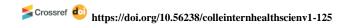# International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

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ABSTRACT
The international cooperation for development system traces its origins from the end of World War II. Currently, it does not revolve exclusively around developed states as principal actors. On the contrary, it possesses a pluralistic and decentralized characteristic, different of what used to dominate between the 50s and the 60s. In this context, this article aims to recognize and highlight the role played by non-governmental development organizations in international cooperation. It was developed from a qualitative approach using bibliographic-documentary review procedures. The case study method was utilized as its research method, basing on the experience of an organization that operates in two impoverished areas of southern India, the Vicente Ferrer Foundation.

Keywords: Cooperation For Development, Covid-19, Health Crisis, Humanitarian Aid, Anantapur.

1 INTRODUCTION

Currently, the international cooperation and development aid system does not exclusively revolve around developed states as principal actors. On the contrary, it possesses a pluralistic and decentralized characteristic, different of what used to dominate between the 50s and the 60s. With the process of globalization, Sanahuja (2021) argues that the structure of international cooperation has experienced changes with reference to its state-centric character. Now, it has a wide array of factors (a multicentric system), such as various international organizations and agencies, governments, public institutions, non-governmental development organizations (NGDOs), private companies, and other civil society entities.

As a response to the centrality of the state in the Official Development Assistance (ODA) (centralized and vertical approach), the decentralized international cooperation model emerged in the beginning of the 90s—a recognized form of cooperation that is being consolidated and maintained in todays' status quo.

Decentralized cooperation can be understood through two main ideas. First, it represents the inclusion of new actors to the cooperation agenda. And second, it represents an activity executed by local, autonomous and regional institutions, and civil society organizations that want a direct form of contact with

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1564

the foreign world. Gómez Gil (2021) points out that this method has a relevant role as *"an instrument to legitimize democracy in human rights monitoring, environmental sustainability actions, and the promotion of real equality between men and women."* (p. 5).

During the movement to decentralize and strengthen non-governmental organizations (NGOs) as relevant development actors—changing its passive role to a more active one—the *Fundación Vicente Ferrer* (FVF) emerged. The FVF, an NGDO with headquarters in Barcelona, Spain, is committed to the process of transforming two impoverished regions in the south of India since 1969: the states of Andhra Pradesh and Telangana, as well as the most excluded communities within the Hindu caste system. The organization works in partnership with its local counterpart, the Rural Development Trust (RDT), located in the Anantapur district in the Andhra Pradesh state. Both offices have grown since their creation in conducting joint actions and international development cooperation projects.

Through an integral and multidimensional development program made up of six sectors—health, education, women, people with disabilities, habitat, and ecology—the FVF has provided concrete solutions, stemmed in the philosophy of action, to eradicate poverty in the most vulnerable communities in India. Apart from these areas of concern, the entity also has an extensive experience in the field of humanitarian intervention and emergencies.

Since the end of 2019, the world has been facing the wrath of the Covid-19 pandemic which had a high destabilizing potential. It also caused health and humanitarian crises, claiming millions of lives and causing worldwide disruption. There is no doubt that these developing countries were the most affected by this disease as they have been previously challenged by inequality, poverty, and deficient public services and institutions. This crisis led them to suffer acute health, economic and humanitarian collapse since the pandemic erupted.

As such, the most vulnerable and historically discriminated groups—such as women, ethnic groups, low members of the caste, and the economically disadvantaged population—were disproportionately subjected to the impacts of the health crisis. India, a highly unequal country, fits in this context, with a health system considered to be one of the most precarious in the world.

The challenges confronted by the Indian health care system are very complex. The lack of medication and essential services, and above all, qualified frontline workers, are some of the problems that have been felt strongly, and at the same time have generated frustration among the population with no access to medical treatments. This scenario has been further accentuated by the arrival of the pandemic in the most vulnerable and remote communities of the country—a situation that has made international cooperation in these areas essential.

The FVF, in collaboration with its local counterpart, launched an emergency campaign called "Oxygen for India" in response to the rapid increase of severe Covid-19 infections and the lack of medical oxygen (an essential resource both in the first and second waves) in its hospital network in Anantapur. Through this initiative, the NGDO sought to provide an effective and efficient response to the oxygen crisis,

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1565

with the aim of guaranteeing adequate medical attention to Covid-19 patients in the Bathalapalli Hospital, which belongs to its health care network.

The campaign mainly centered on the purchase of oxygen generators and concentrators, as well as other supplies. To raise funds for the acquisition of these equipment and other medical supplies, the FVF implemented a strategy based on two major emergency projects. Both projects—and the emergency response undertaken—are backed by the need for and importance of medical oxygen, and other oxygen therapy supplies to address this global health crisis.

2 INDIA AND ITS HEALTH CARE SYSTEM

Halfway through the 20th century, specifically in the beginnings of 1947, India succeeded in adopting the structure of a sovereign state. Since then, the country has been characterized as an underdeveloped nation with extreme internal situations (inequality, poverty and various diseases), ethnic/religious conflicts, and limited capacity to influence the international system. Nonetheless, over the years, especially since the 90s, the way in which the country is observed has changed, mainly because of its actual economic, political, and military affairs at the global level (Pasquale, 2006).

Aside from the state being able to achieve huge advancements in relation to its political institutions, India was also able to progress economically through its own, powerful, bold and flexible manner (Alcalde, 2016), thus obtaining very high economic growth rates, surpassed only by China. This event has led to the country gaining greater visibility (openness to the world) and relevance to the international stage in the recent times. It made it easier for India to propose political and economic interests, as well as it permitted the country to adopt to the dynamics of a globalized world and the challenges of the 21st century.

Today, the country is considered an emerging power due to the number of population, and economic, military and political resources it possesses. During the course of time, it positioned itself as a state with regional and global capacities to contribute to the international order (Barrera, 2019). However, despite its important economic growth, technological competence and nuclear status, India still remains glued to some qualities of an underdeveloped nation (Alcalde, 2016). Distinct structural contrasts, contradictions and issues that exist in this country (subsistence economy, faulty infrastructure, declining urban and rural sectors, etc.) challenge the stability of progress. Hence, India, with the second most dynamic growth in the world until 2013, is also an economy with a medium human development index (HDI) (Silva, 2013)[1].

With regard to its health care system, the country has some differences relative to the quality among the urban centers and rural areas, as well as between public and private health care. Even though the government oversees policy formation, medical education and health programs, the provision of public health care is the responsibility of state governments which decide the implementation of the initiatives of the health sector (Gudlavalleti et al., 2018).

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[1] The HDI in India was 0.645 points according to the 2020 HDI report.

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1566

India has universal health care, and it is estimated that 90% of its citizens depend on public hospitals. But, the system being public and universal in nature has aspects that undermine it mainly because of the prevalence of gaps in the services offered based on gender, social class and geography. In structural terms, the Indian health care system is composed of three levels: the primary, secondary and tertiary, and is divided to public and private (Government of India, 2011).

According to the Indian Public Health Standards, primary health care attention is offered to rural communities through a sub center, primary health center and community health center. The secondary level is provided through the district and sub district hospitals. As for the tertiary level, services are extended to regional institutions, and specialty hospitals and/or medical centers (National Health Mission, 2019).

As stated by Ramani et al, (2019), the Indian public health system has been historically subjected to wide financial cuts, considering the expenditure in this field as one of the world's lowest. This dilemma prevented the system to continually progress in terms of development and infrastructure improvement— which remained very low. And as a consequence claimed by the authors, "primary health care centers focus largely on national (and international) priority programs at a given time, and work in a generally underfunded health system" (p. 8).

Looking through the Indian public health care expenditure in numbers, between 2000 and 2019, the average during that period was 3.58% of the gross domestic product (GDP) with 2.94% as the minimum in 2017 and maximum of 4.26% of the GDP in 2011. For 2019, the expenditure was established at 3% of the total of the country's GDP. (Knoema, 2019). The private sector, on the other hand, represents more than 70% of the total expenditure; while the public is only registered at 27.94%—a situation which has an important relevance to the Indian health system, making the country depend to the private sector on a large-scale basis (Casado, 2020).

Notwithstanding the fact that the Indian government has strived to improve health care access in all territorial levels[2], a structural deficit remains to exist—coupled with the lack of infrastructure, shortages of efficient labor, and uncontrollable patient burden—which prevents the system to fully reach the ends of the community. Other factors like the country's population, and the caste system which continues to discriminate the majority of the citizenry, also influence this problem. Therefore, a lot of people in the present day have difficulty accessing adequate medical attention, primarily in rural areas, which is attributed to the lack of medical professionals, apart from the aforementioned.

According to the data provided by the National Health Profile (Government of India, 2019), an Indian health information database, the number of qualified and recognized doctors (allopathic), registered under the state medical board were 43,581 and 41,371, for 2017 and 2018 respectively. In the same period, an average of 10,926 patients were attended by each government-licensed doctor (p. 220).

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[2] According to Ramani et al. (2019), since its independence, India has achieved tremendous progress in the improvement of health and well-being of its citizens. For example, its life expectancy increased from 44 to 69.42 years.

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1567

3 THE HEALTH CARE NETWORK OF THE *FUNDACIÓN VICENTE FERRER* AND RURAL DEVELOPMENT TRUST

Committed to the mission of guaranteeing access to health care as a human right, the FVF and its counterpart RDT implemented a health program (health network) to the most vulnerable populations of the rural areas of the Anantapur district—a district with a population of 4,083,315 according to the 2011 census (Government of Andhra Pradesh, 2022).

Through this initiative of more than 50 years, both organizations seek to strengthen and complement the shortcomings of India's public health care. They also coordinate, align, and collaborate with the government-run system with the goal of maximizing efforts in favor of public health policies (Aguiló, 2021). The FVF and RDT health program is organized into two main branches: the community health network and the hospital network (RDT, 2020b).

- **Community health network:** Health workers from their own community, rural nurses, rural clinics that provide coverage to the most disadvantaged areas, school doctors, HIV/AIDS counselors who conduct home care, and awareness and prevention campaigns. This network also supervises the following programs: early intervention/detection services, health education, nutrition programs for women and children ages 0 to 6, the elderly, and persons with chronic diseases.

- **Hospital network:** This network has three hospitals: Bathalapalli Hospital, Kalyandurg Hospital and Kanekal Hospital.

According to the 2020 FVF annual report, 554,088 consultations were accommodated in the hospital network and rural clinics during said year (FVF, 2021e). In terms of the number of professionals that make up the network, present-day data show that there are 220 professionals, 70 of which are medical doctors while 150 are nurses.

About the Bathalapalli Hospital: The Bathalapalli Hospital Complex, or simply, Bathalapalli Hospital, was inaugurated on December 30, 2000 in the town of Bathalapalli, located in Anantapur, Andhra Pradesh. Out of the three medical centers of the FVF and RDT, this is the biggest and the most complete with estimated 3,500 patients being attended to every day (RDT, 2020a).

Until 2020, it had a 340-bed capacity with general medicine; anesthetics; general surgery; pediatric and neonatal care; obstetrics and gynecology; infectious disease prevention; orthopedics and traumatology; microbiology; pathology; hematology and biochemistry laboratories; intensive care units (ICUs); 24-hour emergency; central pharmacy; and blood bank services (FVF, 2020).

Since its foundation 21 years ago, this hospital has promoted a public health system committed to the environment, which indeed recognizes the relationship between human health and the earth's natural surroundings. Its management and administration seek to ensure health equity, together with the promotion of environmental sustainability—a principal worry in serving the local needs (RDT, 2020a).

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1568

4 THE EVOLUTION OF THE PANDEMIC IN INDIA

The first months of the pandemic in India did not have a strong impact to the population. However, the impact progressed widely and placed the country as the second in the world with the greatest number of positive cases at the start of July 2020 (BBC News, 2020). During the same period—when the country was under a strict lockdown—the number of infected cases rose to more than five million, with more than 80,000 dead (The Times of India, 2022). To overturn the economic collapse experienced in India, different quarantine guidelines were established starting June 2020. Yet, these measures were not consistent with the rising rate of Covid-19 infections, hospitalizations and deaths collectively.

India experienced the first Covid-19 wave between July and November 2020, with its peak in September, amounting to 98,000 new daily cases and 1,300 deaths per day. This record put the country, in various occasions, at the top of the worldwide Covid-19 tally, with the United States and Brazil behind (France 24, 2021b). After the first wave, stability returned temporarily which led many to think of the virus' inability to continue spreading. By then, there were talks about how heard immunity could be achieved. Together with the advancement of the nation's vaccination campaign, it pushed the authorities to relax the existing health measures.

Nonetheless, India suffered the second wave by mid-March 2021 with the unprecedented spike of positive cases, reaching record-breaking 392,488 infections and 3,689 deaths daily. The rapid transmission of the virus in the country happened in a matter of weeks. In February 2021, India registered less than 10,000 daily cases, a fairly minimum number since the start of the crisis which generated false hopes that India had supposedly overcome the pandemic. During the height of cases in the following month, the country informed the existence of a double mutation Covid-19 variant which resulted in 350,000 daily infections, as well as foreign variants such as the British and the South African ones (France 24, 2021a).

Before the start of the second wave, Indian health minister Harsh Vardhan affirmed that India was already reaching the end of the pandemic. These remarks rationalized the government's decision to export medical equipment to other countries (Hindustan Times, 2021). However, India went through its most complicated weeks after the virus' atrocious spread caused a collapse within the health care system everywhere in the country: unavailability of beds, saturated ICUs, and shortages of essential supplies in the fight against the virus such as oxygen.

In view of the critical situation in the country by the end of April 2021, WHO Director for Europe, Hans Henri P. Kluge, called for European countries to help India with "all the ways they could," as it was experiencing its worst moment in the pandemic (RTVE, 2021).

India has been gravely affected by the pandemic, a situation that exacerbated existing issues of inequality (France 24, 2022). As such, the health crisis and the national containment measures have had a considerable impact on the population, particularly the most vulnerable social groups—such as women and young members of the most disadvantaged caste levels, informal workers, or religious minorities. This, in turn, has caused even more poverty and inequality in these historically disadvantaged groups (Kutlu, 2021).

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1569

5 THE FVF AND RDT HEALTH NETWORK, AND THE PANDEMIC

To manage the first wave of the pandemic in March 2020, the Andhra Pradesh state government (the eighth biggest state in   terms of area and home to more than 50 million inhabitants)—aware of limited resources—elaborated a plan with measures to combat the pandemic. As the main action, the priorities and functionalities of the health care system was reoriented and a list of free designated treatment centers for virus carriers. Likewise, 138 hospitals were designated: 60 public, while 78 private, including the Bathalapalli Hospital by the FVF.

In April 2020, the authorities required the Bathalapalli Hospital to be converted as a Covid-19 reference center for the Anantapur district, with its own microbiology laboratory to be authorized as one of Covid-19 diagnostic and testing centers. The transition had to be fast, with an exponential increase of hospital beds from 40 to 400 in May.

Nevertheless, in spite of the availability of beds in the center, they were not on par with the respective health standards against the Covid-19. Given that, it was necessary to expand the space area and reduce the number of beds according to available rooms. Moreover, as the patient profile was changing and the pandemic continuing, the authorities were referring the most critical cases to the Bathalapalli Hospital because of the hospital's improved facilities (FVF, 2021a).

These demanding changes, according to the FVF, forced to restructure the health network to be able to fulfill its remaining services (FVF, 2021a). Through this, for example, the gynecology and obstetrics department was transferred to an RDT campus in Anantapur which was previously used in family planning programs. On the other hand, the infectious diseases department of the hospital was able to continue functioning as a reference center.

The situation was critical in Anantapur—during the first wave between July and November 2020—not only because of the difficulties accommodating all people with Covid-19, but also because of the lack of resources to attend to other ailments and diseases. Another factor includes a high number of people left in their homes unable to be admitted to hospitals, either because of difficulties in travel, ignorance of the subject or simply because of fear (FVF, 2021a).

As the Bathalapalli Hospital entered the month of November 2020, 6,000 persons were taken care of, holding the highest survival rate of 75% (FVF, 2021c). Afterwards, between the months of December 2020 and March 2021, the situation was contained— relatively calmer—a potential hint of what could progress in the following months, as the FVF reported. In this context, the discussions during that time revolved around what India would and could have had: with numbers being higher than officially recorded in the first wave, as well as the possibility of the country attaining "herd immunity" being considered (ABC, 2021); this, while the experts expected a second wave, more or less intense.

The first wave taught valuable lessons and pushed health care professionals to strive more to be able to improve their response to the expected rise of cases in the future. During that time, the FVF and RDT restructured their plan of action to further upgrade the services offered by the Bathalapalli Hospital in the

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International Development And Health: The Case Of A Development NGO In The Fight Against The
Covid-19 Pandemic In Andhra Pradesh, India

1570

hopes of delivering a more effective action against the threat of a new wave in the district of Anantapur (FVF, 2021b).

And as the second wave of the Covid-19 pandemic hit mid-March of 2021, positive cases started to rise in the country, with even faster rates recorded in the Bathalapalli Hospital (FVF, 2021a). To combat this situation, the said health center was directed to exclusively attend to Covid-19 patients, following the established plan of action, as well as the general plan for the Anantapur district managed by and in collaboration with the local government (FVF, 2021a).

The exponential rise of cases in India caused by the second wave produced grave consequences. The lack of essential medical equipment was seen, alongside to a major death surge, especially in the young population (Dey, 2021). Furthermore, the country showed various cases of mucormycosis, commonly known as black fungus, among Covid-19 positive diabetic patients, and even those in recovery, too (Asrani et al., 2021).

Due to the acceleration of cases, the second wave became more aggressive than the first one in the country (Oaten, 2021). This, in effect, downsized all means and resources—previously revamped, both in the public and private systems in Anantapur—needed to address a wave with similar characteristics as the first one in just a matter of weeks (FVF, 2021a).

According to the topology of the patients that were attended to by the medical personnel of the Bathalapalli Hospital during that period, the FVF and RDT alerted that the second wave was more virulent than the first one (FVF, 2021a). Not only did the center receive a huge number of patients, but these patients came with respiratory failure (very low levels of oxygen) urgently requiring oxygen for their treatment—a medical resource that was short in supply in the country during the second wave. According to Dey (2021) of the Times of India on April 20, 2021, based on an analysis of hospitalized patients with Covid-19 conducted by the Indian Council of Medical Research, 47.50% of patients presented shortness of breath during the second wave, compared to 41.70% on the first, which explains the increase in the demand for medical oxygen.

6 OXYGEN CRISIS IN INDIA

Medical oxygen became the top necessity to confront the health crisis, both in the first and second waves. However, due to the limited capacity of the Indian health care system, resources such as liquid oxygen, oxygen tanks and oxygen concentrators were not sufficient to handle the emergency.

By not having the systems to produce or store oxygen, the effects of the scarcity of oxygen in India were experienced first-hand in the hospitals of the country's biggest cities, like in the case of the prestigious Jaipur Golden Hospital in Delhi in the north (Gettlemean et al., 2021). Nonetheless, what they have referred to the shortage of this resource—that is the oxygen crisis—extended to the rest of the nation, reaching, for example, the state of Andhra Pradesh, in the south, between April and May 2021 when the second wave hit its peak.

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1571

As a consequence, medical oxygen became fundamental in all hospitals in India, including those of the FVF and RDT hospital network. As reported by the United Nations (2022), only a handful of hospitals in this country possesses the necessary and adequate installations to produce oxygen locally, while the rest of the centers depend on private companies.

The lack of the said material during the second wave greatly increased deaths caused by oxygen insufficiency, and collapsed hospitals on a national level. Additionally, this situation worsened public despair which sparked alternatives in response to the crisis. For example, the public had to create face masks out of plastic bottles or even resorted in buying oxygen illegally. State governments also started to brawl among them for the sake of oxygen, while some seized tankers carrying the product, causing bottlenecks and delays (Gettleman et al., 2021).

7 THE NEED FOR OXYGEN AT THE BATHALAPALLI HOSPITAL

As aforementioned, the Bathalapalli Hospital was converted into a reference center and directed to serve exclusively to Covid-19 patients in April 2021. Out of all the beds made available in the center, only 213 were equipped with oxygen, while having only one liquid oxygen tank that was recharged every 12 or 15 days in a normal situation (FVF, 2021d). However, with the rise of patients that needed this supply, RDT reported that they had to recharge the deposit every other day or every day on some occasions.

The situation became delicate during the course of the second wave as oxygen demands had grown too much in the area, causing widespread shortages. In addition, because of the decentralized competencies in the fight against the pandemic, states prioritized oxygen supply within their own borders, which complicated the situation of the FVF and RDT hospital since the main oxygen supplier to the Bathalapalli Hospital is located in the capital of Karnataka, a neighboring state (FVF, 2021d).

The RDT designed an emergency plan which outsourced external support to secure the supply of oxygen in the Bathalapalli Hospital since the oxygen did not reach the region.[3] Through this initiative, it was expected to diversify the sources of the said gas, as well as secure the reserve and supplies. The actions undertaken sought to acquire a medical oxygen generator with a capacity of 500 L/min; other materials such as refillable 50 L oxygen tanks, nebulizer masks, valves, flow meters, 20 cm adult curved cannula and oxygen concentrators; to help patients who require high oxygen concentration (FVF, 2021d).

Indeed, the Bathalapalli Hospital was expected to offer adequate oxygen therapy to the most affected patients by the pandemic through the acquisition and launch of an oxygen generator, and the purchase of oxygen tanks and concentrators and other supplies. However, according to the FVF, the procurement of these products in India was difficult caused by high demands and the situation of the country.

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[3] Through various ways: businesses, public administration and the private sector.

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1572

8 THE FVF AND RDT'S RESPONSE TO THE IMPACT OF THE SECOND WAVE OF THE PANDEMIC IN ANANTAPUR: "OXYGEN FOR INDIA" CAMPAIGN

In the face of the health crisis and the lack of oxygen (as well as other supplies), the FVF launched an emergency campaign called "Oxygen for India" at the end of April 2021. In virtue of this initiative, the NGDO sought to provide an effective and efficient response to the oxygen crisis, with the purpose of ensuring adequate medical care for Covid-19 patients at the Bathalapalli Hospital. The campaign mainly focused the acquisition of oxygen generators and concentrators. To raise funds to procure these equipment and other medical supplies, the FVF's strategy was spread to two main emergency projects.

In both cases, the projects were referred to as the "Acquisition of oxygen therapy resources and appropriate medical care for COVID-19 patients at the Bathalapalli Hospital." Nonetheless, what differentiates them are the acquisitions that are proposed and the number of financiers.

In terms of the direct target population of the two projects, the citizens in the rural areas of Bathalapalli, B.K. Samudram, and Kadiri regions located in the Anantapur district were established. Those part of non-caste groups, tribes, lower levels of the caste system, and the disadvantaged with low literacy level and low financial resources, benefit from the services offered by the Bathalapalli Hospital. As a whole, the population of these municipalities amounts to 6,500,000 people (3,380,000 women and 3,120,000 men) (FVF, 2021d).

Facilitating access to oxygen - Project I

As part of the "Oxygen for India" campaign undertaken by the FVF, this project corresponds to the largest project implemented during the second wave of the pandemic (FVF, 2021f). This initiative had a total cost of €268,151.90 and was set to be implemented in five months, between May and October 2021.

This Project was co-funded by the following 17 entities: *Ayuntamiento de Utrera, Gobierno de Aragón, Ayuntamiento de Málaga, Ayuntamiento de Alcobendas, Fons Pitiús de Cooperació, Ayuntamiento de Terrassa, Diputación de Valladolid, Ayuntamiento de Sant Cugat del Vallès, Universitat Rovira i Virgili, Ayuntamiento de Sant Quirze del Vallès, Ayuntamiento d'Igualada, Ayuntamiento de Callella, Diputación de Castellón, Ayuntamiento de Hondarribia, Ayuntamiento de Getxo, Ayuntamiento de Berrioplano,* and the *Ayuntamiento de Morella.*

In general, the project was advocated for the needs and importance of medical oxygen, and other oxygen therapy supplies in response to the global health crisis. Its objective was to save lives through the procurement of oxygen therapy resources, including other supplies, to the Bathalapalli Hospital in Anantapur. The following equipment were supplied: 50 L oxygen tanks, pallet cages, flow meters, Smarty 10 L/min oxygen concentrators, KSOC 10 L/min oxygen concentrators, Philips Everflo 5 L/min oxygen concentrators, nebulizer masks, aerosol inhalers, and 20 cm adult curved cannula.

Due to the dangerous implications of the second wave in the Anantapur district, as well as the difficulty of obtaining stocks rapidly, an emergency intervention by the FVF was necessary to safeguard

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1573

the provision of oxygen supplies in the hospital network. In this context, the NGDO saw the necessity to change its strategical actions against the crisis and urgently bought oxygen therapy supplies that were available in Spanish territory to later send them to Anantapur by air. The aforementioned health materials were acquired as the foundation secured funding from the donors.

In collaboration with Open Arms and other entities, the FVF facilitated the first humanitarian aid flight to India on May 7, 2021. The aircraft transported an oxygen concentrator, empty oxygen cylinders, 144 50 L oxygen tanks, nebulizer masks, personal protective equipment, valves, flow meters and other materials.

Subsequently, the second flight carrying an oxygen generator (OxyMat O330 ECOV3 Capac.25 SM3/H), 37 10 L/min oxygen concentrators (18 Smarty y 19 KSOC concentrators) and 137 5 L/min Philips Everflo concentrators). On the following days, May 30-31 and June 1, 2021, three other flights were sent to transport more medical equipment. The arrival of medical supplies transported in these first two humanitarian flights sought to increase the supply of oxygen in the Bathalapalli Hospital.

In relation to the results obtained in this project, it achieved the procurement of oxygen therapy equipment and supplies to reinforce the capacity of the Bathalapalli Hospital with its expected 100% success rate (FVF, 2021f). That being the case, thanks to the acquisition of various medical apparatus carried by the aforementioned humanitarian aid flights—the efficiency of the Bathalapalli Hospital was improved during the second wave of the pandemic. In turn, this made it possible to provide a more effective and efficient response to the health emergency faced in the district of Anantapur.

Facilitating access to oxygen - Project II

The purchase of oxygen generators was the principal objective of this project, whose initiative was participated by the *Conselleria de Participación, Transparencia, Cooperación y Calidad Democrática* of the *Generalitat Valenciana* and *Ayuntamiento de Castellón de la Plana* through the del *Comité Permanente de Ayuda Humanitaria y de Emergencia* (CAHE) of the Valencian Community. In both cases, the initiatives were established in five months from August 1 until December 31, 2021 (FVF, 2021g).

Initially, the project had a cost of €420,345.82—€250,000.00 of which correspond to the support requested from the *Generalitat Valenciana,* and €170,345.82 by the FVF and RDT. In the monetary aid requested from the *Generalitat Valenciana,* €186,232.56 were directed to the procurement of an oxygen generator, the Airsep 500 L/min generator, while €63,767.44 were used to fill in the salary of Bathalapalli Hospital's personnel. The contribution made by the FVF and RDT was also used to pay the hospital staff.

The implementation of this intervention, as planned, the purchase of the Airsep 500 L/min generator pushed through. The initial cost was ₹16,016,000.00 (€186,232.56). However, during the second wave, the Indian government promoted a tax emption when buying equipment intended for pandemic use. Hence, the final price of the said equipment amounted to ₹15,015,000.00 (€174,593.02) and left an extra ₹1,001,000.00 (€11,639.54) (FVF, 2021g).

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1574

At this time, RDT health care personnel classified a diagnostic Covid-19 equipment (Genexpert IV/4 10C with Laptop, also capable of diagnosing other infectious diseases such as tuberculosis) which is used to conduct testing within the district and hospital staff. The acquisition of this apparatus aimed to reduce the community transmission in the area coverage of the Bathalapalli Hospital, as well as prevent the infection within heath care workers. This purchase would cost ₹1,781,542.76 (€20,715.61).

In relation to this, the FVF made a new proposal and appealed to the *Conselleria de Participación, Transparencia, Cooperación y Calidad Democrática* of the *Generalitat Valenciana* (Registration no. GVRTE/2021/3190338, December 17, 2021) a substantial modification of the budget which was already approved in a resolution on August 31, 2021 (Generalitat Valenciana, 2021). Through this change, the new proposal consisted of using the remainder of €11,639.54 to support part of the purchase of the Genexpert IV/4 10C with Laptop, an equipment to be used for the same purpose of the project. After the adjustment, the total budget was updated with a slight increase from €420,345.81 to €429,421.89.

In the course of these events, the *Ayuntamiento de Castellón de la Plana*—which has already shown interest in the call of the CAHE of the *Generalitat Valenciana* in the participation of emergency projects by the FVF—informed on December 14, 2021, through their *Departamento de Cooperación al Desarrollo y Solidaridad*, the concession of the subsidy requested by the FVF amounting to €20,000.00. From the total budget, €9,076.07 would be designated to the consignment of supplies and materials to support the payment of the Genexpert IV/4 10C with Laptop. The remaining €10,923.93 would be aligned to salary payments of the Bathalapalli hospital staff. With regard to this part, the *Generalitat Valenciana* approved the FVF's request for the aforementioned modification on December 31, 2021.

As for the payoff of this project, the FVF presented on April 29, 2021 the complete financial and technical reports with the results and conclusions of the project. The NGDO highlights that it was possible to fully complete, with 100% success rate, the expected result of the project: guarantee a continuous oxygen supply to treat Covid-19 patients and save lives. Furthermore, the foundation emphasizes that the initiative has been of great relevance—executed effectively—guaranteeing efficiency and sustainability (FVF, 2021b).

9 CONCLUSION

The Covid-19 pandemic has generated multiple crises: health, financial and environmental. It has affected the whole world and has exposed the fragility of our societies. Nonetheless, after analyzing the situation in India, it is possible to affirm that its damages have been most intense in developing states, further perpetuating poverty and inequality in all its dimensions.

The cooperation for development has assumed an opportunity to reduce the impacts of the pandemic in this very conflictive context. At the same time, the actions undertaken by distinct subnational entities and NGDOs—with the aim of lessening the effects of the virus in developing countries—have responded to a process of health globalization, whereupon international organizations, like the World health

Collection of international topics in health science:
International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1575

Organization, defend the need to promote "Global Health Diplomacy" since health has a direct impact to development, and vice versa.

The FVF, in collaboration with subnational entities and private companies, has been supporting the development of the district of Anantapur in several areas for more than 50 years—with health being one if the principal targets. Through its consolidated development projects and its regional hospital dedicated exclusively to treat Covid-19 patients, the FVF offered a response to the crisis that at first did not seem to have major setbacks. However, with the arrival of the second wave of the pandemic, plus the critical situation of India, it had to change its strategy of action and face an even greater challenge.

As it has been shown in the case study, the FVF's response to the crisis was immediate. The NGDO and its local counterpart had to take over a different responsibility different from its usual obligation. Both sought to ensure adequate medical care during the greatest health crisis in the 21st century thus far. In this way, they have demonstrated that international cooperation for development and international solidarity remain key for the development of our societies around the world.

Collection of international topics in health science:
International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1576

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1577

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1578

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International Development And Health: The Case Of A Development NGO In The Fight Against The Covid-19 Pandemic In Andhra Pradesh, India

1579