

HEALTH STATUS REVIEW REITERATIONS AND DEVIATIONS

A study of 15 villages in Addakal Mandal,
Mahaboobnagar, Andhra Pradesh



Programme Support Unit

ANDHRA PRADESH RURAL LIVELIHOODS PROGRAMME [APRLP]

FOREWORD

This is a study initiated by the Poverty Learning and Facilitation Group during its role as a core group leading the Programme Support Unit of the Andhra Pradesh Rural Livelihoods Programme. The Group, in the pursuit of its innovative role, sought to pursue thematic studies in areas that emerged from the Log Frame Analysis of the Rural Livelihoods Programme. These thematic areas are of critical relevance in the context of poverty alleviation, and continue to engage the Group.

This study on health should be considered more as the beginning of an exploration rather than a conclusive study. It has, in fact raised more questions than providing answers and merely prepares the ground for further research work which will be of importance in the context of poverty reduction and livelihood strategies in Andhra Pradesh and the rest of India.

S.P. Tucker
Project Coordinator

Contents

List of Acronyms

SECTION I: *Introduction*

SECTION II: *Health Indicators at the State and District Level*

- Commonalities and differences

SECTION III: *The Present Study*

- Focus of the study
- Methodology
- A snapshot of the villages
- Findings of the study
 - ◆ Economic status and health
 - ◆ Disease patterns
 - ◆ Age, gender and health
 - ◆ Women's health issues
- Health facilities: quality and access
 - ◆ Public
 - ◆ Private
 - ◆ User perception
 - ◆ Linking people to healthcare: service providers
 - ◆ Banking on social capital
 - ◆ Health expenditure

SECTION IV: *Road Map for the Future*

- Community perceptions and demands
- Short- and long-term action
- Key observations of the study

SECTION V: *Conclusion*

References

List of Appendices

Appendix I: Vision 2020 Health Goals

Appendix II: A tabulation of the hysterectomy cases in Vemula

Appendix III: List of public and private facilities and service providers in the study villages

Appendix IV: Some reasons why women don't join the SHG.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
APRLP	Andhra Pradesh Rural Livelihoods Programme
AWS	Aadarsha Welfare Society
BC	Backward Caste
CPR	Contraceptive Prevalence Rate
GSDP	Gross State Domestic Product
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IMR	Infant Mortality Rate
MMR	Maternal Mortality Rate
NCAER	National Council for Applied Economic Research
NFHS	National Family Health Survey
PHC	Public Health Centre
PSU	Programme Support Unit
RCH	Reproductive and Child Health
RMP	Registered Medical Practitioner
SC	Scheduled Caste
SHG	Self-Help Group
ST	Scheduled Tribe
TB	Tuberculosis
TFR	Total Fertility Rate
UT	Union Territory
VO	Village organisation

INTRODUCTION

Social and economic development is crucially linked to health. In fact, human capital is “one of the most important components of a nation’s wealth.” Andhra Pradesh’s less than satisfactory ranking on the Human Development Index (HDI) is attributed to its mediocre results in health and education. (*Hindu*, April 2002). If AP is to achieve its economic goals, it cannot afford to ignore health. Fully aware of the inter-sectoral implications, the Vision 2020 document outlines health goals and strategies at length. (See Appendix I for Vision 2020 health goals.)

The PSU APRLP undertook a study during early 2003 on health. Unlike the usual macro-level broad general studies on health, this study focused on 15 villages in Mahaboobnagar district and sought to understand local nuances and issues of health. The findings were fairly modest in themselves, but with broader implications on how relevant programming and strategising could be done.

How APRLP came to do this study

The Andhra Pradesh Rural Livelihoods Programme (APRLP) was initiated in the year 2000 with a view to energising the watershed programme by looking at issues of convergence. An important part of its strategy has been to initiate field research on various areas linked to livelihoods with a view to understanding policy implications.

Early in 2003, when the Rhoda Mistry College of Social Work approached the Programme Support Unit (PSU) for field work experience, the latter thought it would be worthwhile for the team to undertake a health survey. There were more than a couple of reasons why the health survey was thought necessary. For one, it definitely linked up to issues of livelihoods; secondly, a strong demand for a health intervention was made by the Self-Help Group (SHG) women of Addakal Mandal. Some of the villages in Addakal Mandal could be rated high on social capital. In other words, they have well-developed social networks, for example women’s self-help groups, which have provided women with income earning opportunities, enabling them to improve their economic status, but health still remains a backward area. Further, health issues would link up to the other areas of PSU research.

HEALTH INDICATORS

A brief overview of the state-level and district-level health status: commonalities and differences

“There are, however, some areas of primary concern, needing priority attention of the (AP) State Government. The average annual growth rates of GSDP (Gross State Domestic Product) and per capita SDP have been lower than the all India average. As per Census- 2001, in literacy, the State ranks 28th amongst 35 States/UTs. In respect of key health indicators like crude birth rate, crude death rate, infant mortality rate and life expectancy, the State lags behind many States though, its position is better than the national average.”

(From: Annual Plan Discussion 2001-2002: Andhra Pradesh: OPENING REMARKS BY DEPUTY CHAIRMAN)

Andhra Pradesh ranks somewhere in the middle on the all-India health ladder. The state government's Strategy Paper on Health, Medical and Family Welfare Department states that, over the last few decades, there has been considerable improvement in the health status of its population.

Small pox has been eradicated. There have been no reported cases of Guinea worm disease since 1997. The prevalence of leprosy has reduced from 124 per 10,000 population in 1983 to 4.43 per 10,000 population by 2001. Polio cases have gone down from 50 in 1995 to nil cases in the year 200. Life expectancy at birth has gone up from 45.6 in 1970 to 64 in 2001. Mortality due to infectious and communicable diseases has also registered a considerable decline. The IMR has gone down from 113 per 1000 live births in 1971 to 60 per 1000 births in 2000. The MMR has declined from 3.8 in 1993 to 1.4 in 2000.”

Government allocation towards health has shown a steady increase from Rs 560 crores in 1994-95 to 1500 crores in 2000-01. Expenditure on health out of the total public expenditure has generally increased from 6% in 1980-81 to about 8% 1988-89.

The most striking recent achievements have been related to fall in population growth. While the all-India decadal growth from 1991 to 2001 is 21.34%, AP registered a growth of 13.83% only.

Table 1: Demographic indicators: comparison of 7 major states in India

	Population (millions, 1991)	Female Literacy Rate (%)	IMR(1997)	TFR(1997)	CPR(1997)%
TAMIL NADU	55.86	51.33	53	2.0	51.7
UTTAR PRADESH	139.11	25.31	85	4.8	37.2
KERALA	29.10	86.17	12	1.8	46.7
PUNJAB	20.28	50.41	51	2.7	76.9
MAHARASHTRA	78.94	52.32	47	2.7	51.0
ANDHRA PRADESH	66.51	32.7	63	2.5	46.9
WEST BENGAL	68.08	46.56	55	2.6	34.2

Source: Ministry of Health and Family Welfare.

Table 2: Demographic and health indicators (detailed comparison of 3 states)

Indicator	Tamil Nadu	Andhra Pradesh	Uttar Pradesh
TFR	2.5	2.6	4.8
CPR, any method	50	47	20
% sterilized	40	45	13
% contraceptive use due to sterilization	79	95	66
Infant mortality (deaths/1,000 births)	68	70	100
Median age at: marriage (women age 25–49)	18.1	15.1	15.1
First birth (women age 25–49)	20.1	17.9	19.5
Sterilization	26.2	24.5	29.6
For births in past four years, % of: mothers receiving antenatal care	94	86	45
Mothers receiving two doses tetanus toxoid vaccine	90	75	37
Births delivered in a health facility	63	33	11
Births delivered by a health professional	71	50	17
% of children (12–23 months) fully immunized	65	45	20

Source: National Family Health Survey Bulletin, No. 2 (based on 1992-93 NFHS)

Table 3: Economic and social development indicators

Indicator	Tamil Nadu	Andhra Pradesh	Uttar Pradesh
% urban (1991)	34	27	20
% illiterate (females age 6+)	44	62	69
% attending school (females age 6–14)	79	55	48
% working (ever-married women)	47	53	13
% “working for someone else” (ever-married women)	35	29	3
% landless (rural households)	22	56	59
% with electricity (households)	64	62	32
% regularly exposed to mass media (ever-married women)	78	75	35
% population below poverty line (1987-88)	34	32	35

Source: National Family Health Survey Bulletin, No. 2 (based on 1992-93 NFHS)

Table 4: Percentage change in health infrastructure facilities in AP between NFHS-I and NFHS-II

Health infrastructural facilities	NFHS I%	NFHS II%	Change%
Village Health Guide	49.0	43.7	-5.3
Trained birth attendant	58.4	72.7	14.3
Ever-married women who can access health facilities	64.6	64.2	-0.4
Mobile unit	10.5	31.2	20.7
Electricity	76.6	100	23.4

Source: NFHS I & II: intra-survey period: (1992–1998)

Environmental Health

Hughes, Lvovsky and Dunleavy (2001) state that, “environmental factors are responsible for a substantial 20% of the total burden of disease in Andhra Pradesh. More than 90% are traditional environmental risks – for instance 73% of Andhra Pradesh’s population does not have access to healthy sanitation facilities.” Environmental factors contribute to 22–23% of the burden of disease. Indoor air pollution because of the use of biomass fuels is a major cause for worry in the areas, especially when it comes to women’s health. According to them, “improvements in the household environment, notably better access to water, sanitation, and clean cooking fuels can have a remarkable impact on child mortality and other indicators of ill health, possibly increasing the average life expectancy in Andhra Pradesh by 3.3 years.”

The district’s performance on health parameters

Mahaboobnagar is one of the five most backward districts in the state and among the 20 most backward in the country. Persistent drought, low levels of literacy and other poor social indicators have contributed to its backward status. The district ranks among the top ten districts with the highest burden of water and sanitation-related diseases. Table 5 compares some of the basic demographic and social indicators of the district with those of Andhra Pradesh.

Table 5: Mahaboobnagar district indicators compared to AP

S.No.	Indicators	Mahaboobnagar	Andhra Pradesh
1.	Population	3506876	75727541
2.	Density per sq. km.	190	275
3.	% of SC Population	17.63	15.93
4.	% of ST Population	7.39	6.31
5.	%of urban population	10.59	27.08
6.	Rural Literacy	41.72	55.33
7.	Female Literacy	28.66	44.36
8.	% of irrigated area to net sown area	18.8%	33.4%
9.	Normal rainfall (annual)	604 mm	940 mm
10.	% of marginal farmers to total farmers	44.75%	59.42%
11.	% of small farmers	26.31 %	21.35 %

(Source: HIS Report—DFHS 2001)

Table 6: Mahaboobnagar's indicators on health

S. No.	Indicator	Status
1.	Incidence of Tuberculosis	98.2 per lakh population*
2.	Amoebiasis	900.8 per lakh population*
3.	Institutional deliveries (up to Jan 2002)	31.27 %*

* Source: District Medical & Health Officer

Table 7: District and divisional estimates of IMR and TFR

District / Division	IMR	TFR
Nellore Dt.	79 (46)	2.13 (3.1)
Gudur Div.	92	2.03
Kavali Div. 58	2.25	
Nellore Div.	81	2.13
Chittoor Dt.	65 (60)	2.17 (3.14)
Madanapally Div.	76	2.17
Chittoor Div.	67	2.21
Tirupati Div.	45	2.1
Mahbubnagar Dt.	115 (77)	2.52 (4.49)
Gadwal Div.	93	2.53
Mahbubnagar Div.	110	2.66
Narayanpet Div.	125	2.41
Wanaparthy Div.	62	2.51
Nagarkurnool Div.	140	2.46

Figures in parentheses indicate estimates derived from 1991 census data.

Table 8: Maternal Mortality Rate

Time location of estimates	District - MMR per 100000 live births			
	Nellore	Chittoor	Mahaboobnagar	Pooled
1988	264	211	202	258
1993-94	248	651	169	321
1994-95	790	234	1,775	997

Source: DFHS-AP pilot study 2000: Sisterhood data.

The above tables reveal Mahaboobnagar's backward status with regard to economic and social indicators. The district is drought-prone and has huge tracts of unirrigated land. As per the DFHS 2001, the percentage of irrigated area to the net sown area in the district is only 18.8 %, while the corresponding figure for the entire state is 33.4%. The level of female literacy is poor (28.66). The district has one of the highest IMR and MMR rates in the state (IMR:115; MMR 1,775 per 10,000 live births).

THE PRESENT STUDY

Focus of this study

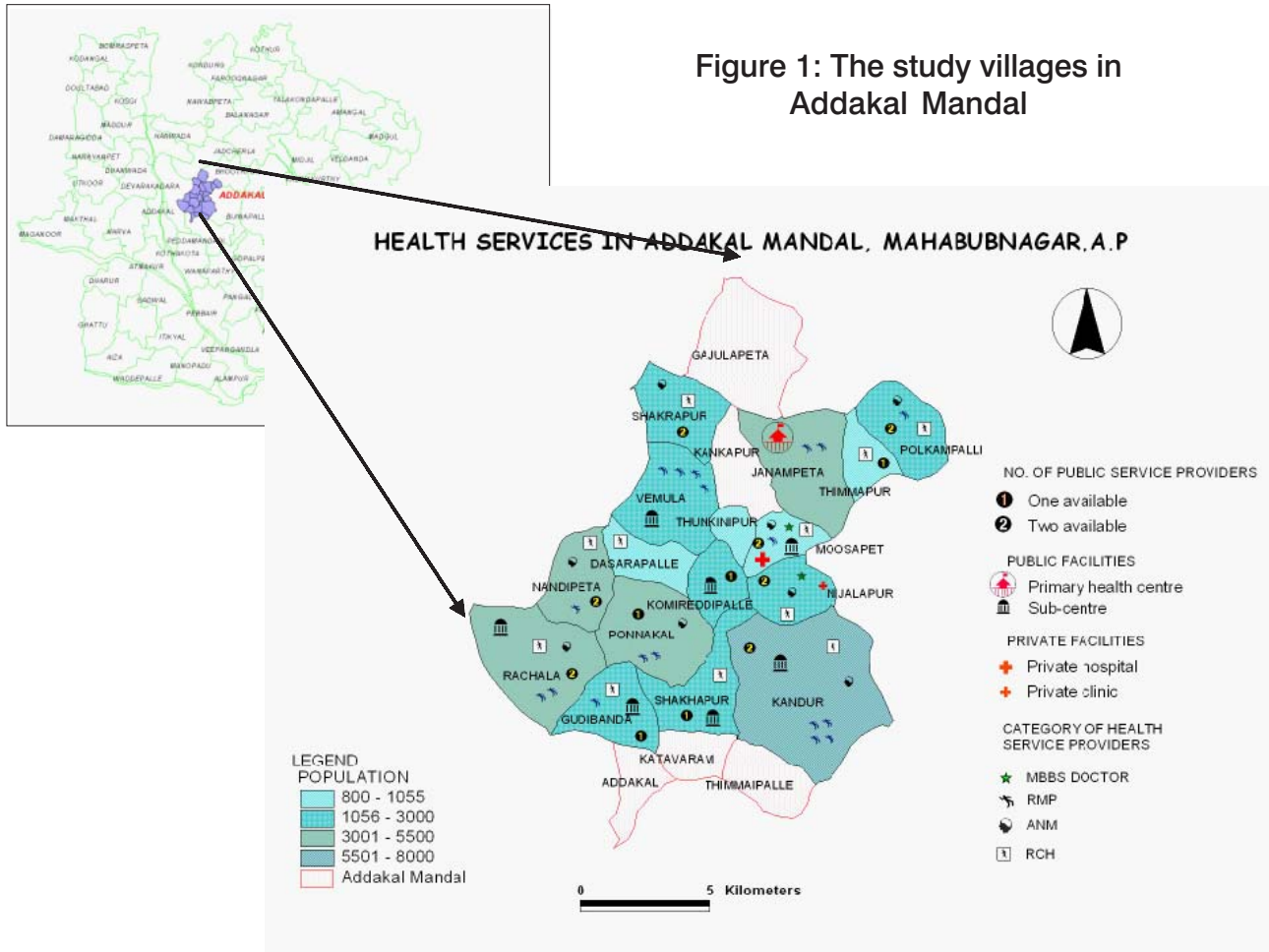
Macro-level health studies which are usually undertaken give us a broad indication of health status and issues. The present study, as already mentioned, is a micro-level one, focusing on 15 villages (See Figure 1) in Addakal Mandal of Mahaboobnagar District. Micro-level studies are important because they help us understand patterns and nuances specific to an area. The present study, while examining the various health-related issues, places special focus on women's health issues. For the purpose of this survey, health has been defined more in the sense of 'absence of disease' rather than in terms of 'well-being'.

Limitations of the study

The study was undertaken during April-May. Therefore many of the seasonal health issues, for instance diseases common during the monsoons, are not reflected. The study only captures the chronic health issues. Further, child health has received little attention. The role of alternative medicine, too, has not been evaluated. Again, the impact of the environment on health has been excluded.

Methodology

The study team consisted of six social work students from the Rhoda Mistry College of Social Work. The period of study was from 17 April 2003 to 23 May 2003. They stayed at the Addakal Centre, travelling every day to the various locations. They covered every household in the 15 villages. They interviewed respondents from those households where ill-health was reported to garner detailed information. Focus group discussions were also held with the community. Both private and government service providers were interviewed. Activists from the local NGO, Aadarsha Welfare Society (AWS), were also interviewed to examine their perception of health issues faced by the community. The team also talked to the NGO to gather more information on the service providers, especially the Arogya Karyakarta or Reproductive and Child Health (RCH) representative. The team visited the Public Health Centres (PHC) both at Addakal and Janampet for a first-hand evaluation of the facilities and staff behaviour.



Once the basic information was collected, it was presented before a larger team. Lacunae were identified and the team returned to the field to gather additional information on various issues, including AIDS, TB, hysterectomies, PHC functioning and social network and its impact on health. The team also sought to elaborate the case studies in greater detail.

A snapshot of the villages

The 15 villages are a study in contrasts. While villages like Musapet, Kandur and Janampet are well-linked by roads, and have most facilities like markets, medical shops, schools, kirana shops, PDS outlets and private clinics and hospitals, there are others like Dasrapally, Shakrapur (which has 2 thandas) and Tunkinpur, where there are no medical personnel or facilities. Tunkinpur, Gudibanda, and Timmapur would fall among the most backward villages in the lot. The first two have no bus facility. Overall, the sanitation and drinking water facilities are poor. Only 2 of the 15 villages have toilets. In some villages people place their faith in 'god-men'. In Dasrapally, for instance, people went to, Kishtappa, who was revered as a person with supernatural powers with all their problems, including ailments. It is said that he could heal by merely touching them. Kiahtappa is believed to have attained Nirvana and now, his son, Ramulu, doles out medicine and continues to heal by touching.

In the study villages, the majority of the inhabitants belong to the Backward Caste (BC) community. Their major occupation is agriculture. The average monthly household income ranges between Rs. 800 to Rs. 1000. The average landholding size is 3 to 5 acres. Ten per cent of the population in each village consists of landless labourers. The average family size is 3 to 6 members.

Findings of the study

Economic status and health

Health, as Prof. Debabar Banerji put it, "...is essentially an economic, political and social issue." (quoted in Health Action, 1999) Economic status affects health status not only in terms of nutritional levels and access to facilities but also quality of living conditions.

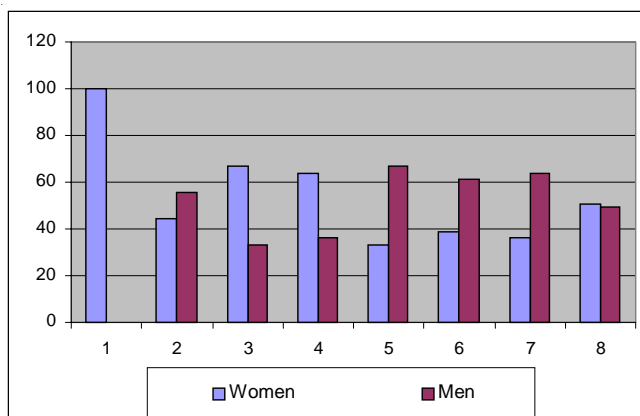
The disease burden is highest in the landless and 0-2 acres category: 47.39% of those who are ill belong to this category, followed by those owning 3-5 acres and depending on construction work.

Age, Gender and Health

Atypically, for both men and women, the 15–30 age group* showed a higher incidence of disease, followed by the 31–45 age group. (This finding needs to be probed further to determine causes for it could have long-term implications for the productive age group. Adolescent health may need greater focus.)

According to the electronic newsletter on population, health and nutrition issues, "... women suffer from more health problems than men. Beginning in infancy, females often receive less and lower-quality food and, when sick, receive treatment less often and at a more advanced stage of disease. Because of their reproductive function, women run risks of morbidity and mortality which men do not face. Their health is also affected by gender-specific cultural practices, (like) ... domestic abuse, which are not a consequence of their behaviour." (Anne Tinker, 1994) Again, according to a national survey carried out by the National Council for Applied Economic Research (NCAER) in 1993, "Morbidity prevalence was slightly higher for females than males in both rural and urban India, with a 2% difference in rural ... India. (As quoted on the Women's Health in South-East Asia website.)

Figure 23: Gender and disease



1. Gynaecological 2. Tuberculosis 3. Leprosy
4. Stomach pain 5. Respiratory 6. Epilepsy
7. Paralysis 8. Others: eye/joint pain/skin ailments/
differently-abled/mental illness/retardation/cancer/
heart ailments/kidney ailments/HIV

This study also confirmed that more women as compared to men suffer from ill-health. It is also a well-known fact, as stated above, that typically women's health problems receive the least priority in households. Further, a woman's health problem tends to get ignored until it reaches a critical point, when a visit to the nearest RMP or PHC is made. Often, she visits the ANM to get free medication.

Disease patterns

The study did not focus on common or seasonal ailments, but looked at diseases that caused long-term debilitating conditions. The reasons could be inappropriate diagnosis, post-operative conditions, discontinuing of treatment, as in the case of TB or even genetic. In some instances, the single or multiple causes were yet to be diagnosed, as in the case of stomach ache, where only the symptom was recorded. Table 9 summarizes the findings related to diseases.

Table 9: Incidence of diseases

S.No.	Disease	No. of cases	Male	Female	Observation
1.	Gynaecological	45		45	White discharge is the major problem and a large number of hysterectomies are being conducted.
2.	Tuberculosis	27	15	12	Till the problem becomes critical the patient does not visit the hospital. Many of the cases reporting severe cough could be unidentified TB cases.
3.	Leprosy	6	2	4	All patients are receiving treatment; though the social stigma is there.
4.	Stomach pain	50	18	32	Cause needs to be diagnosed
5.	Respiratory	21	14	7	Asthma and infected lungs. Usually receiving treatment from the RMPs.
6.	Epilepsy	13	8	5	No treatment.
7.	Paralysis	11	7	4	Hypertension is not diagnosed.
8.	Others	173	85	88	
9.	Mental retardation	13			All cases below 17 years. They are accepted as part of the household. No schooling.
10.	Differently- abled	24			By birth and because of polio.
11.	Skin diseases	22			Lack of personal hygiene.
12.	Mental illness	4			No treatment. The girls stay at home, while the men roam around in the villages.
13.	Kidney problem	11			Kidney stones. Causes need to be probed further.
14.	Eye problem	13			Vision problems.
15.	Joint pain	11			
16.	Heart problem	7			Treatment is expensive.
17.	Malnutrition	7			
18.	Diabetes				
19.	AIDS	2			In both cases, the husband has been a migrant labourer and then the spouse has also contracted the disease. There is very little support available for these patients.

As can be seen from Table 9, in spite of strong government interventions TB and leprosy continue to be areas requiring attention. Though all the 5 leprosy patients were receiving treatment, only 16 of the 27 TB patients were receiving treatment. There were various reasons why the treatment was not being taken, which included migration, lack of financial resources, loss of medical papers or even lack of interest.. There is little awareness among the TB patients as to how important it is to complete the entire course of treatment. The pattern of treatment for TB is usually the same. The patient is unaware in the initial months that s/he has TB. S/He takes treatment for cold and fever or cough over a couple of months or more. When the medication fails to take action, a sputum test or chest X-ray is done to confirm TB. If the patient accesses the initial treatment from a private hospital, the tests are usually done there, and then the patient is referred to the government hospital. In most TB cases, the patients are being treated at the Mahaboobnagar government hospital. Very few TB patients are being treated at the private hospitals. In Janampet and Musapet, the sarpanches have played an important role in ensuring that TB patients receive proper treatment. (See page 21)

As stated earlier, environmental factors are responsible for a substantial 20% of the total burden of disease in Andhra Pradesh, and indoor air pollution is a major area of concern, especially when it comes to women's health. In the study villages, a majority of the household use fuel wood, and the ventilation is poor.

With regard to the 50 cases of stomach pain, they need to be studied further to identify the causes, for, as of now, only the symptom has been identified.

HIV/AIDS

The study team identified 2 households which were affected by HIV/AIDS related symptoms, one in Komerreddypally and the other in Polkampally. In Komerreddypally, the entire family, except for 6-year-old Praveen Naresh and 2-year-old RajuRavi, passed away. Of the 2 surviving members, Rajuvi is also suffering from AIDS-related diseases, but does not seem to be receiving proper medical support. (See Box 1)

AIDS—the need to ensure positive practicesAnjammaShantamma, LaxmanaVenkatiah and their daughter SangeetaLakshmi died of AIDS in May 2003. Their story has been reconstructed through interviews with the husband and wife when the team visited the village in April and subsequently through interviews with AnjammaShantamma's father KrishnaiahBal Venkatiah and her sister MaisRamulamma. Shantamma Anjamma of Komerreddypally married her cousin Venkatiah Laxmana of Dasrapally in 1997. LaxmanaVenkatiah had migrated to Mumbai for work during his teens, and was employed in the construction industry. (According to MaisRamulamma even before her sister's marriage, LaxmanaVenkatiah was on medication.) After her marriage, AnjShantamma accompanied her husband to Mumbai and lived there for a year. Both returned to her father's house at Komerreddypally for the delivery of their first child—PraveenNaresh. This time Laxmana Venkatiah proceeded alone to Mumbai for work. Two years later, in 1999, he returned to Komerreddypally to visit his wife. He appeared to be unwell. A month later, Shantamma Anjamma was pregnant with the second child. During her pregnancy she was unwell. She had a home delivery, giving birth to a daughter, SangeetaLakshmi. Subsequently, both husband and wife suffered from constant fever with shivering, and loose motions. Suspecting TB, they visited the Mahaboobnagar TB hospital. The doctorDr Srinivas Rao tested the sputum and blood samples and also took an X-ray. The tests revealed that the couple was suffering from TB and also HIV AIDS. They took the 6-months treatment course for TB.. They had little awareness about what they should do; neither did the ANM or the other health workers offer any medical support. In fact, most of the neighbours kept away from the household once it was known that they were suffering from the disease. But AnjammaShantamma's family stood by them and her father bore most of the medical expenses. In the meantime, it was diagnosed that SangeetaLakshmi, their daughter, too, had contracted the infection. In 2001, RajuRavi, their third child was born. LaxmanaVenkatiah succumbed to the disease in 2001. In May 2003, Shantamma Anjamma died. A few days later, SangeetaLakshmi, too, passed away. Subsequently, Ravi was tested for HIV and the results were positive. After AnjammaShantamma's death, the paternal grandmother came and took PraveenNaresh and Rajuvi away to her house. When the team visited the paternal grandmother's house, she was away on agricultural work, while PraveenNaresh was left to tend to his little brother, Rajuvi. It was unlikely that those around Rajuvi were aware how to help him. AnjammaShantamma's family has destroyed all the medical papers related to the disease.

Women's health issues

Since mother and child health has received considerable focused attention, the present study examined other aspects of women's health.

For women, the major health issues are gynaecological in nature and relate to white discharge, menstruation problems and post-operative (family planning and hysterectomy) problems.

Hysterectomies

During the survey, the researchers identified a fairly large number of women who had undergone hysterectomy operations and were struggling with post-operative problems. It was then thought necessary to conduct a focused study on hysterectomies. A pilot survey was undertaken in Vemula village. (See Appendix II for a tabulation of the cases, including age, reason for operation, costs, etc)

In Vemula village, which has 400 households, 46 women have undergone the hysterectomy operation. More than 50% of the women on whom the surgery has been performed belong to the 25-35 age group. The expenditure incurred by them ranges between Rs 6000 to Rs 20,000. Most of the women continue to be plagued by post-operative problems and are unfit for strenuous work. Money for the operation is often raised by borrowing. Post-operative care again means continued expenditure, straining their finances even further in a time of drought, as in the case of AshammaSusheelamma. AshammaSusheelamma is 35 years old. Her family consists of herself, her husband, LingaiahKrishnaiah, and her 2 sons and 2 daughters and her married daughter, who does not stay with her. She and LingaiahKrishnaiah own one-and-a-half acres of land and some livestock. They also do coolie work; but that was before AshammaSusheelamma had her operation. In 1998, when AshammaSusheelamma had the problem of white discharge, she ignored it at first. But when the problem did not seem to go away, she went to the RMP. When a year passed with little improvement, she went to the private hospital in Mahaboobnagar and was told she would have to undergo a hysterectomy operation. In October 1999, she had the operation at the private hospital, spending Rs 12,000. Since the operation she has been unwell. She is troubled by joint pains, weakness and lack of appetite. She spends most of her time lying down, and is unable to attend to even household duties. She has been unable to work since the operation. Post-operative medication on an average costs Rs 200 per month. For the last two years, drought has worsened their situation. They had to take a loan for Rs 6000 at 3% interest from the moneylender for fodder. Every six months sell a couple of their goats to raise additional money. This year both her daughters have stopped going to school.

Health facilities: quality and access

Public

"In a study in Mahaboobnagar, the supply of thermometer was found to be available only in 71% of the sub-centres ... One glove is possessed by 54% of the sub-centres ." (Krishna Reddy as quoted by Kapil Sibal in the Rajya Sabha: 4.5.2000)

There are 2 PHCs catering to the 15 villages—one located at Addakal and the other at Janampet. Seven out of the 15 villages have sub-centres. (See Appendix III for a detailed list of private/public facilities and service personnel. See Figure 4 for a plotting of facilities) The distances from the PHC vary from 5 km to 15 km. Most of the villages are linked to the PHC by motorable roads, but for hamlets like Tallagadda (Musapet village), where there is no road, access remains a problem. Tunkinpur and Gudibanda suffer from the lack of a proper bus facility. Nizalapur, on the other hand, faces a different kind of a problem. The road, which has been built over a river, gets flooded during the rains, making access to facilities extremely difficult during these months. Further, in Dasrapally and Tunkinpur, no medical personnel are available locally. Inhabitants have to travel to Janampet to access medical care.

Box 2: Janampet PHC This is a first-hand report based on a visit to the Janampet PHC. The Janampet PHC is easily accessible by road and is located on the highway on which a fairly large number of buses ply. According to the PHC staff, 80-150 patients visit the PHC daily. The PHC is open from 9 am to 12 noon and 2 pm to 6 pm, six days of the week. On Sunday, it is open only till noon. The PHC has Dr Muralidhar as the Family Welfare doctor and a Dr Indira as the General Physician. The PHC has 10 beds and is fairly well-staffed, though the vacancies for Health Assistants. And Health Supervisor have not been filled for the last 3 years and 1 year respectively. The posts of laboratory technician, sweeper and watchman are also lying vacant. When the team visited the PHC, though the doctor's consultation room was fairly clean, the rest of the PHC was not well-maintained. As per the PHC records, the common health problems faced by the community are fever, cold, cough, joint pains and skin infections. In the rainy season, the common problems are diarrhoea, nausea and fever. If the case is complicated, they refer it to the Mahaboobnagar District Hospital. There is no ambulance facility. After the initial registration, the patient is examined by the doctor. There is no standardised examination procedure. Only in some cases is the blood pressure and the weight checked. This is done only for the pregnancy cases. The cases are recorded under each disease and weekly, monthly, and annual reports are submitted. The birth and death cases are registered with the Mandal office. As per the records, there are around 2 tubectomy operations every month, 10 to 15 deliveries and 4 to 5 leprosy cases come for treatment. TB patients are also treated by the PHC. As for staff behaviour, the team observed that they were courteous to the patients

Box 3: Addakal PHC Addakal PHC is located close to the bus stop and is easily accessible. There are 3 beds at the PHC and it caters largely to out patients. The PHC is open from 9am to 12 noon and 2 pm to 6 pm, six days of the week. According to the staff, the PHC sees around 20 patients a day. The PHC records indicate that the common concerns include seasonal ailments like fever, cold, cough, viral infection, joint pain, dehydration, etc. TB, leprosy and hysterectomy cases are referred to the Mahaboobnagar District Hospital. The PHC lacks proper equipment and a good operation theatre. As for the staff, the posts of lab-technician, pharmacist and Community Health Officer have been lying vacant for a long time. The PHC does not have an ambulance facility. The team observed that the doctor was rude in his dealings with the patients. According to the PHC staff, they are handicapped from performing effectively due to lack of equipment, lack of medicine and lack of a laboratory facility and beds.

Private

Two out of the 15 villages have private clinics set up by MBBS doctors. In 8 out of the 15 villages, clinics have been set up by Registered Medical Practitioners (RMPs). In some villages, more than one RMP caters to the medical needs of the people. For instance, in Kandhur, there are 4 RMP clinics, as is the case with Vemula. The RMPS in Kandhur, Janampet, Gudibanda, Ponakkal, Rachala and Nandipeta make home visits. The patient pays a minimum of Rs 15 if an injection is given. And usually an injection is given! The RMP from Musapet was honest with the team and said that injections are given, even when they are not needed, because patients view injections as an essential part of treatment.

User perception

By and large, the private facilities were preferred to the public facilities. This was, of course, linked to the ability to pay. Private facilities were preferred or not preferred for a variety of reasons, as snippets from the interviews with various users reveal below.

Users speak

SashiChandrakala from Vemula

"If I go to the PHC, they will give me 2 tablets and ask me to come again. If they give me medicine for a week it is okay. I have to spend more on travelling charges than medicines so I prefer to go to the RMP."

DevkRajamma from Addakal

"I prefer to go to the PHC because it is closer to my home. It is fine if I have general health problem."

ChenPochamma from Ponakal

"The PHC is concerned about the patients. Every time I visit Addakal PHC at 5.00pm the doctor is there."

Ananth Reddy from Komereddypally

"It's no use for me. The PHC doctor does not give me medicine for diabetes."

Rumark Reddy from Komereddypally

"At the PHC, they don't give me an injection."

D Kondevarakonda Pochamma from Banglagadda

"I have discontinued my TB treatment course. I am scared to go to the PHC. The doctor may scold me. So I visit the Musapet hospital."

KondBuchanna from Musapet

"I like to go the RMP whenever I have the money. At the PHC, they give me old medicine stock. I have no relief from the body pains. If the RMP doctor gives me medicine, the pain relaxes."

"SashiChandrakala from Polkampally"

I don't mind spending Rs100-Rs150 per month. I go to the Musapet doctor."

PochChenamma from Nandipeta

"The Musapet doctor treats me nicely and shows more concern. He is friendly."

"Kusuru Laxmi Devi from Komeretty"

How can you get cured without spending any money?"

Linking people to healthcare: service providers

RMPs and Doctors

RMPs are the most-preferred service providers. As the team's visit to the RMPs' clinics revealed, they have a steady stream of patients visiting them. Interviews with patients at the Musapet RMP's clinic also revealed that patients are willing to travel from nearby villages if they trust the doctor. Some of the RMPs, for instance at Musapet, also handle deliveries.

RCH or Arogya Karyakartas

The Auxiliary Nurse Midwife (ANM) continues to play a role in the delivery of health services related to the mother and child. Though this survey did not assess the quality of her services, the survey revealed a new crucial link in the healthcare delivery system—the Arogya Karyakarta or the RCH as she is popularly referred to.

The RCH is appointed by the Village Organisation (VO). She should be a resident of the village and should have studied at least up to class VII. She is sent to either Kothakota or Jadcherla for training. She helps the ANM with her work. Since the ANM visits the village only twice a month and is responsible for 3-4 villages, the RCH reduces her

burden and supplements her work in the area of mother and child care and immunisation. In some cases, she also handles deliveries. She also follows up with those receiving TB treatment. The RCH is available locally, 24 hours of the day and therefore has built up better links with the women. She has to report at the monthly meetings conducted by the RCH coordinator.

First-person narrative: The Razia Begum, RCH of Vemula When the SHG group started in Vemula, I was the vice-president. When I completed my term, I was searching for another job and was appointed at the Addakal Centre supermarket as a sales woman. As the vice president, I had some exposure to working with the community. I am quite a patient and tolerant person. I also don't mind going from house to house to help people. Also, I have helped with home deliveries when the RMP was not available. Therefore when the need came up for an RCH, the group members selected me. Initially, I had some training at Jadcherla. In the beginning when I started working with the SHG group, my husband would scold me. But when I discussed the matter with him and told him I was serving the community and he had the right to scold me if I was doing something wrong, he changed his attitude. Today, he even helps me with the housework

Sarpanches take the initiative

In 2 villages, Musapet and Janampet, the sarpanches also play a role in linking the inhabitants of the village to the healthcare delivery system. Bhaskar Chandra Goud, the young sarpanch of Musapet village, is a man with a mission, especially with regard to the TB patients. Prior to being unanimously elected as the sarpanch, he was a member of the Musapet Youth Club. Over the years, a relationship of trust has been built up between him and the people. Whenever any person from the village has high fever or continuous cough, s/he comes to him for advice or asks him for money. Instead of giving money, he takes the person to the Mahaboobnagar Hospital. He has taken many TB cases to the hospital. He also follows up with the patients till they complete the course of treatment. He also ensures that the accident cases and snake bite cases receive timely treatment. He takes the snake bite cases to Yenugonda Hospital because the treatment there is good. He has also initiated quite a few health camps in the villages.

As a Telugu Desam party member and sarpanch, he has political power backing him. Therefore, even the government doctors listen to him. They do not charge for the treatment.

Banking on social capital: social network and health

The survey revealed a critical link between social capital and health. Women who are SHG members have better access to healthcare and are better informed about health issues. SHG women also have access to cheaper credit for healthcare expenditure. Since the RCH is appointed by the VO, the SHG women have better access to her. They are comfortable discussing their health problems with her and consulting her regarding health issues. Very often she is able to direct the SHG member to the proper and less expensive source of treatment. Take the case of SarojPochamma of Komereddy pally. Observing that her neighbours had become members of SHG, she too joined the group. During one of the meetings, the discussion turned to health matters. She shared her problem with the group. One of the members suggested that she visit a particular doctor, which she did. The problem was diagnosed as breast cancer and she required an operation. Once again her SHG came to her aid, extending her a loan on a low rate of interest. She was operated and is today thankful to the SHG. She says she owes her life to the group, which guided her to the right medical facility and also extended financial help. The non-SHG women, on the other hand, are often unaware of the existence of the RCH and also tend to be neglected by the ANM.

Members from joint families have better support systems, as the AIDS case revealed.

Health Expenditure

The average household expenditure on health in the study villages ranges from Rs 200-500. Minimum expenditure on per visit to a private doctor/RMP is around Rs 100, inclusive of medication. The expenditure varies depending on

the illness. If surgery is performed, as in the case of hysterectomies, the expenditure can be even more than Rs. 10,000. Table 10 shows the average expenditure incurred to treat various ailments.

Table 10: Average expenditure incurred to treat various ailments

S. No.	Diseases	Money spent
1.	Cough, cold etc.	Rs 70 – Rs 100
2.	Stomach pain, skin disorders, kidney problems	Rs 100 – Rs 500
3.	Tuberculosis	Rs 400 – Rs 600
4.	Heart problems	Rs 1000 –Rs 6000
5.	Hysterectomy	Rs 6000 – Rs 20 000
6.	Post-hysterectomy	Rs 200 – Rs 500

Source of Funds

Health expenditure is most often met through borrowing, either from the SHG, if the woman is a member, or from the sahkukar (moneylender) or bank. The SHG charges an interest of 1.5%, while the moneylender charges 3% interest or even more. SHG records show that around 15% to 20% of the loans taken go towards health. Sometimes, health expenditure is also met through the sale of livestock or land.

Box 6: Burdened with debt due to health problemsKodera Maniyam Subanna of Gudibanda belongs to the Scheduled Caste (SC) community. His family consists of himself, his wife and 2 children. Though he himself is illiterate, both his children, Veeriah Anjanaeylu and PentiahYadiah have been attending school. Kodera owns no land, and supports his family through daily labour, earning Rs 25 per day. Since the last one year he has been suffering from TB. Initially, he visited the Mahaboobnagar Government Hospital, but the careless attitude of the doctor put him off. Then the couple visited the Yenukonda Private Hospital and then the Ananthagiri Govt. Hospital at Vikarabad. The routine sputum test and X-ray confirmed that he had TB. At the Yenukonda Private Hospital, Kodera SubannaManiyam spent Rs. 14,000 towards tests and treatment. At the Ananthagiri Hospital he spent Rs. 9000. SubannaManiyam has not been working since one year. The financial burden has fallen on his wife’s shoulders. There is no family support system for them. His wife borrowed Rs 10,000 for his treatment from the SHG. She also borrowed Rs 6000 from one money lender at 4% interest and Rs 3000 at 3% interest from another. Some of the money also went into running the household. SubannaManiyam weeps as he says that the family often has no food to eat.

ROAD MAP FOR THE FUTURE

Community perceptions and demands

- The ANM's services should be extended beyond maternity and immunization to cover other areas.
- The gender of the doctor is important when it comes to the comfort level for women. If the doctor is a male, they are often uncomfortable consulting him with regard to personal gynecological problems. (The SHG women have asked for a lady gynecologist, whose salary they are willing to pay.)
- The equipment at the PHCs should be upgraded.
- The PHC timings should be extended.
- Information on HIV/AIDS should be widely disseminated.
- Infrastructure in terms of roads should be provided for the hamlets
- The government should provide essential basic medical facilities through the sub-centres.
- The RCH should be given more training, so that she is able to handle basic ailments since she is more accessible than the ANM.
- The PHC should provide medicines for most ailments. (For instance, it does not stock medicine for diabetes.)
- The doctor should prescribe medicines which would at least cost more than the bus fare. Otherwise it is a waste for the patient to travel all the distance and consult him.

Short- and long-term action

- Supply information on HIV, TB, hysterectomies and other immediate areas of concern. The information could also be uploaded at the internet hub at Addakal.
- Appoint a lady gynecologist.

- Information with regard government schemes to be shared with the community.
- Conduct eye and gynecological health camps.
- Train RCH to undertake more responsibilities. The SHGs should be persuaded to invest more in her as she takes on additional functions.
- Skill upgradation for RMPs.
- Initiate more women to participate in SHGs, since the SHG women have better access to healthcare and healthcare information. (See Appendix IV for some of the reasons which come in the way of women becoming SHG members.)
- Since the average household expenditure ranges from Rs 200-500, an insurance cover could be considered, with the premiums being collected by the SHGs.
- Chalk out a long-term health education strategy with the RCH, Janani teams, etc. The adolescent girl should receive focused attention in the health education programme.
- Inculcate health-seeking behaviour.
- Construct toilets and disseminate information on how to use them.
- Additional health camps to be planned with the community.
- Provide essential infrastructure.
- Include health education as a part of school syllabi. The adolescent girl/boy should receive basic education related to sex, personal hygiene, nutrition, etc.

Key observations of the study

- Members of joint families are better cared for when ill than nuclear families.
- SHG women are better informed about health matters and have better access to healthcare.
- The RCH is important for healthcare delivery and is more relied upon by the women.
- Women need to be educated about hysterectomies and make informed choices.
- There is a crying need among the women for information regarding health.
- Considerable expenditure is incurred on treating stomach pains. The causes need to be probed further.
- Only 2 out of the 15 villages surveyed had latrines. Sanitation and drinking water facilities need to be evaluated.
- Age of marriage plays an important role in the health of the woman.
- The general health behaviour is highly drug and doctor dependent. Injections and saline bottles are preferred to Oral Rehydration Solution (ORS) when it comes to diarrhoea!

CONCLUSION

Any approach tackling poverty has to be multisectoral. Health impacts livelihoods both in terms being a major component of household expenditure and in terms of loss of man days.

“The monthly average household income ...in the rural areas is (Rs.) 2445. 40% of the rural monthly household income is spent on health every month.” (Institute of Health Systems, 2001) While individual household expenditure on health has gone up, government spending on health has reduced. “A disturbing aspect of the impact of the Centre’s ‘adjustment programme’ is its targeting of the expenditure on public health care for achieving economies. The reduction in the expenditure on health programmes financed by the Centre starting with 2.5 per cent of the Gross Domestic Product (GDP) in 1991-92 went up to 4 per cent in 1996-97. ... Andhra Pradesh and Maharashtra, ever since 1987-88, continue to show a steady decline in the expenditure on health programmes as a percentage of their total expenditure.” (Gopalakrishnan, 2001)

Sustainable livelihoods programmes have necessarily to examine issues of health. Micro-level studies, as the present one, are necessary to understand how systemic and programming changes can be made relevant to specific contexts. In the case of the 15 villages, the findings confirmed many of the well-established facts, like the link between the age of marriage and a woman’s health, and also identified new areas of concern like the large number of hysterectomy operations being performed on women. The study reiterated that health-seeking behaviour is highly drug and injection dependent. It also revealed that social capital, in terms of the SHG network or the joint family, has a bearing on health, helping the individual to cope with shocks and stresses related to health. In addition, the study revealed that village-level personnel like the RCH or even the sarpanch can be a crucial link in the health delivery system.

REFERENCES

- Anne Tinker (1994) as quoted in PHNFLASH, issue 44, Nov. 7, Population, Health and Nutrition (PHN) Department, World Bank.
- Banjerji, Debbbar (1982) as quoted in Health Action, vol. 12, no.11, Nov.1999.
- Gopalakrishnan, C.V. (2001), Declining interest in healthcare, The Hindu, June 7, 2001.
- Hughes Gordon, Meghan Dunleavy and Kseniya Lvovsky (2001), Environmental Health in India: Priorities in Andhra Pradesh, World Bank.
- Institute of Health Systems (2001), Preliminary Findings of Andhra Pradesh Health Systems Responsiveness Study-2001, <http://www.ishnet.org>.
- Reddy, C. Rammanohar, ‘National Human Development’, The Hindu, April 27, 2002
- Reddy, M.M Krishna (2000), Health and Family Welfare: Public Policy and People’s Participation in India, Vedam Books, New Delhi, 2000.
- WHO, Women’s Health Status: Part I, http://w3.whosea.org/women/chap1_2.htm.

Appendix i: Vision 2020 Health Goals

By 2020, health indicators in the State will reach international levels. Population growth will stabilise, reaching sustainable levels and households in Andhra Pradesh will have smaller, better spaced families. An emphasis on disease prevention and control and on nutrition, sanitation, personal hygiene and fitness will sustain high levels of health in the State.

Andhra Pradesh's people will have access to responsive basic healthcare services. The poor and vulnerable groups will enjoy free healthcare, both basic and specialised; other sections of the population will have access to these services through health insurance. Today's major health burdens will have disappeared. Pregnancies will be safe and infants will no longer die of easily curable ailments like diarrhoea or acute respiratory infection, even in remote villages. Malnutrition will have been eliminated. Major diseases like tuberculosis and malaria will have been contained and emerging diseases like AIDS and cancer successfully prevented.

This vision will translate into the following key health and development indicators by 2020: infant and child mortality rates of 10 per 1,000 (live births) and 20 per 1,000 respectively; life expectancy of 68.1 years for men and 70.6 years for women; a total fertility rate of 1.5 (average number of children per woman) and population growth of 0.8 per cent a year.

This vision is bold and demanding, particularly in the context of current health levels in the State. However, with a comprehensive plan to provide both curative and preventive healthcare to all its people, Andhra Pradesh can certainly realise it. To successfully do so, the State will focus on the following key priorities:

- Providing universal access to primary healthcare.
- Encouraging private investment in tertiary healthcare.
- Focusing on specific programmes to promote family welfare, particularly the health of women and children, and family planning.
- Focusing on improving health levels in disadvantaged groups and backward regions.
- Ensuring a strong prevention focus.
- Enhancing the performance of the public health system.
- Formulating a State IEC (Information, Education and Communication) programme, which includes leveraging the electronic media.

Appendix ii: A tabulation of the hysterectomy cases in Vemula village

S.No.	Name	Age	Reason & year of removal	Govt./Pvt.	Expenses(in Rs.)
1.	B alamamma	40	White discharge(3 months ago)	Pvt	10,000
2.	V enkatamma	50	White discharge(1 year ago)	Pvt	10,000
3.	L axmamma	25	White discharge(1 year ago)	Pvt	10,000
4.	T hikka Laxmamma	35	White discharge(3 years ago)	Pvt	10,000
5.	P illy Kandla Sayamma	30	White discharge(1 year ago)	Pvt	11,000
6.	N agamma	40	White discharge(1 year ago)	Pvt	11,000
7.	S ara Venkatamma	50	White discharge(3 years ago)	Pvt	10,000
8.	R amulamma	25	White discharge(1 month ago)	Pvt	10,000
9.	K amamma	40	Stomach pain & white discharge (6 years ago)	Pvt.	20,000
10.	S atamma	25	Uterus problem(3 years ago)	Pvt.	3,000
11.	J ayamma	40	White discharge(1 year ago)	Pvt.	20,000
12.	A njamma	30	White discharge	Pvt.	10,000
13.	T hirupamma	40	Some problem linked to the kidney	Pvt.	10,000
14.	A njamma	36	White discharge(1 year ago)	Pvt.	20,000
15.	L akshamma	35	White discharge(2 years ago)	Pvt.	10,000
16.	Golla Ashamma	32	White discharge(1 year ago)	Pvt.	10,000
17.	Sara Santhamma	30	White discharge(2 months ago)	Pvt	10,000
18.	S ayamma	30	White discharge(1 year ago)	Pvt	10,000
19.	Alampally Ayamma	30	White discharge(2 years ago)	Pvt	10,000
20.	K urma Chandamma		Uterus prolapse(3 years ago)	Pvt.	10,000
21.	M anikyamma	32	White discharge(1 year ago)	Pvt	10,000
22.	P ollam Laxamma	30	White discharge	Pvt	10,000
23.	C henna Sayamma	35	White discharge	Pvt	10,000
24.	Vadla Padma	40	Continuous bleeding & White discharge	Pvt	10,000
25.	Thatti Konda Laxamma	20	White discharge(1 year ago)	Pvt	10,000
26.	M alamma	20	Uterine cancer(uterus yet to be removed)	Govt.	6,000
27.	Nirmala	20	Uterine cancer(uterus yet to be removed)	Pvt	10,000

28.	Pedda Balamma	26	Uterus problem, excessive bleeding & White discharge since 3 months (uterus to be removed)	Pvt	300
29.	C hennamma	35	Failure of family planning & white discharge (1 month ago)	Pvt.	10,000
30.	Kumari Manemma	30	Stomach pain & white discharge (1 year ago)	Govt.	7,500
31.	Anj amma	25	White discharge(1 year ago)	Pvt.	6,000
32.	L axmamma	40	White discharge(3 years ago)	Govt.in Hyd.	4,500
33.	Y aata Seethamma	35	Stomach pain(5 years ago)	Pvt.	10,000
34.	M anikyamma	45	Failure of family planning operation (7 years ago)	Pvt.	10,000
35.	V enkatamma	30	White discharge(1 year ago)	Pvt.	15,000
36.	Sara Venkatamma	35	White discharge(1 year ago)	Pvt.	10,000
37.	Amrutha	30	White discharge & uterus problem	Govt.	300
378.	Aradi Karre bakkamma	35	White discharge(2 years ago)	Pvt	10,000
389.	Narmada	28	Linked to appendicitis (2 years ago)	Pvt	15,000
3940.	L akshamma	35	Continuous bleeding & White discharge	Pvt.	15,000
401.	L akshmma	40	Uterine cancer	Pvt.	12,000
412.	Chandrakala	35	White discharge & burning sensation when passing urine (6 years ago)	Pvt.	8,000
423.	M anikayamma	31	Failure of family planning operation (3 years ago)	Pvt.	10,000
43.4.	J anakamma	45	Continuous bleeding & white discharge (10 years ago. Costs quoted include post-operative medication costs.)	Pvt.	15,000
44.5.	M aneamma	40	Urinary problem, weakness and digestion problems	Pvt.	10,000
456.	G ovindamma	30	White discharge & bleeding (3 years ago)	Pvt.	10,000
467.	N arayanamma	30	White discharge & bleeding (1 year ago)	Govt.	8,000
478.	Padma	30	White discharge & bleeding (7 years ago; continues to take medication)	Pvt	18,000

Appendix iii: List of public/private health facilities and service personnel in the study villages

Village	Pop	Distance from PHC	Private Service Provider	Public Service Provider	Private Facility	Public Facility
1. Nizalapur	2000	12 km from Addakal; PHC 4 km from Janampet PHC	Dr Satyanarayana (MBBS)	Mrs Nagavathamma (ANM) Mrs Bhagvathi (RCH)	Private clinic	
2. Shakapur	2400	3 km from Addakal ;8 km from Janampet	Mrs Sashikala (RCH)		Sub centre	
3. Kommreddy pally	1889	8 km from Addakal;3 km from Janampet		Mrs Jayasheela (ANM) Mrs Sunitha (RCH)		Sub centre
4. Gudibanda	1964	13 km from Addakal;12 km from Janampet	Mr Shaikbal (RMP)	Mrs Parvathi (RCH)		Sub-centre
5. Shakarapur		14 km from Addakal;3 km from Janampet		Mrs Shantamma (ANM) Mrs Laxmi (RCH)		
5. Kandhur	8000	9 km from Addakal;9 km from Janampet	Mr Ramu (RMP) Mr Venkataswamy (RMP) Mr Rasheed (RMP) Mr Shankar (RMP)	Mrs Balamani (ANM) Mrs Lalithamma (RCH)		Sub-centre
6. Musapet	800	8 km from Addakal;3 km from Janampet	Dr Ramachandriah (MBBS)(RMP)	Mrs Nagarathamma (ANM) Mrs Sujatha (RCH)	Private Hospital	Sub-centre
7. Rachala	5500	11 km from Addakal;11 km from Janampet	Dr Vijaybhaskhar (RMP) Dr Venkatswamy (RMP)	Mrs Nirajamma (ANM) Mrs Jayalaxmi (RCH)		Sub-centre
8. Timmapur	1050	18 km from Addakal;5 km from Janampet		Mrs. Chenamma (RCH)		
9. Nandipet	4000	10 km from Addakal;12 km from Janampet	Mr Ramesh (RMP)	Mrs Nirajamma (ANM) Mrs Amani (RCH)		
10. Polkampally	2500	16 km from Addakal;2 km from Janampet	Dr Bhrmachary (RMP)	Mrs Chandrakala (ANM) Mrs Subhadaramma (RCH)		Sub centre
11. Ponakal	5000	6km from Addakal 8 km from Janampet	Mr MD Haseen (RMP) Mr Waheed (RMP)	Mrs Jayashree (ANM)		
13. Janampet	4600	PHC	Mr Satyanarayana (RMP) Mr MD Gaffar (RMP)			PHC
14. Dasarapally	1055	9 km from Janampet				
15. Tunkinpur	1000	6 km from Janampet				

Appendix iv: Some reasons why the women do not join the SHG

During the health survey, both the SHG and the non-SHG women were interviewed to understand the role the SHG had played in their lives when it came to health issues. The interviews gave some indication as to the reasons why some women do not join the SHG. The reasons include the following:

- Husbands do not permit them.
- Lack of money
- Inability to pay their contribution on time
- Lack of communication skills
- Inefficient group leader
- Lack of trust in the group leader
- Migration outside the village
- Lack of time to attend to meetings because they are busy with agricultural work.

1. Gynaecological
2. TB
3. Leprosy
4. Stomach pain
5. Respiratory
6. Epilepsy
7. Paralysis
8. Others: eye/joint pain/skin ailments/

differently-

abled/mental

illness/ retardation/

cancer/

heart ailments/

kidney ailments/HIV



Andhra Pradesh Rural Livelihoods Programme

(Government of Andhra Pradesh)

AMR - Academy of Rural Development

Rajendranagar, Hyderabad - 500 030. India.

Ph: +91-40-2400 1953, 2400 1954 Telefax: +91-40-2401 8773

E-mail: psu@aprlp.org URL: www.aplivelink.org