development. This ITDA is entirely different from other ITDA areas spread over in 6 districts.

The ITDA Head Quarters are linked to district head quarters, but there are few motorable roads in the area. However, almost 60% of the villages can be reached on foot, goods have to be transported on pack animals or head loads. The elevation varies from 200 mts. to 1600 mts. Around 60% of the area is under forests.

VI. PROJECT INTERVENTIONS :

The data on the villages, the interactions with tribal folk through PRA exercises revealed that there are deficiencies in the health care delivery system in the project area. There is an imminent need for improving MCH services in the tribal areas.

The proposed project would focus all efforts to strengthen primary health care delivery system with special emphasis on MCH services, and adopt sharply targetted strategy for reduction in the morbidity and mortality rates and initiate measures to improve the technical skills of the health personnel by imparting training, so as to strengthen the existing health delivery services. The project would foster a cadre of "Development Organiser's" (village health workers) who would provide preventive and promotive health care to the community and would be net worked with the formal health care delivery system.

The service delivery is proposed to be improved through the following interventions :

1. Earliest registration of all pregnant women.
2. Regular and effective antenatal care.
3. Intra-natal care by trained personnel only.
4. Effective management of high risk pregnancies.
5. Child health services would be strengthened by reinforcing the linkage between growth monitoring, nutritional support, immunisation and prevention and early treatment of common infectious diseases like acute respiratory infection, gastroenteritis etc,.
6. Reproductive health services for adolescents.
7. Strengthening of the referral services from village level to community health centre.
8. Immunisation to all the children should be ensured.
9. Increased demand for ORS packets by women in the project are should be made.
10. Reduction in number of child marriages and increase in age of marriages.

A. RE-ORGANISATION AND RATIONALISATION

Several PHC's and sub-centres are unable to provide effective health care to the target group due to large distances between habitations, the inaccessible nature of the terrain, absence of communication facilities and aggregation of all institutions of health care in an around the growth centres. Hence, the PHCs and the sub centres find it difficult to provide health support to the population. This is inspite of the fact that the number of PHCs and sub centres that have been established are within the norms prescribed for hilly and backward areas. Though problems are inherent in the situation, a study of the situation reveals that significant scope exists for improvement of service delivery through a process of geographical rationalisation and reorganisation of the primary health care institutions.

Some issues which are relevant to the question of access are as follows :

1. At present the area of operation of the PHC is congruent with mandal boundaries. In some cases, this method of organisation is not the most efficient. Sub centres are more easily accessible from PHC situated in the adjoining mandal. This could be either because of geographical proximity or due to availability of transport. Sub Centres would be attached to the PHC to which it is most accessible.

2. A similar situation exists with reference to the sub centres and we find that some villages should logically be served by another sub centres to which it is in close geographical proximity.

3. In several instances PHCs and sub centres are situated in villages which do not have any amenities and are difficult to reach. The living conditions are such that the staff posted in such places rarely reside there. These sub centres need to be relocated to villages which are more conveniently situated. Such instances could be identified and logistic support could be provided to ANMs for better mobility. In extreme cases two to three ANMs would be posted at a base camp (instead of the sub centre) from where they could cover their allotted villages with the help of transport facilities and through the para health workers (Development Organisers).

B. TRANSPORT

The Medical Officer along with the Lab, Technician, Ophthalmic Assistant and other paramedical staff will hold a camp at each sub centre at least once a month. During this camp, activities such as ante-natal checkups, detection of TB and other chronic diseases, collection of blood and sputum samples etc., will be held. The Medical Officer can also supervise the work of the ANMs. The staff of the PHC are also required to visit the schools and hostels in the area regularly.

At present the medical staff of the PHC are immobile because of the lack of a vehicle. Since the terrain is difficult and the area covered is interior a vehicle with a four wheel drive must be made available to the PHC. The possibility of hiring such a vehicle on a monthly basis can be explored as the experience with purchased vehicles has not been satisfactory because the time spent off the road and the maintenance costs are very high after the initial period. Jeeps must be made available to the 77 PHCs and 17 MM Units.

The possibility of providing subsidised credit to paramedical staff for purchase of two-wheelers must be explored.

SUMMARY OF REQUIREMENTS

New PHCs to be started in Project Area.

The MMU at some places to be shifted to Centrally located places, so as to cover more population.

New sub centres to be started.

Vehicles to be provided to all PHCs & MMUs and the existing vehicles to be repaired.

While it is necessary for the PHCs to be housed in properly constructed buildings with the requisite infrastructure, the Government should explore alternatives to investing in construction of sub centres[2]. The money saved can be utilised to increase the funds available for the Village Health Fund, increased drug supply, increased mobility etc.

B. COMMUNITY PARTICIPATION AND CONTROL

The ills from which the tribal people continue to suffer are amenable to interventions in health and health related sectors such as that of food and agriculture, water and sanitation and information, education and communication rather than the more costly classical medical inputs such as drugs, doctors and dispensaries.

The primary health centre or sub centre network, although designed to provide denser coverage than in the plains, could give at best an intensive peri-institutional and an extensive para-community coverage. An example to cite is that of the coverage made by the average ANM who is the most peripheral level field based female health worker covering not more than 3,000 population. Whilst she will have on average 100 pregnant ladies in her charge in a year on the basis of the prevailing birth rate of 33 per 1,000 per year, she is only able to attend to the delivery of a mere 17.

While it is necessary to build up the minimum needed health services infrastructure, this cannot be expected to provide on effective coverage that will reach out to all the needy individuals in all the households in every village, particularly given the nature of the terrain in the tribal areas and the dispersion of the tribal communities. It is essential, therefore, to develop village based health care with community participation and control.

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2 The sub centres can be located in the same building as the Anganwadi Centres, or Single Teacher School premises, or private premises can be hired.

In the preliminary stage, ... Community Health Workers will be selected from villages where there are no sub centres or Anganwadis and according to the need as assessed by the PHC staff. The women selected must be residents of the village and married. Preference should be given to literate women though this is not compulsory.

Every village/hamlet/habitation must have a 'Village Tribal Development Association' consisting of all male and female members of the village belonging to the tribal group. The Women Development Group in the village (Avval Committee or Mahila Sangam etc.,), which will include the Health/Development Worker, the Anganwadi Worker and the Dai, will be responsible for the effective integration of the health programmes into the development activities taking place in the village. They will function under the overall umbrella of the VTDA which is responsible for planning, implementation and monitoring of all developmental activities.

ACTIVITIES

The focus on supporting village health mobilization activities will be possible with the augmentation of community responsibility for health management and promoting self-care at the village level, which include :

a) Training of local midwifery and mother-child care.

b) Community selection and accountability of Community Health Workers (CHLW) who will provide health prevention and curative services at the village level and as liaison between the community and the MOs of the PHC.

c) Access to funds to implement community health action schemes through the Village Development Fund.

The Group shall take responsibility and initiate the following activities.

1) Registration of all pregnant and lactating mothers and arranging monthly stipend for them.

2) Identifying and arranging institutional deliveries of high risk pregnancies

3) Administering the Referral Fund

4) Training of dais and ensuring delivery kits for dais

5) Prevention of diarroheal diseases and use of ORS

6) Early detection and treatment of ARI

7) Ensuring supply of safe drinking water

8) Drainage channels, sanitation facilities

9) Health Education

10) Identifying of women's disorders like vaginal infections, prolapse and back pain and arranging for medical help.
11) Identifying and arranging medical help for Malaria, TB, Blindness due to malnutrition.
12) Labour room construction and maintenance
13) Physically handicapped, mentally ill, cases to be identified and medical help to be arranged.

VILLAGE HEALTH FUND

In the Tribal Health Project, it is proposed to create appropriate opportunities for the community to participate and contribute towards self-help in health. With this in mind, 3 components of community participation have been proposed ie., CHW scheme, Village Health Fund and Cropus Grant. These funds are proposed to be initiated in those villages where CHW will be appointed under the project. CHW, being a nominee of the community and being a link worker between the community and Government will play essential role in the utilisation of the funds. VHF is a notional fund contributed by the villagers, supported by appropriate matching grant from the IFAD initially for a period of 5 years. The fund is a pool of money entrusted to the President of the VTDA who will be responsible to operate it. As a token grant, the Tribal Welfare Department will offer Rs.5000/- per year to all villages where CHW is operative. Ideally the VTDA must be able to collect contribution from the Community to the tune of another Rs.3000/- per year. While the theoretical planning aims at monthly contribution of Rs.4/- per household to fund, practical situation seems to suggest that at this juncture it may not be possible to encourage every household to contribute Rs.4/-. Consequently, in IFAD Phase-II areas, the VHF consists of IFAD projects, contribution essentially of Rs.5000/- p.a. and some contribution unspecified from the community.

VHF will be utilised for the following purposes:

i) Referring the needy & deserving patients from the village to a outside place for higher level of medical care
ii) To contribute towards environmental cleanliness of the village
iii) To pay the honorarium of the C.H.W.

CORPUS GRANT

The Corpus grant is a one time grant of Rs.32000/- to be deposited in a nationalised bank. The interest on which the VTDA will spend for MCH services, environmental sanitation and control of communicable diseases. The same numbers of villagers as mentioned above will be allotted corpus grant. So far the scheme has not yet been initiated.

TRAINING

a). For Female Health Workers : In service training for three months to improve technical knowledge and skills and to orient them to tribal health problems and practices.

b). For Tutors in ANM Schools and also for tutors of in service training : One month intensive training in training methodology and providing clinical and field training in tribal areas.

c). For Female Health Supervisors : Training in Supervision and working in tribal areas.

d). Other Staff : The Medical Officer, Public Health, Nurses and others will be given orientation training about the project and also on specific areas on tribal health.

e). For dai : An intensive MCH training for one month.

f). For tribal women : selected tribal women will be trained at the rate of one woman per hamlet or village for three months in basic maternal, child and general health care.

The training load and training plan for each category needs to be finalised. The first category to be trained will be the tutors and core training team.

The training of the CHWs is the most crucial aspect. The CHWs will be trained for two months at the PHC on preventive care and also curative aspects of smaller and common ailments like malaria, scabies, fever, ARI, diarrohea etc. She will be supplied with a health kit. The CHW will continue to be trained by the ANM in preventive and curative health care delivery both in the village and at the sub centre. The sub centre training will be at least one day every two months for which the Health Worker will received travel and daily allowances, and material supplies for her village training programmes. She will initiate and assist in health participatory activities; provide first aid and basic health services, eg., community construction of compost pit, nutrition chart making, etc; and inform and educate on health and food security related issues in bi-monthly community meetings.

Time Frame for Training Programme

Training Programme	Activities to be carried out	Time Frame
Tutors and core Trainers for Mobile Training Team	Designing module, preparing material and conducting training programme	Three months - to be done by the state institute or NGO
Female Health Workers (ANMs)	Examining existing syllabus, designing the curriculum and preparing background material conducting the training	Three months to prepare the material and training in batches of twenty. To be conducted in Bhadrachalam
Female Health Supervisors	Available material is sufficient with some additions	One month
Other Staff	Designing and conducting training	Training in different batches of teams
Dais	Available material is sufficient plan has to be modified	Different batches of 40 each
Community Health Workers	Separate module was developed by TRI	In several batches of 35 each - at ITDA level.

VII. INFORMATION, EDUCATION & COMMUNICATION ACTIVITIES (I.E.C) :

The question of health services coverage, however, is only one side of the picture. The other, more important, issue is the health service utilisation by the tribal population. This is an aspect which is beset with many attitudinal issues associated with awareness, acceptability, accessibility and affordability. In tribal areas, all these issues are aggravated by educational inadequacy, cultural diversities, geographical problems and communications constraints.

The health seeking behaviour among the tribals is markedly low, there is a complacent and fatalistic attitude towards deprivations, diseases and even death. The gap in health services in the case of the tribals is not only one between what is desirable and what is available, but one between what is available and what is availed of.

The specific objectives of the I.E.C., approach would be :

a). Enhance the level of public awareness, knowledge and concern about health problems and health programmes.

b). Improving the health services image and health services through more effective action by health personnel.

c). Increasing acceptance and utilisation of health services on the part of the people through need based messages and actions integrated with other relevant development programmes.

d). Participation of 'Community interest groups' (existing as well as newly formed) in the programming, implementation and control of specific health tasks and activities including related communication - education aspects.

e). Promoting education on and acceptance of national health programmes including the one for MCH and family welfare in view of its relation to the most vulnerable sector of the community.

The activities which will contribute to this will be the Baseline Health Survey which will cover all the households in the ITDA area. The major issues which are highlighted by the Survey will form the basis of a sustained Health Campaign.

Two Health Jatras will be held in each PHC area every year where tribals can be exposed to a lot of information and provide an opportunity to share experiences related to health. These jatras will derive from the logic of intensified social activity, while attempting to disseminate health messages. Stalls on various health related issues will be set up and managed by the Community Health Workers. As in the case of traditional jatras these occasions will also provide an opportunity for the exchange of cultural and social information.

VIII MONITORING AND EVALUATION :

This is an important aspect of the study, through which the benefits accrued by the tribals will be known. At every level and upto micro level, ie., upto V.T.D.A. level a perfect Monitoring system will be evolved basing on the M.I.S. developed by Indian Institute of Health and Family Welfare, will be adopted. Information will flow from V.T.D.A. to P.H.C. and then to I.T.D.A's. All the information will be monitored through computer system.

The Monitoring and Evaluation system will have the following components 1). a base line survey at the beginning of the project for establishing the various health indicators and assessing the requirements of clients. 2). A continuous Management Information System (MIS) which has been developed by the I.I.M & H Department, would be used with slight modifications to suit the tribal area, for monitoring purpose with emphasis on assessment of outcome rather than process evaluation as per the indicators listed in Annexure I. 3). An end line survey at the end of six months period to assess the impact of the Project interventions in sending reproductive services in the Project area. An I.T.D.A level committee with Project Officer as Chairman will be constituted in the implementation, supervision, management and monitoring of the project.

Focuses attention on the need to evaluate the various project components at periodic intervals and conduct a monitoring survey. The components of evaluation are as follows :

- **i)** Evaluation of Training Programmes
- **ii)** Evaluation of CHW Programmes
- **iii)** Evaluation of Dais Programmes
- **iv)** Evaluation of kit usage by CHWs
- **v)** Evaluation of Equipment usage
- **vi)** Evaluation of Environmental Sanitation Activities.

Experts with back-ground experience in evaluation will be of criteria to assign the evaluation responsibility. The Tribal Welfare Department which is overall incharge of the project will be assisted in regular evaluation at State Level through the Health & Nutrition division of Tribal Welfare Department on periodic basis.

IX - A DETAILED NOTE ON THE PROPOSED ACTIVITY

IX - PROPOSED ACTIVITIES

1. C.H.W.SCHEME

The concept of the C.H.W. has now taken a concrete shape in APTDP areas. The C.H.W. will be a woman representative of the Community preferably a married woman, having studied in a primary school.

The CHW is selected and recommended by the Community with the help of VTDA under the guidance of CDC and Medical Officer. She will be intensively trained for a period of 1 month initially during which period she will receive a stipend of Rs.300/- p.m. from IFAD fund. CHW training contents have been defined with the help of experts and topics identified. The CHW module which has been finalised will be presented with pictoral description of her expected activities on one side of the book and appropriate written description of the activities in Telugu on the other side of the book. The training of CHW will be as a periodic basis each time upgrading her skills. Thus, it is envisaged that the CHW's training will be for upgrading the skills. Accordingly, by training components will include theoretical background of health and diseases, practical training for antenatal and intra-natal services and qualitative methods of locally relevant topics. After the training, the CHW will be provided with a health kit. The contents of which have been recently finalised. CHW, while acting as community representative, will also help in mobilising the community on health issues including health education and National Programmes.

2. CHW Health Kit & Stationery

It has been decided to give one health kit to each of the trained CHW at a cost of Rs.1500/- per kit. The kit contents have been finalied and the kit will be used by the CHW after intensive training. The contents will include safe delivery kit, medicines to tackle acute clinical situations, ORS packts. In addition, CHW will act as FTD or Drug Deposit Centre (DDC) as a part of malaria programme. The kit contents will be synthesized at a single point and supplied to all the CHWs. The replenishment strategy consists of 3 months replenishment at the rate of Rs.500/- per each quarter for 5 years Nodal points by A.D.M.&H.O as a routine and to replenish in individual cases at an earlier time based on monitoring of the usage pattern. At no point of time the kit should be empty since this would cause breach of confidence among tribal population.

Stationery Material

Simple statinery material including specified registers, papers, reply post cards and pens etc to perform the documentation work including early information system, will be met with the help of the amount being aportioned per year per CHW.

3. TRAINING

In the IFAD supported health project, the following training component is proposed.

a) T O T for Paramedical staff : The staff of TCR & TI, Community Health Co-ordinators Medical Officers and other experts will impart training for the paramedical staff. The Paramedical workers to be trained will include MPHEO, 1

Health Supervisor (M&F); 1 Health Assts. (F). In addition to paramedical staff CDC and the member from DDT will be trained. They will be trained for a period of 3 days. This combined training of health personnel is aimed at upgrading their skills in imparting the same to the CHWs undergoing training and also to give refresher training to improve their own knowledge. Para Medical Staff will be supplied with modules prepared by IIH & FW, Hyderabad at the end of the training.

b) Dais Training : The focus of Dais training is to sharpen their intra-natal services skills through a defined 5 - day training at the end of which, each one of them will receive a Dai kit, which is meant for conducting safe delivery.

Selection of Community Health Co-ordinators/ Consultants :

The Community Health Co-ordinators will be selected on honorarium basis, one for each ITDA. They will impart training to para-medical personnel and CHWs.

4. Village Health Fund (VHF)

In the Tribal Health Project, it is proposed to create appropriate opportunities for the community to participate and contribute towards self-help in health. With this in mind, 3 components of community participation have been proposed i.e. CHW scheme, Village Health Fund and Corpus grant. These funds are proposed to be initiated in those villages where CHW will be selected under the project. CHW, being a nominee of the community and being a link worker between the community and Government will play essential role in the utilisation of the

funds. VHF is a notional fund contributed by the villagers, supported by appropriate matching grant from the IFAD initially for a period of 5 years. The fund is a pool of money entrusted to the President of the VTDA who will be responsibile to operate it. As a token grant, the Tribal Welfare Department will offer Rs.10,000/- per year to all villages where CHW is operative. Ideally the VTDA must be able to collect contribution from the Community. While the theoretical planning aims at monthly contribution of Rs.4/- per household to fund, practical situation seems to suggest that at this juncture it may not be possible to encourage every household to contribute Rs.4/-.

VHF will be utilied for the following purposes:

i) Referring the needy & deserving patients from the village to a outside place for higher level of medical care

ii) To contribute towards environmental cleanliness of the village

iii) To pay the honorarium of the CHW

The VHF is basically a revolving fund which has to be totally taken over by the VTDA in due course of time. It is proposed to have VHF in 98 villages of Eturungaram, 63 in K.R.Puram, 400 in Bhadrachalam, 213 in Utnoor & 242 in Chenchu Project.

5. Corpus Grant

The corpus grant is a one time grant of Rs.32000/- to be deposited in a nationalised Bank. The interest on which the VTDA will spend for MCH services, environmental sanitation and control of communicable diseases. The same numbers of villagers as mentioned above will be allotted corpus grant.

6. Buildings

It is proposed to construct subcentres buildings for providing space for ANM to carry out her work and also to provide accommodation for her stay. There are standard designs for sub centre buildings under the Health Department. The proposal is for utilising 90% matching grant of Rs.1,00,000 per sub centre from the IFAD funds. The remaining Rs.10,000/- will be either borne by Government of Andhra Pradesh, ITDA or the Community itself. The total number proposed are 64 for Eturunagaram, 60 for K.R.Puram, 192 for Bhadrachalam, 140 for Utnoor & 67 for Chenchu Project Area.

7. Vehicles

The greatest problem which is hampering the smooth delivery of health care to the tribal population is lack of transport facilities in the tribal areas. The contact between community and health providers (Medical & Para Medical staff) can be improved either by enabling the tribal people to move or by moving the health staff to rach the tribals on a continuous basis. The latter require transport facilities. Currently, most PHCs do not possess a vehicle. Provision of vehicles for each PHC will enable the health staff to make village insists, to visit nodal points, to organise medical health during out breaks to shift dangerously illgratient to better and higher levels of medical care and also to facilitate UIP. It is proposed to provide 15 vehicles for Eturungaram, 8 to K.R.Puram, 37 to Bhadrachalam, 25 to Utnoor & 13 to Chenchu Project.

8. Strengthening of existing Primary Health Centre set up

The PHCs and Community Health Centres require upgradation in diagnostic facilities. A list of equipments to be purchaed for strengtheing of diagnostic facilities at each PHC. The sub centre when constructed as proposed above, will need to be strengthening in terms of improved intra-natal services for which a marginal amount for each sub centre not exceeding Rs.37,500/- for each PHC area. The numbers are as above. Strengthening of sub centres after they are constructed is being planning to provide other facilities in addition to intra-natal care. Such facilities and strengthening would cost Rs.25,000/- per sub centre and bsaed on the requirement, it is proposed to strengthen 64 sub centres in Eturungaram, 60 in K.R.Puram, 192 in Bhadrachalam, 140 in Utnoor & 67 in Chenchu Project.

9. Information, Education and Communication (IEC)

The tribal area is unique in several aspects. In relation to health in tribal population, there are two important factors ie. a system must be made available to generate information on their health which in turn will enable to take appropriate steps to impart health related information back to the community in a proper manner. The general education levels, particularly among adults being poor and far from satisfactory, it is important to develop appropriate health education materials. Similarly communication of messages as a mode of health education and health knowledge also needs to be strengthened.

In the development of IEC material, the first step is to generate baseline information on health through a baseline survey. It is proposed to organise one IEC workshop in each of the ITDA areas during the year 1996-97. An amount of Rs.1.0 lakhs for each ITDA is proposed for Workshops & IEC materials.

10. Morbidity Survey

Morbidity Survey is proposed for each P.H.C. to know the morbidity pattern before starting of the project.

11. Health Campaigns

The tribal population who live in inaccessible areas need to hve a sustained system to deliver specialist health care. Till such time has the PHCs are posted with specialists, it is proposed to organise specialist camps coordinated by Medical Officer and all the staff of the PHC with view to identify special diseases and to deliver specialist treatment to the needy. The specialist camps are proposeed to be organised on a shandy day in the shandy places of the PHCs. This will enable a close contact between the tribals and health specialists. it is also proposed to conduct health education sessions during the health campaings. An amount of Rs.32.00 lakhs is proposed for health campaigns. Each PHC will be asked to organise atleast one health campaign on the shandy day every month. Emphasis will be laid on follow-up of such beneficiaries who may receive specialist diagnosis and advice.

12. NUTRITION

Repeated surveys indicated that under nutrition is a health problem in the tribal areas. This is particularly proved for mother and children. In the project, it is envisaged that the CHW will play a major role in nutrition education of the women group in addition to health education. The 3 common nutritional disorders are caloric deficiency, Vit-A deficiency and Iron deficiency. In villages where Anganwadi Worker is working (ICDS Programme), she will be responsible for nutrition of under 5 years children as a part of ICDS. In those villages, the CHW will work collaboratively with Anganwadi worker. In other villages, CHW will independently perform nutrition education of the mother and introduction of low cost locally available weaning foods for the children. The expertise of NIN, Hyderabad is being utilised for this component of the IFAD project.

13. Fever Treatment Depots (FTD)

Malaria is the most important problem in tribal areas. The existing Primary health care programme is not able to provide infrastructural opportunity for early detection and treatment of malarial fevers. Due to the isolated and widespread nature of the tribal areas, it has not been possible for the delivery of radical treatment for the needy persons in time. The time taken from the time of slide collection to the time of radical treatment to the needy patients is getting delayed. This is due long distances between the people and the health care providers. As a practical measure, it is proposed to utilise the CHW of this programme as fever treatment depot holder. Hitherto, the FTD has

been entrusted to individuals such as shopowners, teachers or some other persons who may not actually belong to that village community. In order to increase the communities commitment for their health care particularly for fever control, the CHW is being utilised as the FTD holder. the Department of Malaria, Government of Andhra Pradesh has already intiated this step.

14. Nodal Points visits

Another alternative to bring community closer to the health services is to make the primary health care mobile in the tribal areas. The PHC Medical Officers, as a part of this modified strategy, will have to visit the nodal points on regular basis according to the planned tour programme. This mobility of health personnel in tribal areas is likely to be successful since the tribals attract by such an approach.

15. Monitoring and Evaluation

The IFAD health Project envisages several community based activities, training programmes and action points. The area being widespread and the activities being multiple, it is necessary to keep tract of various components of the project activity. This monitoring activity will be internally organised by Tribal Welfare Department through the following strategy:

I.
- i) Field visits and physical verification
- ii) Examining the minutes of the meeting
- iii) Internal evaluation of the training programmes
- iv) Analysis of feed back given by the trainees from time to time
- v) Creation of data base
- vi) Establishment of Tribal Health & Nutrition Monitoring Bureau (THNMB) at Hyderabad.

X BUDGET

BUDGET REQUIREMENTS FOR STRENGTHENING HEALTH SERVICES IN A.P.F.T.D.P. AREA

(Rs. in Lakhs)

ITEM	Eturnagaram No.	Eturnagaram Amount	K.R.Puram No.	K.R.Puram Amount	Bhadrachalam No.	Bhadrachalam Amount	Utnoor No.	Utnoor Amount	Chenchu Project No.	Chenchu Project Amount	TOTAL No.	TOTAL Amount
I. COMMUNITY HEALTH FUND:												
a) For providing accommodation and space for ANM @ Rs.1.00 lakh per sub-centre.	64	64.00	60	60.00	192	192.00	140	140.00	67	67.00	523	523.00
b) Honorarium & allowances for Community Health Workers @ Rs.300/-P.M for 5 years.	98	17.64	63	11.34	400	72.00	213	38.34	242	43.56	1016	182.88
c) Preparation and printing of C.H.W & V.T.D.A modules @ Rs.100/-.	98	0.10	63	0.06	400	0.40	213	0.21	242	0.24	1016	1.01
d) Community Referral Fund @ Rs.10000/- P.A for 5years	98	49.00	63	31.50	400	200.00	213	106.50	242	121.00	1016	508.00
e) Corpus grant for CHW scheme in MCH services and control of communicable diseases @ Rs.32,000/-.	98	31.36	63	20.16	400	128.00	213	68.16	242	77.44	1016	325.12
Sub Total :		162.10		123.06		592.40		353.21		307.24		1540.01
II. TRAINING:												
a) i. Stipends for CHWs training @ Rs.300/-.	98	0.29	63	0.19	400	1.20	213	0.64	242	0.73	1016	3.05
ii. Medical Kits @ Rs.1500/- per quarter.	98	1.47	63	0.95	400	6.00	213	3.19	242	3.63	1016	15.24
iii. Stationery and Material @ Rs.150/-.	98	0.15	63	0.09	400	0.60	213	0.32	242	0.36	1016	1.52
iv. Quarterly Replenishment of drugs @ Rs.500/- for 5 years.	98	9.31	63	5.98	400	38.00	213	20.23	242	23.00	1016	96.52
b) i. Stipends for Dais Training @ Rs.12500/- per PHC	14	1.75	4	0.50	31	3.88	19	2.38	9	1.12	77	9.63
ii. Delivery Kits @ Rs.25,000/- per PHC.	14	3.50	4	1.00	31	7.75	19	4.75	9	2.25	77	19.25
iii. Stationery and Material @ Rs.1500/- per PHC.	14	0.21	4	0.06	31	0.46	19	0.28	9	0.14	77	1.15
c) Training for Medical and Para Medical functionaries @ Rs.1000/- per head.	180	1.80	45	0.45	532	5.32	169	1.69	160	1.60	1086	10.86

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.
d) Strengthening of ANM training centres at Bhadrachalam @ Rs. 10.00 lakhs.	--	--	--	--	1	10.00	--	--	--	--	1	10.00
e) Selection of Community Health Co-ordinator for a honorarium of Rs.5000/- p.m and fixed TA & DA allowances of Rs.1000/- P.M for a period of 5 years.	1	3.60	1	3.60	1	3.60	1	3.60	1	3.60	5	18.00
Sub Total :		22.08		12.82		76.81		37.08		36.43		185.22
III. INFOR., EDUCATION & COMMUNICATION												
a) Baseline survey @ Rs.6000/- per PHC.	14	0.84	4	0.24	31	1.86	19	1.14	9	0.54	77	4.62
b) Health campaigns @ Rs.1.00 lakh per PHC for 2 times in a year.	14	70.00	4	20.00	31	155.00	19	95.00	9	45.00	77	385.00
Sub Total :		70.84		20.24		156.86		96.14		45.54		389.62
IV. INFRASTRUCTURE:												
1. Vehicles:												
a) New vehicles for PHCs and MMUs @ Rs.3.00 lakhs.	15	45.00	8	24.00	37	111.00	25	75.00	13	39.00	98	294.00
(To carry MMR for TB control at Utnoor & Chenchu Project)												
2. Equipment:												
a) Strengtheing of Diagnostic facilities in PHCs and community Health Centres @ Rs.0.5 lakhs per PHC.	14	7.00	4	2.00	31	15.50	19	9.50	9	4.50	77	38.50
b) Strengthening of Intra-natal services in sub-centres @ Rs.37500/- per PHC.	14	5.25	4	1.50	31	11.62	19	7.13	9	3.38	77	28.88
c) Strengthening of sub-centres @ Rs.25000/- per PHC.	92	23.00	60	15.00	400	100.00	140	35.00	85	21.25	777	194.25
d) Purchase of MMR units for TB Control.	--	--	--	--	--	--	1	12.00	1	12.00	2	24.00
3. Recurring Expenditure:												
a) Additional grant for drugs for PHCs, MMUs and @ Rs.1.50 lakhs per year.	15	112.50	8	60.00	37	277.50	24	180.00	11	82.50	95	712.50
Sub Total :		192.75		102.50		515.62		318.63		162.63		1292.13

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.
V. RESEARCH & DEVELOPMENT:	--	3.00	--	3.00	--	3.00	--	3.00	--	3.00	-	15.00
To Conduct Health Studies												
Sub Total :		3.00		3.00		3.00		3.00		3.00		15.00
VI. MONITORING AND EVALUATION Establishment of TRIBAL HEALTH AND NUTRITION MONITORING BUREAU Data base and Purchase of Computers etc.	--	10.00	--	10.00	--	10.00	--	10.00	--	10.00		50.00
Sub Total :		10.00		10.00		10.00		10.00		10.00		50.00
Grand Total :		460.77		271.62		1354.69		818.06		566.34		3471.7[illegible]

OSVD/APFTDP.wki

* One vehicle proposed to N & H Division at Hyderabad for THMD Chenchu Project.

40

ANNEXURES

MONITORING & REPORTING SYSTEM

COMMISSIONER OF TRIBAL WELFARE

PROJECT OFFICER - I.T.D.A.

ADDITIONAL DM & HO(T) & PROGRAMME OFFICER (ICDS)

P.H.C. LEVEL (MANDAL LEVEL COMMITTEE)
(MEDICAL OFFICER / CDPO)

SUB CENTRE LEVEL
VILLAGE TRIBAL DEVELOPMENT AGENCY (ITDA)

A.N.M./ ANGANWADI/ COMMUNITY
HEALTH WORKER / DAI

SCHEDULED TRIBE POPULATION - 1991 CENSUS

Sl. No.	Name of the District	Total Population	Sch.Tribe Population	% of ST Population to Total Population
1.	Srikakulam	23.21	1.34	5.8
2.	Vizianagaram	21.11	1.90	9.0
3.	Visakhapatnam	32.85	4.69	14.3
4.	East Godavari	45.41	1.76	3.9
5.	West Godavari	35.18	0.85	2.4
6.	Krishna	36.99	0.92	2.5
7.	Guntur	41.07	1.82	4.4
8.	Prakasam	27.59	0.99	3.6
9.	Nellore	23.92	2.14	8.9
10.	Chittoor	32.61	1.05	3.2
11.	Cuddapah	22.68	0.47	2.1
12.	Anantapur	31.84	1.11	3.5
13.	Kurnool	29.73	0.56	1.9
14.	Mahboobnagar	30.77	2.27	7.4
15.	Ranga Reddy	25.52	1.09	4.3
16.	Hyderabad	31.46	0.29	0.9
17.	Medak	22.70	0.95	4.2
18.	Nizamabad	20.38	1.21	5.9
19.	Adilabad	20.82	3.55	17.0
20.	Karimnagar	30.37	0.83	2.7
21.	Warangal	28.19	3.85	13.7
22.	Khammam	22.16	5.59	25.2
23.	Nalgonda	28.52	2.76	9.7
	Total :	665.08	41.99	6.3

Source : N.I.C. (SR), A.P. Unit.

BY THE END OF THE PROJECT IT IS EXPECTED TO ACHIEVE THE FOLLOWING OUTCOMES

Maternal Indicators

1. A 50% increase in the registration of pregnant women in the first trimester of pregnancy
2. Coverage of all pregnant women with T.T. (100 %) injection
3. Increase in distribution and consumption of Iron and Folic acid tables by 75%
4. Increase in the percentage of pregnant women being covered by three antenatal visits either in the home or in the sub-centre by 100%
5. All deliveries in the project area will be attended only by trained persons either dai, ANM or other professionals both Government and Private.
6. All post-natal women and newborn will be paid three visits by health functionaries during the six weeks.
7. Increased demand for disposable delivery kits by women.

Women's Health Indicators

1. Increase in number of abortions referred to health centres and hospitals
2. Regular women's health clinics at the sub-centres - once a week
3. Attendance at the women's health clinical should be atleast 20 on each day of the clinic.
4. Increase in the women referred to hospital with gynaecological problems like white discharge, cervical and vaginal and breast problems.
5. Increased use of disposable and clean material during menstruation.

Family Welfare Indicators

1. Increase in the use of temporary methods of contraception (50%) by women
2. Increase in the use of condoms by men (10%)

Child Care Indicators

1. Increase in the fully immunized children to 75%
2. Increased demand for ORS packets by women in the project area
3. Increased attendance of children at Anganwadi centres.

Community Participation Indicators

1. Increased membership in DWCRA groups, Mahila mandals
2. Increased participation of women in immunization programme, village meetings, cultural programmes
3. Reducation in child marriages and increase in age of marriages.

EXPECTED IMPACT OF PROJECT

PROBLEMS	OBJECTIVES	INTERVENTIONS/ INSTRUMENTS (Programmes/ Schemes)	EXPECTED OUTCOMES OF RESULTS
Insufficient coverage of existing organisations/ institutions	Increasing the number of organisations and redelineating the existing area of operation	1. Establishment of village level health and family welfare institutions Village Tribal Development Areas. 2. Strengthening of PHC's with medical and infrastructure 3. Strengthening ANM's training centres at Paderu and Bhadrachalam.	Improved coverage both qualitatively and quantitatively No.of villages : 12,717
Under utilisation of existing delivery system	Introduction of innovative delivery system through people's participation and NGO's support.	1. Awareness training camps 2. Introduction of tribals to work as para medical staff 3. Upgrading retining the skills of local dayas 4. Appropriately designed and door step availability of faculty.	Increase in services utilisation
Weak community health environment and amenities	Provision of amenities	Community health projects	Preventive measure Population 23.50 lakhs
Area and Tribe- specific endemic diseases.	Identification of areas and preventive curative actions.	1. Health survey and specialised health camps 2. Awareness programmes on both preventive and curative aspects.	Better appreciation of the problems for appropriate action.

EXPECTED OUTCOME ON HEALTH INDICATORS

	PERCENT Present RATE	EXPECTED BY 2000
Institutional deliveries for highrisk mothers	N.A.	100 %
Immunisation	30 %	100 %
I.M.R.	100-215	50 for 1000
M.M.R.	4-8	< 2
T.B.	5.4 %	< 2 %
Malaria	44.5 %	100 % control
Goitre	Endemic in Adilabad	Total eradication by supply of ensuring iodised salt.
Yaws	Tribes specific in Khammam & W.G. Districts	Total eradication

ADDITIONAL INFORMATION ON VARIOUS PARAMETERS ON CHENCHUS

1. Incidence of T.B. among males is 5.73% and for females 3.50%; total : 4.43%; General Rate is 1.8% to 2.5%
2. Sex Ration : 940 females per 1000.
3. Cross - cousin marriages are common.
4. Average marriage age for males is 18 and for females, it is 15 years.
5. Child marriages are not uncommon.
6. Average Household size is 4.38
7. IMR : 215 (latest findings of the survey) - Measles & diarrhoea, all cohorts (old findings) : 140.32. For Andhra Pradesh general population, it is 73.
8. MMR : 7 per 1000. For general population : 4 per 1000
9. Medical Institutions :

Government Civil Hospitals	:	5
Primary Health Centres	:	10
Health Units	:	1
Mobile Medical Units	:	2
Ayurvedic Dispensaries	:	3
Homoeopathic Dispensaries	:	1
Total :	:	22

The concentration of Medical Institutions is more in Mahboobnagar District (12) when compared to Prakasam District (5), although the populations in both the district are almost equal.

10. Under UNFPA, strengthening of the medical units are proposed. Health Camps and encouragement of loca/native medical systems are also proposed.
11. Under PTG Action Plan by Government of India, 6(six) Mobile Medical Units are proposed.
12. Under NMEP which is aided by World Bank, complete eradication of malaria will be taken.
13. There are only 2 ICDS Projects functioning which cover only the periphery of tribal areas which are located at Achampet and Dornala.

For complete coverage of the Chenchu area, 2 more ICDS Projects are necessary.

C.B.R : ***35.29 per thousand*** **(present rate)**

5.97 per thousand (old rate of Andhra Pradesh)

26 to 29 per thousand (old rate of India)

C.D.R : 7.6 per thousand (present rate)

28.11 per thousand (old rate of Andhra Pradesh)

9.7 to 9.8 per thousand (old rate of India)

Annual Growth Rate : 3.53 (present rate).

2.17 (old rate of Andhra Pradesh)

2.14 (old rate of India).

3.23 (for Scheduled Tribes only)

Infant Mortality Rates (IMR)

All India General Population : 80.00

Andhra Pradesh General Population : 73.00

All India Scheduled Tribe Population : 8.08

Andhra Pradesh Scheduled Tribe Population : 6.31

1992 Studies :

Chenchus : 215 (General Population)

Chenchus : 298.00 (Core Area)

Chenchus : 177.00 (Periphery)

Maternal Mortality Rates (MMR) :

All India General Population : 4-5 per 1000 Live Births (estimated figure).

Andhra Pradesh General Population : 3-4 per 1000 live Births

Chenchus : 7 per 1000 Live Births (General)

Chenchus (Core ARea) : 9 per 1000 Live Births.

Chenchus (Periphery) : 4 per 1000 Live Births.

Source : UNICEF, New Delhi, Children & Women in India - a situation Analysis, 1990.

INFRASTRUCTURE FACILITIES IN SUB PLAN AREAS OF ANDHRA PRADESH

Background:

The total S.T. population in Andhra pradesh is about 42 lakhs and tribals are spread over in 23 districts with distinct cultures and varied cultural practices. More than 50% of the population is in 9 ITDA's districts i.e., Srikakulma, Vizianagaram, Visakhapatnam, East Godavri, West Godavari, Warangal, Khammam, Adilabad and Chenchu areas of Nallamalai forest.

Andhra Pradesh is the 7th largest Tribal populous state in India having 6.31 percent Tribal population. They are economically backward people and a large section of this population has evolved a life syle of its own based on its customs, traditions and environmental conditions.

Tribal habitation pattern is characterised by its small size distributed over different terrains. Most of the tribal communities have retained their traditional social and economic life styles.

In correct to the rural areas the tribal women enjoy a signficant status in this society. Women are engaged in child care, maintaining cleanliness of the surroundings, fetching water, besides working as labour to augment the family income and they also take part in social and religious functions.

The Trbial population in Andhra Pradesh can be broadly categorized as those living in remote and hilly inaccessible areas (22.09 lakhs) and those living in the rural areas of plains (19.90 lakhs). The problem of health is more acute for those in remote hilly areas.

Present Scenario:

To cater to the health needs of the scheduled tribe population there are 120 PHC's, 29 MM units and 110 sub-centres serving nearly 35 lakhs population (both S.T.&Others). A survey was conducted to assess the present situation of the PHC-sub-centre-MM units. The following are the findings of survey. But in schedule are, there are only 111 PHC's 29 MM units and 823 sub-centres. Analysis is made for 120 PHC's.

Important Findings:

Each PHC on an average is having 10 sub-centres. The least number in West Godavari, where there are 50 sub-centres and of maximum them are 379 centres in Khammam district.

- Each PHC is covering on an average 74 villages, and minimum no. of villages are in West Godavari i.e., 143 and maximum 1461 in Khammam.

- The distance from ITDA Head quarters to PHC ranges between 120 to 200 kms. and the average distance is 54.63 kms, this reflects the interior placement of PHC.

- The minimum population served by PHC's in a district is 81,544 and maximum is 9,33,510 and an average each PHC is serving a population of 30,363 above the norms.

But if we glance at Schedule area, where there are only 11 PHC's they are serving. Only 18,879 population on an average and the geographical area is 279 sq.kms.

- Regarding buildings 78.3% are situated in Government, where as the remaining are in Private Buildings. No definite pattern is followed in the type design of PHC's. In Bhamini PHC staff quarters are available but there is no building for PHC, where as in other areas the phenomenon is reversed.

- Type or construction:-1.8% of PHC's are situated in thatched houses, while 22% are in semi pucca and 76.1% are in pucca buildings.

- In a district for PHC's a minimum of 29 rooms and maximum of 172 rooms are found. Out of 738 rooms 624 are located in Government buildings and 114 are in private buildings. An average of 6 rooms are available for each PHC.

- The sub-centre and population ratio reveals in Warangal district the population is 9 lakhs and the sub-centres are only 109, which does not cater to the health needs of the people. In Utnoor and bhadrachalam, additional S.C's are required as per norms.

- Only a small No.of PHC's i.e., 11.8% does not require any repairs while 55.5% require minor repqairs and 32.8% major repairs. The smae is the situation of Medical Officers Quarters and also staff quarters which require major repairs where it is 53.7% for Medical Officer and it is 78.*% for staff quarters.

Staff Position:

This is the most vital part of Medical services and a No.of vacancies can be seen in tribal areas - coming in the way of proper delivery of health services. The vacancy position is more among MPHS(M) and MPHS(F) followed by Medical Officers, where 26.08% sanctioned posts are vacant. In Adilabad district 59% of M.O.Posts are vacant, where as in Visakhapatnam it is 37%.

- A contrasting feature is that staff position is satisfactory where there are staff quarters and building facilities in PHC, and also those PHC's/Sub-centres which are well connected by Road. 25% of ANM posts are also vacant.
- Water Supply:- Nearly 40% of PHC's are having no water supply, only 7.5% of PHC's are having tap faculty while 30% have bore well, and the remaining have open well. The situation is not a happy one.
- The MTP facilities are absent in 85.8% of PHC's, which is distressing. Only 2.5% are equipped with staff, while 3.3% have no staff, the remaining 3.3% having staff without equipment. As a vital component of MCH services more stress has to be laid on providing facilities.
- Though sterilisation facilities are absent in 38.3% of PHC's, 25% of tubectomy and 36.7% vasectomy have been conducted.
- In ANC facilities the B.P.apparatus is absent in 80% of PHC's. The weighing machines are present only in 5% of PHCs. The Haemoglobin testing equipment is present only in 1.6% of PHC which is not an encouraging factor.
- Nearly 62% of the PHC's are having no labour room-A vital component of delivery services. Only 16.7% of PHC's are having this facility with equipment while 21.7% are having labour room without any facilities. This is one of the reasons for tribal to depend upon their local sources.
- The same is the situation for operation theatre also. Nearly 52.5% pf PHC's are having no such facility. Only for 25.8% of PHC's have operation theatre and equipment. For remaining 21.7% of PHC's the theatre is present but not equipped.
- The power supply is there only to 70%. Even among them 40% are having supply.. without proper equipment. Without power supply the status of immunisation is doubtful.

- Regarding Refrigeration facilities, nearly 30% of PHC's are having no facility and even among the PHC's having this facility only 30.80% are in working condition.

- Thermocol box- an important link in UIP is present in 75.8% PHC's, while it is not avaialable in 14.2% of PHC's. 10% of PHC's are having thermocol box without provision for ICE- an immediate action in this regard is to be taken for effective implementation of UIP programme.

- Post operative ward is absent in nearby 70% of PHC's and only 14.2% are equipped properly while in 17.5% of PHC have no equipment.

- A maximum no. of Beds i.e. 1715 are availabel in East Godavari district, while a minimum of 18 in Srikakulam district. On an average 176 beds are available, and on an average 29 persons per year are utilising the PHC beds, which may be during sterilisation period.

Sub-centres:

Nearly 25% of ANM posts are vacant and the area of operation is 17 Sq.Km to 19Sq.Kms in agency area, with 5 to 20 villages in difficult terrain and the villages are also sparsely populated.

13% of theSub-centres are located in Government buildings and a majority of them require (nearby 50%) major repairs. Out of this 6% are provided with electrical supply and even among this 6% of them are having regular electric supply. Water Supply is adequate to only 1% of Sub-centres.

- With reference to Toilet conditions only in 3% of sub-centres they are in good condition. Only 11% of sub-centres are having quarters. Regarding other facilities 8% of sub-centres are having examination table and delivery table. 19% of sub-centres are having delivery kits and drug kits. The remaining are devoid of the kits which are important in safe delivery, and which will act in reducing MMR/IMR rates.

M.M.Units:

Data relating to 22 M.M.Units was analysed.

As per analysis the mobility rate of M.M.Unit is almost minimal while 60% of M.M.Unit vehicles are off the road. In the remaining 27.3% of units are not provided without any vehicle, and only 13.6% vehicles are on road. In Khammam district while vehicle is sanctioned, driver post is not sanctioned. These are some of the contributing factors in No-functioning of M.M.Units. In a year on an average 80 days the 80 days the vehicle was on road. Majority of M.M.units (that is 60%) are having no buildings, while 31% are having Governmetn buidlings and only 9% are located in rented buildings. Even in this 31% of Government buildings, 55% require major repairs and only 11% are free from any repairs. Residential quarters are available only to 9% of the staff, while in the remaining 91% the situation can be imagined.

-Regarding supply of medicines, 60% are getting adequate supply while for 40% OF M.M.Units are not getting supplies. these M.M.units are mostly depending upon ITDA for medicines,as these are the only link to those tribals living in interior areas.

Staff Position:

The staff position of M.o's is quiet pathetic. Nearly 50% of the M.o's posts are vacant. nearly 60% of Pharmacist posts and M.N.O posts are vacant. 33% of driver posts are vacant. it is interesting to note that Dayas posts are not vacant.

All these factors are contributing to the non-functinoning of M.M.units and ultimately the sufferer is poor tribal.

Service Area:

On an average, each M.M unit is covering 32 villages, in a year out of 1434 villages, the coverage is only 705 villages.

The frequency of coverage of villages is that 41% of M.M. units are covering about 9 villages in a week and 22.73% of 5 villages in a fortnight. This is due to lack of mobility and other constraints. Each m.M unit is covering 1 to 3 sub-centres and there are 46 sub-centres and 33 PHC's under these 22 M.M units.

Conclusions:

The situation analysis reveals that there is need to fillup the existing vacancies, besides providing infrastructure facilities like construction of buildings/staff quarters, and provision of labour room, MTP facilities and small equipment like weighing machines etc., for better A.N.Care. Refrigeration or provision of kits for effective implementation of UIP is necessary and it to be strengthened. All these factors are contributing for poor health delivery services in tribal areas which are making tribals still depending on their own traditional magico religious practices. The situation is to be changed by giving stress from micro level planning i.e., by filling up of ANM posts and providing them with delivery kits and health kits. Training to Dayas is necessary. Now in a phased manner budget estimates are to be calculated depending on present conditions of infrastructure and other facilities. A rough estimate shows that nearly 57 areas are required to fully equip the systems with buildings, and other Medical Equipment.

INFRASTRUTURE FACILITIES IN SUB-PLAN AREAS

BUILDINGS	*REPAIRS*	*POWER SUPPLY*	*WATER SUPPLY*
Govt 15.8 Pvt 84.82	No repairs 74.33 Major 11.95 Minor 13.72 Pre. 12.06	Absebt 64.76 Reg 23.18 No. supply 87.95	Ade. 4.57 Inade. 7.48
TOILET	*ANM QTRS*	*DELIVERY KITS*	*DRUG KITS*
Abs 84.82 Good 6.76 Bad 8.42	Abs 86.80 Pre 13.20	Abs 56.55 Pre 43.45	Abs 56.86 Pre 43.14

Service Area of M.M.U.

Number of Villages	1434
Covered villages	705
Average	32

Frequancy of Coverage of Villages by M.M.U.

Weekly	9 (40.90%)
Fortnightly	5 (22.73%)
Monthly	3 (13.64%)
Not Furnished	5 (22.73%)

No. of PHC's & Subcentres covered by MMU

Total Covered PHCs	33	Total Covered S.Cs.	152
Minimum Coverage	1	Minimum Coverage	1
Maximum Coverage	5	Maximum Coverage	46
Average	3	Average	23

Number of Days, the M.M.U. Vehicle on the Road since 3 years

NO. OF VEHICLES	:	13
ON THE ROAD	:	3
OFF THE ROAD	:	(6) 10

Condition of PHC Buildings

Sl.No.	District	No Repairs	Minor Repairs	Major Repairs
1.	E.Godavari	-	5	3
2.	Khammam	2	1	5
3.	Warangal	-	4	1
4.	Vizianagaram	1	5	3
5.	Srikakulam	3	3	2
6.	Adilabad	2	6	4
7.	W.Godavari	2	5	2
8.	Visakhapatnam	-	9	5
	Total	**10**	**48**	**25**

Existing Medical Institutions in different periods in Sub-Plan Area.

Sl.No.	Medical Institution	Upto 1982	Upto 1989	As on 1995
1.	PHCs	32	90	111
2.	M.M.Units	26	29	29
3.	Subcentres	108	729	824
	Total	166	1658 858	964

Literacy rate in 1981 is 7.82; and it is 17.16 in 1991.

There is an increase of 30% in all developmental indicators.

No. of beds in Rural areas is 71 for 1 lakh population and it is 42 in tribal areas.

STAFFING PATTERN

Dist	M.Os		PHN		MPHS (M)		MPHS (F)		MPHA (M)		MPHA (F)		Pharmacist	
	S	V	S	V	S	V	S	V	S	V	S	V	S	V
E.God	18	4	9	-	37	14	16	4	72	11	133	35	10	31
KHMM	40	10	14	-	60	10	104	28	208	55	310	94	26	11
WRGL	16	6	5	-	18	2	18	2	56	7	91	18	14	1
VZM	19	4	7	2	38	15	16	7	60	9	104	19	11	4
SKLM	22	4	5	-	28	2	14	-	74	11	92	6	13	2
ADL.	22	13	7	4	19	7	14	5	46	6	83	25	14	3
W.GOD	5	1	2	-	6	2	7	2	7	1	28	6	3	1
VSP	27	10	9	2	38	14	23	8	165	35	189	57	11	5
	169	44	58	8	244	66	215	56	690	135	1030	260	102	30

P.H.C.S AND THEIR SUBCENTRES

Maximum No. of Sub-centres : 379 (Khammam)

Minimum No. of Sub-centres : 50 (W. Godavari)

Average : 10.25

NUMBER OF VILLAGES COVERED BY P.H.C.S

Minimum : 143

Maximum : 1461

Average : 73.59

COMPARATIVE ACCOUNT OF IMR AND MMR IN THE SUB-PLAN AREA

I.T.D.A.	IMR		MMR	
	1981	1991	1981	1991
SEETGANPETA	151	114	25	7
PARAVATHIPURAM	185	110	18	5
PADERU	-	-	-	-
R.C. VARAM	153	108	11	6
K.R. PURAM	145	91	15	9
BHADRACHALAM	109	89	12	7
ETUR NAGARAM	135	96	9	5
UTNOOR	-	-	14	8
CHENCHU AREA	165	215	44	8

EXISTING MEDICAL INSTITUTIONS IN DIFFERENT PERIODS IN SUB-PLAN AREA

MEDICAL INSTITUTION	UPTO 1982	UPTO 1989	AS ON 1995
PHCS	32	90	111
M.M.UNIT	26	29	26
SUB-CENTRES	108	729	824
TOTAL	*166*	*1658*	*964*

* Literacy rate in 1981 is 7.82 and it is 17.16 in 1991.
  There is an increase of 30% in all developmental indicators.

* No. of Beds in Rural areas is 71 for 1 lakh population and it is 42 in Tribal areas.

POPULATION COVERAGE OF M.O.S & M.P.H.A. (M&F) IN SUB-PLAN AREA

Dist	I.T.D.A.	I.T.D.A. Population	No. of M.O.s	Coverage (Lakhs)	No. of MPHA (M&F)	Coverage (Lakhs)
SKLM	SEETHAMPET	1.05	15	0.07	166	0.006
VZM	P.PURAM	1.53	30	0.051	164	0.009
VSP.	PADERU	3.55	56	0.06	354	0.01
E.G.	R.C.VARAM	1.74	20	0.087	205	0.008
W.G.	K.R.PURAM	0.64	16	0.004	35	0.018
KHMM	B.CHALAM	7.78	66	0.118	518	0.015
WGRL.	ETURNAGARAM	3.99	17	0.23	149	0.026
ADL.	UTNOOR	1.25	54	0.023	129	0.009
		21.53	**277**	**0.077**	**1720**	**0.0125**

AREA COVERAGE OF MEDICAL INSTITUTIONS IN SUB-PLAN AREA

Dist	I.T.D.A.	I.T.D.A. (Sq.Kms)	No. of PHC's	Coverage Area Sq.Kms	No. of SCs	Coverage Area Sq.km
SKLM	SEETHAMPET	1389.32	8	161.16	41	31.44
VZM	P.PURAM	1740.98	11	158.27	66	26.37
VSP.	PADETU	5904.51	15	393.63	189	31.24
E.G.	R.C.VARAM	4191.65	9	465.74	93	45.07
W.G.	K.R.PURAM	1006.10	4	251.53	56	17.96
KHMM	B.CHALAM	6899.92	31	222.58	192	35.93
WGRL.	ETURNAGARAM	3122.46	14	223.03	64	48.78
ADL.	UTNOOR	6138.50	19	323.07	123	49.90
		30293.44	**111**	**272.91**	**824**	**36.76**

M & H INSTITUTION IN TRIBAL AREAS (SUB PLAN)

DIST	ITDA	ITDA POPUL.	EXISTING PHCS	COVERAGE @20,000 PER PHC	ADDITIONAL NO. OF PHCS REQUIRED	EXCISTING SCS	COVERAGE @3.000/- PWE SC	ADDL. NO. OF SUB CENTRES REQUIRED
SKLM	SEETHAMPET	1.05	8	13125	-	41	2.560	-
VZM	P.PURAM	1.53	11	13909	-	66	2318	-
VSP.	PADETU	3.55	15	23667	3	189	1879	-
E.G.	R.C.VARAM	1.74	9	19333	-	93	1871	-
W.G.	K.R.PURAM	0.64	4	16000	-	56	1142	-
KHMM	B.CHALAM	7.78	31	25096	8	192	4052	67
WGRL.	ETURNAGARAM	1.25	14	8928	-	64	1953	-
ADL.	UTNOOR	3.99	19	21000	1	123	3243	10
	Total	21.53	111	19,396	12	824	2612	77