Reproductive and Child Health Programme
Terms of Reference for "Small NGOs"

Background

The Reproductive and Child Health (RCH) Program being implemented by the Ministry of Health & Family Welfare(MOHFW) supports various interventions aimed at enabling clients to receive counselling and education for responsibile and healthy sexual behaviour, make informed choices, access user-friendly services for preventing unwanted pregnancy and safe abortion, maternity care, child survival and management of reproductive tract infections and sexually transmitted diseases.

One major thrust of the RCH Program during the ninth plan will be to increase NGO involvement through participation in innovative projects. NGOs have the advantage of flexibility in procedures and rapport and credibility with local communities. They are therefore often better placed to test innovations than the government system.

An *"innovative" project* would adopt appraoches that are supplementary to, or different from those implemented by the government health system. It would address one or more of the objectives of the RCH programme, and should be able to demonstrate impact in terms of improvement in RCH outcomes for the poor and disadvantaged groups in the community. Projects, could, for example,

- increase community participation in, and responsibility for RCH activities;
- mobilise support from opinion leaders;
- improve health and care seeking behaviour among target populations;
- enhance or supplement appropriate services for the poort for example through mobile clinics, referral transport, private hospitals and clinics;
- promote baby friendly practices in hospitals;
- supplement or enhance government capacity, for example in implementing the Prenatal Diagnostic Technique Act.

In addition to these examples, NGOs would be encouraged to suggest other approaches congruent with RCH objectives.

Given the range of NGOs in the country, for the purpose of participation in the RCH Program NGOs would be considered in three major categories;

- Small NGOs working at the village and Panchayat and Block levels;
- Medium-sized NGOs working at state level and national NGOs working in more than one state;

- Selected medium sized and national NGOs who would also function as mother NGOs serving 5-10 districts each, to mentor and provide support to small NGOs

2. A concise Statement of Objectives of small NGOs

To reduce unwanted fertility, improve maternal and child health, and promote responsible and healthy sexual behaviour by implementing innovative projects for specific disadvantaged target populations.

3. Outline of Tasks to be carried out

Preparation of Project proposal

(Also see Attachment A for procedures for sanctioning of Projects)

3.1 Identify the geographic location, nature and estimated size of specific disadvantaged target population(s).

3.2. Develop and submit a project propoosal that includes the following elements:

(a) Measurable objectives with key indicators and expected achievement levels for the indicators. For example, measurable objectives for an advocacy project, should be stated., as far as possible, in terms of a change in behaviour of the target population that is feasible to be achieved within the project period. If the project is proposed for a period of more than one year, objectives for the first year, and for end of project period should be specified. There should be a clear indication on how the achievement of objectives would be measured.

(b) Activities with a time schedule.

(c) Organisational arrangements. Describe implementation arrangements including management, staffing, technical supervision, linkages with existing government or private sector services, inputs(if any) expected from government services.

(d) Monitoring and evaluation plan.

(e) Budget.

3.3 Submit proposal to mother NGO for review and consideration for funding.

Implementation of Project

3.4. Establish management structure required for project implementation.

3.5. Recruit, manage and supervise required personnel;

3.6. Receive and disburse funds for project activities in a timely fashion;

3.7. Procure and deliver required supplies to project site;

3.8. Establish and maintain effective communication with relevant government authorities;

3.9. Implement a monitoring system(including feedback from beneficiaries) and with regular reporting of project activities:

3.10. Collaborate with the mother NGO to conduct periodic evaluation of project efficiency, effectiveness and impact;

3.11. Maintain a separate financial account for the proposed project;

3.12. Submit timely Utilisation Certificates to the mother NGO;

3.13. Submit annual audited statement of accounts and audit certificates to the mother NGO within a time period to be specified by the mother NGO.

4. Schedule for Completion of Tasks

The duration of the project will be initially for one year which may be extended depending upon performance of the NGO.

5. Data, Services and Facilities to be provided to the Small NGO

5.1 MOHFW would provide, through a mother NGO, grants to the small NGO for approved projects.

5.2 The small NGO would be provided appropriate technical and managerial support(including training) by a mother NGO.

5.3 The mother NGO would:

- Screen the eligibility of small NGOs in accordance with criteria that have been specified(see Attachment A);
- Review and approve proposed projects;
- Make timely release of funds to small NGO, from funds that will be provided to the mother NGO by the Ministry of Health and Family Welfare(MOHFW);
- Monitor and report on the performance of small NGOs

6. Final output by Small NGO

(a) Narrative report of project detailing results of project e.g. number of beneficiaries, achievements in relation to stated objectives, project impact.

(b) Financial report of project

7. Composition of Review Committee to Monitor the Small NGO's work

The work of the small NGO will be reviewed by a Project Review & Sanctioning Committee(PRSC), established by the mother NGO. The PRSC would include community members, NGO representatives and two nominees, one each from the State Government and the MOHFW, Government of India.

Attachement A

Eligibility conditions for small NGOs

The NGO will be required to fulfill the following conditions:

1. NGO should have the character of a Registered Society or Trust.
2. NGO should have been in existence preferably for atleast three years but this can be considered for beingwaived of in areas which are weak in NGO coverage.
3. NGO should have office premises either its own or rented in the state where it wishes to work. There should be at least minimum necessary furniture and office equipment.
4. NGO should have atleast one full time or part time specialist relating to field of activity and at least one full time/part time person for administration/financial management.
5. The governing body of NGO must have at least 35% members with background in the field of activity.
6. NGO should have at least Rs. 25,000/- in fixed/cash assets to ensure that it is an organisation of substance.
7. An NGO blacklisted by any Ministry/Department of Government of India/State would not be sanctioned a project for next five years.
8. The documents/reports submitted by the NGO should have been verified and found to be in order.

Procedure for sanctioning projects proposed by small NGOs

1. Proposals would be reviewed and approved by the Project Review & Sanctioning Committee(PRSC) of a mother NGO, at meetings that must have attendance of at least one of the 2 governmet nominees. PRSC decisions regarding approval of NGOs or of specific projects would not be valid if there is no governmentr nominee at the meeting.
2. The NGO should be capable of implementing the project efficiently and effectively.
3. There will be no insistence on any share of funds being contributed by the small NGO for implementation of the project.
4. The duration of the project would be initially for one year, and may be extended depending on the performance of the NGO.
5. Before the first project is assigned to the NGO its credentials must be verified by an independent agency.
6. Individual projects of up to Rs.1/- lakh each would be considered for small NGOs.
7. The annual grant to the small NGO will be released in timely fashion

Reproductive and child health program

The Reproductive and child health program addresses the needs that have emerged over years of implementing the Family Welfare Program. Unification of many women and child health areas will now enable health workers to more easily and completely understand service needs and deliver services accordingly.

As opposed to the Family Welfare Program, the RCH Program aims to be more in tune with the ground realities concerning the:

- Overall health needs of women and children
- Implementation needs of health workers
- Local demographic needs and conditions

CHILD CARE COMPONENT OF THE RCH PROGRAMME

The Reproductive and Child Health Program lays emphasis on identification of community needs and promotion of peoples active participation in implementing relevant integrated health programs for the mother and child.

MAGNITUDE OF THE PROBLEMS

Some of the current statistical data are noted below:

♦ Neonatal mortality rate	48.6/1000 live births
♦ Prenatal mortality rate	29.6/1000 total births
♦ Infant mortality rate	78.5/1000 live births
♦ Child mortality rate (1-4 yr. age)	33.4/1000 Total No of children aged 1-4 Year's at the middle of the year
♦ Under five mortality rate	109.3/1000 live births

(National Family Health Survey 1992-93)

Name of the State_____

Name of the Project: National RCH/Sub-Projects/Urban RCH/ Tribal RCH

Estimated expenditure likely to be incurred by State Government of.... .....in its..... .....project for the years 2001-02-03

Items	Project Cost	Project Exp. incurred upto 31.3.2001	Balance Exp. up to 31.3.2003	Estimated Expenditure 2001-2002	Estimated Expenditure 2002-2003	Likely savings/Deficit
1.Civil Works						
Major Civil Works						
Minor Civil Works						
Sub-Total						
2.Procurement						
RCH Drugs						
Absorbent Cotton						
Computer & Furniture						
P. Injection						
RTI/STI Consumable						
Sub-Total						
3.TRAINING/IEC/ CONSULTANT						
Dai Training						
IEC/(State Share)						
Consultant						
Sub-Total						
4. Operating Cost						
ANM						
PHNS						
Lab. Techinician						
SCOVA Staff						
Tpt. Charges Drugs						
24 hours delivery						
CC maintanence/Inj Sfty						
I Cards						
Inm Str. Project.						
Registers						
CNA/TFA						
other operating charges						
Sub-Total						
5. Miscellaneous						
Referral Transport						
Financial Envelopes						
Out reach Services						
RCH Camps						
PPI						
Sub-Total						
Grand-Total						

Review Workshop for Maternal Health Interventions under the RCH Programme.

AGENDA NOTES

The maternal mortality rate in the India is 407 per 100,000 live births (SRS, RGI, 1998). This means that more than 100,000 women die each year due to pregnancy related causes. Besides socio-economic factors, high maternal mortality is due to inadequate access of women living in remote rural areas and urban slums to maternal health services; large number of deliveries being conducted by untrained persons and also lack of adequate referral facilities to provide emergency obstetric care for complicated cases.

The major causes of maternal mortality are ante and post partum hemorrhage, anaemia, obstructed labour, hypertensive disorders, abortion and sepsis. A large number of these causes are preventable by promoting institutional deliveries, improving safe delivery practices for domiciliary deliveries and ensuring referral and timely treatment of complications and providing safe abortion services.

The Maternal Health Programme which is a component of the Reproductive and Child Health Programme aims at reducing maternal mortality to less than 100 by the year 2010.

The major interventions related to Maternal Health are:

Essential Obstetric Care

Essential obstetric care intends to provide the basic maternity services to all pregnant women through:

- Early registration of Pregnancy (within 12-16 weeks)
- Provision of minimum three ante natal check up by the ANM or Medical Officers to monitor the progress of the pregnancy and to detect any risk/complications so that appropriate care including referral could be given on time.
- Promotion of institutional delivery and provision of safe delivery at home.
- Provision of postnatal care to monitor the postnatal recovery of the women and to detect complications, which include appropriate referral.

This component of the RCH Programme is relevant to all States but more so to the States namely: Assam, Bihar, Rajasthan, Orissa, Uttar Pradesh and Madhya Pradesh because most of the deliveries are still conducted at home in unclean environment causing high maternal morbidity and mortality.

Emergency Obstetric Care

Complications associated with pregnancies are not always predictable. Therefore, emergency obstetric care is an important intervention to prevent maternal morbidity and mortality. Under the CSSM Programme, 1748 referral units were identified and provided with equipment Kit 'E' to 'P'. However, they did not become fully operational due to lack of skilled manpower particularly anaesthetists and

gynaecologists, adequate infrastructure, and medicines. Under the RCH Programme, efforts are being made to strengthen the emergency Obstetric Care services and make the FRUs operational.

Schemes for improving Obstetric Care Services

Additional ANMs

In order to improve delivery of these services, all category C districts of 8 States of Uttar Pradesh, Bihar, Madhya Pradesh, Orissa, Haryana, Assam, Nagaland and Rajasthan are being supported for providing additional ANMs in 30% of sub-centres of these districts. The scheme has been extended to the remaining 6 North eastern States during 1999-2000. In addition, Delhi is eligible for appointing 140 ANMs for extending services to slum areas. Funds have been released to all States except Bihar, Arunachal Pradesh, Sikkim and Tripura as these States have not submitted their proposals. Rs. 2773.25 lakhs have been released to the States for appointment of additional ANMs since 1997-98 (Annexure I).

Public Health/Staff Nurses

Under the programme, Public Health/Staff Nurses are also provided to 25% PHCs in C category districts and 50% PHCs in B category districts. Rs 229.10 lakhs have been released to 7 States. The details of the releases are at Annexure II.

Laboratory Technicians

To build the capacity of the First Referral Units for looking after the needs of emergency Obstetric care and RTIs/STIs, the districts are being assisted to engage two laboratory Technician on contractual basis for doing routine blood, urine and RTI./STI tests. 199 Laboratory Technicians have been appointed in 14 States/UTs. Rs 270.66 lakhs have been released to 23 States based on the proposals received from them. The details of the releases are at Annexure III.

Private Anesthetists

Complications associated with pregnancies are not always predictable. Therefore, emergency obstetric care is an important intervention to prevent maternal morbidity and mortality. Under the CSSM Programme, 1748 referral units were identified and provided with equipment Kit 'E' to 'P'. However, they did not become fully operational due to lack of skilled manpower particularly anaesthetists and gynaecologists, adequate infrastructure, and medicines.

Under the RCH programme FRUs are also being strengthened through supply of drugs in the form of emergency obstetric drug kits and skilled manpower on contractual and hiring basis. The sub-district hospitals, CHCs and FRUs are entitled to hire services of Private Anesthetists for conducting emergency operations for which they are to be paid Rs 1000 per case. Rs 83.17 lakhs have been released to 12 States based on the proposals received from them. The details of the releases are at Annexure IV.

Gynaecologist Rs 800/- per case.

Safe Motherhood Consultants

To alleviate the shortage of trained manpower in PHCs/CHCs and sub-district hospitals, Govt., of India is assisting the States/UTs for engaging the doctors trained in MTP techniques (Safe Motherhood Consultants) to visit these institutions one a week or at least once a fortnight on a fixed day for performing MTPs and providing other services like ante-natal check up and treatment of pregnancies with complications. These doctors are being paid at the rate of Rs. 500/- per day visit. All the States/UTs are eligible for this facilities. Rs 98.81 Lakhs have been released to 19 States based on the proposals received from them. The details of the releases are at Annexure V.

24 Hours Delivery Services at PHCs/CHCs.

To promote institutional deliveries, provision has been made under the current RCH Programme to give additional honorarium to the staff to encourage round the clock delivery services at PHCs and CHCs. This is to ensure that at least one medical officer, nurse, and cleaner are available beyond normal working hours. Under this scheme Rs. 931.49 lakhs have been released to 19 States based on the proposals received from them. The details of the releases are at Annexure VI.

Referral Transport

Time is an important factor for obstetric emergencies. Women who undergo deliveries at home and develop complications often find it difficult to be transported to a referral unit. Under the current RCH Programme Provision has been made to assist women from indigent families in 25% of the sub-centres in selected States to provide a lump sum corpus fund to Panchayat through District Family Welfare Offices. Since 2000-2001, the scheme has been extended to all the States and UTs.

Rs 229.10 have been released to 7 States based on the proposals received from them. The details of the releases are at Annexure VII. Proposals have been received from Himachal Pradesh and Mizoram and being processed.

Integrated Financial Envelop

The purpose of the envelope is to provide flexibility to better performing States to design package of interventions to address problems of Maternal Health care instead of tying them to national schemes. An amount of Rs.270 lakhs have been released to the State of Tamil Nadu, Rs.337.73 lakhs to Andhra Pradesh, Rs. 69.90 lakhs to Kerala and Rs 209 lakhs to Karnataka. The details of the releases are at **Annexure-VIII.** The States of Punjab and Maharashtra are also being considered for this scheme. Letters have been sent to the States for submission of their proposals.

Issues for discussions on the above Schemes

With regard to the schemes mentioned above it has been observed that the utilisation of funds has not been encouraging. In the case of many States, no details of expenditure incurred have been made available to the department of Family Welfare. During the meeting the States are requested to

i. Give financial and physical achievements for each scheme
ii. Outline reasons and bottlenecks for shortfalls in terms of both physical and financial targets
iii. Impact of the schemes on improvement of obstetric care- Coverage levels achieved for various indicators like ANC check up, IFA utilisation, TT Coverage etc, improvement in institutional deliveries particularly in PHCs and CHCs. Increase in the number of case of complications of pregnancies referred to and treated at FRUs.

First Referral Units

1748 first referral units were identified and equipped during 1992-97 as part of the CSSM Programme. Most of these units, however, could not become fully operational due to lack of adequate manpower and blood storage facilities etc. under the RCH Programme a provision for hiring of Anaesthetist has been made for operationalising emergency obstetric care services. The extent to which the FRUs have become functional and are providing the required services is not known. With this in view the State Programme Officers are requested to bring with them the following details:

i. Number of FRUs in the State, district-wise, indicating their location i.e. how of these are in CHCs/Sub-district/District/other hospitals.
ii. How many of these are functional i.e. providing emergency obstetric care.
iii. The number of FRUs where the required specialists i.e. Gynaecologists, Paediatricians, Surgeons etc. are in position.
iv. Any future requirement of equipment for FRUs.

Medical Termination of Pregnancy (MTP)

Medical Termination of Pregnancy is an important component of the on going RCH Programme and it is one of the important means of reducing maternal mortality. A significant proportion of maternal deaths is due to unsafe abortion. For expanding and strengthening safe abortion services under RCH Programme it is proposed to amend the MTP Act for delegation of powers to recognise MTP centres to the Districts and also to make punishment for violation of the provisions of Act more stringent.

In order to increase availability and accessibility to abortion services, MTP equipment are to be procured centrally and provided to District Hospitals, CHCs and PHCs wherever required. Whereever required services of Safe Motherhood Consultants are now available for improving MTP services at PHCs. MTP equipments as well as free training in MTP technique will be provided to recognized MTP centres in the Non-government sector. NIHFW has identified 238 institutions for MTP specialized skill training, although as of now there are 190 recognised MTP training centres in the country.

It is however observed that the number of reported cases of MTP over the years have not gone up (Annexure- IX). It is felt that even though a large number of

maternal deaths continue to take place due to unsafe abortions, monitoring of MTP Act and implementation of safe delivery services has not got much attention of the States. State Programme Officers are requested to bring with them the information on the status of MTP services and action taken by them for improving the situation in the performa at Annexure X.

NEW SCHEMES

Dai Training

Traditional Birth Attendant (TBA) still plays and important role during the Deliveries in our society. The training of TBAs, therefore, was an important activity of this Department. Under the CSSM Programme (1992-97) Dais Training was a uniform countrywide activity. A new scheme for training of Dais has been initiated during this year. The scheme is being implemented in 142 districts in 15 States of the country i.e. Assam, Arunachal Pradesh, Bihar, Gujarat, J&K, Madhya Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Orissa, Rajasthan, Sikkim, Uttar Pradesh and West Bengal. The districts have been selected on the basis of the safe delivery rates being less than 30%. Rs. 5.21 crores have been released for this scheme in the current year against the total requirement of Rs.20 crores in two years. The balance funds will be released during the next financial year. States are requested to indicate the status of implementation and details of how they propose to implement the scheme.

RCH Camps

In order to provide the RCH services to people living in remote areas where the existing services at PHC level are under utilized, a scheme for holding camps has been initiated during this year. Initially 102 districts have been selected in 17 States i.e. Assam, Bihar, Chhatisgarh, Haryana, Jharkhand, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Sikkim and Tripura. More districts would be added next year. States are requested to indicate the status of implementation and details of how they propose to implement the scheme.

Strengthening RCH Outreach services

The RCH house hold surveys conducted in 252 districts have shown that only 53.5 percent of all children are fully immunized with a range of 16.8 percent in Bihar to 89.5 percent in Tamil Nadu. The situation in the eight large northern and eastern States has been a cause of concern with the coverage for fully immunized children in most of these states being below the national average. Coverage levels for other services also followed similar pattern.

For improving the Maternal and Child Health coverage in these State, it has been decided to strengthen outreach services by providing inputs to increase coverage and improve quality of immunization, child health interventions and maternal health services by addressing gaps in services delivery and improving outreach and creating demand through IEC and social mobilization both in urban and rural areas within the

districts. In the current financial year the scheme has been initiated in 50 districts in the State of Assam (3 districts), Bihar (8 districts), Gujarat (3 districts), Madhya Pradesh (11 districts), Orissa (5 districts), Rajasthan 5 districts), Uttar Pradesh (12 districts) and West Bengal (3 districts) and is likely to be extended to 150 districts during the next financial year.

The States were requested to identify the districts and implement the scheme with immediate effect. Only Rajasthan and Uttar Pradesh have intimated the names of the districts. The status of implementation of this scheme will be discussed with the concerned States. As the scheme is of crutial importance for improving coverage of Immunization and Essential Obstetric Care, Programme Officers are requested to bring all relevant details with them.

Supplies of Equipment Kits

Supplies of Essential Obstetric Care Drug Kit (PHC Drug Kit); Emergency Obstetric Care Drug Kit (FRU.CHC Drug Kit); RTI/STI Drug Kits; have started being made to the districts based on the number of institutions covered under the Year 2 of RCH Programme. Some of the items of these kits like IV Infusions and IV Canulas etc are being separately by the MSDs. The State Directorates were informed of these supplies vide letter no H.15012/46/2000-RCH (P) dated 5.9.2000. A feed back on the receipt of the kits and supplies in the districts, further distribution by the districts to the institutions like PHCs and FRUs and problems if any, is requested and will be discussed during the meeting.

State Governments were requested (vide letters no M.15012/46/2000(RCH-P) dated 8.8.2000 and reminders issued vide same number dated 8.9.2000 & 25.9.2000) to provide detailed consignee addresses and district wise quantities of each kit to be supplied to institutions covered under the programme up to Year –2. State-wise allocation of each kit was sent along with the letter referred above. Though some States have responded, a number of States still have not made the information available despite a lapse of 3 months. This is leading to a lot of problems at the MSDs. This information may be sent immediately and any problems in this regard will be discussed during the meeting.

Funds for procurement of some items like Inj Pethidine were sent to the States during the first year of the Programme. No feedback on procurement or expenditure Statements have been received from the most of the States. Details may be brought with the programme officers.

Reproductive and Child Health Programme

Dear Health Worker,

You are well-acquainted with the Government's Family Welfare Programme. You are the backbone of this programme that reaches out to millions of people in our country. Your sustained efforts in implementing family welfare and maternal and child health programmes have benefitted large numbers of people. Today, as a result of your immunization efforts, innumerable children are living healthy and happy lives.

Over the course of implementing the Family Welfare Programme, you may have felt that more needed to be done to completely address the health needs of women and children. You may have also felt that at times your own workload was not set in accordance with the needs of the population you served.

In response to these concerns, the Government has now decided to re-orient the Family Welfare Programme. Since April 1996, the programme has been given a new name and focus. It has been re-oriented to provide an integrated package of family welfare and women and child health services. The new programme is known as the Reproductive and Child Health (RCH) Programme. The objective of the programme is to improve the quality, coverage, effectiveness and access of services.

The target approach that you so far adhered to has also been changed. Now you will no longer have to meet pre-determined targets. Instead, you will be a part of the planning process to plan your own workload for service provision. Health plans will now be formulated not at the national or state level but at the Primary Health Centre (PHC) and Sub Centre level. To participate in the process, you will have to effectively communicate with the people to determine their needs. Information, education and communication will be an important tool for generating awareness of the new programme, promoting informed choice among people and motivating them to avail services.

The quality of services provided will be an important consideration. The new programme emphasizes the client-centred approach and the importance of ensuring client satisfaction when providing health services.

This booklet is meant to briefly acquaint you with the Reproductive and Child Health Programme. By reading this, you will be able to familiarize yourself with the changes that have come about in the Family Welfare Programme and the manner in which the new programme seeks to better address people's health needs.

Your help in making the RCH Programme successful is invaluable. We welcome your comments and suggestions for making this programme truly a people's programme.

Background

For over 30 years, the Family Welfare Programme in India has popularized the small family norm. To assist couples in planning small families, the programme has made available both spacing and permanent methods of contraception.

People have not responded enthusiastically to this because of several reasons. A key reason was that they were not sure if children born to them would survive and be healthy. To address this problem, the Government launched several successful initiatives that reduced child mortality:

A lot of deaths among children were taking place due to vaccine-preventable diseases such as diphtheria, whooping cough, polio, tetanus, tuberculosis and measles. Large-scale immunization of children was carried out under the Universal Immunization Programme (UIP).

Diarrhoea was a major cause of child mortality. The Oral Rehydration Therapy programme succeeded in significantly reducing diarrhoea-related mortality in children.

Poor health of mothers also had a profound impact on the health of their children. Maternity-related conditions such as bleeding during pregnancy and toxemia were causing a large number of deaths. The Child Survival and Safe Motherhood (CSSM) Programme was started to improve the health and survival of mothers and children.

However, experience over the years has shown that though these programmes were successful in their own way, more needed to be done to improve the overall health of women and children.

Reproductive and Child Health Programme

The Reproductive and Child Health Programme addresses the needs that have emerged over years of implementing the Family Welfare Programme. Unification of many women and child health areas will now enable health workers to more easily and completely understand service needs and deliver services accordingly.

As opposed to the Family Welfare Programme, the RCH Programme aims to be more in tune with the ground realities concerning the:

- Overall health needs of women and children
- Implementation needs of health workers
- Local demographic needs and conditions

Health Worker Shows Vidya the Way

Fifteen-year old Vidya lives in Danapur village. She is studying in Class VIII of the village school. Her grandmother feels that it is time to look for a suitable match for her as she wants to see Vidya married in her lifetime. Vidya's father Phool Singh has been a jawan in the army. He now does farming. He is keen on Vidya studying further.

Vidya continued go to school and passed the Class X examination with a First Class. Vidya has also successfully completed a vocational training course in hand pump repairing. Vidya's parents are proud of tbeir daughter. They feel now she is ready for marriage. They ask Shyama, the Health Worker, whom they have known for years, to suggest a suitable boy for Vidya.

Programme Components

The RCH Programme will build on the success of the UIP and the CSSM Programme. In addition, it will cover all aspects of women's reproductive health across their reproductive cycle, from puberty to menopause. In a nutshell, RCH will cover the services offered under the CSSM and the Family Welfare Programme as well as two new interventions, namely management of reproductive tract infections and adolescent reproductive health.

RCH Package of Services

For Mothers

- All pregnancies have to be registered by health workers.
- Pregnant women must be given two doses of tetanus toxoid immunization.
- Pregnant women must be given Iron Folic Acid tablets for prevention and treatment of anaemia.
- Pregnant women must be given three antenatal checkups which include checking their blood pressure and ruling out complications.

Shyama tells them not to worry. She says that they should encourage Vidya to learn more and be a confident and responsible young woman. Finding a suitable husband will not be difficult.

She also tells them that before marriage it is important for Vidya to know the facts about family life so that she is well-prepared to handle the responsibilities that lie ahead. She gently persuades Vidya's parents to let her talk to their daughter about family life and reproductive health. Vidya's parents are hesitant at first but eventually agree.

- Deliveries by trained personnel in safe and hygienic surroundings must be encouraged.
- Institutional deliveries should be encouraged for women having complications.
- Referrals should be made to First Referral Units for management of obstetric emergencies
- Three post-natal checkups should be given to mothers after the delivery.
- Spacing of atleast three years between children must be encouraged.

For Children

- Essential newborn care like keeping the baby warm, checking the baby's weight and giving the baby mother's first milk is important. Babies that are premature or have low birth weight need special care. Babies with any complications should be referred to the health centre.
- Exclusive breast feeding must be encouraged for the first three months. Weaning or starting the baby on semi-solid food should start in the fourth month.
- BCG, DPT, Polio and Measles immunization should be administered to every child meticulously to prevent death and disabilities.
- Vitamin A prophylaxis for children is necessary to prevent blindness.
- Parents must be informed about oral rehydration therapy and correct management of diarrhoea. The availability of ORS packets in the villages should be ensured.

Shyama asks Vidya and her friends to join her in the afternoons for an informal chat. She tells the girls facts regarding menstruation, hygiene and of life. The girls feel shy at first but slowly come up with numerous questions regarding menstruation, changes in their body, marriage, pregnancy, etc., things they could never ask anyone before.

Meanwhile, Vidya's parents continue their search for a suitable boy. After a few months they are able to find a suitable groom, Ajay, who is a young farmer from Panapur, the adjoining village. A wedding is organised. While everyone showers the couple with plenty of gifts, Vidya feels Shyama's gift, the sessions on reproductive health and family life, is the most valuable.

- Acute respiratory infections in children should be detected early. They can be treated by cotrimoxazole tablets. Acute cases should be referred to health centres.
- Treatment of anaemia

For Eligible Couples

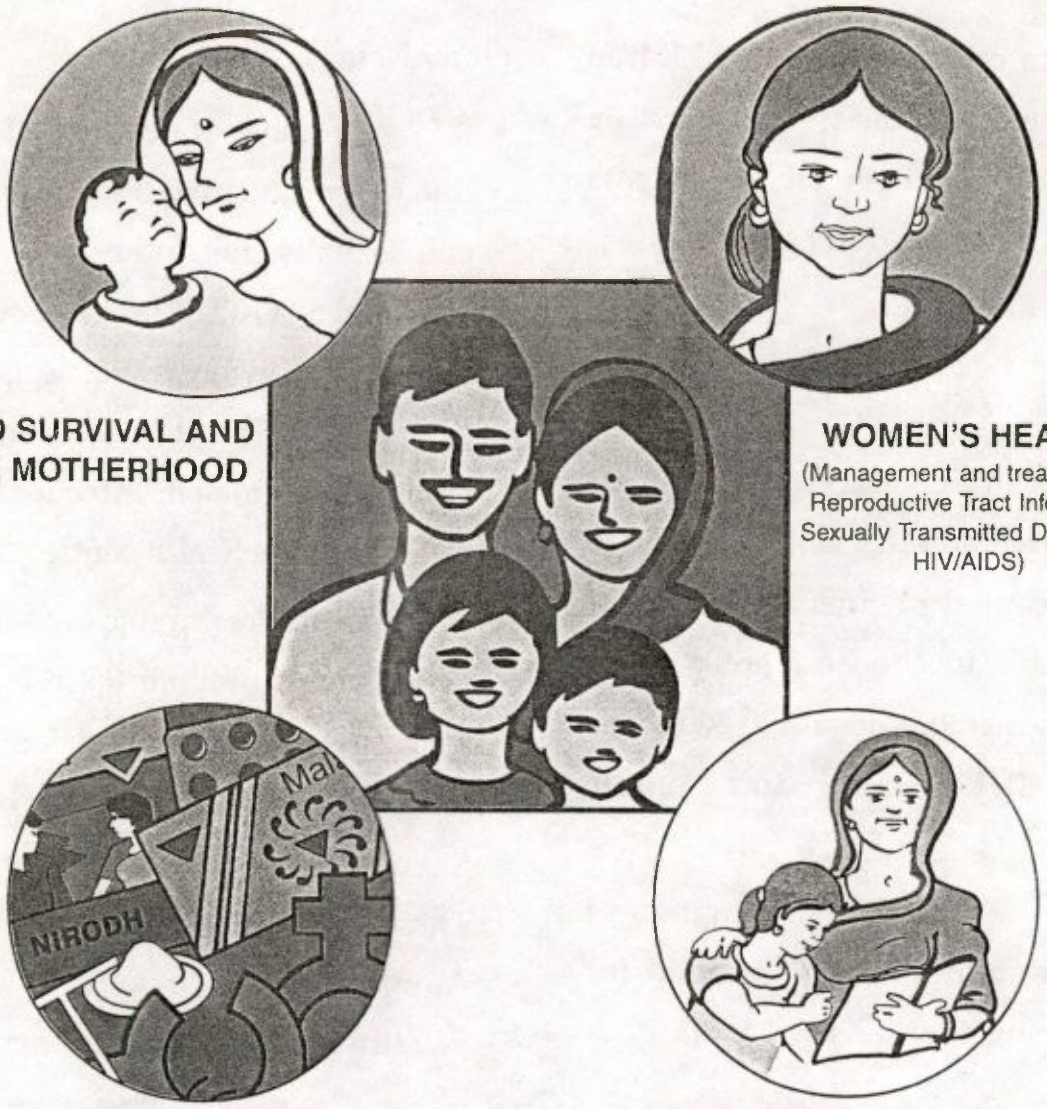
- Promoting use of contraceptive methods among eligible couples is important to prevent unwanted pregnancies. Couples should be able to choose from various contraceptive methods including condoms, oral pills, IUDs, male and female sterilization.
- Safe services for medical termination of pregnancies should be encouraged for women desiring abortions.

Other New Services

- A large number of people suffer in silence due to reproductive tract infections (RTIs) and sexually transmitted diseases (STDs). RTIs and STDs can make people infertile. If a pregnant woman has RTIs or STDs, it can affect the health of her child. People suffering from such infections should be referred to the health centre.
- Adolescents are parents of tomorrow. It is important to prepare them for the future by counselling them on family life and reproductive health. This can be a sensitive topic as it has not been addressed before. Therefore, the involvement of parents, Aanganwadi workers, and Mahila Swasthya Sanghs should be ensured.

Soon after the wedding, Shyama visits Vidya in her new home and talks to her about her plans to have a family. She advises Vidya and Ajay on the various contraceptive methods they can use till they decide to start a family. Vidya and Ajay choose oral pills. Vidya takes the pills every day. The couple is carefree and they spend the first year getting to know each other.

Vidya's mother-in-law is now keen to have a grandchild. After a year of marriage, Vidya and Ajay decide to have a baby. Vidya stops taking the pills. Everyone is jubilant at the news of her pregnancy. Vidya remembers Shyama's advice to get her pregnancy registered.



CHILD SURVIVAL AND SAFE MOTHERHOOD

WOMEN'S HEALTH
(Management and treatment of Reproductive Tract Infections/ Sexually Transmitted Diseases/ HIV/AIDS)

FAMILY PLANNING

ADOLESCENT EDUCATION

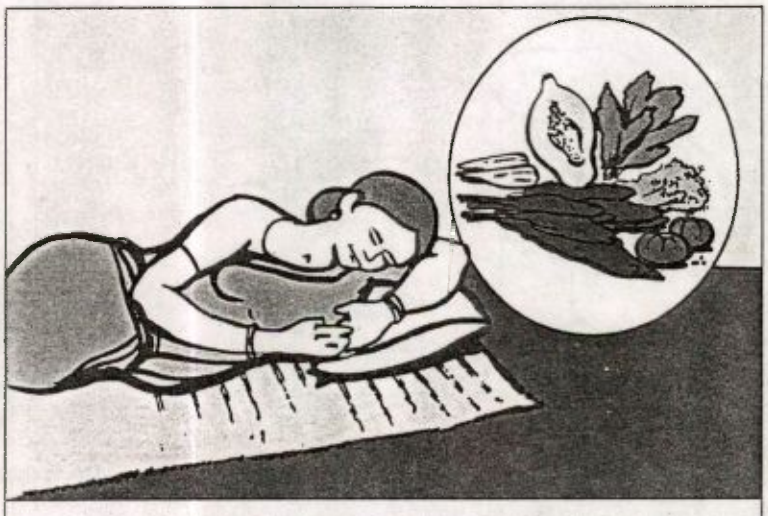
Vidya visits Shyama at her fixed day session in the village to get her pregnancy registered within the first month. Shyama advises Vidya to continue visiting her regularly during her pregnancy for antenatal care. Shyama conveys the news of Vidya's pregnancy to her parents in Danapur.

Thereafter, Shyama gives Vidya two doses of tetanus toxoid immunization with a one month interval between doses. Vidya is also checked for anaemia and given iron and folic acid tablets. Though Vidya is not anaemic, she has to take one tablet a day for 100 days.

Life-Cycle Approach

The Reproductive and Child Health Programme addresses women's health across their life cycle. Women's health is important during all phases of their lives, from childhood to adulthood. Good health is cyclical in nature. In a woman's lifetime, her health status during any phase of life impinges upon the next phase. When she gives birth, she passes on the gift of good health to the next generation. A healthy child grows up into a healthy adolescent; good health during adolescent years leads to health during reproductive years; the cycle continues into the next generation when a healthy pregnancy ensures a healthy child. After the reproductive years, women face health problems during menopause that also need to be addressed in order to ensure a good quality of life. Health care for elderly women will have a positive impact on the health of the future generations. To ensure good health across the life cycle, all components of the RCH programme must be implemented fully. Good implementation of one component supports implementation of other components. If implemented in an integrated manner, the RCH programme will go a long way towards improving the overall health of women and that of society as a whole.

Over the course of Vidya's pregnancy, Shyama gives her seven antenatal check-ups. Her blood pressure is normal and she is gaining weight gradually. Vidya does not have abnormal swelling of feet. Shyama checks her urine and it has no sugar. She watches her for other signs like headaches.



On Shyama's advice, Vidya takes rest and eats nutritious food for her own and her baby's health. She has increased her food intake and makes sure she eats fruits and green leafy vegetables every day. Even though Vidya feels nauseous, she has extra meals. She takes care to use only iodised salt to prevent iodine deficiency in herself and the baby.

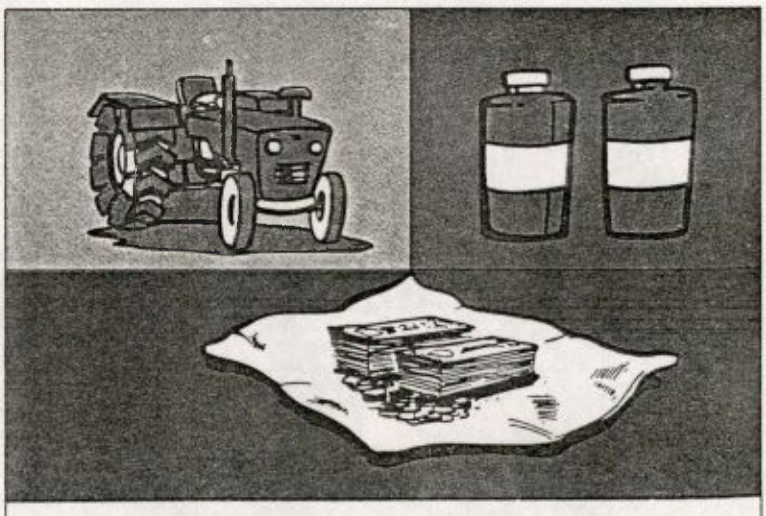
Programme Strategy

The Family Welfare Programme so far had a singular objective of reducing fertility as quickly as possible. In order to achieve this goal, the programme employed a strategy based on contraceptive targets and cash incentives to acceptors and providers. Data now clearly shows that this approach has not been able to reduce fertility quickly enough.

The RCH Programme will now address those problems by using the following strategies:

- Community participation in planning for services and prioritizing
- Client-centred approach to service provision
- Upgraded facilities and improved training
- Emphasis on good quality care
- Absence of contraceptive targets and incentives
- Making services gender sensitive
- Multi-sectoral approach in implementing and monitoring services

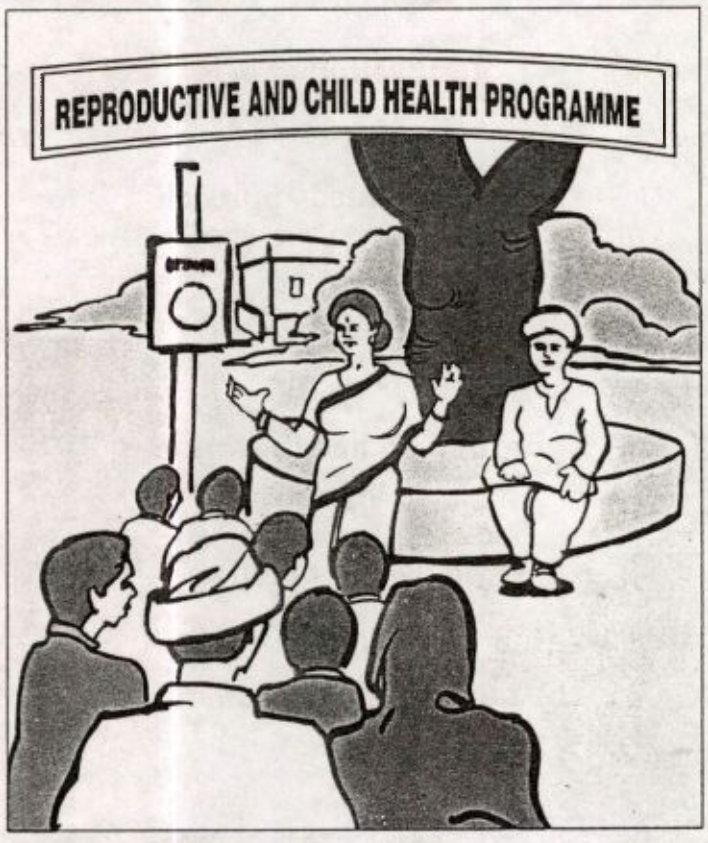
Shyama and Panna Bai, the trained village dai, talk to Vidya, Ajay and his mother about having a safe hygienic delivery. Shyama gives them a disposable delivery kit.
She also tells them to be prepared for an emergency, in case there is one.



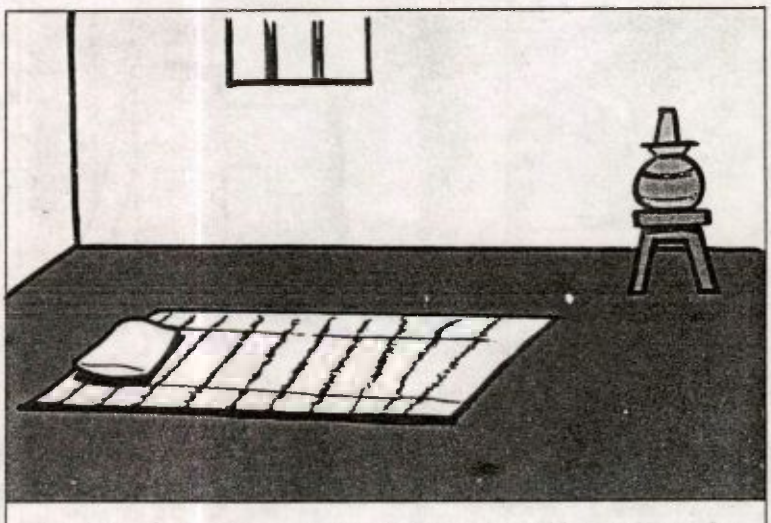
She tells them to make sure certain things are available such as transport for going to the hospital. They should also identify someone in the family who can donate blood if required. She tells them to save some money, which could come in need later.

Participatory Planning

People's participation is the basis of the RCH programme as it will depend upon the bottom-up planning approach instead of the top-down approach that has been followed so far. The health worker will determine her own workload on the basis of the felt needs of the community and service needs, as determined by the number of pregnancies and births in her area. The health workers' action plan will make the foundation for all action plans. Plans formulated at the Sub-centre and PHC level will be integrated to form the



Both Vidya and Ajay go to see the nearest First Referral Unit which is 20 kilometers away. They are glad they know its exact location in case they have to come here for the delivery.



The ninth month of the pregnancy is fast approaching and there is a lot of anticipation in the family. Panna Bai advises Vidya and her mother-in-law to properly clean a room inside the house and prepare it for the delivery. She tells Vidya to be prepared for feeding the child immediately after birth. This is very important for the baby's health.

PREVIOUS APPROACH

Sterilization targets

•

Camp-oriented approach

•

Cash incentives for sterilization cases

•

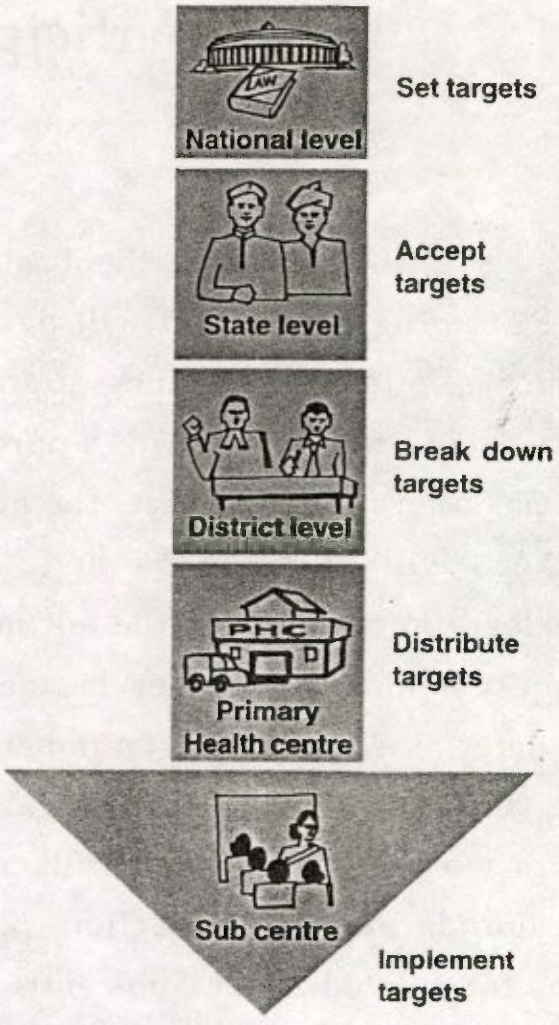
Burden on health worker

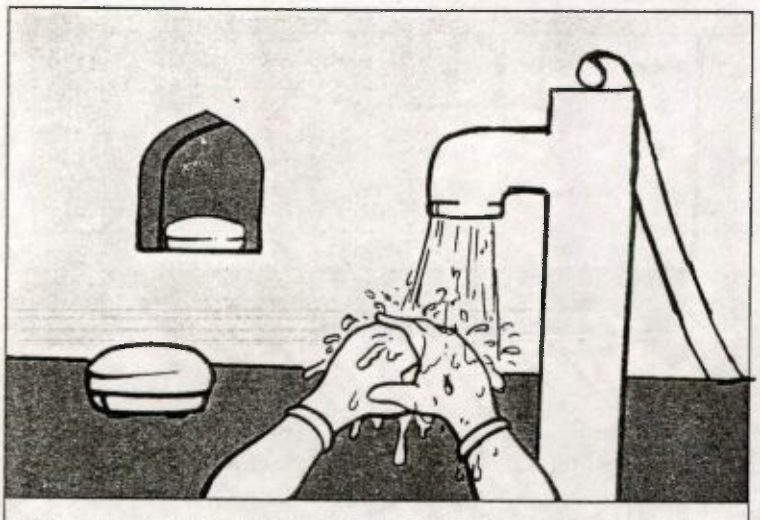
•

Neglect of quality

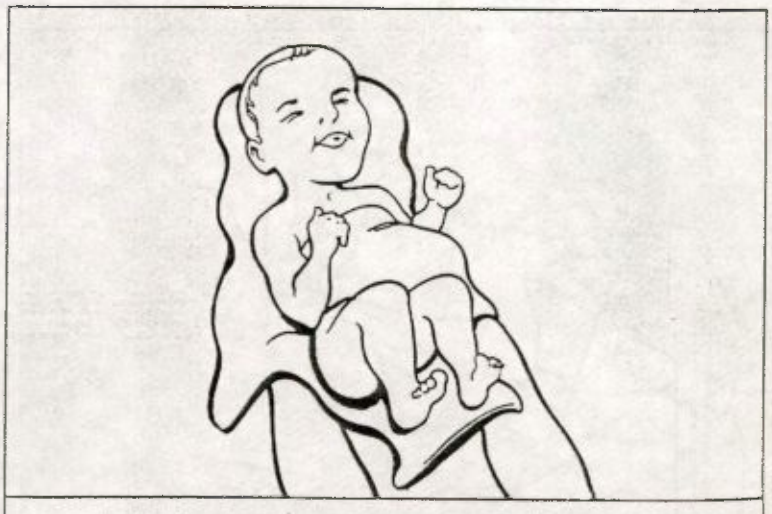
•

Inflation of target statistics





Vidya's labour pains start. Panna Bai is called to conduct the delivery. She prepares for the delivery by cutting her nails and cleaning her hands. She requests Vidya's mother-in-law to bring in hot water and the disposable delivery kit.



A beautiful baby girl is born to Vidya. Panna Bai wipes the baby dry with a clean, soft cloth and wraps her before laying her next to Vidya for breast feeding. Vidya is tired but she wants the best for the baby. She knows that the first milk colostrum contains good nutrients. It's like a first vaccination. She is grateful for Shyama's and Panna's advice because of which she was well-prepared for all this.

Quality of Care

Provision of good quality care is the crux of the RCH Programme. Quality has not been given adequate attention in Family Welfare Programme. This is one of the reasons why people have not availed family welfare services to the desired extent. Every individual desires good quality of care when seeking health services. Good quality of care ensures satisfied clients, who in turn come back for services if they are satisfied. Therefore, provision of good quality care by health workers will determine the overall success of the programme.

What is quality of care?

Quality of care is what we want for ourselves and our family. The manner in which a client is treated determines quality of care. Even though quality may seem like a minor thing in front of the mammoth task of service provision, it's the little things that make a big difference.

Factors that determine good quality of care:

Service delivery

- Promoting informed choice
- Needs-based service delivery

Vidya takes Sona regularly to the fixed day session for immunization. When she turns one-and-a-half months old, she gets her first dose of DPT and Polio vaccination. At one-month intervals, she gets the second and third doses. At the end of nine months, she is given the measles vaccination and vitamin A drops. All the vaccinations are registered in the immunization card that Vidya keeps carefully.

Sona is weaned at five months. While continuing feeding, Vidya gives Sona half-a-katori of food four times a day. The food is usually mashed dal, roti and vegetables. Vidya takes care to give Sona green leafy vegetables, pumpkin and papaya which is good for her eyes. She takes care to get Sona's weight checked regularly at the aanganwadi centre. Ritu, the aanganwadi worker, checks Sona's weight and records it on the growth chart.

- Providing follow-up care

Interpersonal communication

- Friendly and cooperative attitude of health workers
- Spending time with the client
- Caring for client's privacy and dignity

Technical factors

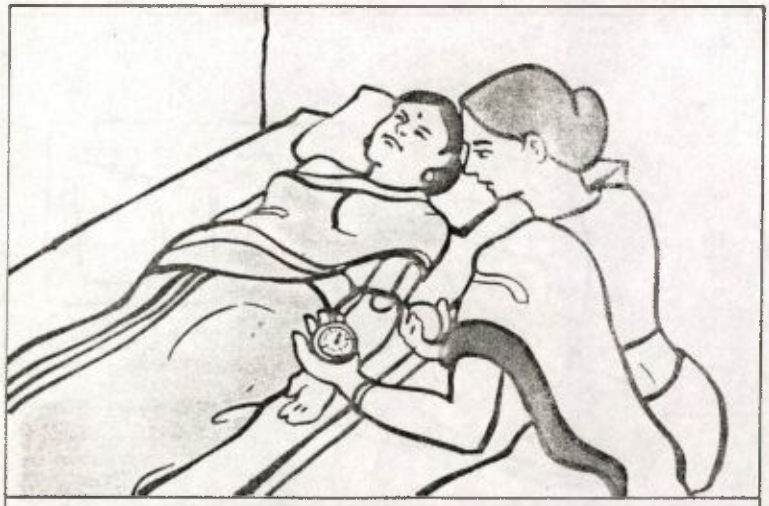
- Technical competence of service providers
- Usage of good quality equipment and drugs
- Maintaining highest standards of hygiene

Social aspects

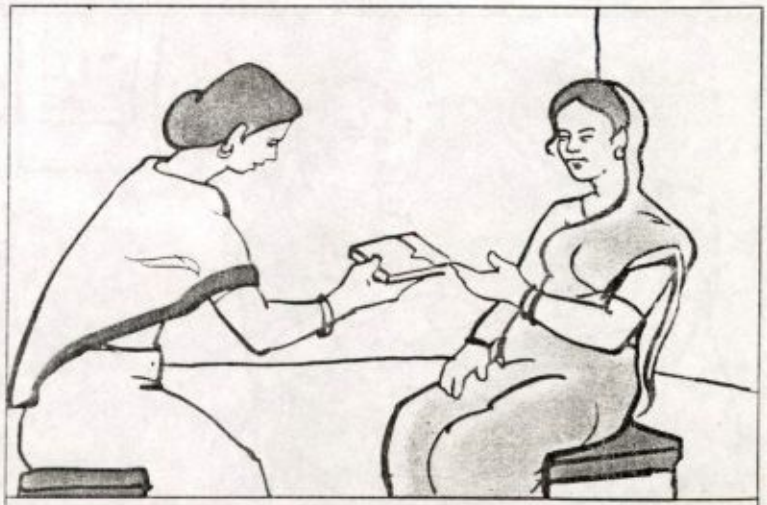
- Gender sensitive service provision
- Encouraging male participation
- Increased role of women in the programme

It is important to care for quality

- Only if clients are satisfied with the quality of services will they return to seek additional services.
- In the absence of targets, work will now be assessed using achievement of indicators of quality. For example, the registration of pregnant women will be measured not in the numbers registered but the numbers registered before 16 weeks of pregnancy.
- Quality of care is not a one-time effort, it's an ongoing process. A relationship of care has to be built with a client both inside and outside the health centre. If health workers fully inform and motivate women to seek services during their field visits, they are more likely to come to the health centre for



During one fixed day session, Vidya takes her friend Neela to Shyama. Neela is having vaginal discharge and has pain in her waist and hips. Shyama examines Neela. It appears that she has a reproductive tract infection. She is immediately referred to the health centre. Reproductive tract infections are serious because they can impact Neela's ability to conceive. Had Neela been pregnant, it could have affected her child.



At the health centre, Neela is examined by a doctor. She is given appropriate medication as well as advice. She is told to maintain hygiene and practice safe sex for protecting herself from reproductive tract infections and sexually transmitted diseases in the future. The doctor especially tells her about the HIV infection that leads to AIDS and tells her to practice safe sex by using condoms.

Sona is growing fast. Since Shyama had told Vidya about correct diarrhoea management, she was well-prepared when Sona got diarrhoea. She gave her plenty of rice water and coconut water frequently. Ajay went to the health centre to get packets of ORS. Sona was given the ORS solution in addition to home available fluids.

One day, Vidya takes Sona to visit her neighbour Meeta's son Rahul. Meeta tells Vidya that Rahul can't play with Sona because he is sick. Vidya notices that the boy has a cough and cold.

services. On getting the services, they have to be followed up regularly in their communities to rule out complications and determine if additional services are required.

Gender Sensitivity

Gender sensitivity is an important consideration in the provision of good quality care. Making the RCH Programme gender sensitive or responsive to the needs of women must be an important concern for everyone involved in planning and implementation. The following are some strategies that are aimed at making the programme gender sensitive:

- Focussing on women's health problems such as reproductive tract infections
- Encouraging male participation in family planning
- Keeping clinics open at time suitable to women
- Training in gender sensitivity for service providers
- Getting women's feedback in monitoring
- Encouraging involvement of panchayats that now have thirty per cent women members.

Vidya recalls Shyama telling her about care during acute respiratory infections. She tells Meeta to give plenty of fluids to Rahul, breast feed him and give him home remedies such as ginger and tulsi tea. When Vidya notices that the child is developing fast breathing (50 in-drawing breaths per minute), she tells Meeta to keep the child warm and take him to the health centre as soon as possible.

At the health centre, Shyama examines the child. As he has fast breathing, and his chest is indrawing slightly, she prescribes cotrimoxazole tablets for five days.

Urban Health

Under the new programme, special attention will be paid to urban health. Urban health planning and service delivery will get priority. Health services in urban areas will no longer be centre-based, outreach services will also be introduced. Health workers will be allocated a defined population around post-partum centres to which they will provide outreach services. The workers will also be trained in participatory planning so that they can actively involve community members and women's groups in the programme. Regular supply of drugs and equipment to urban health centres will be ensured.

Rapid urbanisation is leading to large-scale migration to the cities. Migrants move to the cities in search of employment leaving behind their dwellings, open spaces, and strong social ties in the village. In the cities, they live in slums with unhygienic living conditions where basic amenities like water and toilets are not available. Slums are not only characterised by a poor quality of life, they are breeding grounds for diseases that endanger the health of the residents. So far, the focus of health care system, which is based on the primary health care approach, has been on rural areas. Consequently, the urban health infrastructure is inadequate. In urban areas, people usually rely on health services offered by municipal corporations and town administrations. Growing number of migrants are putting increased pressure on the already overburdened urban health care system.

Soon Rahul is feeling better, he is able to play with Sona. Meeta is grateful to Vidya for her timely advice. Vidya tells her that it is Shyama, the Health Worker, who should be thanked since it was her advice that she passed on to Meeta.

Vidya tells Meeta that Shyama will be available at the Pulse Polio immunization camp the following day. She has asked for all village children to be brought to the camp for the polio vaccination. She plans to take Sona and advises Meeta to take Rahul.

Information Education Communication (IEC)

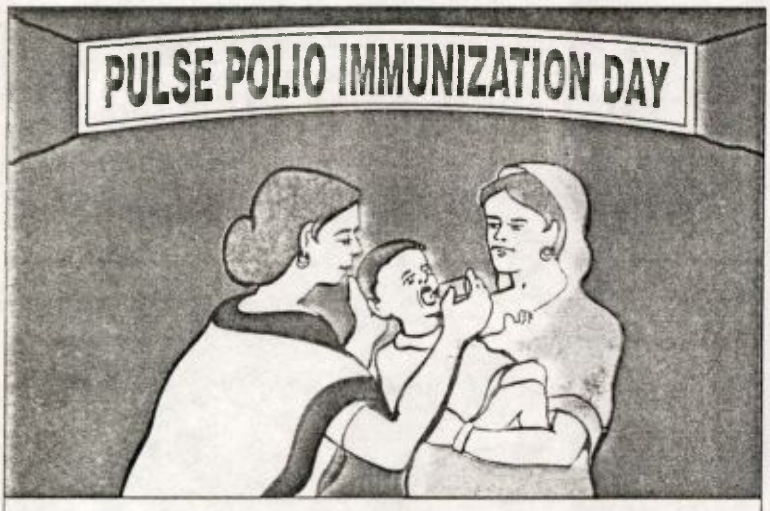
There is a wide gap between awareness about health and family welfare and acceptance of services. Even where services are available, people often do not know about them. Even when awareness is high, attitudes do not necessarily change or new behaviours practiced.

Communication should:

- Generate awareness of services
- Generate demand for better utilization of health services
- Motivate and support behavioural practices at home
- Act as a support to service provision

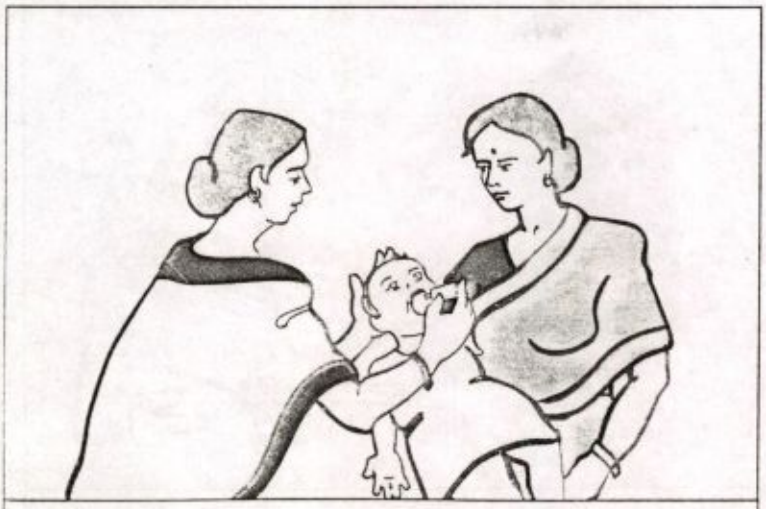
Under the RCH Programme, planning for IEC will go hand-in-hand with the decentralised planning approach.

- Combination and mix of media addressing different target audiences at different levels.
- IEC activities will be planned at the Primary Health Centre level after identifying service and communication needs in the area.
- Locally available communication channels will be identified and utilised.
- Interpersonal counselling skills of health



At the Pulse Polio camp, Sona and Rahul are given vaccinations. Meeta has the opportunity to thank Shyama in person for her advice that helped save her son's life.

Sona took her first steps today. She is almost a year old. She weighs seven-and-a-half kilos, almost three times the weight she was at birth. Vidya and Ajay are pleased with the baby's growth and development.



At one year and three months of age, Shyama gives Sona the follow-up dose of vitamin A and her reimmunization.

Vidya's mother-in-law feels she should soon have another child but Vidya wants to have a space of at least three years between her children. At the moment she is busy taking care of Sona and participating in numerous activities in the village.

workers will be strengthened so that they are able to effectively motivate clients to avail services.

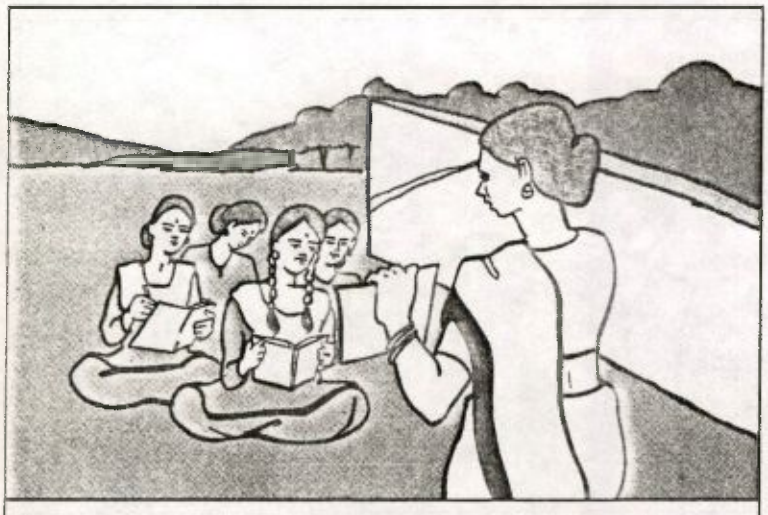
IEC will promote:

Awareness

- Increasing age at marriage
- Nutrition during pregnancy
- Feeding of colostrum
- Exclusive breast feeding
- Correct newborn care practices
- Birth spacing
- Diarrhoea management
- Acute Respiratory Infection management
- Male responsibility
- Good sanitary practices

Services

- Reproductive health of adolescent girls
- Family life education for adolescents entering reproductive age
- Women's education
- Early registration of pregnancies and antenatal care
- Institutional delivery
- Preventing diseases by vaccination



Vidya decides to stand for panchayat elections and wins. She now spends her afternoons looking after her responsibilities as a panchayat member. She takes a lot of interest in village cleanliness, construction of handpumps, road laying, primary school activities and the ration shop. Sometimes, Vidya repairs the handpumps herself since she has the training. She teaches the skills to young girls in the village.

At night, she takes a literacy class where she has motivated women to start a "Bachat Kosh" savings fund. These women soon form a community development society for income generation activities.

Conclusion

The responsibility of making the RCH Programme a success lies in the hands of health managers, workers and the people. It offers an unusual opportunity for decentralised planning that can be availed by everyone for providing their valuable inputs to the programme. It is expected that the programme will have wide acceptance and ownership not only because it will be developed with people's inputs but also because it will raise the standards of quality. Ultimately, indicators of quality will determine the effectiveness of this programme. It is now up to policy makers and managers to utilize this opportunity and meet the challenge of making RCH a people's programme.

Vidya participates in the Participatory Learning for Action training organised by the Health Department where she learns community needs assessment and participatory planning. Vidya becomes a great help to Shyama and Ritu, the aanganwadi worker.

Ajay is proud of Vidya and so are others in the village. They feel Vidya should become the Sarpanch. For now she is happy contributing to the village in whatever way she can. Lets see what the future holds.

DEPARTMENT OF FAMILY WELFARE
MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA, NEW DELHI

This booklet has been produced and printed by kind courtesy of UNICEF India, Ministry of Health and Family Welfare, Government of India.

Reproductive and Child Health Programme

Dear Health Worker,

You are well-acquainted with the Government's Family Welfare Programme. You are the backbone of this programme that reaches out to millions of people in our country. Your sustained efforts in implementing family welfare and maternal and child health programmes have benefitted large numbers of people. Today, as a result of your immunization efforts, innumerable children are living healthy and happy lives.

Over the course of implementing the Family Welfare Programme, you may have felt that more needed to be done to completely address the health needs of women and children. You may have also felt that at times your own workload was not set in accordance with the needs of the population you served.

In response to these concerns, the Government has now decided to re-orient the Family Welfare Programme. Since April 1996, the programme has been given a new name and focus. It has been re-oriented to provide an integrated package of family welfare and women and child health services. The new programme is known as the Reproductive and Child Health (RCH) Programme. The objective of the programme is to improve the quality, coverage, effectiveness and access of services.

The target approach that you so far adhered to has also been changed. Now you will no longer have to meet pre-determined targets. Instead, you will be a part of the planning process to plan your own workload for service provision. Health plans will now be formulated not at the national or state level but at the Primary Health Centre (PHC) and Sub Centre level. To participate in the process, you will have to effectively communicate with the people to determine their needs. Information, education and communication will be an important tool for generating awareness of the new programme, promoting informed choice among people and motivating them to avail services.

The quality of services provided will be an important consideration. The new programme emphasizes the client-centred approach and the importance of ensuring client satisfaction when providing health services.

This booklet is meant to briefly acquaint you with the Reproductive and Child Health Programme. By reading this, you will be able to familiarize yourself with the changes that have come about in the Family Welfare Programme and the manner in which the new programme seeks to better address people's health needs.

Your help in making the RCH Programme successful is invaluable. We welcome your comments and suggestions for making this programme truly a people's programme.

Background

For over 30 years, the Family Welfare Programme in India has popularized the small family norm. To assist couples in planning small families, the programme has made available both spacing and permanent methods of contraception.

People have not responded enthusiastically to this because of several reasons. A key reason was that they were not sure if children born to them would survive and be healthy. To address this problem, the Government launched several successful initiatives that reduced child mortality:

A lot of deaths among children were taking place due to vaccine-preventable diseases such as diphtheria, whooping cough, polio, tetanus, tuberculosis and measles. Large-scale immunization of children was carried out under the Universal Immunization Programme (UIP).

Diarrhoea was a major cause of child mortality. The Oral Rehydration Therapy programme succeeded in significantly reducing diarrhoea-related mortality in children.

Poor health of mothers also had a profound impact on the health of their children. Maternity-related conditions such as bleeding during pregnancy and toxemia were causing a large number of deaths. The Child Survival and Safe Motherhood (CSSM) Programme was started to improve the health and survival of mothers and children.

However, experience over the years has shown that though these programmes were successful in their own way, more needed to be done to improve the overall health of women and children.

Reproductive and Child Health Programme

The Reproductive and Child Health Programme addresses the needs that have emerged over years of implementing the Family Welfare Programme. Unification of many women and child health areas will now enable health workers to more easily and completely understand service needs and deliver services accordingly.

As opposed to the Family Welfare Programme, the RCH Programme aims to be more in tune with the ground realities concerning the:

- Overall health needs of women and children
- Implementation needs of health workers
- Local demographic needs and conditions

Health Worker Shows Vidya the Way

Fifteen-year old Vidya lives in Danapur village. She is studying in Class VIII of the village school. Her grandmother feels that it is time to look for a suitable match for her as she wants to see Vidya married in her lifetime. Vidya's father Phool Singh has been a jawan in the army. He now does farming. He is keen on Vidya studying further.

Vidya continued go to school and passed the Class X examination with a First Class. Vidya has also successfully completed a vocational training course in hand pump repairing. Vidya's parents are proud of their daughter. They feel now she is ready for marriage. They ask Shyama, the Health Worker, whom they have known for years, to suggest a suitable boy for Vidya.

Programme Components

The RCH Programme will build on the success of the UIP and the CSSM Programme. In addition, it will cover all aspects of women's reproductive health across their reproductive cycle, from puberty to menopause. In a nutshell, RCH will cover the services offered under the CSSM and the Family Welfare Programme as well as two new interventions, namely management of reproductive tract infections and adolescent reproductive health.

RCH Package of Services

For Mothers

- All pregnancies have to be registered by health workers.
- Pregnant women must be given two doses of tetanus toxoid immunization.
- Pregnant women must be given Iron Folic Acid tablets for prevention and treatment of anaemia.
- Pregnant women must be given three antenatal checkups which include checking their blood pressure and ruling out complications.

Shyama tells them not to worry. She says that they should encourage Vidya to learn more and be a confident and responsible young woman. Finding a suitable husband will not be difficult.

She also tells them that before marriage it is important for Vidya to know the facts about family life so that she is well-prepared to handle the responsibilities that lie ahead. She gently persuades Vidya's parents to let her talk to their daughter about family life and reproductive health. Vidya's parents are hesitant at first but eventually agree.

- Deliveries by trained personnel in safe and hygienic surroundings must be encouraged.
- Institutional deliveries should be encouraged for women having complications.
- Referrals should be made to First Referral Units for management of obstetric emergencies
- Three post-natal checkups should be given to mothers after the delivery.
- Spacing of atleast three years between children must be encouraged.

For Children

- Essential newborn care like keeping the baby warm, checking the baby's weight and giving the baby mother's first milk is important. Babies that are premature or have low birth weight need special care. Babies with any complications should be referred to the health centre.
- Exclusive breast feeding must be encouraged for the first three months. Weaning or starting the baby on semi-solid food should start in the fourth month.
- BCG, DPT, Polio and Measles immunization should be administered to every child meticulously to prevent death and disabilities.
- Vitamin A prophylaxis for children is necessary to prevent blindness.
- Parents must be informed about oral rehydration therapy and correct management of diarrhoea. The availability of ORS packets in the villages should be ensured.

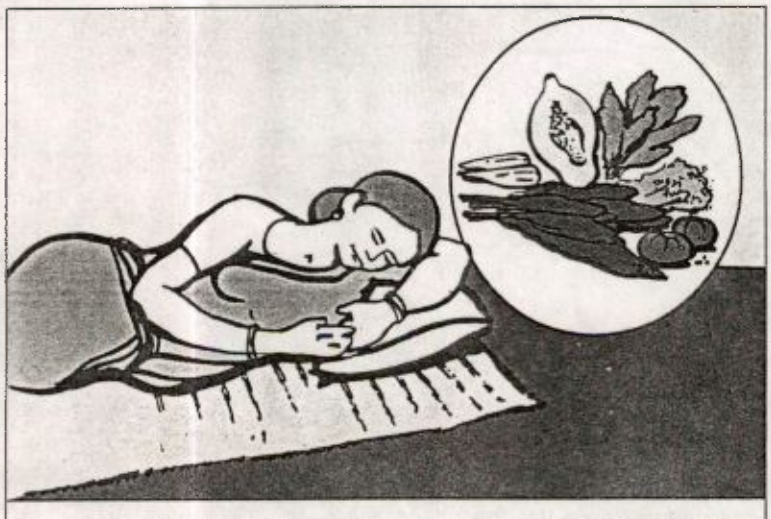
Shyama asks Vidya and her friends to join her in the afternoons for an informal chat. She tells the girls facts regarding menstruation, hygiene and of life. The girls feel shy at first but slowly come up with numerous questions regarding menstruation, changes in their body, marriage, pregnancy, etc., things they could never ask anyone before.

Meanwhile, Vidya's parents continue their search for a suitable boy. After a few months they are able to find a suitable groom, Ajay, who is a young farmer from Panapur, the adjoining village. A wedding is organised. While everyone showers the couple with plenty of gifts, Vidya feels Shyama's gift, the sessions on reproductive health and family life, is the most valuable.

Life-Cycle Approach

The Reproductive and Child Health Programme addresses women's health across their life cycle. Women's health is important during all phases of their lives, from childhood to adulthood. Good health is cyclical in nature. In a woman's lifetime, her health status during any phase of life impinges upon the next phase. When she gives birth, she passes on the gift of good health to the next generation. A healthy child grows up into a healthy adolescent; good health during adolescent years leads to health during reproductive years; the cycle continues into the next generation when a healthy pregnancy ensures a healthy child. After the reproductive years, women face health problems during menopause that also need to be addressed in order to ensure a good quality of life. Health care for elderly women will have a positive impact on the health of the future generations. To ensure good health across the life cycle, all components of the RCH programme must be implemented fully. Good implementation of one component supports implementation of other components. If implemented in an integrated manner, the RCH programme will go a long way towards improving the overall health of women and that of society as a whole.

Over the course of Vidya's pregnancy, Shyama gives her seven antenatal check-ups. Her blood pressure is normal and she is gaining weight gradually. Vidya does not have abnormal swelling of feet. Shyama checks her urine and it has no sugar. She watches her for other signs like headaches.



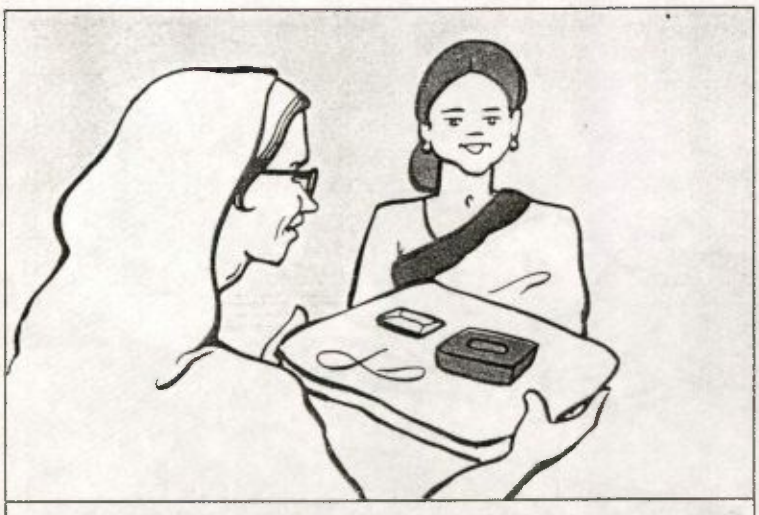
On Shyama's advice, Vidya takes rest and eats nutritious food for her own and her baby's health. She has increased her food intake and makes sure she eats fruits and green leafy vegetables every day. Even though Vidya feels nauseous, she has extra meals. She takes care to use only iodised salt to prevent iodine deficiency in herself and the baby.

Programme Strategy

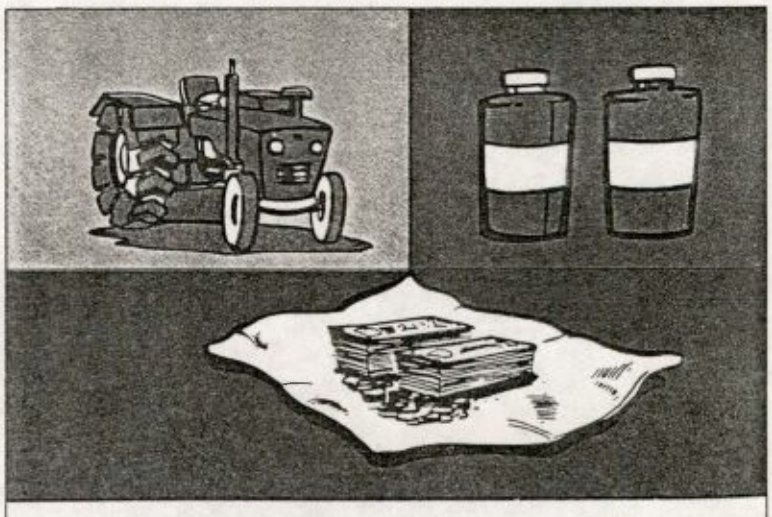
The Family Welfare Programme so far had a singular objective of reducing fertility as quickly as possible. In order to achieve this goal, the programme employed a strategy based on contraceptive targets and cash incentives to acceptors and providers. Data now clearly shows that this approach has not been able to reduce fertility quickly enough.

The RCH Programme will now address those problems by using the following strategies:

- Community participation in planning for services and prioritizing
- Client-centred approach to service provision
- Upgraded facilities and improved training
- Emphasis on good quality care
- Absence of contraceptive targets and incentives
- Making services gender sensitive
- Multi-sectoral approach in implementing and monitoring services



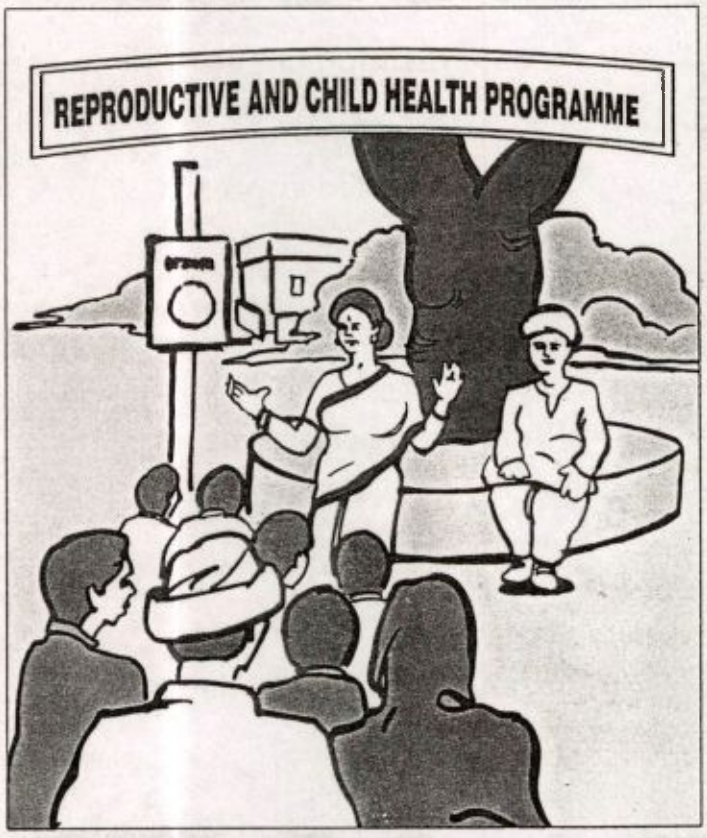
Shyama and Panna Bai, the trained village dai, talk to Vidya, Ajay and his mother about having a safe hygienic delivery. Shyama gives them a disposable delivery kit.
She also tells them to be prepared for an emergency, in case there is one.



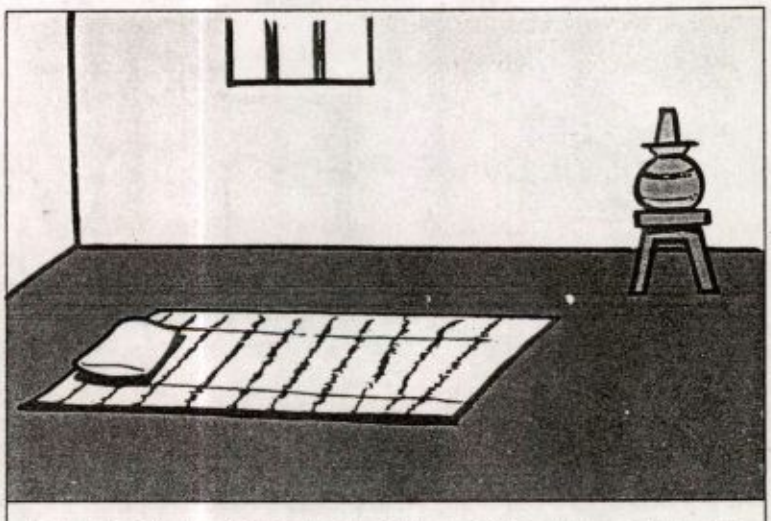
She tells them to make sure certain things are available such as transport for going to the hospital. They should also identify someone in the family who can donate blood if required. She tells them to save some money, which could come in need later.

Participatory Planning

People's participation is the basis of the RCH programme as it will depend upon the bottom-up planning approach instead of the top-down approach that has been followed so far. The health worker will determine her own workload on the basis of the felt needs of the community and service needs, as determined by the number of pregnancies and births in her area. The health workers' action plan will make the foundation for all action plans. Plans formulated at the Sub-centre and PHC level will be integrated to form the



Both Vidya and Ajay go to see the nearest First Referral Unit which is 20 kilometers away. They are glad they know its exact location in case they have to come here for the delivery.



The ninth month of the pregnancy is fast approaching and there is a lot of anticipation in the family. Panna Bai advises Vidya and her mother-in-law to properly clean a room inside the house and prepare it for the delivery. She tells Vidya to be prepared for feeding the child immediately after birth. This is very important for the baby's health.

PREVIOUS APPROACH

Sterilization targets

•

Camp-oriented approach

•

Cash incentives for sterilization cases

•

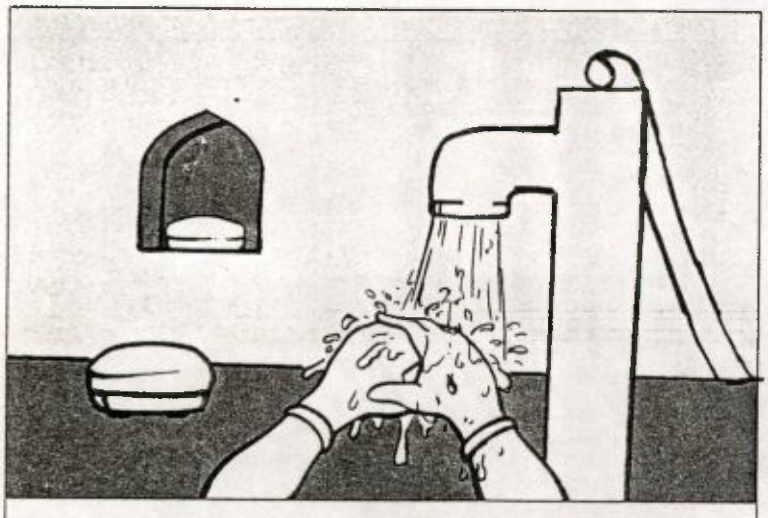
Burden on health worker

•

Neglect of quality

•

Inflation of target statistics



Vidya's labour pains start. Panna Bai is called to conduct the delivery. She prepares for the delivery by cutting her nails and cleaning her hands. She requests Vidya's mother-in-law to bring in hot water and the disposable delivery kit.

A beautiful baby girl is born to Vidya. Panna Bai wipes the baby dry with a clean, soft cloth and wraps her before laying her next to Vidya for breast feeding. Vidya is tired but she wants the best for the baby. She knows that the first milk colostrum contains good nutrients. It's like a first vaccination. She is grateful for Shyama's and Panna's advice because of which she was well-prepared for all this.

Quality of Care

Provision of good quality care is the crux of the RCH Programme. Quality has not been given adequate attention in Family Welfare Programme. This is one of the reasons why people have not availed family welfare services to the desired extent. Every individual desires good quality of care when seeking health services. Good quality of care ensures satisfied clients, who in turn come back for services if they are satisfied. Therefore, provision of good quality care by health workers will determine the overall success of the programme.

What is quality of care?

Quality of care is what we want for ourselves and our family. The manner in which a client is treated determines quality of care. Even though quality may seem like a minor thing in front of the mammoth task of service provision, it's the little things that make a big difference.

Factors that determine good quality of care:

Service delivery

- Promoting informed choice
- Needs-based service delivery

Vidya takes Sona regularly to the fixed day session for immunization. When she turns one-and-a-half months old, she gets her first dose of DPT and Polio vaccination. At one-month intervals, she gets the second and third doses. At the end of nine months, she is given the measles vaccination and Vitamin A drops. All the vaccinations are registered in the immunization card that Vidya keeps carefully.

Sona is weaned at five months. While continuing feeding, Vidya gives Sona half a katori of food four times a day. The food is usually mashed dal, roti and vegetables. Vidya takes care to give Sona green leafy vegetables, pumpkin and papaya which is good for her eyes. She takes care to get Sona's weight checked regularly at the aanganwadi centre. Ritu, the aanganwadi worker, checks Sona's weight and records it on the growth chart.

- Providing follow-up care

Interpersonal communication

- Friendly and cooperative attitude of health workers
- Spending time with the client
- Caring for client's privacy and dignity

Technical factors

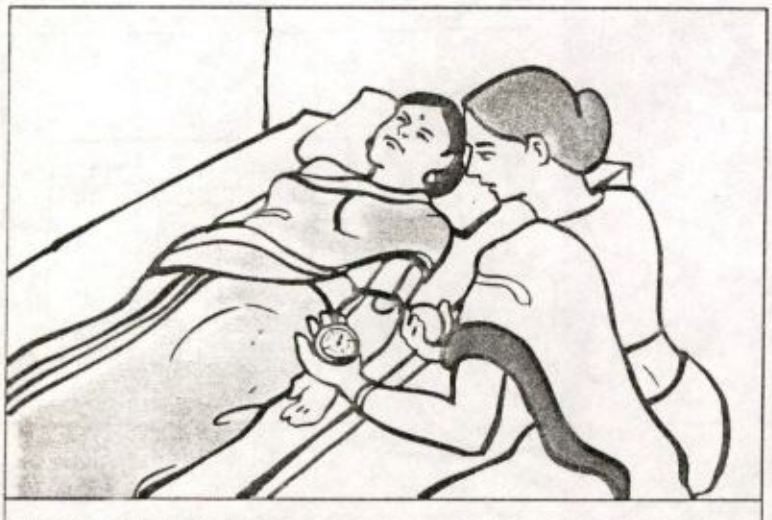
- Technical competence of service providers
- Usage of good quality equipment and drugs
- Maintaining highest standards of hygiene

Social aspects

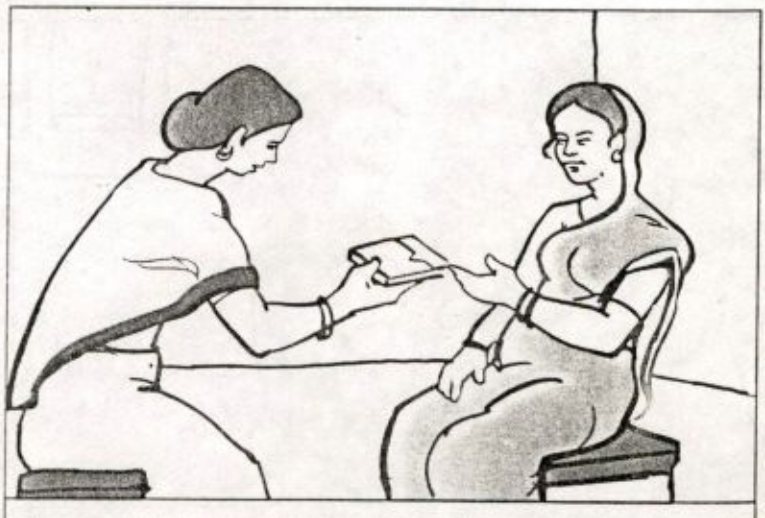
- Gender sensitive service provision
- Encouraging male participation
- Increased role of women in the programme

It is important to care for quality

- Only if clients are satisfied with the quality of services will they return to seek additional services.
- In the absence of targets, work will now be assessed using achievement of indicators of quality. For example, the registration of pregnant women will be measured not in the numbers registered but the numbers registered before 16 weeks of pregnancy.
- Quality of care is not a one-time effort, it's an ongoing process. A relationship of care has to be built with a client both inside and outside the health centre. If health workers fully inform and motivate women to seek services during their field visits, they are more likely to come to the health centre for



During one fixed day session, Vidya takes her friend Neela to Shyama. Neela is having vaginal discharge and has pain in her waist and hips. Shyama examines Neela. It appears that she has a reproductive tract infection. She is immediately referred to the health centre. Reproductive tract infections are serious because they can impact Neela's ability to conceive. Had Neela been pregnant, it could have affected her child.



At the health centre, Neela is examined by a doctor. She is given appropriate medication as well as advice. She is told to maintain hygiene and practice safe sex for protecting herself from reproductive tract infections and sexually transmitted diseases in the future. The doctor especially tells her about the HIV infection that leads to AIDS and tells her to practice safe sex by using condoms.

Sona is growing fast. Since Shyama had told Vidya about correct diarrhoea management, she was well-prepared when Sona got diarrhoea. She gave her plenty of rice water and coconut water frequently. Ajay went to the health centre to get packets of ORS. Sona was given the ORS solution in addition to home available fluids.

One day, Vidya takes Sona to visit her neighbour Meeta's son Rahul. Meeta tells Vidya that Rahul can't play with Sona because he is sick. Vidya notices that the boy has a cough and cold.

services. On getting the services, they have to be followed up regularly in their communities to rule out complications and determine if additional services are required.

Gender Sensitivity

Gender sensitivity is an important consideration in the provision of good quality care. Making the RCH Programme gender sensitive or responsive to the needs of women must be an important concern for everyone involved in planning and implementation. The following are some strategies that are aimed at making the programme gender sensitive:

- Focussing on women's health problems such as reproductive tract infections
- Encouraging male participation in family planning
- Keeping clinics open at time suitable to women
- Training in gender sensitivity for service providers
- Getting women's feedback in monitoring
- Encouraging involvement of panchayats that now have thirty per cent women members.

Vidya recalls Shyama telling her about care during acute respiratory infections. She tells Meeta to give plenty of fluids to Rahul, breast feed him and give him home remedies such as ginger and tulsi tea. When Vidya notices that the child is developing fast breathing (50 in-drawing breaths per minute), she tells Meeta to keep the child warm and take him to the health centre as soon as possible.

At the health centre, Shyama examines the child. As he has fast breathing, and his chest is indrawing slightly, she prescribes cotrimoxazole tablets for five days.

Urban Health

Under the new programme, special attention will be paid to urban health. Urban health planning and service delivery will get priority. Health services in urban areas will no longer be centre-based, outreach services will also be introduced. Health workers will be allocated a defined population around post-partum centres to which they will provide outreach services. The workers will also be trained in participatory planning so that they can actively involve community members and women's groups in the programme. Regular supply of drugs and equipment to urban health centres will be ensured.

Rapid urbanisation is leading to large-scale migration to the cities. Migrants move to the cities in search of employment leaving behind their dwellings, open spaces, and strong social ties in the village. In the cities, they live in slums with unhygienic living conditions where basic amenities like water and toilets are not available. Slums are not only characterised by a poor quality of life, they are breeding grounds for diseases that endanger the health of the residents. So far, the focus of health care system, which is based on the primary health care approach, has been on rural areas. Consequently, the urban health infrastructure is inadequate. In urban areas, people usually rely on health services offered by municipal corporations and town administrations. Growing number of migrants are putting increased pressure on the already overburdened urban health care system.

Soon Rahul is feeling better, he is able to play with Sona. Meeta is grateful to Vidya for her timely advice. Vidya tells her that it is Shyama, the Health Worker, who should be thanked since it was her advice that she passed on to Meeta.

Vidya tells Meeta that Shyama will be available at the Pulse Polio immunization camp the following day. She has asked for all village children to be brought to the camp for the polio vaccination. She plans to take Sona and advises Meeta to take Rahul.

Information Education Communication (IEC)

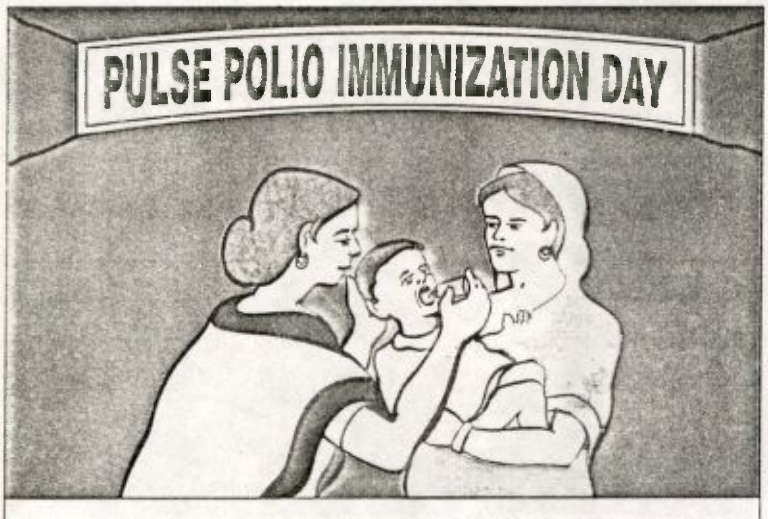
There is a wide gap between awareness about health and family welfare and acceptance of services. Even where services are available, people often do not know about them. Even when awareness is high, attitudes do not necessarily change or new behaviours practiced.

Communication should:

- Generate awareness of services
- Generate demand for better utilization of health services
- Motivate and support behavioural practices at home
- Act as a support to service provision

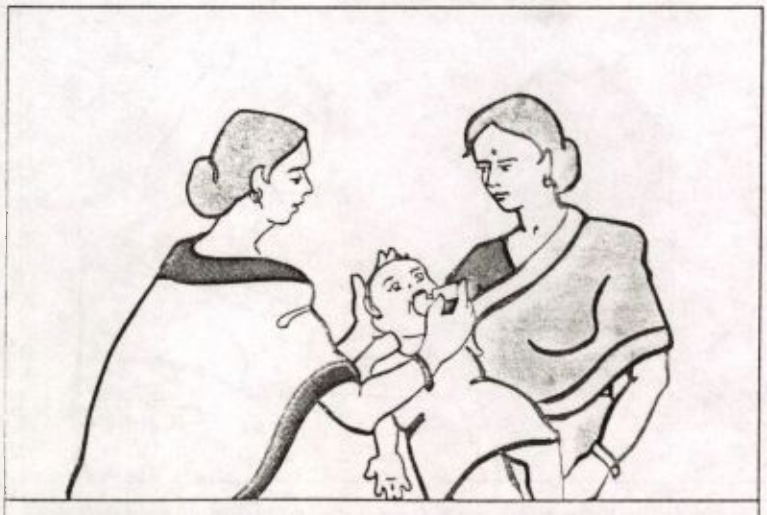
Under the RCH Programme, planning for IEC will go hand-in-hand with the decentralised planning approach.

- Combination and mix of media addressing different target audiences at different levels.
- IEC activities will be planned at the Primary Health Centre level after identifying service and communication needs in the area.
- Locally available communication channels will be identified and utilised.
- Interpersonal counselling skills of health

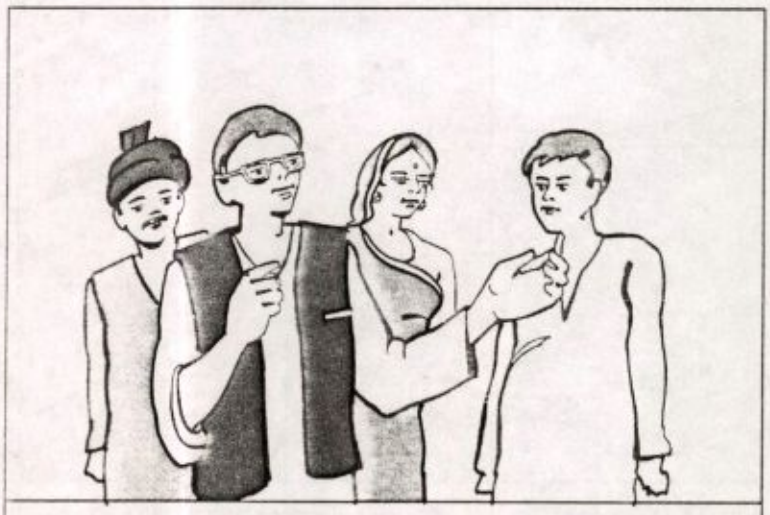


At the Pulse Polio camp, Sona and Rahul are given vaccinations. Meeta has the opportunity to thank Shyama in person for her advice that helped save her son's life.

Sona took her first steps today. She is almost a year old. She weighs seven-and-a-half kilos, almost three times the weight she was at birth. Vidya and Ajay are pleased with the baby's growth and development.



At one year and three months of age, Shyama gives Sona the follow-up dose of vitamin A and her reimmunization.



Vidya's mother-in-law feels she should soon have another child but Vidya wants to have a space of at least three years between her children. At the moment she is busy taking care of Sona and participating in numerous activities in the village.

workers will be strengthened so that they are able to effectively motivate clients to avail services.

IEC will promote:

Awareness

- Increasing age at marriage
- Nutrition during pregnancy
- Feeding of colostrum
- Exclusive breast feeding
- Correct newborn care practices
- Birth spacing
- Diarrhoea management
- Acute Respiratory Infection management
- Male responsibility
- Good sanitary practices

Services

- Reproductive health of adolescent girls
- Family life education for adolescents entering reproductive age
- Women's education
- Early registration of pregnancies and antenatal care
- Institutional delivery
- Preventing diseases by vaccination

Vidya decides to stand for panchayat elections and wins. She now spends her afternoons looking after her responsibilities as a panchayat member. She takes a lot of interest in village cleanliness, construction of handpumps, road laying, primary school activities and the ration shop. Sometimes, Vidya repairs the handpumps herself since she has the training. She teaches the skills to young girls in the village.

At night, she takes a literacy class where she has motivated women to start a "Bachat Kosh" savings fund. These women soon form a community development society for income generation activities.

Conclusion

The responsibility of making the RCH Programme a success lies in the hands of health managers, workers and the people. It offers an unusual opportunity for decentralised planning that can be availed by everyone for providing their valuable inputs to the programme. It is expected that the programme will have wide acceptance and ownership not only because it will be developed with people's inputs but also because it will raise the standards of quality. Ultimately, indicators of quality will determine the effectiveness of this programme. It is now up to policy makers and managers to utilize this opportunity and meet the challenge of making RCH a people's programme.

Vidya participates in the Participatory Learning for Action training organised by the Health Department where she learns community needs assessment and participatory planning. Vidya becomes a great help to Shyama and Ritu, the aanganwadi worker.

Ajay is proud of Vidya and so are others in the village. They feel Vidya should become the Sarpanch. For now she is happy contributing to the village in whatever way she can. Lets see what the future holds.

DEPARTMENT OF FAMILY WELFARE
MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA, NEW DELHI

This booklet has been produced and printed by kind courtesy of UNICEF India, Ministry of Health and Family Welfare, Government of India.

Reproductive and Child Health Programme
Terms of Reference for "Small NGOs"

Background

The Reproductive and Child Health (RCH) Program being implemented by the Ministry of Health & Family Welfare(MOHFW) supports various interventions aimed at enabling clients to receive counselling and education for responsibile and healthy sexual behaviour, make informed choices, access user-friendly services for preventing unwanted pregnancy and safe abortion, maternity care, child survival and management of reproductive tract infections and sexually transmitted diseases.

One major thrust of the RCH Program during the ninth plan will be to increase NGO involvement through participation in innovative projects. NGOs have the advantage of flexibility in procedures and rapport and credibility with local communities. They are therefore often better placed to test innovations than the government system.

An *"innovative" project* would adopt appraoches that are supplementary to, or different from those implemented by the government health system. It would address one or more of the objectives of the RCH programme, and should be able to demonstrate impact in terms of improvement in RCH outcomes for the poor and disadvantaged groups in the community. Projects, could, for example,

- increase community participation in, and responsibility for RCH activities;
- mobilise support from opinion leaders;
- improve health and care seeking behaviour among target populations;
- enhance or supplement appropriate services for the poort for example through mobile clinics, referral transport, private hospitals and clinics;
- promote baby friendly practices in hospitals;
- supplement or enhance government capacity, for example in implementing the Prenatal Diagnostic Technique Act.

In addition to these examples, NGOs would be encouraged to suggest other approaches congruent with RCH objectives.

Given the range of NGOs in the country, for the purpose of participation in the RCH Program NGOs would be considered in three major categories;

- Small NGOs working at the village and Panchayat and Block levels;
- Medium-sized NGOs working at state level and national NGOs working in more than one state;

- Selected medium sized and national NGOs who would also function as mother NGOs serving 5-10 districts each, to mentor and provide support to small NGOs

2. A concise Statement of Objectives of small NGOs

To reduce unwanted fertility, improve maternal and child health, and promote responsible and healthy sexual behaviour by implementing innovative projects for specific disadvantaged target populations.

3. Outline of Tasks to be carried out

Preparation of Project proposal

(Also see Attachment A for procedures for sanctioning of Projects)

3.1 Identify the geographic location, nature and estimated size of specific disadvantaged target population(s).

3.2. Develop and submit a project propoosal that includes the following elements:

(a) Measurable objectives with key indicators and expected achievement levels for the indicators. For example, measurable objectives for an advocacy project, should be stated., as far as possible, in terms of a change in behaviour of the target population that is feasible to be achieved within the project period. If the project is proposed for a period of more than one year, objectives for the first year, and for end of project period should be specified. There should be a clear indication on how the achievement of objectives would be measured.

(b) Activities with a time schedule.

(c) Organisational arrangements. Describe implementation arrangements including management, staffing, technical supervision, linkages with existing government or private sector services, inputs(if any) expected from government services.

(d) Monitoring and evaluation plan.

(e) Budget.

3.3 Submit proposal to mother NGO for review and consideration for funding.

Implementation of Project

3.4. Establish management structure required for project implementation.

3.5. Recruit, manage and supervise required personnel;

3.6. Receive and disburse funds for project activities in a timely fashion;

3.7. Procure and deliver required supplies to project site;

3.8. Establish and maintain effective communication with relevant government authorities;

3.9. Implement a monitoring system(including feedback from beneficiaries) and with regular reporting of project activities:

3.10. Collaborate with the mother NGO to conduct periodic evaluation of project efficiency, effectiveness and impact;

3.11. Maintain a separate financial account for the proposed project;

3.12. Submit timely Utilisation Certificates to the mother NGO;

3.13. Submit annual audited statement of accounts and audit certificates to the mother NGO within a time period to be specified by the mother NGO.

4. Schedule for Completion of Tasks

The duration of the project will be initially for one year which may be extended depending upon performance of the NGO.

5. Data, Services and Facilities to be provided to the Small NGO

5.1 MOHFW would provide, through a mother NGO, grants to the small NGO for approved projects.

5.2 The small NGO would be provided appropriate technical and managerial support(including training) by a mother NGO.

5.3 The mother NGO would:

- Screen the eligibility of small NGOs in accordance with criteria that have been specified(see Attachment A);
- Review and approve proposed projects;
- Make timely release of funds to small NGO, from funds that will be provided to the mother NGO by the Ministry of Health and Family Welfare(MOHFW);
- Monitor and report on the performance of small NGOs

6. Final output by Small NGO

(a) Narrative report of project detailing results of project e.g. number of beneficiaries, achievements in relation to stated objectives, project impact.

(b) Financial report of project

7. Composition of Review Committee to Monitor the Small NGO's work

The work of the small NGO will be reviewed by a Project Review & Sanctioning Committee(PRSC), established by the mother NGO. The PRSC would include community members, NGO representatives and two nominees, one each from the State Government and the MOHFW, Government of India.

8. Procedure for Review of Progress Reports, Inception Status, Final Draft and Final Reports

8.1 *Approval of eligible NGOs* Sanctions by the PRSC of eligible small NGOs and of projects submitted by such NGOs would be valid only if the PRSC meeting has had attendance of at least one of the two government nominees i.e. State Government representative or Government of India representative. (See Attachment A for details on eligibility criteria for small NGOs)

8.2 *Monitoring* . The small NGO would be required to submit utilisation certificates and progress reports to the mother NGO at mutually agreed dates not less frequent than everyt 6 months. The small NGO would provide reasonable access to officers appointed by the mother NGO to review and advise on managerial, technical and financial issues where necessary, including visits to field sites and review of records and financial accounts. The small NGO would be responsible for sending its officers to training sessions organised by the mother NGO.

8.3. *Evaluation.* Report of evaluation would be submitted by the samll NGO to the mother NGO who would be responsible for providing advice on improving quality of evaluations, reviewing and making recommendations to the Government on extensions of the project.

9. List of key positions whose CVs and Experience would be evaluated.

The CVs of Chief Executive and the Executive Committee Members alongwith the Staff working with the NGO will be evaluated. The working experience of NGO in the field of Health & Family Welfare will also be taken in account during evaluation.

Attachment A: Eligibility Conditions for small NGOs and Procedures for sanction and financing of projects.

Attachement A

Eligibility conditions for small NGOs

The NGO will be required to fulfill the following conditions:

1. NGO should have the character of a Registered Society or Trust.
2. NGO should have been in existence preferably for atleast three years but this can be considered for beingwaived of in areas which are weak in NGO coverage.
3. NGO should have office premises either its own or rented in the state where it wishes to work. There should be at least minimum necessary furniture and office equipment.
4. NGO should have atleast one full time or part time specialist relating to field of activity and at least one full time/part time person for administration/financial management.
5. The governing body of NGO must have at least 35% members with background in the field of activity.
6. NGO should have at least Rs. 25,000/- in fixed/cash assets to ensure that it is an organisation of substance.
7. An NGO blacklisted by any Ministry/Department of Government of India/State would not be sanctioned a project for next five years.
8. The documents/reports submitted by the NGO should have been verified and found to be in order.

Procedure for sanctioning projects proposed by small NGOs

1. Proposals would be reviewed and approved by the Project Review & Sanctioning Committee(PRSC) of a mother NGO, at meetings that must have attendance of at least one of the 2 governmet nominees. PRSC decisions regarding approval of NGOs or of specific projects would not be valid if there is no governmentr nominee at the meeting.
2. The NGO should be capable of implementing the project efficiently and effectively.
3. There will be no insistence on any share of funds being contributed by the small NGO for implementation of the project.
4. The duration of the project would be initially for one year, and may be extended depending on the performance of the NGO.
5. Before the first project is assigned to the NGO its credentials must be verified by an independent agency.
6. Individual projects of up to Rs.1/- lakh each would be considered for small NGOs.
7. The annual grant to the small NGO will be released in timely fashion

4619393

Externally Aided RCH Sub-Project - Monitoring Detai

Report for the Month ending:

PART - I (PROJECT DETAILS)

1. Name of Project: RCH-Sub-Project in Bellary district of Karnataka State.

2. Main objectives: (i) To greatly increase access of FW Services in the district with an to drastically reduce birth rate & increase the Contraceptive Prevalance Rate(CPR) especially in rural areas & local priority groups of the district. The ground for selecting this district that fertility rate & infant mortality rate (IMR) inter alia, of district are much higher than the corresponding averages of the St i.e. Karnataka.The aim of the sub-project is to greatly reduce t disparity.

(ii) To greatly increase the % of safe deliveries out of total deliver so that disparity between the district & the State w.r.t. % of deliveries by Mid- Wifery trained persons can be geately reduce

(iii) To greatly increase the household visits by health workers so t disparity between the district & the State w.r.t. % of household reporting having been visited by HWs during last 3 months can greatly reduced.

For achieving the above objectives,inter alia, GOI would finance ci works,procurement of medical & non-medical equipments,furniture,drugs,vehicles,hiring consultants,contractual services,IEC activities besides NGO schemes,honoraria for commu Health (Link) persons & Women Village Health Committees.

3. Dt. of: a) Start: 01.10.97 b) Completion: 30.09.2002 c) Credit Closing: ---------

4. Total Project cost (for five years): Rs.--------Crores

5. Cost approved for current year (as per Action Plan):- Rs.--------Crores

6. Total Money released: Upto last year: Rs.--------Crores

During current year: Rs.--------Crores

(Rs. in Crores)

Sr. No.	Item	Amount/figure	Remark, if any
1.	Expenditure		
	i) upto last year		
	ii) during the current year till date		
	(As against the current year target of)		
	iii) cummulative till date		
2.	Claims filed		
	i) upto last year		
	ii) during the current year till date		
	iii) cummulative till date		
3.	Cummulative Reimbursement Received by MOHFW so far		
4.	Indicators		
	i) % of cummulative exp. to total cost		
	ii) % of exp. during current year to the targetted exp. as per action plan		
5.	Remarks, if any:		

PART – IV CATEGORY WISE EXPENDITURE DETAILS

(Rs. in crores)

Sr.-No.	Item	Amount/figure	REMARKS (if any)
1.	CIVIL WORKS		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
2	PROCUREMENT		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
3	I.E.C.		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
4	N.G.O. SCHEMES		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
6	OPERATING COST		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
5	REMARKS (if any)		

PART – V : CATEGORY-WISE FINANCIAL PROGRESS

(Rs. in crores)

Activity	Total Project Provision	Upto the end of last year		During the current year			Cummulative position		Rem: if
		Exp.-incurred	Claims filed	Total provision (target)	Exp.incurred	Claims filed	Cummulative exp.incurred so far (3)+(6)	Cummulative claims filed so far (4)+(7)	
1	2	3	4	5	6	7	8	9	
Construction									
Procurement of:									
a) Equipments & furniture									
b) Drugs									
c) Vehicles									
Training									
Information, Education & Communication									
N.G.Os.									
Operational Costs									
Others, if any									
Total									
Remarks									

FORMAT FOR MONITORING PHYSICAL ACTIVITIES UNDER RCH SUB-PROJECT

Name of the District: Bellary Reporting for the month ending:

Project Activities	Project target	Sites identified	Work in progress	Work completed	Already operationalised	Remarks, if
1	2	3	4	5	6	7
CIVIL WORKS						
a)CONSTRUCTION RELATED TO EXPANSION OF SERVICE DELIVERY						
1)Sub-centres (New Buildings)	76					
2) PHCs (New Buildings)	10					
3) Expansion of Primary Health Units(PHUs) to provide RCH services	11					
4) Upgradation of urban PHU as Maternity Homes	4					
Other Remarks						
c)OTHER CONSTRUCTION						
)						
)						
)						
Other Remarks						

PROCUREMENT & SUPPLY OF EQUIPMENTS, FURNITURE & VEHICLE

Project Activities :	Project target	Achi-eve-ment	Remarks, if any
1	2	3	4
B. EQUIPMENTS (For Health Centres)			
) Kits A,B,C & G for Sub-centres with new buildings	76		
) Kit G for other Sub-centres	174		
) Kits D,F,G,H,I & J for PHCs & upgraded PHUs	10		
) Kits D to P and for urban PHUs converted as Maternity Homes	71		
C. FURNITURE			
a) Furniture for new sub-centre buildings (As per list)	76		
) Examination table	1		
) Foot step	1		
) Wash basin with stand	1		
) Stool	1		
) Cot with mattress	1		
) Bench for visitors	2		
) Cupboards for equipment and supplies	2		
) Office table	1		
) Side rack	1		
) Chairs	2		
) Container for water storage	1		
) Bucket with lid	2		
b) Furniture for New PHC Buildings & Upgraded PHUs (As per list)	10 PHCs 11 PHUs		
) Examination table	1		
) Foot step	1		
) Wash Basin	1		
) Stool	1		
) Cot with mattress	6		
) Bedside locker	6		

) Bench for visitors	4		
) Cupboards for equipments & supplies	4		
c) Furniture for Maternity Homes (As per list)	4 Maternity Homes		
) Examination table	2		
) Delivery table	1		
) Foot steps	2		
) Bedside screen	4		
) Revolving stool	4		
) Saline Stand	4		
) Wheel chair	1		
) Stretcher on trolley	1		
) Oxygen trolley	1		
) Iron cot with mattress & pillow	20		
) Baby cot	10		
) Bedside locker	20		
) Dressing trolley	1		
) Instrument cabinet	1		
) Instrument trolley	1		
) Linen trolley	1		
) Attendant stool	20		
) Steel cupboard	4		
) Blood donor table (wooden)	1		
) Wooden benches	4		
) Bucket (galvanised)	4		
) Bed pans & urinals	5		
) Bowls	5		
) Kidney tray	5		
D. Communication Facility (Telephone) to PHCs/upgraded PHUs	71		

E. VEHICLES			
) Jeeps	44		
F. Supply of Drugs			
PHCs/PHUs - EOC drugs and drugs for treatment of STI/RTI (The name of drugs may be given here)	71 (No. of units)		
Maternity Homes, CHCs & Taluk Hospitals (The name of drugs may be given here)	14 (No. of units)		
Other Remarks			

INFORMATION, EDUCATION & COMMUNICATION

Project activity	Project target	Achie-vement	Remarks, if any
) Training to improve communication skills of paramedical staff			
) Providing each ANM with inter personal communication kit consisting of items such as flash cards, flip charts, slide viewers and other educational aids			
) Conducting communication need assessment survey for working out target groups for RCH activities, messages to be conveyed; and appropriate media mix for each target group			
) Preparation of IEC Material for field exhibitions			
) Preparation of IEC Materials for being broadcast/telecast by AIR/Doordarshan			
) Preparation of IEC Materials for inter-personal communication			
) Conducting audio-visual programmes/campaigns along with inter personal communication to achieve maximum impact			
) Pre-testing IEC Materials			
) 15 minutes Video Film	6		

) Flip Chart	900		
) Pamphalets (thousands)	3000		
) Participation in Swasthaya melas/Involvement of NGOs	32		
H. Community Participation			
i) Formation of Health Advisory Committees	253		
ii) Appointment of voluntary workers & incentives to voluntary workers	625 (No.of persons)		
iii) Allocation of villages to NGOs for RCH Services	20 (No. of N.G.Cs.		
Other Remarks			

VACANCY POSITION

Sr.-No.	Name of Post provided as incremental staff under the Project	Target as approved by GOI	Sanctioned by State	Filled up	REMARKS
1	Project Assistant	1			
2	LMO for PHCs	19			
3	Staff Nurse	39			
4	Lab. technician	4			
5	Anaesthetist	4			
6	Drivers	41			
	TOTAL	108			

BASELINE SURVEY

Name of Organisation undertaking survey	Date of Initiation of survey	Target date of completion	Date of submission of Report

4619393

Externally Aided RCH Sub-Project - Monitoring Detai

Report for the Month ending:

PART - I (PROJECT DETAILS)

1. Name of Project: RCH-Sub-Project in Bellary district of Karnataka State.

2. Main objectives: (i) To greatly increase access of FW Services in the district with an to drastically reduce birth rate & increase the Contraceptive Prevalance Rate(CPR) especially in rural areas & local priority groups of the district. The ground for selecting this district that fertility rate & infant mortality rate (IMR) inter alia, of district are much higher than the corresponding averages of the St i.e. Karnataka.The aim of the sub-project is to greatly reduce t disparity.

(ii) To greatly increase the % of safe deliveries out of total deliver so that disparity between the district & the State w.r.t. % of deliveries by Mid- Wifery trained persons can be greately reduce

(iii) To greatly increase the household visits by health workers so t disparity between the district & the State w.r.t. % of household reporting having been visited by HWs during last 3 months can greatly reduced.

For achieving the above objectives,inter alia, GOI would finance ci works,procurement of medical & non-medical equipments,furniture,drugs,vehicles,hiring consultants,contractual services,IEC activities besides NGO schemes,honoraria for commun Health (Link) persons & Women Village Health Committees.

3. Dt. of: a) Start: 01.10.97 b) Completion: 30.09.2002 c) Credit Closing: ---------

4. Total Project cost (for five years): Rs.--------Crores

5. Cost approved for current year (as per Action Plan):- Rs.--------Crores

6. Total Money released: Upto last year: Rs.--------Crores

During current year: Rs.--------Crores

(Rs. in Crores)

Sr. No.	Item	Amount/figure	Remark, if any
1.	Expenditure		
	i) upto last year		
	ii) during the current year till date		
	(As against the current year target of)		
	iii) cummulative till date		
2.	Claims filed		
	i) upto last year		
	ii) during the current year till date		
	iii) cummulative till date		
3.	Cummulative Reimbursement Received by MOHFW so far		
4.	Indicators		
	i) % of cummulative exp. to total cost		
	ii) % of exp. during current year to the targetted exp. as per action plan		
5.	Remarks, if any:		

PART – IV CATEGORY WISE EXPENDITURE DETAILS

(Rs. in crores)

Sr.-No.	Item	Amount/figure	REMARKS (if any)
1.	CIVIL WORKS		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
2	PROCUREMENT		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
3	I.E.C.		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
4	N.G.O. SCHEMES		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
6	OPERATING COST		
	Total cost		
	Expenditure		
	i) upto the end of previous year		
	ii) during the current year		
	iii) cummulative till date		
5	REMARKS (if any)		

PART – V : CATEGORY-WISE FINANCIAL PROGRESS

(Rs. in crores)

Activity	Total Project Provision	Upto the end of last year		During the current year			Cummulative position		Rem if
		Exp.-incurred	Claims filed	Total provision (target)	Exp.incurred	Claims filed	Cummulative exp.incurred so far (3)+(6)	Cummulative claims filed so far (4)+(7)	
1	2	3	4	5	6	7	8	9	
Construction									
Procurement of:									
a) Equipments & furniture									
b) Drugs									
c) Vehicles									
Training									
Information, Education & Communication									
N.G.Os.									
Operational Costs									
Others, if any									
Total									
Remarks									

FORMAT FOR MONITORING PHYSICAL ACTIVITIES UNDER RCH SUB-PROJECT

Name of the District: Bellary Reporting for the month ending:

Project Activities	Project target	Sites identified	Work in progress	Work completed	Already operationalised	Remarks, if
1	2	3	4	5	6	7
CIVIL WORKS						
a) CONSTRUCTION RELATED TO EXPANSION OF SERVICE DELIVERY						
1) Sub-centres (New Buildings)	76					
2) PHCs (New Buildings)	10					
3) Expansion of Primary Health Units(PHUs) to provide RCH services	11					
4) Upgradation of urban PHU as Maternity Homes	4					
Other Remarks						
c) OTHER CONSTRUCTION						
)						
)						
)						
Other Remarks						

PROCUREMENT & SUPPLY OF EQUIPMENTS, FURNITURE & VEHICLE

Project Activities :	Project target	Achi-eve-ment	Remarks, if any
1	2	3	4
B. EQUIPMENTS (For Health Centres)			
) Kits A,B,C & G for Sub-centres with new buildings	76		
) Kit G for other Sub-centres	174		
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C. FURNITURE			
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) Examination table	1		
) Foot step	1		
) Wash basin with stand	1		
) Stool	1		
) Cot with mattress	1		
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) Bench for visitors	4		
) Cupboards for equipments & supplies	4		
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) Examination table	2		
) Delivery table	1		
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) Saline Stand	4		
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) Attendant stool	20		
) Steel cupboard	4		
) Blood donor table (wooden)	1		
) Wooden benches	4		
) Bucket (galvanised)	4		
) Bed pans & urinals	5		
) Bowls	5		
) Kidney tray	5		
D. Communication Facility (Telephone) to PHCs/upgraded PHUs	71		

B. VEHICLES			
) Jeeps	44		
F. Supply of Drugs			
PHCs/PHUs - EOC drugs and drugs for treatment of STI/RTI (The name of drugs may be given here)	71 (No. of units)		
Maternity Homes, CHCs & Taluk Hospitals (The name of drugs may be given here)	14 (No. of units)		
Other Remarks			

INFORMATION, EDUCATION & COMMUNICATION

Project activity	Project target	Achie-vement	Remarks, if any
) Training to improve communication skills of paramedical staff			
) Providing each ANM with inter personal communication kit consisting of items such as flash cards, flip charts, slide viewers and other educational aids			
) Conducting communication need assessment survey for working out target groups for RCH activities, messages to be conveyed; and appropriate media mix for each target group			
) Preparation of IEC Material for field exhibitions			
) Preparation of IEC Materials for being broadcast/telecast by AIR/Doordarshan			
) Preparation of IEC Materials for inter-personal communication			
) Conducting audio-visual programmes/campaigns along with inter personal communication to achieve maximum impact			
) Pre-testing IEC Materials			
) 15 minutes Video Film	6		

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) Pamphalets (thousands)	3000		
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H. Community Participation			
i) Formation of Health Advisory Committees	253		
ii) Appointment of voluntary workers & incentives to voluntary workers	625 (No.of persons)		
iii) Allocation of villages to NGOs for RCH Services	20 (No. of M.G.Cs.		
Other Remarks			

VACANCY POSITION

Sr.-No.	Name of Post provided as incremental staff under the Project	Target as approved by GOI	Sanctioned by State	Filled up	REMARKS
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2	LHO for PHCs	19			
3	Staff Nurse	39			
4	Lab. technician	4			
5	Anaesthetist	4			
6	Drivers	41			
	TOTAL	108			

BASELINE SURVEY

Name of Organisation undertaking survey	Date of Initiation of survey	Target date of completion	Date of submission of Report

CONTRACT FOR CONSULTING SERVICES

Small Assignments

Lump Sum Payments
(IBRD/IDA Financed)

(April 1998)

CONTRACT FOR CONSULTING SERVICES
SMALL ASSIGNMENTS
LUMP SUM PAYMENTS
(IBRD/IDA FINANCED)

CONTRACT

THIS CONTRACT ("Contract") is entered into this _____ [starting date of assignment] day of _____, 19___, by and between _____ ("the Client") having its principal place of business at _____, and _____ ("the Consultant") having its principal office located at _____.

WHEREAS, the Client wishes to have the Consultant perform the services hereinafter referred to, and

WHEREAS, the Consultant is willing to perform these services,

NOW THEREFORE THE PARTIES hereby agree as follows:

1. Services

(i) The Consultant shall perform the services specified in Annex A, "Terms of Reference and Scope of Services", which is made an integral part of this Contract ("the Services").

(ii) The Consultant shall provide the personnel listed in Annex B, "Consultant's Personnel", to perform the Services.

(iii) The Consultant shall submit to the Client the reports in the form and within the time periods specified in Annex C, "Consultant's Reporting Obligations".

2. Term

The Consultant shall perform the Services during the period commencing _____ and continuing through _____, or any other period as may be subsequently agreed by the parties in writing.

3. Payment

A. Ceiling

(i) For Services rendered pursuant to Annex A, the Client shall pay the Consultant an amount not to exceed _____.

(ii) The above amount has been established based on the understanding that it includes all of the Consultant's costs and profits as well as any tax obligation that may be imposed in the case of all domestic Consultants and foreign Consultants who are residents in India. The Client will perform such duties in regard to the deduction of such tax at source as may be lawfully imposed.

In the case of foreign Consultants who are not the residents in India, the Client will pay directly the taxes, dues, fees, levies and other impositions in India related to:

(a) payments to the consultants in connection with carrying out this assignment;

(b) equipment, materials and supplies brought into India for the purpose of carrying out the study, provided they are subsequently withdrawn; and

(c) property brought in for your personal use, provided the property is subsequently withdrawn.

(Modify this clause as appropriate)

B. Schedule of Payments

The schedule of payments is specified below*:

Currency	Amount	
_____	_____	upon the Client's receipt of a copy of this Contract signed by the Consultant and upon submission of inception report;
_____	_____	upon the Client's receipt of the draft report, acceptable to the Client; and
_____	_____	upon the Client's receipt of the final report, acceptable to the Client.
_____	_____	Total

C. Payment Conditions

Payment shall be made in _____ [specify currency], no later than 30 days following submission by the Consultant of invoices in duplicate to the Coordinator designated in paragraph 4.

4. Project Administration

A. Coordinator. The Client designates Mr./Ms. _____ as Client's Coordinator; the Coordinator will be responsible for the coordination of activities under this Contract, for acceptance and approval of the reports and of other deliverables by the Client and for receiving and approving invoices for the payment.

B. Reports. The reports listed in Annex C, "Consultant's Reporting Obligations", shall be submitted in the course of the assignment, and will constitute the basis for the payments to be made under paragraph 3.

5. Performance Standards

The Consultant undertakes to perform the Services with the highest standards of professional and ethical competence and integrity. The Consultant shall promptly replace any employees assigned under this Contract that the Client considers unsatisfactory.

6. Confidentiality

The Consultants shall not, during the term of this Contract and within two years after its expiration, disclose any proprietary or confidential information relating to the Services, this Contract or the Client's business or operations without the prior written consent of the Client.

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* Modify in order to reflect the output required, as described in Annex C

7. Ownership of Material

Any studies, reports or other material, graphic, software or otherwise, prepared by the Consultant for the Client under the Contract shall belong to and remain the property of the Client. The Consultant may retain a copy of such documents and software. The consultants shall not use these documents and software for purposes unrelated to this contract without the prior written approval of the client.

8. Consultant not to be engaged in certain activities

The Consultant agrees that, during the term of this Contract and after its termination, the Consultant and any entity affiliated with the Consultant, shall be disqualified from providing goods, works or services (other than the Services and any continuation thereof) for any project resulting from or closely related to the Services.

9. Insurance

The Consultant will be responsible for taking out any appropriate insurance coverage.

10. Assignment

The Consultant shall not assign this Contract or sub-contract or any portion of it without the Client's prior written consent.

11. Law Governing Contract and Language

The Contract shall be governed by the laws of Union of India, and the language of the Contract shall be English.

12. Dispute Resolution*

Any dispute arising out of the Contract, which cannot be amicably settled between the parties, shall be referred to adjudication/arbitration in accordance with Indian Arbitration & Conciliation Act 1996.

FOR THE CLIENT	FOR THE CONSULTANT
Signed by _____	Signed by _____
Title: _____	Title: _____

* In the case of a Contract entered into with a foreign Consultant, the following provision may be substituted for paragraph 12: "Any dispute, controversy or claim arising out or relating to this Contract or the breach, termination or invalidity thereof, shall be settled by arbitration in accordance with the United Nations Commision on International Trade Law (UNCITRAL) Arbitration Rules as at present in force."

LIST OF ANNEXES

ANNEXURE A

TERMS OF REFERENCE AND SCOPE OF SERVICES

[Refer Clause 1 (i)]

Give detailed descriptions of the Services to be provided; dates for completion of various tasks, place of performance for different tasks; specific tasks to be approved by Client, etc. as indicated below:

1. Background
2. A Precise Statement of Objectives
3. An Outline of the Tasks to be Carried Out (Scope of the Services)
4. Schedule for Completion of Tasks
5. Data, Services and Facilities to be Provided by the Client
6. Final Outputs (i.e. Reports, Drawings etc.) that will be Required of the Consultant
7. Composition of Review Committee to Monitor Consultant's Work
8. Procedure for Review of Progress Reports, Inception, Status, Final Draft and Final Reports

ANNEXURE B

CONSULTANT'S PERSONNEL

(Refer Clause 1 (ii) of the Contract)

[List under: C-1 Titles [and names, if already available], detailed job descriptions, minimum qualifications and experience of Personnel to be assigned, and staff-months for each.

ANNEXURE C

CONSULTANT'S REPORTING OBLIGATIONS

[Refer clause 1 (iii)]

[List format, frequency and contents of reports; persons to receive them; dates of submission, number of copies etc. If no reports are to be submitted, state here "Not applicable".]

Sl. No.	State	Issues identified	Action Taken	Progress Report	Remarks
15.	**West Bengal: Asansole**	**A. Civil Works** New Const. HAU 13 ESOPD 2 Mat. Home 2 Med. Store 1 Add-on/Repairs Nil	i)Bidding Process started. Evaluation Report for Civil Works forwarded to Bank for approval. ii)The State Govt. has escalated the cost of individual units significantly because of increase in the covered area. A letter to this effect requesting to restrict the activities upto the approved cost ceiling, was sent.	Approval is still awaited. A further letter dt 28.9.99 from the Advisor health (SUDA) has been sent justifying the cost escalation	This cost escalation is necessary to maintain the world Bank norms and guidelines, with a view to maintain minimum facilities without any curtailment.
		b)Action Plan	b)Action plan for civil works is awaited.	Being followed as per the approved Project Report	8 HAU by March 2000 2 ESOPD by June 2000
		B Procurement	i)Whether approval for FY 1999-2000 received.	Plan Submitted	
			ii) Number of procurement action planned in FY 1999-2000. a)drugs 1 b)furniture 4 c)equipment 6 d)vehicle. 1 (e) Misc 2 (family schedule, Instr. Manual, Kit Bag, Walt Cofteni)	Submitted	
			iii)Number of procurement actions completed. a)drugs b)furniture c)equipment d)vehicle. (e) Misc	1 2 4 - Tender Apprasial Completed 2 - Under process NIL 2.	
		C.IEC & NGO	Not reported	Identified and activities are going on — TOR & Model Contract form received.	
		D.Consultancies	-do-	Under processing - Consultancy in awareness generation and Program Coordination	
	West Bengal: Murshidabad	**A. Civil Works** New Const. SC 99 Add –on/Repairs Nil	i)Number planned up to March, 2000. ii)Number completed by Sept.' 99	- Drawing cleared.	

		iii)If planned facilities are not operational, reasons.		
	B.Procurment.	i)Whether approval for FY 1999-2000 received. ii) Number of procurement action planned in FY 1999-2000. a)drugs b)furniture c)equipment d)vehicle. iii)Number of procurement actions completed. a)drugs b)furniture c)equipment d)vehicle. iv)If planned procurement actions not completed, reasons.		
	C.Selection of volunteers	i)Project Dir. assured that by 30th Sept.,' 99, 1927 volunteers would be appointed.		
	D. Proposal for appointment. Of Asstt.Health Officer	i)Proposal awaited.		
	E.Proposal for institutional - deliveries in private nursing home.	i)It was suggested that by 31st October, Proposal would be submitted to MOHFW.		
	F.ESOPDs should be combined with maternity homes for which buildings will be hired.	i)Proposal awaited.		
	G .For construction of	i) State Government assured that by 31st Dec.'		

	21 Sub Centres, money will be given by Dec.' 99. 55 sites will be identified by Dece.' 99 and construction will start immediately.	99, all action will be completed.		

Sl. No.	State	Issues identified	Action Taken	Progress Report	Remarks
15.	**West Bengal: Asansole**	**A. Civil Works** New Const. HAU 13 ESOPD 2 Mat. Home 2 Med. Store 1 Add-on/Repairs Nil	i)Bidding Process started. Evaluation Report for Civil Works forwarded to Bank for approval.	Approval is still awaited.	
			ii)The State Govt. has escalated the cost of individual units significantly because of increase in the covered area. A letter to this effect requesting to restrict the activities upto the approved cost ceiling, was sent.	A further letter dt 28.9.99 from the Advisor Health (SUDA) has been sent justifying the cost escalation	This cost escalation is necessary to maintain the World Bank norms and guidelines, with a view to maintain minimum facilities without any curtailment.
		b)Action Plan	b)Action plan for civil works is awaited.	Being followed as per the approved Project Report.	BHAU by March 2000 2 ESOPDs by June 2000
		B Procurement	i)Whether approval for FY 1999-2000 received.	Plan Submitted	
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			iii)Number of procurement actions completed. a)drugs b)furniture c)equipment d)vehicle. (e) Misc	1 2 4 - Tender Approval Completed 2 - Under process NIL 2.	
		C.IEC & NGO	Not reported	Identified and activities are going on — TOR & Model Contract form resolved.	
		D.Consultancies	-do-	under processing - Consultancy in awareness generation and Program Coordination	
	West Bengal: Murshidabad	**A. Civil Works** New Const. SC 99 Add –on/Repairs Nil	i)Number planned up to March, 2000.	- Drawing cleared.	
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		iii)If planned facilities are not operational, reasons.		
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15. **West Bengal: Asansole**	**A. Civil Works** New Const. HAU 13 ESOPD 2 Mat. Home 2 Med. Store 1 Add-on/Repairs Nil	i)Bidding Process started. Evaluation Report for Civil Works forwarded to Bank for approval. ii)The State Govt. has escalated the cost of individual units significantly because of increase in the covered area. A letter to this effect requesting to restrict the activities upto the approved cost ceiling, was sent.	Approval is still awaited. A further letter dt 28.9.99 from the Advisor Health (SUDA) has been sent justifying the cost escalation	This cost escalation is necessary to maintain the World Bank norms and guidelines, with a view to maintain minimum facilities without any curtailment.
	b)Action Plan	b)Action plan for civil works is awaited.	Being followed as per the approved Project Report.	8 PHC by March 2000 2 ESOPD by June 2000
	B Procurement	i)Whether approval for FY 1999-2000 received. ii) Number of procurement action planned in FY 1999-2000. a)drugs 1 b)furniture 4 c)equipment 6 d)vehicle. 1 (e) Misc 2 iii)Number of procurement actions completed. a)drugs b)furniture c)equipment d)vehicle. (e) Misc	Plan Submitted Submitted 1 2 4 - Tender Appraisal Completed 2 - Under process NIL 2.	
	C.IEC & NGO	Not reported	Identified and activities are going on — TOR & Model Contract form resolved.	
	D.Consultancies	-do-	under processing - Consultancy in awareness generation and Program Coordination	
West Bengal: Murshidabad	**A. Civil Works** New Const. SC 99 Add -on/Repairs Nil	i)Number planned up to March, 2000. ii)Number completed by Sept.' 99	- Drawing cleared.	

		iii)If planned facilities are not operational, reasons.		
	B.**Procurment.**	i)Whether approval for FY 1999-2000 received. ii) Number of procurement action planned in FY 1999-2000. a)drugs b)furniture c)equipment d)vehicle. iii)Number of procurement actions completed. a)drugs b)furniture c)equipment d)vehicle. iv)If planned procurement actions not completed, reasons.		
	C.**Selection of volunteers**	i)Project Dir. assured that by 30th Sept.,' 99, 1927 volunteers would be appointed.		
	D. Proposal for appointment. Of Asstt.Health Officer	i)Proposal awaited.		
	E.Proposal for institutional - deliveries in private nursing home.	i)It was suggested that by 31st October, Proposal would be submitted to MOHFW.		
	F.ESOPDs should be combined with maternity homes for which buildings will be hired.	i)Proposal awaited.		
	G .For construction of	i) State Government assured that by 31st Dec.'		

	21 Sub Centres, money will be given by Dec.' 99. 55 sites will be identified by Dece.' 99 and construction will start immediately.	99, all action will be completed.		