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STAFF APPRAISAL REPORT

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

MAY 26, 1992

India Country Operations Department
Population and Human Resources Division

CURRENCY EQUIVALENTS
(as of May 26, 1992)

Currency Unit = Rupee
Rupee 26.2 = US$1.00
Rupee 1.00 = US$ 0.038

METRIC EQUIVALENTS

1 Meter (m) = 3.28 Feet (ft)
1 Kilometer (km) = 0.62 Miles

FISCAL YEAR

April 1 - March 31

ABBREVIATIONS AND ACRONYMS

ANM	-	Auxiliary Nurse Midwife
AP	-	Andhra Pradesh
BCC	-	Bangalcre City Corporation
CMDA	-	Calcutta Metropolitan Development Authority
CMOH	-	Chief Medical Officer of Health
CSIP	-	ODA-Assisted Calcutta Slum Improvement Project
CUDP III	-	Third IDA-Assisted Calcutta Urban Development Project
ESIP	-	Environmental Sanitation Improvement Program
ECCR	-	Eligible Couple and Children Register
ESOPD	-	Extended Special Out-Patient Department
FP	-	Family Planning
GOI	-	Government of India
GOWB	-	Government of West Bengal
HAU	-	Health Administrative Unit
HHW	-	Honorary Health Worker
IEC	-	Information, Education and Communications
MIS	-	Management Information System
MCD	-	Municipal Corporation of Delhi
MCH	-	Municipal Corporation of Hyderabad
MOHFW	-	Ministry of Health and Family Welfare
MCH	-	Maternal and Child Health
NGO	-	Non-Government Organization
PVO	-	Private Voluntary Organization
PMP	-	Private Medical Practitioners
RTC	-	Regional Training Center
RMC	-	Regional Medical Stores
SHE	-	Social, Health and Environmental (Clubs)
UBSP	-	Urban Basic Services for the Poor Scheme
UFWC	-	Urban Family Welfare Center
UHC	-	Upgraded Health Center
UNFPA	-	United Nations Fund for Population Activities
UNICEF	-	United Nations Childrens Fund
UIP	-	Universal Immunization Program
URS	-	Urban Revamping Scheme
WHO	-	World Health Organization

DEFINITIONS

Crude Birth Rate	Number of live births per year per 1,000 population.
Crude Death Rate	Number of deaths per year per 1,000.
Natural Increase Rate	Difference between crude birth and crude death rates; usually expressed as a percentage.
Population Growth Rate	Rate of natural increase adjusted for (net) migration, expressed as a percentage of the total population in a given year.
Contraceptive Prevalence Rate	The percentage of married women of reproductive age who are using a modern method of contraceptive at any time.
Total Fertility Rate	The average number of live children that would be born per women if she were to live to the end of her childbearing years and bear children according to a given set of age-specific fertility rates. The Total Fertility Rate often serves as an estimate of the average number of children per family.
Net Reproduction Rate	The number of live-born daughters a cohort of females would bear under a given fertility schedule and a given set of survival probabilities, from birth to the end of the childbearing years.
Perinatal Mortality	Mortality related to the period between 28 weeks gestation and one week postnatal.
Infant Mortality Rate	Annual number of deaths of infants under one year per 1,000 live births during the same year.
Child Mortality Rate	Annual deaths of children 1-4 years of age per 1,000 children in the same age group.
Maternal Mortality Rate	Number of maternal deaths per 1,000 births attributable to pregnancy, childbearing, or puerperal complications (i.e., within six weeks following childbirth).
Morbidity	Any departure, subjective or objective, from a state of physiological or psychological well-being. In this sense, sickness, illness, and morbid condition are synonymous.

DEFINITIONS (continued)

Morbidity Rate	The frequency of disease and illness in a population.
Prevalence Rate	The number of persons having a particular disease at a given point in time per population at risk; usually expressed per 1,000 persons per year.
Life Expectancy	Average number of years expected to be lived by children born in a given year if mortality rates for each age/sex group remain the same in the future.
Low Birth Weight (LBW)	Infant weight at birth less than 2,500 gr. LBW may be associated with either pre-term (less than 37 weeks gestation) of full-term but small for dates (38 weeks or more) of gestation.
Toxemia of Pregnancy	Group of metabolic disturbances occurring during gestation or shortly after delivery, characterized by the appearance of hypertension, edema, and proteinuria (preeclampsia) and, in severe case, convulsions and coma (eclampsia).
Puerperium	The period after completion of the third stage of labor until involution of the uterus is complete, usually six weeks.
Puerperal sepsis	Infection of the reproductive organs caused by septic childbirth conditions (also called puerperal fever).
Risk	A probability that an unfavorable outcome related to morbidity or mortality will occur within a stated period of time or age.
Dependency Ratio	Population 14 years or under and 65 years of age or over as percentage of active population (aged 15 to 64 years). Indicates proportion of population that needs economic support.

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FAMILY WELFARE PROJECT FOR URBAN SLUMS

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This report is based on the findings of preappraisal and appraisal missions to India from December 3-15, 1991 and February 25 - March 14, 1992. The Project Team included Messrs. R. Cambridge, Principal Economist - Task Manager, and A. Andonyadis, Senior Architect and Mrs. A. Hill, Senior Population Specialist (SA2PH), and the following consultant specialists; Dr. D. Foster, Human Resources Development; Ms. P. Randall, Community Participation and Private Voluntary Organizations; Ms. W. Lynn, Information, Education and Communication; Dr. K. Chowdhury, Female Education/Women in Development; and Ms. P. Khetrapal, Administration and Management. Ms. S. Pak, Mr. Bill Keene and Ms. M. Chatterji (NDO) assisted in preparing the Report. The Peer Reviewers were Messrs. J. Greene, Principal Nutrition Specialist, S. Cochrane, Principal Population Specialist and S. Stout, Health Specialist. The Project is endorsed by Mr. Richard Skolnik, Chief, Population and Human Resources Division and Mr. Heinz Vergin, Director, India Country Department.

CHARTS

INDIA

FAMILY WELFARE PROJECT FOR URBAN SLUMS

BASIC DATA
(1990)

	INDIA	ANDHRA PRADESH	DELHI	KARNATAKA	WEST BENGAL
Total Area (km^2) 1/	3,287,263	275,043	1,483	191,791	88,752
Total Population 1/	844.0	66.35	9.37	44.80	67.98
Density per km^2	267	241	6,319	234	766
Total Fertility Rate	3.9	3.3	NA	3.4	3.5
Crude Birth Rate	29.9	25.6	22.8	27.8	27.3
Crude Death Rate	10.2	10.2	6.9	8.8	8.9
Rate of Natural Increase	20.5	20.8	NA	19.7	18.35
Life Expectancy at Birth	55	55.7	NA	58.5	55.1
Infant Mortality Rate	80	70	NA	71	63
Maternal Mortality Rate	5	NA	NA	NA	3
Urban Population as Percent of Total Population	25.72	26.84	89.93	30.91	27.39
Literacy Rate (age 7 and above)					
Males	63.86	56.24	82.63	67.25	67.24
Females	39.42	33.71	68.01	44.34	47.15
Primary School Enrollment	97.86	103.45	90.81	104.7	118.09
Males	113.13	118.15	89.65	112.96	134.87
Females	81.75	88.47	92.15	96.19	101.02
Age Structure 1/					
0-14	37.9	36.5	NA	37.8	36.3
15-59	56.2	57.2	NA	56.3	58.4
60 and over	5.9	6.3	NA	5.9	5.3
Current Contraceptive Prevalence Rate 2/	42	44.3	40.4	46.9	33.7
Age at Marriage	18.3	17.3	NA	19.2	19.2

1/ Bank estimate.
2/ Operations Research Group Survey.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

CREDIT AND PROJECT SUMMARY

Borrower:	India, acting by its President
Beneficiaries:	Governments of Andhra Pradesh, Karnataka, and West Bengal; Bangalore City Corporation (BCC); Calcutta Metropolitan Development Authority (CMDA); Municipal Corporation of Delhi (MCD); New Delhi Municipal Committee (NDMC); and the Municipal Corporation of Hyderabad (MCH).
Amount:	SDR 57.7 million (US$79.0 million equivalent).
Terms:	Standard with 35 years maturity.
On-Lending Terms:	Government of India (GOI) to Andhra Pradesh, Karnataka, and West Bengal in accordance with standard arrangements for development assistance to States and Union Territories to be passed on by the respective States and Union Territory to BCC, CMDA, NDMC, MCD and MCH respectively. At present, central assistance for family welfare is provided on a grant basis.
Description:	The project would include the following components: Increasing the Supply of Family Welfare Services to slum populations through improvements in outreach services using volunteer female health workers recruited from the slum communities, and the upgrading of existing and construction of new health facilities; Improving the Quality of Family Welfare Services provided to slum populations, by upgrading the supervisory, managerial, technical and interpersonal skills of all levels of new and existing medical and para-medical workers through pre-service, institutional in-service, and on-the-job recurrent training; and increasing the availability of drugs, medicines and other appropriate health supplies;

Increasing the Demand for Family Welfare Services through expanded information, education and communication activities, increased participation of the community in the preparation and implementation of various project activities and increased participation of Private Voluntary Organizations (PVOs) and Private Medical Practitioners (PMPs) in the delivery of health and family welfare services to the slum communities; Improving the Management and Administration of the municipal Health Departments through appropriate upgrading of project supervision, management information systems (MIS), information, education, and communication (IEC) functions, as well as integrating and/or strengthening co-ordination of health services with the provision of environmental sanitation, water supply, education and other critical services; Innovative Schemes which cover a range of additional services including supplementary nutrition, creche programs, environmental sanitation drives, female (particularly adolescent girls) education and skill training; and Preparation of Future Projects which would support the detailed preparation and project launch activities in another fifteen designated cities.

Benefits and Risks: The project would assist GOI to further refine its Urban Revamping Scheme to develop operational models for nationwide replication. It would also provide a suitable vehicle for participation of urban slum communities in determining the mix of services which are most appropriate to their felt needs. Further, the project would confer direct social benefits to low-income slum dwelling families, particularly women and children, by increasing access to and the quality of family planning and maternal and child health care services. In so doing, it would promote a decline in fertility, morbidity, and mortality among mothers, infants and young children. The major risks would be institutional and relate to the capacity of municipalities to implement the project, particularly to develop outreach services and work collaboratively with slum populations and PVOs. To minimize these risks, Municipal Health Departments would be strengthened under the project. Arrangements would be made to increase the cooperation between State governments, municipalities, private voluntary organizations, slum communities and private medical practitioners. Committees would be established with representatives from each group, to provide inputs to

project design, implementation and supervision, as well to undertake modifications if necessary.

Estimated Costs:

	LOCAL	FOREIGN	TOTAL
	--------US$ Millions-------		
Expanding the Supply of Family Welfare Services	37.60	3.30	40.90
Improving the Quality of Family Welfare Services	8.98	1.03	10.01
Increasing the Demand for Family Welfare Services	8.27	0.91	9.18
Improving the Management of Family Welfare Services	2.62	0.52	3.14
Innovative Schemes	7.23	0.53	7.76
Preparation of Future Projects	7.06	0.94	8.00
Total Base Costs	71.76	7.24	79.00
Contingencies	15.74	1.86	17.60
Total Project Costs	87.50	9.10	96.60

Financing Plan:

GOI	17.60	___	17.60
IDA	69.90	9.10	79.00
Total Project Costs	87.50	9.10	96.60

Estimated Disbursements:

IDA FY	FY93	FY94	FY95	FY96	FY97	FY98	FY99	FY2000
Annual	8.00	9.40	12.80	12.50	12.40	11.00	10.70	2.20
Cumulative	8.00	17.40	30.20	42.70	55.10	66.10	76.80	79.00

Economic Rate of Return: Not applicable.

INDIA

FAMILY WELFARE PROJECT FOR URBAN SLUMS

I. FAMILY WELFARE IN INDIA

A. Introduction

1.01 The proposed project is a critical part of IDA's strategy of supporting human capital development and poverty alleviation in India. It provides IDA with the opportunity to extend rapid but targeted assistance to the most vulnerable groups, about 1.6 million poor women between 15-44 years of age and about 850,000 children between 0-4 years of age (**Annex 1.** Table 1) who reside in urban slums and who are at risk of falling through the already tenuous social safety net, during a period of severe budgetary constraints on publicly-financed social programs. The special features of the project are that it would: (a) assist the Government of India (GOI) in expanding the coverage of family planning (FP) and maternal and child health (MCH) services (family welfare) to previously unserved urban slum areas and beneficiaries; (b) act as a vehicle of reform to improve the quality of services to be delivered to the urban poor; (c) increase the demand for family welfare services by substantially improving the participation of private voluntary organizations and communities in the design, delivery and supervision of family welfare services to be delivered to slum communities; and (d) institute an Innovative Schemes program under which investments in female education and training, nutrition awareness and environmental sanitation among others, would be supported. These aspects of the proposed project would enhance policy dialogue, monitoring, supervision and evaluation of the national family welfare program. They would also lead to the more effective delivery of essential health services, resulting in decreased rates of fertility, and infant, young child and maternal mortality and morbidity.

B. Population Characteristics and Trends

1.02 Fertility and Population Growth. India's population of over 840 million in 1991 (Annex 1, Table 2) is the world's second largest. The population has more than doubled since 1950, the result of long-term mortality declines combined with slower and less consistent fertility declines (Annex 1, Table 3). Across India, the total fertility rate (TFR) for urban areas is on average lower at 3.9 than the 4.6 rate for rural areas. However, the data available suggest higher TFRs among slum populations. The most important factor in recent fertility decline has been increasing contraceptive prevalence, which reached about 42% effective prevalence in 1990. Although the current population growth rate of around 2% per annum is modest when compared with many developing countries, the base population is so large that the absolute number added each year, some 17 million, is a serious constraint to India's development efforts. Even if India is able to achieve its goal of replacement fertility in the second decade of the coming century, the momentum of population growth will ensure absolute increases in the population for several decades thereafter.

1.03 Mortality. The maternal mortality rate in India is unacceptably high, estimated at 500 per 100,000 live births a year. This compares with 280 per 100,000 live births for the world as a whole. There are more than 25 million births a year in India, and around 30%-40% of these are high risk pregnancies. In the process, more than 100,000 women are estimated to die

each year, while over 1.6 million women suffer morbidity of varying degrees. Early marriage and early and frequent child bearing with short spaced pregnancies contribute to risk. These conditions are aggravated by over work, malnutrition and anemia, low levels of female literacy, and lack of access to health facilities. The situation with children is no better. The infant mortality rate (IMR) was 80 per 1,000 live births in 1989. Peri-natal mortality rates are above 50 per 1,000 live births in the most populous States, reflecting not only the poor health status and care of women during pregnancy, but also the poor quality of services at birth. The child death rate among those below five years of age is estimated at 38.4 per 1,000 children. Though the infant mortality rate does not vary much with gender, the mortality rates among children aged 1-5 years of age have been consistently higher for females than males, in both urban and rural areas and reflect the slower response of both the community and the health care system to the health and medical needs of females.

1.04 Urbanization. While India's population has more than doubled since 1947 to nearly 840 million in 1991, the urban population has grown almost twice as fast. Today, over 200 million people live in about 3,600 cities and towns in India. Nearly one of every three urban residents live below the poverty line, and their ranks grow each year by about 15 million. About 50 million of these people live on pavements, in poorly serviced tenement houses, in unhygienic slums and in illegal squatter colonies. They work as street vendors, domestic servants, scavengers, small time mechanics, rag pickers, and perform a host of other activities comprising the informal sector. About 68% of the urban poor are women and children. They are very vulnerable. Their large numbers and unacceptable living conditions challenge both government and the private sector to find solutions to break the cycle of deprivation. It is accepted that a most critical point at which to begin is with the mother and child. Their survival, development, and ability to secure a respectable place in society is vital. Ensuring that they have access to basic social services such as health care, nutritional supplementation, education, employment and income is key to the success in overcoming urban want.

1.05 **Bangalore** is the fastest growing city of India. The total population was 4.1 million in 1991. The decennial growth rate of population was 4.1% as compared to 2.1% for the State of Karnataka in which Bangalore is located. The slum population is estimated to be about 0.36 million. Of 401 identified slums, 93% are located in residential areas, 3.9% in industrial and 2.7% in commercial areas. The Bangalore City Corporation (BCC) covers only 6 of these slums. **Calcutta** is the largest metropolis of India with a population of 12.1 million in 1991. The population of Calcutta Metropolitan Standard Urban Area (CMSUA) increased about five times between 1921 and 1991. The density of population is 8,132 per sq km which is one of the highest in the world. About 45% of total CMSUA population (5.5 million) live in slums which have been categorized by different names according to their composition, structure and nature. There are bustees, refugee colonies, fringe area settlements with self help housing, pucca buildings with poor conditions of living, jute lines, squatter settlements and pavement dwellers. **Delhi** is the capital city of India with an area of 1,489 sq kms. The population was estimated to be about 9.4 million in 1991. About 3.5 million people live in slums which are categorized into four groups: jhuggi jhompri, resettlement colonies, walled city or katras, jhuggi jhompri clusters (bustees) and

unauthorized colonies. The majority of slum dwellers do not have access to basic facilities or clean water and latrines. Hyderabad's population is estimated at 3.1 million in 1991. There are 662 slums in Hyderabad with an estimated population of 0.7 million. Most of the slum population consists of rural migrants and only 25% of them are covered by safe water supply and sewerage and solid waste disposal. A more detailed profile of the four cities and slum populations is outlined in Annex 2.

C. The National Family Welfare Program

1.06 The Indian Family Welfare Program was established in 1951 and is one of the most extensive programs of its type in the world. The program is managed by the Ministry of Health and Family Welfare (MOHFW) and provides FP and MCH services to reduce morbidity and mortality among mothers and children and to reduce fertility. Since its inception, the program has contributed to reducing the infant mortality rate from about 135 per 1,000 live births in the early 1970s to about 80 in 1989, and contributed to the decline in fertility from a total fertility rate (TFR) of almost 6.0 in the 1960s to 3.9 in 1988. Despite its successes, there is a consensus that the program still needs to: improve access to services, particularly to disadvantaged areas; improve the quality and efficiency of services, especially the productivity of workers; and maximize impact by increasing the provision of temporary family planning methods to younger, lower parity couples. Towards these aims, the Government of India (GOI) is promoting a Revised Family Welfare Strategy (Para. 2.02). The term "family welfare" covers two parts of the current program: Family Planning (FP) and Maternal and Child Health (MCH). The program promotes family planning on a voluntary basis by making available family planning methods, and maternal and child health care through immunization and other preventive interventions, ante- and post-natal care and nutritional awareness. In order to promote the small family norm and maternal and child health, information and educational methods are used. The goals and achievements of the National Family Welfare Program are outlined in Annex 3. The organization and management of the Family Welfare Program in Bangalore, Calcutta, Delhi and Hyderabad is described in Annex 4.

1.07 India's Family Welfare Program has grown rapidly during the Sixth and Seventh Five-Year Plan periods (1980-1990). Improvement in the availability of services has resulted in steady growth in the performance of the program. Besides the fact that over 40% of the eligible couples in India currently use some form of modern contraception, immunization coverage of both pregnant women and children has improved substantially. Family planning achievements from 1986-1991 are shown in Section 3 of Annex 3. The growth in MCH coverage under the National Family Welfare program is shown graphically in Charts 1 and 2.

D. Problems and Issues of the Family Welfare Program in Urban Areas

1.08 Despite the achievements in contraceptive prevalence, the present level of infant and maternal mortality remains unacceptably high, partly due to constraints in the Family Welfare Program. There has to be a de-emphasis on the sterilization of older high parity women, the introduction of a wider variety of contraceptives in the program, an expansion of the quantity and quality of service delivery and strengthened management of the program. The sources of supply of services also needs to be broadened. These issues and

possible solutions have been discussed at length in previous Staff Appraisal Reports. 1/ However, there are a number of issues which are particular to urban areas and these are discussed further, below.

1.09 Lack of Outreach. The provision of health services to urban slum populations is stymied by a number of problems. Not the least among these is the fact that slum dwellers themselves are reluctant to visit the hospitals and other health facilities which are available in all metropolitan areas. Ignorance of the services available, the cost of travelling to these institutions, and above all else, the negative attitude of the health workers to the urban slum clientele, have been identified as major reasons for under-utilization of government-supported urban health facilities. Slum dwellers typically resort to registered or unregistered private medical practitioners who provide mainly curative care for fees. The result is that preventive and promotive care offered from a facility, which is often devoid of any element of privacy, or is open only when people are working, is not utilized by slum dwellers. The lack of an outreach capability, especially one staffed by medical and para-medical staff who are not alien to the slum population, and who are willing to visit and counsel pregnant and lactating women and younger couples in their homes in the slums, is a major underlying constraint. Where this outreach capacity has been systematically established and properly supervised, positive results in utilization of service delivery facilities for preventive and promotive care have been recorded.

1.10 Inadequate Training. As presently organized, the Family Welfare program does not have an entity with the primary responsibility for addressing the discrete health problems of urban slum dwellers. The major focus of the program's training efforts has been to develop health workers and managers for rural India. This task, while not excluding the urban poor, has resulted in ad-hoc training for crises (cholera, typhoid) in the urban slums rather than a strategy for coordinating the training of health and family welfare services with those of other basic social services delivered through the myriad of national, State, urban and non-governmental agencies. The Health and Family Welfare Training Centers (HFWTC), the newly constituted State Institutes for Health and Family Welfare (SIHFW) under IDA-assisted Population projects, and the Auxiliary Nurse Midwife (ANM) Training Centers, all have a rural orientation and full-time training schedules. The Urban Training Centers have neither an infrastructure nor a system for training that is dedicated to the problems which are unique to the slums. Moreover, the urban problems of law and order, transportation, water-supply and sewage disposal have left little time, effort and budget for planners and administrators to address the chronic health problems of the urban poor. Pre-service training, for example, is designed and carried out without reference to the particular problems of urban slums such as sexually transmitted diseases (STD), trauma from violence, alcohol and substance abuse, continual rather than seasonal bacterial infections, and rapid spread of contagious disease. Recurrent in-service training for health workers and volunteers in upgrading clinical skills, outreach,

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1/ Child Survival and Safe Motherhood (Report No.9489-IN), pages 2-8; Fourth Population (Report No.5523-IN), pages 7-14; Fifth Population (Report No.7077-IN), pages 6-10; Sixth Population (Report No.7731-IN), pages 3-11; Seventh Population (Report No.8385-IN), pages 6-13.

focussed care priorities, or liaison with Private Voluntary Organizations (PVOs) and Private Medical Practitioners (PMPs) have not taken place.

1.11 Lack of Community Participation. The design and delivery of health and family welfare services in urban slums has been typically done on the basis of norms established in the Center, modified by the States, and adapted for implementation by the municipalities. This top-down directive approach which develops pre-determined services to targeted beneficiaries, has meant that the recruitment of staff and location of facilities are determined with little reference to the needs and preferences of the urban slum dweller. This lack of community participation in program design and implementation has led to under-utilization (para 1.09), and problems of maintenance and the ultimate sustainability of the program. The GOI has recognized that the lack of participation has affected the implementation and success of the program. The Revised Strategy (para 2.02) calls for more community participation. In rural areas, progress has been made in involving local panchayats, Mahila Mandals and other local representative groups in the family welfare program. For most municipalities this involvement has not yet taken place. However, where this "learning process approach" of community participation has been undertaken as in Madras and Calcutta, progress is quite evident. What is therefore required, even in the absence of a politically elected representative who can ensure to some extent that his or her constituency is served, is the formation of slum dweller groups to give voice to their legitimate demands for health and family welfare services. The Urban Basic Services for the Poor Scheme (paras 2.05-2.06) is an initial step in this direction.

1.12 Constraints to the Participation of Private Voluntary Organizations. There are mainly four types of Private Voluntary Organizations (PVOs) operating in the slums of the metropolitan cities in India. These are: (a) grassroot PVOs which usually lack technical, managerial and financial resources and are therefore limited to micro-projects; (b) community-initiated PVOs such as Mahila and Yuvak Mandals which are government funded; (c) State-aided PVOs which are project-specific and hence lack flexibility; and (d) national/-international groups such as the Red Cross and Lions which have an established range of services. The GOI has encouraged them to participate in the family welfare program. However, bureaucratic hurdles constrain the transfer of resources from government to PVOs, and there are other obstacles to their participation. First, the range of problems is so large and complex that the typically small PVO can only tackle single or smaller dimensions of the urban slum condition. Even when a PVO is successful, replication of their experience on a larger scale is difficult to achieve. There is also the view held by many in the government sector that unless the PVO is operating primarily in the field of health and family welfare, their motives are questionable when they come forward to work on government-financed family welfare schemes. In brief, PVOs with some exceptions, are usually small organizations, flexible and responsive to community needs, but resistant to the norms and practices which govern the national family welfare program. A possible solution is to find ways to encourage the many small PVOs to involve themselves in the program, and for mechanisms to be developed by government which are more amenable to the PVOs' desire to be flexible in dealing with the provision of health and family welfare services.

1.13 Weak Information, Education and Communication Programs. Research studies conducted in India indicate that despite years of exposure to health

education programs, urban slum dwellers remain ignorant about available health services and health promoting behavior which can save lives. Family welfare mass media campaigns and interpersonal communication activities in urban areas have been successful primarily in promoting awareness of the need for adopting family planning and in the use of permanent methods. They have been less successful in increasing client use of maternal and child health services or the adoption of temporary family planning methods. Poor design and implementation of IEC activities, budgetary constraints and weak management of human and material resources hamper program efficacy. This does not have to be the case. IEC interventions utilizing social marketing and other approaches can increase the demand for and utilization of health and other social services, as well as promote increased acceptance and use of family planning methods. To do this, IEC programs must go beyond awareness generation among target groups to promoting desired behavior changes. There is a need also to adopt more focused, target-specific approach to the use of IEC and social marketing interventions. This involves the development of strong institutional capabilities to design and execute meaningful IEC programs; clearer definition of the roles and functions of the various service delivery functionaries in conducting interpersonal communication and utilizing mass media support; greater understanding of the various socio-cultural barriers to client use of health services, and the acceptance by program implementors of a comprehensive approach to planning and implementing IEC programs. Better IEC intervention with a strong focus on the social marketing approach has proved particularly effective in urban audiences. The government's Social Marketing of Condoms and Oral Pills Program must be more specifically targeted to slum areas, and the private sector encouraged to further increase its investment in this market.

1.14 Limited Female Education Opportunities. The linkages between female literacy and fertility decline are unassailable. Although India has expanded its educational system considerably since independence and enrollment of girls and boys has improved over the years, females still have limited access to education and training opportunities. Almost 60%, or 200 million, of India's illiterates are female. Effective literacy rates (age 7 and over) are 63.9% for males and 39.4% for females. Female literacy rates vary significantly between the States and rural and urban areas, as well as slums and non-slums areas. Literacy rates among females from rural areas, Scheduled Castes and from urban slums are considerably lower in all the States. Gender disparities in access to formal education explain this situation. In 1985/86 the gross enrollment ratio for girls in lower primary school (class I-V) was 77% as against 108.8% for boys. As a proportion of total enrollment, girls' enrollments were only 41% in primary and 35% in upper primary schools, respectively in 1986. There are also regional, class and caste disparities in schooling, with urban areas having a larger female participation than rural areas and poor urban slum girls having more limited access to schooling than do upper and upper-middle class non-slum girls. The problems of primary education for females are compounded by the fact that only 30% of all school teachers are female and only 15% of the schools in the country are dedicated to females. Girls' schools suffer from a paucity of trained teachers, facilities, learning materials, equipment and inconvenient location. Even when girls are enrolled, several factors operate against successful completion and achievement; these include competing demands on their time, early marriage and pregnancy, a lack of positive role models, the poor quality of education of women, and the direct cost as well as the opportunity cost of schooling.

The status of basic education for females in Andhra Pradesh, Delhi, Karnataka and West Bengal is shown in **Annex 5.**

II. GOVERNMENT PLANS AND POLICIES IN FAMILY WELFARE

A. Health and Population Policy

2.01 In 1983, the GOI established a National Health Policy in the context of the world-wide objective of "Health for All by 2000 A.D." The broad goals of this policy are to achieve by 2000 A.D.: (a) reduction of maternal mortality to below 200 per 100,000 live births; (b) reduction to 10% or less of the proportion of low birth weight babies defined as those weighing less than 2500 grams at birth; and (c) reduction in infant mortality from 94 to 50 or less per thousand. While many of these goals are ambitious and may not be fully achieved by 2000, substantial progress has been made in most areas. With some reorientation of program design, implementation and financing, targets could be approached by the end of the first decade of the twenty-first century.

B. The Revised Family Welfare Strategy and The Eighth Five-Year Plan (1992-1997).

2.02 In 1986, the MOHFW revised its population (family welfare) strategy in order to make the National Family Welfare Program more responsive to the segmented market for the provision of family welfare services. The **Revised Strategy** calls for new efforts to raise the average age of marriage of women to over 20 years, by intensifying female literacy programs, curbing the school dropout rate for girls, and offering better employment opportunities for rural women. To supplement this, greater emphasis was to be given to IEC and an effort made to move away from simple publicity to more targeted programs to overcome provider and client resistance to temporary methods. Linkages were to be established with adult education programs, schools, colleges, trade unions, employers associations and PVOs which are seen as most effective in motivating people at the grassroots level. The effort to reduce infant mortality below 60 per 1,000 births was to be concentrated in the universal immunization program (UIP). The goal was to immunize every child and expectant mother by 1990. However, by the end of 1990 coverage had reached only 70%. A nutrition intervention program was also to be expanded to distribute iron tablets, Vitamin A, and iodized salt. This has been less successful, due mainly to a shortage of resources. The Integrated Child Development Services program (ICDS) was expanded to provide immunization, nutritional supplementation, nutrition education, maternal and child health check-ups, pre-school education and female adult literacy to a larger number of deprived areas. ICDS now covers 40% of India's rural blocks.

2.03 Under the Eighth Five-Year Plan (1992-1997), the important family welfare goals remain as outlined in the National Health Policy and Revised Family Welfare Strategy. To achieve these, the Plan includes: (a) promotion of temporary contraceptive methods for couples for whom sterilization is inappropriate; (b) intensive implementation of the Universal Immunization Program (UIP); and (c) IEC efforts to increase knowledge and acceptance of both family planning and MCH components of the program. In support of the family welfare program, female education would be expanded and compliance with

the legal ages for marriage, which is 18 for females and 21 for males, would be enforced. Other features of the Plan call for increased involvement of local communities and private voluntary organizations. A comparison of Seventh and Eighth Five-Year Plan targets and financial outlays is provided in **Annex 6.**

2.04 The Urban Revamping Scheme. Questions concerning the inadequate provision of health and family welfare services in urban slums were raised in 1982 during a meeting of the Central Council for Health and Family Welfare. A Committee, known as the Krishnan Committee, was then constituted to make recommendations about the reorganization of family welfare and primary health care services for urban areas, with emphasis on the need to provide family welfare and preventive health services through an outreach program for the poor. The Krishnan Committee's recommendations, which focused on population-based facility and staffing norms, have become de facto government policy regarding urban health and family welfare services. Subsequently, under the Seventh and Eighth Five-Year Plans, the Urban Revamping Scheme (URS) was launched and supported. The core of the scheme is the Health Post (HP). The HP differs functionally from previously established urban facilities by providing an outreach capability designed to develop closer links with the community and to bring services to clients. The outreach program is conducted by the Multi-purpose Worker (female) (MPW) supported by female voluntary health workers (FVHWs), one FVHW for every 2000 population. There is also provision for social workers to assist in the establishment and strengthening of community links. There are four types of HPs categorized as A, B, C and D depending on population size. Implementation of the URS varies from city to city. The HP represents the first systematic attempt by government to provide integrated health and family welfare services to urban slum populations based on concepts of interaction between the community and service providers. The URS is outlined in **Annex 7.**

2.05 Urban Basic Services for the Poor (UBSP). This is a more recent GOI program which has as its principal objective education and motivation of urban low-income communities to take care of their own needs with the assistance of the Municipality and other agencies. It provides required financial and supervisory assistance to urban local bodies to help slum communities organize into Community Development Committees comprising women volunteers representing every 20 to 25 households. The women volunteers regularly discuss the needs of their children and the community at large and, under the guidance of a full-time municipal field level worker, plan and obtain assistance from various schemes available within and outside government. The municipal field worker trains the volunteers, organizes them into a committee, assists them in conducting needs surveys, facilitates meetings with municipal and other officials of various sectors, and obtains assurance of the provision of services for the community from each sector. These assurances form the implementation plan of each community. Under the UBSP, 11 types of activities including immunization, MCH, disability prevention, and early learning opportunities are supported. However, the support is only a topping-up fund until more permanent and adequate services and facilities are provided through the concerned sectors. Each Municipality implementing the UBSP scheme is expected to ensure that all Departments plan the convergence of Primary Health Care services in the selected slums. Where sectoral agencies are unable to extend the services immediately, funds under the Scheme can be used by the local community groups to employ a doctor and/or a nurse/midwife, on a part-

time basis, to operate a health clinic in the community. The Organizational Structure and Action Plan for UBSP is shown in Chart 3.

2.06 The Community Development Committee network in each town provides in-situ assistance to the sectoral agencies in identifying sites, the beneficiaries, voluntary support systems and also appropriate maintenance systems where necessary. The program is financed by Government of India with UNICEF support for the training component. In addition to the UBSP, the Government has instructed the States to ensure convergence of the Environmental Improvement in Urban Slums Program and the Nehru Employment Scheme which jointly provide nearly US$ 500 million per year to urban areas for shelter improvement, self-employment, wage employment through creation of public assets, such as roads and pathways, drains, and also community centers to house health clinics, pre-schools, women's income generation activities, literacy and non-formal education, etc. UNICEF has pledged to provide a grant of US$ 20 million to improve the training and management capacity of the government NGOs and the community volunteers.

C. Financing of Family Welfare

2.07 The National Family Welfare Program is a centrally-sponsored scheme which means that the majority of the capital and recurrent expenditures of the program are borne by the Center, under the annual budget and Five-Year Plan of the Ministry of Health and Family Welfare (MOHFW). Allocations over the last two decades reflect the government's commitment to the Program (Annex 6). The share of family welfare to total health expenditures increased from 10% during the Third Plan to almost 50% under the draft Eighth Five-Year Plan (1992-97) and as a share of total public sector expenditures, increased from 0.3 to 1.8%.

2.08 In the past, as public sector budgets increased, family welfare competed favorably receiving more than proportionate increases. However, during the current difficult budgetary conditions, allocations to the family welfare program were reduced in 1990/91. The decline was the first in the history of the program and implies vulnerability during periods of fiscal constraint and reductions in government budgets. However, in the 1992/93 budget, the Family Welfare program received an increase of Rs. 2,000 million, an indication of the continuing commitment of the Government to the Program. The proposed project will be one other vehicle to protect family welfare allocations.

2.09 International Assistance has supported health and family welfare activities in India since 1963. Support has come from UNFPA, UNICEF, and WHO, as well as from the governments of the United Kingdom (ODA), Norway (NORAD), Denmark (DANIDA), Sweden (SIDA), and the United States (USAID). The Area Projects program (para 2.10) is also being assisted by UNFPA, ODA, DANIDA, and USAID (Annex 8). Specifically, USAID has assisted Punjab, Haryana and Gujarat; UNFPA, Bihar, Rajasthan and Himachal Pradesh; DANIDA, Tamil Nadu and Madhya Pradesh; and ODA, Orissa. The International Planned Parenthood Federation provides financial support to the Family Planning Association of India (FPAI). UNICEF has concentrated its efforts on UIP and has mobilized and coordinated support from a number of bilateral donors for this program. UNICEF also supports the UBSP Scheme, as well as several NGOs, in Delhi to strengthen the health care delivery system among slum dwellers. UNICEF and

IDRC are also supporting action research efforts in Calcutta, Bombay and Alleppey district to tackle urban malnutrition. Among private organizations, the Population Council, the Ford Foundation, and the Rockefeller Foundation support demographic and biomedical research. WHO provided US$0.3 million during 1990-91 for Family Planning and MCH services in urban areas and for developing the Mid-Term Plan for the Prevention and Control of AIDS. The Japanese Government has provided about US$ 600,000 under the Japanese Human Resources Development Fund (Japanese Grant Agreement) to assist the preparation of this and other family welfare projects suitable for IDA financing.

D. IDA-Assisted Population (Family Welfare) and Nutrition Projects and Sector Strategy

2.10 Since 1973, IDA has supported seven population, one maternal and child health and three nutrition projects for a total of US$700.0 million **(Annex 9)**. The First and Second Population and the Tamil Nadu Integrated Nutrition Project (TNINP) have been completed and Project Completion Reports (PCRs) and Project Performance Audit Reports (PPARs) issued. The Third Population Project has also been completed and the PCR is under preparation. The PCRs have shown that although these projects suffered delays in implementation, each has achieved its principal objectives, although the gains were only marginally higher than in non-project districts. Preliminary indications for the Third Project demonstrate that project objectives were fully achieved in Kerala and that there were significant differences between project and non-project districts. Karnataka's results seem to be more in line with the experience of the first two projects. Implementation of the on-going Fourth, Fifth, Sixth and Seventh Population projects and the Child Survival and Safe Motherhood project has been largely satisfactory. Very encouraging results are emerging from the Fourth and Fifth Projects. In West Bengal, contraceptive prevalence rates have increased and the training of staff and construction of facilities have been implemented with a large degree of success. In Bombay and Madras, in addition to increases in contraceptive use, both cities have pursued "beyond family planning" strategies including linking health education and IEC strategies for family welfare with parallel sanitation and clean drinking water programs financed by the government, and with the active cooperation of non-governmental organizations, private medical practitioners and public health departments. The Sixth and Seventh projects are still relatively new, but initial review of implementation has reported progress in most areas. The Tamil Nadu Nutrition project succeeded in halving the rate of severe malnutrition among young children and has been very influential in the design of other nutrition interventions in India, and elsewhere.

2.11 Lessons Learned. Previous experience with population projects has given both technical and implementation lessons. On the technical side, it has been shown that: (a) there is low awareness among pregnant and lactating women of the need for effective care, including ante-natal check-ups, improved nutrition, temporary methods of family planning, and the benefits of child spacing; (b) maternal mortality and morbidity will remain at high levels unless there is prompt and adequate medical care for those who develop obstetric complications; (c) the quantity and quality of MCH care is far below desired levels; (d) to achieve significant changes in performance, it is desirable to forge linkages between training efforts and improvements in the use of management information and evaluation systems; (e) clinical skills and use of the referral structure and temporary methods of contraception are weak

among all levels of staff and can be improved through short-term in-service training efforts; and (f) management interventions, including training efforts and/or changes in performance measurement, require strong commitment and support from top administrators.

2.12 Implementation lessons show that (a) an analysis of local demographic and sociological characteristics is fundamental to the efficient use of resources at local levels; (b) skills and aptitudes in community mobilization, which are limited among medical and para-medical staff, are nonetheless critical to the success of outreach; and (c) it should be ensured that field workers' jobs are manageable and their daily and monthly routines clearly defined. Experience has also shown that when population projects are prepared with due attention to detailed design of training programs, IEC strategies, and an appropriate service delivery model, including early selection of sites for construction and the preparation of standard bidding documents for early procurement, that some measure of success is ensured.

2.13 The proposed project takes account of these lessons as much as possible, but would specifically assist the Government to develop and replicate a series of service delivery models designed to meet the specific health needs of the urban poor. Two models and experience which are more directly relevant to this project were developed in Bombay and Madras under the Fifth Population Project (Para. 2.10). Another model which would be used is based on the health provision component of the Calcutta Urban Development Project (CUDP III). This component was evaluated in September 1991 by the World Health Organization (WHO), and rated as one of the most successful health service schemes in the world which concentrates on urban slum populations. Implementation experience with variants of this model, especially the ODA-assisted health projects in Calcutta and Hyderabad as well as the evaluated experiences of UNICEF, PVOs and PMPs in the provision of health services to urban slum populations, has also been taken into account.

2.14 The major lessons incorporated in project design are that: (a) family planning services can also be effectively delivered by non-family planning organizations; (b) a women-to-women approach increases client's accessibility to and acceptability of family planning in restricted societies; (c) reaching women with information and services is enhanced when field workers serve as informal support groups; (d) participatory management develops a sense of ownership among field workers and clients; (e) the effectiveness of delivering family welfare services and the demand for these services is enhanced when the outreach effort includes the involvement of community groups, volunteer women and supervisors who are recruited from the specific slum community; and (f) success is more likely when the management of the health facility is undertaken by community personnel and the timing of operation of the facility is adjusted so that it is convenient to women who work both in and outside of the home.

2.15 Sector Strategy. In January 1987, India and IDA agreed on a Population Sector Strategy which would guide future collaboration in the sector. It was agreed that IDA's broad goal in the family welfare sector is to support GOI's National Family Welfare Program. Specifically, IDA support would assist in (a) reorienting the family welfare program from its present static facility-based orientation to include a larger element of outreach to the communities in which the health and family welfare facilities are located;

(b) shifting the focus of the program from the sterilization of older, high parity women to a more balanced mix of contraceptive methods emphasizing increased use of temporary methods by younger couples; (c) increasing the attention given to the implementation of the maternal and child health elements of the program; and (d) supporting, as a priority, programs which enhance service delivery, training and IEC, and are concentrated in urban slums and backward high fertility States.

2.16 The approach is to use each specific project, regardless of its size and content, to seek changes which would reorient and make the national program more effective. Starting with the Fifth Population Project in 1988, and the Sixth, Seventh and Child Survival and Safe Motherhood Projects in 1989, 1990 and 1991, IDA has tried to assist GOI in improving policies and programs concerning: training of health workers including personnel management; roles and work routines of health workers; target-setting mechanisms; social marketing of condoms and pills; and involving PVOs more actively in the program. Under the Seventh Population Project, GOI and IDA agreed that the current incentive structures which provide funds for motivators and acceptors of permanent methods (sterilization) needed to be reviewed and revised given the new orientation of the program, and the results of this review provided to IDA by December 31, 1991. The GOI has informed IDA of the findings of this review and has issued the appropriate directives/instructions to the States and municipalities on the revised policy on incentives for sterilizations and the use of temporary methods of contraception.

2.17 In addition to supporting one population project each year since 1987, a program of sector work was also initiated. To date, three studies have been completed: "Family Welfare Strategy in India: Changing the Signals" (1989); "Improving Family Planning, Health and Nutrition Outreach in India" (1989); and "Strengthening the Role of NGOs in the Health and Family Welfare Sector in India (1989)." Two other studies are underway: "The Status of Women's Health in India" and "Health Financing." In summary, through project lending, sector work and increased policy dialogue, IDA has supported a number of important program developments. These include: reorienting the overemphasis given to sterilization; changing the target-setting system; increasing the role of PVOs, the private sector (social marketing), and PMPs; and changing the administration of program incentives. The proposed project reflects continued movement along this path of cooperation and will allow GOI to address more clearly some of the systemic and policy issues which retard effective implementation of the family welfare program.

III. THE PROJECT

A. Rationale and Strategy

3.01 Rationale. There are several reasons for IDA's involvement with the proposed project. First, the project would be a critical part of IDA's strategy of supporting human capital development and poverty alleviation in India. Second, it would provide IDA with the opportunity to extend rapid but targeted assistance to the most vulnerable groups, poor women and children, who are at risk of falling through the social safety net during a period of severe budgetary constraints on publicly-financed social programs. Third, the project would support the Urban Revamping Scheme (URS) which takes into

account the linkages between the provision of family welfare services with other appropriate health interventions, specifically clean drinking water and sewerage/sanitation facilities. Fourth, the project would be based on a mix of successful local experiences in implementing health projects among slum populations, while at the same time providing for trials and the introduction of innovative models of service delivery. Fifth, the project would include several areas where private voluntary organizations and local communities will play a major role in service delivery. Sixth, the project would represent an opportunity for continued cooperation between IDA and UNICEF, as well as the initiation of closer coordination with WHO, UNFPA and ODA in India. This would enhance policy dialogue, project monitoring and supervision, as well as overall program evaluation. Finally the project would represent GOI's initial attempt to integrate community participation activities systematically in its urban family welfare scheme. Without the project, it is likely that slum dwellers of these specific cities would continue to lack satisfactory access to appropriate family welfare services.

3.02 Strategy. Improving service quantity and quality, increasing demand for services, and assuring appropriately planned and implemented expansion involves using project resources to influence both consumer and worker perceptions of the goals and services to be delivered by the Health Departments of the respective municipalities. All municipalities would therefore focus on: (a) strengthening their capabilities to deliver health services in general, and to deliver family welfare services, in particular, to younger, lower parity families who reside in slums, especially pregnant and lactating women and children; (b) strengthening outreach capacity to slum populations; (c) assuring that workers have the appropriate skills in both the educational and clinical aspects of their jobs, especially to provide counselling and follow-up services to slum families; and (d) varying service delivery and IEC strategies to meet the local needs which may differ from slum to slum. The proposed strategic approach to these issues will be to concentrate on increasing the participation of community groups and private voluntary organizations in the design, implementation and supervision of the family welfare program in the slums; increasing the involvement of women as workers, supervisors and administrators in the project; and assisting the municipalities in improving further institutional capacity to ensure that strengthened training efforts are matched with appropriate changes in logistics, IEC, management information and maintenance systems.

B. Scope

3.03 In early 1989, the GOI commissioned a study from its National Institute of Health and Family Welfare (NIHFW) with assistance from WHO, to assess the family welfare needs in selected urban areas and to determine how the Urban Revamping Scheme could be adapted and expanded to meet these

needs. 1/ The Study, which covered 18 cities, was completed in August 1991. Calcutta prepared a plan for the extension of the model used for CUDP III (para 2.13). Bangalore, Calcutta, Delhi and Hyderabad were selected for this specific investment operation and have customized the general models developed by NIHFW to meet the specific needs of their slum populations. Through this process, a set of criteria have been developed by which cities could be made eligible for participation in the project. In addition to the community participation dimension which is critical to implementation success, the criteria include detailed survey of public and private sector health facilities and preparation of new and/or rehabilitation requirements, development of plans for inter-agency coordination, establishment of new and appropriate management structures, and the initiation of more comprehensive beneficiary needs assessments to include both training and communications needs and a wider cross-section of the slum community. The four cities have been selected because they are the largest metropolitan cities and logically follow Bombay and Madras which are being supported under the Fifth Population project. They met the established criteria for inclusion in the project as conditions of appraisal. The proposed project is therefore the second of a series of proposed projects (para 3.23) designed to cover additional cities and assist in meeting the particular needs of urban slum populations and is consistent with the agreed sector strategy (para 2.15).

C. Goals and Objectives

3.04 Goals. The goal of the proposed project is to provide further support to the Government's National Family Welfare Program. More specifically, this project would provide support to assist four municipalities in adapting and refining the Urban Revamping Scheme to meet the particular needs of slum populations in their jurisdictions, as well as to make it affordable and sustainable given the weak financial status of the municipalities. A particular aspect of this project's goals would be to ensure that close linkages are established with preventive health programs, including clean drinking water and environmental sanitation.

3.05 Objectives. The major objectives of the proposed project would be to: (a) reduce fertility among slum populations in the four municipalities; and (b) improve maternal and child health, by helping to decrease maternal and infant mortality rates among slum populations. These objectives would be achieved by undertaking activities in five broad areas:

(a) Expanding service delivery to slum populations through improvements in outreach services using volunteer female health workers recruited from slum communities, and the upgrading of existing and construction of new health facilities;

1/ "Plan for the Delivery of Family Welfare Services in Urban Slums based on the Needs Assessment of Beneficiaries (Slum Dwellers), Communications, Training of Staff, and Knowledge, Attitudes and Practices (KAP) of Private Practitioners in Urban Slums of Cities with more than Five Lakh (500,000) Population;" National Institute of Health and Family Welfare: New Delhi, August 1991.

(b) Improving the quality of family welfare services provided to slum populations, by upgrading the supervisory, managerial, technical and interpersonal skills of all levels of new and existing medical and para-medical workers through pre-service, institutional in-service and on-the-job recurrent training; and increasing the availability of drugs, medicines and other appropriate health supplies;

(c) Increasing the demand for family welfare services through an expanded program of information, education and communications (IEC); increased participation of the slum community through their representatives and groups in the preparation and implementation of various project activities; and the increased participation of private voluntary organizations and private medical practitioners in the delivery of family welfare services to slum communities;

(d) Strengthening the management and administration of municipal Health Departments through appropriate upgrading of management information systems (MIS), IEC, training, civil works, and audit and accounting functions, as well as integrating and/or strengthening coordination of health services with the provision of environmental sanitation and water supply services;

(e) Supporting Innovative Schemes which cover a range of additional services including supplementary nutrition, creche programs, environmental sanitation drives, education and skill training programs for females, especially adolescent girls; and

(f) Preparation of Future Projects which would support the detailed preparation and project launch activities in another fifteen designated cities.

Project components, objectives, targets and indicators of progress by city are shown in **Annex 10.**

D. Expanding the Supply of Family Welfare Services (Proposed Outlay US$49.94 million equivalent) 1/

3.06 In order to overcome the problems associated with the limited access of slum populations to existing urban health facilities (para 1.09), and the lack of demand for services, especially from public sector preventive and promotive programs, each municipality, as part of its implementation of the Urban Revamping Scheme, will develop an Outreach Program aimed at the slum communities in their jurisdictions. All of the programs will rely on recruiting Female Workers (Bustee Sevikas, link workers, trained Dais, Honorary Female Health Workers) who would be residents of the slum community and be responsible for working closely with the community and the health workers (ANMs; LHVs) who operate the Health Posts (Hps), Health Administrative Units (HAUs), Urban Family Welfare Centers (UFWCs) sub-centers and Maternity Homes. The details of the Outreach Program in each city are given in Annex 7 Part C.

1/ This and subsequent references to outlays refer to base costs.

3.07 Although a large part of the Outreach Programs will be staffed by Volunteer Female Health Workers, they will be supervised by staff appointed to operate the health facilities which would be located in or near the slums. Further, to determine the impact of the various interventions proposed and whether the benefits truly reach the intended beneficiaries, the municipalities have each initiated Baseline Surveys/Community Needs Assessments Studies. During negotiations, the GOI and Project States provided assurances that they shall cause the project cities to: (a) furnish to the Association by June 30, 1993, baseline surveys and beneficiary and community needs assessments with format and content satisfactory to the Association, and (b) promptly thereafter suitably adjust the hours of operation of health facilities located in slum areas in its jurisdiction so as to be fully responsive to the findings of the above beneficiary and community needs assessment. The GOI also provided an assurance that it shall ensure that the volunteer workers participating in the Urban Revamping Scheme would be eligible to receive payment of honoraria in respect of their work in the scheme (Annex 7, para 5). The GOI and Project States also provided assurances that they shall cause the project cities to provide staff according to a time schedule agreed with the Association, and thereafter maintain adequate salaried staff and honorary health workers and other resources as shall be necessary to ensure the effectiveness of its outreach programs under the project.

3.08 Access to family welfare services will also be expanded by upgrading and rehabilitating a number of existing health facilities, as well as the construction of a number of new health facilities which would be located in or near the slums. The details of the construction program are given in **Annex 11.** The municipalities have each initiated Facility Surveys which would determine the location of all existing and proposed new institutions and the extent of rehabilitation and renovation required (para 4.06). The municipalities have also developed Two-Year Construction Plans. During negotiations, the GOI and Project States provided an assurance that they shall cause the project cities to furnish to the Association by January 31 of each year, commencing January 31, 1993, for review and comment, and thereafter duly take into account any comments provided by the Association in respect of an annual plan for civil works in respect of its immediately succeeding financial year. The project would support service delivery expansion by financing the costs of civil works, furniture, equipment, vehicles, and the salaries of additional staff on a declining scale.

E. Improving the Quality of Family Welfare Services (Proposed Outlay US$12.74 million)

3.09 The quality of Family Welfare services would be improved in the four cities by increased emphasis on four activities: (a) recruiting and training the appropriate level of staff; (b) developing and implementing a systematic recurrent in-service training program; (c) the recruitment and training of slum dwellers as para-technical health workers for outreach; and (d) increased involvement of PVOs and PMPs in training. These actions would enable the municipalities to train approximately 21,000 health workers and local leaders over the project period, as shown in **Annex 12.** The training system would be based on appropriate studies and procedures as outlined in this Annex.

3.10 Bangalore would train over 2,500 persons, including medical officers, health workers, members of the Slum Clearance Board and about 300

private medical practitioners. Calcutta would train over 9,000 staff and local leaders, of whom 75% will be women from the community who would be trained as Honorary Health Workers. Delhi would provide orientation and recurrent in-service training to about 500 professional health worker staff, and continuing on-the-job training to approximately 1,300 local women trained as Bustee Sevikas. Hyderabad would train approximately 2,300 staff including 1,000 link workers and Dais, and 600 PMPs, both in orientation and recurrent courses. During negotiations, the GOI and Project States provided an assurance that they shall cause the project cities to furnish to the Association by January 31 of each year, commencing January 31, 1993, for review and comment, and thereafter duly take into account any comments provided by the Association in respect of an annual plan for training in respect of its immediately succeeding financial year.

3.11 The project would support the provision of essential supplies such as health worker kits, disposable delivery kits, medicines and family welfare supplies. The system of storage, distribution and logistic support developed under the National Family Welfare Program would be used. At present, many of the drugs are located at Regional Medical Stores and released periodically to various health facilities. Municipalities would be given assistance for improved systems of planning, ordering, monitoring stock levels and usage. The medicines recommended for use in urban slums have been agreed to by the Indian Medical Association (IMA) and the Indian Council for Medical Research (ICMR). Since the recurrent supply of drugs and medicines, including maintenance of the operation of the health facility would be, in part, a responsibility of the community, the GOI and Project States provided an assurance during negotiations that they shall cause the project cities to: (a) establish by January 31, 1994, community-based management committees for facilities and programs developed under the project; and (b) institute no later than April 1, 1994 such measures as shall generate resources from the direct beneficiaries of said facilities and programs to support a portion of the operation and maintenance costs thereof, including medicines. The project would support the improvement in the quality of family welfare services by financing the costs of medicines, equipment, local and foreign training, local and foreign consultants, and the salaries of additional staff and honoraria of additional volunteers on a declining scale.

F. Increasing the Demand for Family Welfare Services (Proposed Outlay US$11.23 million)

3.12 Increasing the participation of urban slum communities in the design, implementation and supervision of the family welfare services being provided to the slums would be a major activity of the project. As a first step, to increase the involvement in project design, each municipality initiated a Beneficiary/Community Needs Assessment prior to appraisal (para 3.07). It is expected that community groups will undertake and/or participate significantly in these assessments. In further support of community inputs to project design, each municipality undertook a series of workshops designed to increase community participation, and in which participants drawn directly from the targeted slum communities commented on and recommended changes to project design.

3.13 The community participation implementation methods to be used by the municipalities can be grouped into four categories: (a) the establishment of

neighborhood committees on the UBSP model (para 2.06); (b) the promotion of PVO partnerships; (c) the organization of supplementary health support schemes such as sanitation and nutrition awareness; and (d) the strengthening of community-initiated ideas by assisting with financial, material and staff resources. **Annex 13** outlines the approaches to be used by each municipality. Given the importance of community participation in each phase of the project, training in this area is required. A Technical Assistance Program in community participation is outlined in Section 2 of Annex 13.

3.14 Increasing the involvement of Private Voluntary Organizations in the delivery of family welfare services to slum communities would also be supported under the project. On-going schemes of the GOI will be expanded to some extent in the slum areas. PVOs would also be given the opportunity to recommend and be funded for Innovative Schemes (para 3.22). A list of the PVOs which have been identified already to participate in the project is outlined in **Annex 14**, together with a description of the procedures to be used in recruiting and monitoring them. As with the community groups, the municipalities have involved the PVOs in the workshops on project design. Further, each municipality has included representation in their Project Implementation Committee from PVOs which operate in the slum communities covered by the project.

3.15 Increasing the Involvement of Private Medical Practitioners (PMPs) in the Delivery of Family Welfare Services. Experience in both Bombay and Madras under the IDA-supported Fifth-Population Project demonstrated that with the active cooperation of local medical associations, the participation of PMPs of both allopathic and indigenous systems of medicine (ISM) in providing family welfare services to slum populations can be increased. Under the project, Bangalore will provide, free of charge, family welfare supplies to registered Nursing Homes and Polyclinics operated by PMPs. In Calcutta, PMPs are already intricately involved as part-time volunteers in the delivery of services at HAUs and EPSODs. Hyderabad will provide training for PMPs at government hospitals and through the Family Planning Association of India (FPAI). PMPs will be encouraged to undertake sterilizations, both vasectomy and tubectomy, IUD insertions, administration of oral pills and distribution of condoms. They will be paid fees and be required to maintain and report statistical information to the municipalities. In Delhi, there are two categories of PMPs functioning in and around the vicinity of Jhuggie Jhomprie Bustees. Those living and operating inside the Bustees are either unqualified or qualified in ISM, but dispensing allopathic medicines. Because of the lack of any curative services in the neighborhood, Bustee residents depend on these unqualified PMPs for curative services. It is proposed that the PMPs who work in the Bustees would be given training in primary health care and health education and act as motivators for the family welfare program. The PMPs who operate outside Bustees are qualified to offer curative services and will be motivated to play a greater role in preventive and promotive health care.

3.16 Information, Education and Communication (IEC). Another important element in increasing the demand for Family Welfare in urban slum areas is the development of a sustainable IEC capability. This will ensure better utilization and targeting of resources because programs will be planned and implemented to meet the differentiated perspectives and needs of segmented urban clientele. Involvement of the community in IEC program design and execution, promoting the availability and benefits of maternal and child health and

family planning services to slum dwellers and persuading them to utilize services efficiently are critical to program success. Under the project, IEC cells would be established in Delhi and Bangalore and strengthened in Hyderabad and Calcutta. A departure from traditional approaches to the planning and execution of family welfare/IEC efforts would be stressed and is detailed in **Annex 15**. Elements of the program's approach would be: (a) emphasis on using IEC activities and messages to trigger and sustain attitudinal and behavioral changes rather than to merely increase awareness about programs and activities; (b) use of applied communications research to aid the design and development of appropriate programs to support media strategies and materials designs; (c) enhanced communication training for the various categories of service delivery personnel; and (d) involvement of the community in the design and implementation of IEC activities to ensure efficiency and sustainability. In all the cities, a mix of mass media and interpersonal communication activities would be undertaken.

3.17 Because of the importance of providing specific messages and information tailored to individual client needs, emphasis would be placed on using Outreach Teams comprised of slum-based health workers (ANMs), Bustee Sevikas, and voluntary health and link workers to educate and motivate key target groups in the slums. These workers would make one-on-one and group contacts at the family level to persuade and motivate changes in attitudes and behavior related to MCH and FP practices. Training in communications, behavioral and social sciences would be given to the members of the Outreach Teams to enhance their ability to interact with their clients. The work of such outreach teams would be reinforced and supported through well planned and executed media campaigns developed in line with the priority program areas such as increasing demand for temporary contraceptive methods; promotion of maternal and child health practices; and compliance with the Child Marriage Restraint Act. A new generation of media materials which are better designed and pre-tested to respond to client educational and communications needs would be developed with guidance from the Mass Media Division of MOHFW. More program planning and implementing responsibility would be given to the private sector, particularly PVOs working in family welfare and providing interpersonal communication such as family welfare counseling and motivation. Through the joint work of the IEC, Training and MIES Units within the project, small-scale process and impact evaluation activities would be conducted to help adjust and shift the IEC program as needed. The findings of such research and feedback would be incorporated into program plans which would be developed on an annual basis. During negotiations, the GOI and Project States provided an assurance that they shall cause the project cities to: (a) establish by January 30, 1993, IEC Program Planning and Implementing Committees with membership and terms of reference satisfactory to the Association; and (b) furnish to the Association by January 31 of each year commencing January 31, 1993, for review and comment, and thereafter duly take into account any comments provided by the Association in respect of an annual plan for IEC in respect of its immediately succeeding financial year.

3.18 Increasing female education opportunities has been demonstrated to be one of the most effective ways to increase the demand for family welfare services and reduce fertility. Early childhood marriage, which still exists in some communities in India, and the overall general low age of marriage in the country are factors which inhibit full access of girls to education and stymie efforts to reduce fertility. During negotiations, the GOI provided an

assurance that it shall develop by June 30, 1993, a program of measures to improve compliance with its Child Marriage Restraint Act, 1929, as amended. The municipalities have developed their own proposals on how to improve compliance in their jurisdictions (Annex 5, Part 2). During negotiations, the GOI and Project States provided assurances that they shall cause the project cities to: (a) develop by June 30, 1993, a program of measures to improve compliance with the Borrower's Child Marriage Restraint Act, 1929, as amended; and (b) furnish to the Association by January 31, 1994 and by January 31 each year thereafter, a report for review and comment by the Association on steps taken in the previous year toward the said improvement.

3.19 Programs which deal directly with the provision of formal primary and secondary education are financed and managed by State and Municipal Directorates of Education. Under the project, major investments in physical infrastructure (school buildings, teacher training institutes) would not be covered, but modest support would be provided to a selected few of a range of programs which support increases in access (scholarships, incentives to parents, girls' uniforms, free school textbooks, limited primary school construction/rehabilitation) and improvements in the quality of basic education. The out-of-school adolescent girls would be a special focus of the project as they will soon be mothers. The details of the various education and training programs for females to be supported under the project are outlined in Annex 5, Part 3. During negotiations, the GOI and Project States provided assurances that they shall cause the project cities to furnish to the Association by January 31 of each year, commencing January 31, 1993, for review and comment, and thereafter duly take into account any comments provided by the Association in respect of a report on progress achieved during the previous year in basic education for females. The project would support activities which increase the demand for family welfare services by financing the costs of books, IEC and educational materials, equipment, vehicles, contracts for innovative schemes, local training, local experts, and the salaries of additional staff and honoraria of additional volunteers on a declining scale.

G. Improving the Management of the Family Welfare Program (Proposed Outlay US$3.78 million)

3.20 While no major reorganization would be necessary, the respective Family Welfare Bureaus in the municipalities would have to be suitably strengthened to expand services as envisaged under the project. The Bureaus will also need to improve coordination with other municipal Departments providing services to slum communities, especially those dealing with sanitation and water supply, education and nutrition. Coordination of activities with, and providing funding for health and family welfare to PVOs, PMPs and the community at large, will also require the strengthening of coordination mechanisms. The municipalities have established Project Implementation Committees with such representatives and powers as agreed with the Association (para 3.14).

3.21 In addition to strengthening inter-departmental coordination, the respective Bureaus will be strengthened to implement and supervise various project activities. Special emphasis would be given to training, IEC, management information systems (MIS), the supervision of Innovative Schemes and Auditing and Accounting. The additional staff to be recruited, and the schedule of appointment, are outlined in **Annex 16**. During negotiations, the GOI and Project States provided assurances that they shall cause the project

cities to establish within their Family Welfare Departments or agencies in accordance with a time schedule agreed with the Association, and thereafter maintain, cells with adequate staff and other resources with responsibility for planning and implementing programs in each of the following areas: training, IEC, grants-in-aid to PVOs and PMPs, women in development, management information systems and accounting and auditing. The staffing of Family Welfare Bureaus has been determined according to norms developed under the Urban Revamping Scheme (Annex 7, para 4). Unfortunately, these norms when rigidly applied do not capture the varying needs of the individual municipalities nor the large growth of urban slums since the norms were established. During negotiations, the GOI provided an assurance that it shall: (a) under arrangements satisfactory to the Association to be instituted by June 30, 1993, examine issues relating to population growth, health and the environment for urban areas; (b) undertake by January 31, 1994, a reassessment of the Urban Revamping Scheme and the norms by which it provides support for the said scheme; and (c) discuss with the Association the results of such reassessment including the implementation of proposed actions resulting from the said reassessment. During negotiations, the GOI and Project States also provided assurances that they shall cause the project cities to: (a) prepare in accordance with terms of reference agreed with the Association and furnish to the Association for review and comment by January 31, 1994, a City Health Plan covering the area under each city's jurisdiction; and (b) discuss the said Plan with the Association, including proposed actions for implementing such Plan. The Plan will cover public and private provision of curative and preventive health services and plans for their rationalization including financing, a regime of fees, insurance, and subsidization. The project would support improvements in the management of the family welfare program by financing local and foreign training, local and foreign experts (city health planning), equipment, vehicles, and the salaries of additional staff on a declining scale.

H. Innovative Schemes (Proposed Outlay US$9.54 million)

3.22 It has been recognized that one of the reasons for some of the limitations of the Family Welfare Program is that it has been run as a government program and not as a people's program. With the objective of making the program more community-based, a concerted effort would be made under this project to secure greater involvement of private voluntary organizations. It is recognized that these organizations can significantly increase the pace of program implementation by supplementing governmental activities and bridging gaps in communication between the municipality and the slum community. These PVOs generally take up innovative programs by adopting strategies and methodologies which are aimed at fostering social transformations, thereby generating attitudinal changes and improving quality of life of women in particular. Various Innovative Schemes have been suggested by the four municipalities and these are outlined in **Annex 17**. During negotiations, the GOI and Project States provided assurances that they shall cause the project cities, in consultation with the concerned Project State and GOI, to prepare and furnish to the Association for its approval prior to their implementation, all proposed innovative schemes. The project would support Innovative Schemes by financing the costs of the contracts which the municipalities would enter into with PVOs, community groups and PMPs. Each municipality would establish a Revolving Fund Account for Innovative Schemes and replenish it as and when the initial allocation is exhausted.

I. Preparation of Future Projects (Proposed Outlay US$9.33 million)

3.23 As noted in paragraph 3.03, another 15 cities were also covered by the initial study conducted by the National Institute of Health and Family Welfare. These cities are Patna in the State of Bihar; Bhopal, Durg, Gwalior, Jabalpur and Indore in Madhya Pradesh; Jaipur and Jodhpur in Rajasthan; Agra, Allahabad, Kanpur, Lucknow, Meerut, Varanasi in Uttar Pradesh; and Aurangabad in Maharashtra. The project would provide resources so that these cities can initiate and complete Beneficiary/Community Needs Assessments, Facility Surveys and detailed Two-Year Construction Plans including detailed designs and cost estimates for new facilities as well as for rehabilitation and additions. Where necessary, the preparation phase would include the acquisition of land and final site selection. The cities would also be asked to establish Project Advisory and Coordination Committees, and Project Implementation Committees with representation from slum communities and PVOs. The slum communities would also be expected to have formed Neighborhood Committees as called for under the UBSP model (para 2.05). The municipalities would also be expected to use this project preparation phase to establish and staff their project implementation organizations including the appropriate Cells for IEC, training, grants, accounting and auditing. The project would finance the cost of consultant services, selected equipment, vehicles and furniture. Because these "designated cities" would only undertake project preparation activities, a separate disbursement category has been created in the Credit for these resources. A condition of disbursement for the preparation of future projects in "designated cities" would be that GOI shall obtain from each State of the "designated cities" and furnish to the Association, a Letter of Undertaking in a form and substance satisfactory to the Association which shall include, inter-alia, the terms and conditions of their participation in the project.

J. Role of Women in the Project

3.24 The health sector provides extensive opportunities for the involvement of women. The project would provide for women's participation at all levels of design, implementation and supervision. Women would play a significant role in motivating and providing health and family welfare services in the slums. They would be involved in identifying needs through active participation in the Beneficiary/Community Needs Assessment, and designing strategies to provide services to meet those identified needs. The female volunteer link worker, the ANM and LHVs are the main implementors of the project. Women also play a key role in generating demand and in the administration and management of health services in the municipalities. The active participation of female-led community groups and PVOs, and the large number of female PMPs, would help to ensure that family welfare services reach the targeted population through training and IEC programs. All staff of the administration, the community in general, and men specifically, would be sensitized through training to the impact of gender issues on the implementation of the project. A more extensive analysis of the role of women in the project is given in **Annex 18**.

IV. PROJECT COST, FINANCING, IMPLEMENTATION AND DISBURSEMENTS

A. Costs

4.01 Summaries of Costs. The total cost of the project would be Rs. 3,044.44 million or US$96.60 million equivalent. A breakdown of costs by component, and categories of expenditure is summarized in Tables 4.1 and 4.2. Detailed costs by component, categories of expenditure and time are given in Annex 19. Estimated project costs include physical and price escalation contingencies (US$17.60 million). Physical contingencies are estimated at 10% of all physical components and 5% for salaries of incremental staff, training costs, consultants and operation and maintenance. Price escalation contingencies are estimated as follows: for civil works, goods, salaries, and technical assistance--foreign costs: 3.7% in CY93 through CY99; local costs: 10.5% in CY92, 8.5% in CY93, 7.5% in CY94, 6.5% in CY95, 6.0% in CY96 and 5.0% in CY97 through CY99. The estimated cost of the project includes import duties and taxes estimated at about US$2.90 million (3.0%). The foreign exchange component of the project is estimated at about US$9.10 million (9.4%).

Table 4.1: Costs by Component

Component	Local	Foreign	Total	Local	Foreign	Total	% of Base Costs
	------Rupee (Million)------			------US$ (Million)------			
Increasing the Supply of F.W. Services	1,015.07	89.17	1,104.24	37.60	3.30	40.90	51.8
Improving the Quality of F.W. Services	242.57	27.71	270.28	8.98	1.03	10.01	12.7
Increasing the Demand for F.W. Services	223.26	24.63	247.89	8.27	0.91	9.18	11.6
Improving the Management of F.W. Services	70.75	14.04	84.79	2.62	0.52	3.14	4.0
Innovative Schemes	125.29	14.22	209.51	7.23	0.53	7.76	9.8
Preparation of Future Projects	190.48	25.46	215.94	7.06	0.94	8.00	10.1
BASE COSTS	1,937.42	195.23	2,132.65	71.76	7.24	79.00	100.0
Contingencies							
Physical	141.79	18.61	160.40	5.25	0.70	5.95	7.5
Price	689.91	70.50	760.41	10.49	1.16	11.65	14.7
TOTAL PROJECT COSTS	2,769.12	284.34	3,053.46	87.50	9.10	96.60	122.2

Table 4.2: Costs by Categories of Expenditure

Component	Rupee (Million)			US$ (Million)			% of Base Costs
	Local	Foreign	Total	Local	Foreign	Total	
Investment Costs							
Civil Works	360.68	45.40	406.08	13.36	1.68	15.04	19.1
Professional Fees	16.25	---	16.25	0.60	---	0.60	0.8
Department Charges	45.79	---	45.79	1.70	---	1.70	2.2
Furniture	58.83	5.92	64.75	2.18	0.22	2.40	3.0
Equipment & MCH Materials	263.03	99.60	362.63	9.74	3.69	13.43	17.0
Vehicles	42.56	4.29	46.85	1.57	0.16	1.73	2.2
Medicines	192.59	21.79	214.38	7.13	0.81	7.94	10.1
Land	77.29	---	77.29	2.86	---	2.86	3.6
Books & Training Materials	7.31	---	7.31	0.27	---	0.27	0.3
Local Training	56.30	1.04	57.34	2.10	0.03	2.13	2.7
Local Consultants	303.42	---	303.42	11.24	---	11.24	14.2
Foreign Training	0.90	8.29	9.19	0.03	0.31	0.34	0.4
Foreign Consultants	0.91	8.34	9.25	0.03	0.31	0.34	0.4
Subtotal	1,425.86	194.67	1,620.53	52.81	7.21	60.02	76.0
Recurrent Costs							
Salaries of Incremental Staff	351.41	---	351.41	13.02	---	13.02	16.5
Honoraria	138.29	---	138.29	5.12	---	5.12	6.5
Operation and Maintenance	21.86	0.56	22.42	0.81	0.02	0.83	1.0
Subtotal	511.56	0.56	512.12	18.95	0.02	18.97	24.0
BASE COSTS	1,937.42	195.23	2,132.65	71.76	7.24	79.00	100.0
Contingencies							
Physical	141.79	18.61	160.40	5.25	0.70	5.95	7.5
Price	689.91	70.50	760.41	10.49	1.16	11.65	14.7
Subtotal	831.70	89.11	920.81	15.74	1.86	17.60	22.2
TOTAL PROJECT COSTS	2,769.12	284.34	3,053.46	87.50	9.10	96.60	122.2

NOTES: Subtotals may not add to totals due to rounding. Costs include taxes and duties.

B. Financing Plan

4.02 The estimated cost of the project of US$96.60 million would be financed by an IDA Credit of US$79.00 million equivalent which would cover about 84% of project cost net of taxes and duties. The GOI would finance the remaining net project costs of US$14.70 million and all taxes. The financing plan by component and categories of expenditure is outlined in **Annex 20.**

C. Recurrent Costs and Sustainability Implications

4.03 When the Project is completed in FY99, it would require a total of about Rs. 222.6 million (US$6.4 million equivalent) annually in recurrent costs. These expenditures would be borne fully by the State of Karnataka for Bangalore, Andhra Pradesh for Hyderabad, West Bengal for Calcutta, the Municipal Corporation of Delhi and the MOHFW. Assuming no real growth in budget allocations, except for the proposed investments in the project, it is estimated that the impact of recurrent project expenditures on the family welfare budgets of the States and MCD would be negligible as shown in **Annex 21.** Under the present financial circumstances in India, it is difficult to ensure the sustainability of family welfare activities at the levels to be achieved during the life of the project. However, in addition to government assurances which include maintaining the National Family Welfare program as a centrally-financed program during the Eighth Five-Year Plan (1992-97), several other factors provide positive indications of sustainability. First, additional new staff have been kept to a minimum by the redeployment of existing staff and the use of volunteer and part-time workers. Second, the increased participation of the community in the management and maintenance of services

and the expanded role of PVOs and PMPs, should assist sustainability. Lastly, as quality improves and demand increases, it may be possible to recover some funds from beneficiaries to use for system maintenance. Issues relating to the sustainability of family welfare investments are being addressed comprehensively in a Health Financing Study which is underway in close collaboration with GOI.

D. Project Implementation

4.04 The Ministry of Health and Family Welfare (MOHFW), the Directorate of Health and Family Welfare in the respective States, and the Family Welfare Bureaux/Health Units in the municipalities would all have responsibilities for implementing the project. The MOHFW has a Division headed by a Joint Secretary, which is currently responsible for coordinating and monitoring the implementation of all externally-aided family welfare area projects, and would also coordinate all project inputs from other relevant Ministries. The Government has established a Project Advisory and Coordinating Committee (PAAC) with representatives from the Women and Child Department, Ministry of Urban Development, other key ministries, PVOs, and community groups for the purpose of coordinating several project interventions. The respective States have also established PAACs, headed by the Chief Secretary. At the municipal level, the project would be implemented by the respective Family Welfare Bureaux/Health Units with guidance from Project Implementation Committees which include PVO and community group representations.

E. Monitoring, Evaluation and Studies

4.05 At present, the MOHFW collects information on all Schemes which make up the national family welfare program. This level of monitoring would be further supplemented under the Project. Currently, each scheme has some form of built-in evaluation, and the implementing institutions utilize these to make adjustments when and if necessary in their delivery of services. Overall monitoring and evaluation, such as the use of credit proceeds, and the achievement of objectives would be undertaken by municipalities with the assistance of the State Directorate of Health and Family Welfare. As part of its normal reporting responsibility, each municipality would submit Semi-Annual Progress Reports to IDA. The format and content of these reports is outlined as part of the Supervision Plan (**Annex 22**). As regards evaluation, the Government has discussed with the Association key indicators (Annex 10) and also indicated a willingness to undertake special studies to determine whether program objectives are being achieved. Rapid Low Cost Studies (RLCS) would be used as a technique to achieve this end. The major impacts which would be measured would be reductions in maternal and infant mortality and morbidity and the increase in contraceptive prevalence, especially the use of temporary methods. Under the project, a number of these studies would be undertaken, as outlined in Annex 22, Section 3. During negotiations, the GOI and Project States provided assurances that they shall cause the project cities to: (a) utilize the Key Indicators agreed with the Association for evaluating performance of the project; and (b) use rapid low cost studies as agreed with the Association for the purposes of such evaluation. During negotiations, the GOI and Project States also provided an assurance that they shall furnish or cause to be furnished to the Association by September 30, 1995, a mid-term review of the progress of the project.

F. Status of Preparation

4.06 Prototype designs for the construction of new health facilities already exist. Each municipality has initiated a Facility Survey to identify existing institutions which are to be upgraded/renovated and is preparing a detailed Two-Year Construction Plan which would be completed within six months of the final Facility Survey. The Engineering Departments of the Municipalities will be responsible for the contracting and supervision of civil works. Architectural designs were prepared either by private consultants or in-house architects of the municipalities. Locations for the construction of the health facilities and medical stores facilities have been identified in all cities. Where no municipal land is available, sites would be acquired. This is expected in Delhi and Calcutta. Lists for equipment, vehicles, medicines, and family welfare supplies (consumable materials) have been prepared by GOI and the municipalities and are based on standards used by MOHFW for the other seven IDA-assisted Population projects and the Child Survival and Safe Motherhood project approved by the Board in September 1991. Draft terms of reference for local consultants have been prepared and development of the various types of training programs has begun. Beneficiary/Community Needs Assessments, as well as Baseline Surveys have been initiated in all municipalities. Community participation workshops have also been undertaken in all municipalities. The MOHFW, States and municipalities have formed Project Advisory and Coordinating Committees and Project Implementation Committees. A list of Innovative Schemes has been prepared. Arrangements for the procurement of goods and services are in place. Standard bid documents prepared for the procurement of goods and works under the IDA-assisted Technician Education projects of 1990 and 1991 would be utilized as applicable.

G. Disbursements

4.07 Disbursement Profile. The proposed IDA credit would be disbursed over seven years and is in line with the standard profile of population projects in India and the Asia Region. The project is expected to be completed on March 31, 1999 and the Credit closed on December 31, 1999. The nature of the project, including emphasis on community participation and experience with the implementation of other IDA-financed population projects, reinforce the justification for a standard disbursement profile.

4.08 Disbursement Percentages and Required Documentation. The IDA Credit would be disbursed against 90% of expenditures on civil works, 100% of CIF and of local ex-factory cost or 80% of other locally procured equipment, vehicles, medicines, furniture, IEC and MCH materials, 100% of consultants', PMPs' and PVOs' services and training, and an average of about 70% of total expenditures (90% for Indian FY92-95, and 65% thereafter) on the salaries of incremental staff and honoraria for incremental volunteer workers. Disbursements in respect of contracts for civil works and goods estimated to cost less than US$50,000 equivalent would be made against statements of expenditure (SOEs) certified by the municipalities. Documentation would be retained by the municipalities and made available for review by IDA staff (headquarters and NDO) during supervision missions. All other disbursements would be made against fully-documented withdrawal applications. A forecast of annual expenditures and disbursement is given in **Annex 23.**

4.09 Special Account and Retroactive Financing. To accelerate disbursements in respect of IDA's share of expenditures pre-financed by GOI, and to allow for direct payment of other eligible local and foreign expenditures, a Special Account would be opened in the Reserve Bank of India with an authorized allocation of US$4.0 million equivalent to cover four months of expected requirements for IDA financed items. Retroactive financing up to SDR 0.4 million (US$0.5 million) is provided to cover eligible expenditures after November 30, 1991 for costs incurred in implementing appraised activities.

H. Procurement

4.10 Procurement arrangements are summarized in Table 4.3. Project related procurement for goods and services would follow procedures acceptable to IDA. Project financed consultants would be selected according to IDA's guidelines for the use of Consultants by World Bank Borrowers. Procurement of equipment, vehicles, furniture, medicines, MCH and educational materials would be bulked to the maximum extent possible and any individual contract exceeding US$200,000 equivalent would be procured using ICB.

Civil Works (US$18.80 million)

4.11 Sixty percent of the civil works contracts, estimated at US$10.9 million would cost between US$50,000 and US$100,000 each and would be awarded using LCB procedures acceptable to IDA. Forty percent (US$7.9 million) would be for contracts below US$50,000 each and would be procured using appropriate procedures including force account, community participation or LCB.

Furniture, Equipment, Vehicles, Medicines, and IEC and MCH Materials (US$30.70 million)

4.12 Most of the equipment is medical in nature. Generally, it is manually powered and includes such items as small clinical equipment and tools, kits for nurses, syringes, needles, and other medical accessories and would be procured annually based on identified needs. Contracts for equipment and MCH materials (US$16.90 million) estimated to cost less than the equivalent of US$200,000 per contract, up to an aggregate amount not exceeding US$9.0 million may be procured on the basis of competitive bidding advertised locally, in accordance with procedures satisfactory to IDA. Contracts valued at US$50,000 equivalent or less, up to an aggregate total of US$5.9 million would be awarded on the basis of prudent shopping procedures. Specialized medical equipment (US$2.0 million) would be procured using ICB. Vehicles (US$2.1 million) and furniture (US$3.0 million) would be procured over the life of the project through LCB procedures acceptable to IDA. Medicines (US$10.4 million) would be procured by LCB and other methods as explained in Annex 24. Contracts for medicines estimated to cost over US$50,000, up to an aggregate of US$6.0 million would be awarded on the basis of LCB. Contracts estimated to cost US$50,000 or less, up to an aggregate of US$4.4 million would be awarded on the basis of prudent shopping procedures and by direct contracting. Contracts for training and IEC materials costing US$50,000 or less, up to an aggregate of US$0.3 million would be awarded on the basis of prudent shopping procedures and by direct contracting. For all contracts over US$200,000 procured using ICB, a 15% domestic preference or the prevailing import duties, whichever is lower, would be granted to qualifying local manufacturers.

Bank Review

4.13 All items procured using ICB would be subject to IDA's prior review. All LCB contracts over US$200,000 would be subject to prior review. Appointment of all consultants, including PMPs and PVOs, will be in accordance with IDA guidelines. The procurement arrangements which would be used in the project are similar to the previous IDA-assisted Population Projects and have been found to be satisfactory.

Table 4.3: Procurement Method

Procurement Elements	Procurement Method ICB	LCB	OTHER	N/A	TOTAL COST
1. Works					
1.1 Civil Works		10.90 (9.80)	7.15 (6.40)		18.05 (16.20)
1.2 Dept. Charges				2.10	2.10
2. Goods					
2.1 Furniture		3.00 (2.70)			3.00 (2.70)
2.2 Equipment & MCH Materials	2.00 (1.80)	9.00 (8.10)	5.90 (5.31)		16.90 (15.21)
2.3 Vehicles		2.10 (1.90)			2.10 (1.90)
2.4 Medicines		6.00 (5.50)	4.40 (3.70)		10.40 (9.20)
2.5 Training and IEC Materials			0.30 (0.27)		0.30 (0.27)
3. Consultancies					
3.1 Local Consultants, PMPs and PVOs				14.75 (14.72)	14.75 (14.72)
3.2 Foreign Consultants				0.40 (0.40)	0.40 (0.40)
3.3 Local Training				2.50 (2.50)	2.50 (2.50)
3.4 Foreign Training				0.40 (0.40)	0.40 (0.40)
4. Miscellaneous					
4.1 Salaries of Additional Staff and Honoraria of Additional Volunteers				22.20 (15.50)	22.20 (15.50)
4.2 Operation and Maintenance				1.00	1.00
4.3 Land				2.50	2.50
TOTAL	2.00	31.00	17.75	45.85	96.60
IDA	1.80	28.00	15.68	33.52	79.00
GOI	0.20	3.00	2.07	12.40	17.60

NOTE: Figures in parentheses represent IDA financing.

I. Accounting and Auditing

4.14 The project would be subject to normal GOI accounting and auditing procedures which are considered satisfactory to IDA. The audit reports for the on-going population projects are in a form satisfactory to IDA and would be used for this project. The municipalities have all established accounting procedures and systems which are satisfactory to IDA. They would maintain separate project accounts and provide IDA with semi-annual statements of

expenditures. During negotiations, the GOI and Project States provided assurances that they shall cause the project cities to: (a) have the accounts and financial statements of the project, including Statements of Expenditure (SOE) and the Special Account for each fiscal year, prepared in accordance with sound accounting practices and audited by independent auditors acceptable to IDA; (b) maintain supporting documentation for statements of expenditures at least one year after the completion of the audit for the fiscal year in which the last withdrawal was made; (c) include a separate opinion on SOEs in the annual audit; and (d) furnish to the Association as soon as available, but not later than nine months after the end of each fiscal year, certified copies of the audited accounts and financial statements for each fiscal year, together with the Auditors Report in the form of a Consolidated Report. IDA will accept the Municipal Chief Auditors of the respective project cities (DMC, NDMC, BMC and MCH) as independent, and the Controller and Auditor General (CAG) of India as an independent auditor for CMDA.

V. BENEFITS AND RISKS

A. Benefits

5.01 The proposed project would assist GOI in further developing operational models and refining its Urban Revamping Scheme for nationwide replication. It would also provide a suitable vehicle for the participation of urban and slum communities in determining the mix of services which are most appropriate to their felt needs. Further, the project would confer direct social benefits to low-income slum dwelling families, particularly women and children, by increasing access to and the quality of family planning and maternal and child health care services. In so doing, it would promote a decline in fertility, morbidity and mortality among mothers, infants and young children. The project would also help to improve government and community responsiveness to the needs of women and create a greater awareness among policy makers of the impact of development on women.

B. Risks

5.02 The major risks would be institutional and relate to the capacity of municipalities to implement the project, particularly to develop outreach services and work collaboratively with slum populations and PVOs. To minimize these risks, Municipal Health Departments would be strengthened under the project. Arrangements would be made to increase the cooperation between State governments, municipalities, Private Voluntary Organizations, slum communities and private medical practitioners. Committees would be established with representatives from each group, to provide inputs to project design, implementation and supervision as well as to undertake modifications if necessary.

VI. AGREEMENTS REACHED

6.01 During negotiations, the GOI provided assurances that it shall:

(a) ensure that volunteer workers participating in the Urban Revamping Scheme shall be eligible to receive payment of honoraria in respect of their work in the said scheme (para 3.07);

(b) develop by June 30, 1993, a program of measures to improve compliance with the Child Marriage Restraint Act, 1929, as amended (para 3.18); and

(c) (i) under arrangements satisfactory to the Association to be instituted by June 30, 1993, examine issues relating to population growth, health and the environment for urban areas; (ii) undertake by January 31, 1994, a reassessment of the Urban Revamping Scheme and the norms for it to provide support for the said Scheme; and (iii) discuss with the Association the results of such reassessment including the implementation of proposed action resulting from the said reassessment (para 3.21).

6.02 During negotiations, the GOI and States of Karnataka, Andhra Pradesh and West Bengal (Project States) provided assurances that they shall cause the municipalities of Bangalore, Calcutta, Delhi and Hyderabad (project cities) to:

(a) (i) furnish to the Association by June 30, 1993, baseline surveys and beneficiary and community needs assessments with format and content satisfactory to the Association; and (ii) promptly thereafter, suitably adjust the hours of operation of health facilities located in slum areas in its jurisdiction so as to be fully responsive to the findings of the above beneficiary and community needs assessment (para 3.07);

(b) (i) provide in accordance with a time schedule agreed with the Association, and thereafter maintain, adequate salaried staff and honorary health workers and other resources as shall be necessary to ensure the effectiveness of its outreach programs under the Project; and (ii) establish within its Family Welfare Department or agency in accordance with a time schedule agreed with the Association, and thereafter maintain Cells with adequate staff and other resources with responsibility for planning and implementing programs in each of the following areas: IEC, management information systems, training, grants-in-aid to PVOs and PMPs, women in development and accounting and auditing (paras 3.07, 3.21);

(c) furnish to the Association by January 31 of each year, commencing January 31, 1993, a report on the following for review and comment, and thereafter duly take into account any comments provided by the Association in respect thereof: (i) annual plan for civil works, training and IEC in respect of its immediately succeeding financial year; and (ii) progress achieved during the previous year in basic education for females (paras 3.08, 3.10, 3.17, 3.19);

(d) (i) establish by January 31, 1994, community-based management committees for facilities and programs developed under the project; and (ii) institute no later than April 1, 1994 such measures as shall generate resources from the direct beneficiaries of the said facilities and programs to support a portion of the operation and maintenance costs thereof, including medicines (para 3.11);

(e) establish by June 30, 1993, an IEC Program Planning and Implementation Committee with membership and terms of reference satisfactory to the Association (para 3.17);

(f) (i) develop by June 30, 1993 a program of measures to improve compliance with the Borrower's Child Marriage Restraint Act, 1929, as amended; and (ii) furnish to the Association by January 31, 1994, and by January 31 each year thereafter, a report for review and comment by the Association on steps taken in the previous year toward the said improvement (para 3.18);

(g) (i) prepare in accordance with terms of reference agreed with the Association and furnish to the Association for review and comment by January 31, 1994, a City Health Plan covering the area under its jurisdiction; and (ii) discuss such Plan with the Association, including proposed actions for implementing the Plan (para 3.21);

(h) in consultation with the concerned State and the GOI, prepare and furnish to the Association for its approval prior to their implementation, all proposed innovative schemes (para 3.22);

(i) (i) utilize key indicators agreed with the Association for evaluating performance of the Project; and (ii) use rapid low cost studies as agreed with the Association for the purposes of such evaluation (para 4.05); and

(j) (i) prepare in accordance with sound accounting practices, and have audited by independent auditors acceptable to the Association, accounts and financial statements of the project including statements of expenditure (SOE) for each fiscal year and the Special Account; (ii) maintain documents supporting statements of expenditures at least one year after the completion of the audit for the fiscal year in which the last withdrawal was made; and (iii) include a separate opinion on SOEs in the annual audit. The GOI would furnish to the Association as soon as available, but not later than nine months after the end of each fiscal year, certified copies of the audited accounts and financial statements for each fiscal year, in the form of a Consolidated Report (para 4.14).

6.03 During negotiations, the GOI and Project States agreed to furnish or cause to be furnished to the Association by September 30, 1995, a mid-term review of the progress of the project (para 4.05).

6.04 As a condition of disbursement for the preparation of future projects in "designated cities," the GOI would obtain from each State of the "designated cities" and furnish to the Association, a Letter of Undertaking in form and substance satisfactory to the Association which shall include, inter alia, the terms and conditions of their participation in the project (para 3.23).

6.05 Subject to the above assurances, the proposed project constitutes a suitable basis for an IDA Credit of SDR 57.7 million (US$79.00 million equivalent) to India at standard IDA terms with 35 years maturity.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

Table 1: BENEFICIARIES

	BANGALORE	CALCUTTA	DELHI	HYDERABAD
Actual Population (1992) (million)	4.18	12.10	9.30	4.28
Project Area Slum Population (million)	0.36	5.50	1.25	0.75
Percentage of Children (0-4) in slums	10	10	10	9.9
Number of Children (0-4)	36,000	605,000	125,000	74,250
Percentage of married women (15-44) in slums	34%	15.7%	33.5%	25%
Number of married women (15-44)	122,400	863,500	418,750	187,500
Total Number of Beneficiaries	158,400	1,468,500	543,750	261,750

Table 2: Population Size and Growth 1961-1991

Year	Census Population (Million)	Decadal change	Average Annual Exponential Growth Rate
		INDIA	
1961	439.2	21.51	1.96
1971	548.2	24.80	2.20
1981	683.3	24.66	2.22
1991	844.3	23.56	2.12
		BANGALORE (UA)+	
1961	1.21	64.17	
1971	1.66	54.57	
1981	2.92	57.09	
1991	4.09	46.18	

CALCUTTA (UA)+

1961	5.98	10.48
1971	7.42	43.80
1981	9.19	42.65
1991	10.92	67.04

DELHI (UA)+

1961	2.36	53.49
1971	3.65	37.88
1981	5.73	75.56
1991	8.38	39.87

HYDERABAD (UA)+

1961	1.25	28.14
1971	1.80	24.01
1981	2.55	23.90
1991	4.28	18.73

Source: + Statement 23, Paper-2 of 1991 - Provisional Population Totals Census of Inda
UA - Urban Agglomearation.

Table 3: Demographic Data: India 1985-1991

INDIA

Year	CBR	CDR	IMR	ECPR
1985	32.9	11.8	97	32.1
1986	32.6	11.1	96	34.9
1987	32.2	10.9	95	37.5
1988	31.3	10.9	94	39.9
1989	30.6	10.3	91	41.9
1990	29.9	9.6	80	43.3
1991	NA	NA	NA	44.1

BANGALORE

1985	26.8	7.6	36.5	-
1986	25.4	7.2	41.0	-
1987	25.4	7.3	44.0	43.8
1988	25.9	7.1	34.0	43.8
1989	25.1	7.2	36.9	54.9
1990	25.3	6.8	32.0	47.3
1991	25.4	7.3	26.7	54.7

CALCUTTA 1/

1985	20.5	6.8	46	43.82
1986	20.1	6.9	55	42.37
1987	20.9	6.5	53	46.11
1988	18.7	5.7	43	47.37
1989	18.4	7.0	53	44.60
1990	18.3	6.8	42	52.31
1991	NA	NA	NA	52.52

DELHI

1985	27.93	6.71	39.69	37.8
1986	26.97	6.39	42.23	36.4
1987	28.31	6.63	49.71	39.0
1988	29.08	6.86	37.90	39.8
1989	28.02	6.77	40.2	42.4
1990	NA	NA	NA	41.7
1991	NA	NA	NA	40.4

HYDERABAD

Year	CBR	CDR	IMR	ECPR
1985	37.6	7.0	30.8	37.37
1986	35.8	6.7	38.4	41.28
1987	39.3	7.6	34.4	43.79
1988	38.5	7.6	27.6	47.77
1989	37.4	7.4	33.0	50.29
1990	37.4	6.8	24.5	52.35
1991	NA	NA	NA	NA

Table 4: Population Projections:

India, New Delhi, Calcutta, Hyderabad and Bangalore 1990-2000

Year	India*	New Delhi	Calcutta	Hyderabad	Bangalore
			(In Millions)		
1990	843.6	8.91	10.92	2.90	4.10
1995	923.7	10.74	13.60	3.31	4.88
2000	1003.1	12.82	14.80	3.75	5.87

* For India, reference period is 1991, 1996 and 2001 instead of 1990, 1995 and 2000.

1/ Information on vital rates of Calcutta CMC are not readily available. Calcutta urban Agglomearation's population is about 70% of urban population of West Bengal. Vital rates given here are for urban population of West Bengal.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

PROFILE OF PROJECT CITIES

	Bangalore	Calcutta	Delhi	Hyderabad
1. AREA (SQ.KMS)	451	1,488	1,484	500
2. DENSITY OF POPULATION (PER SQ. KM)	9,099	8,132	6,314	14,248
3. NUMBER OF SLUMS	401	2,200,000	--	92
4. DEMOGRAPHIC DATA				
Population (million)				
1981 : Overall	2.9	9.2	5.7	2.5
Slum	--	3.3	--	--
1991 : Overall	4.1	10.9	8.4	4.3
Slum	0.3	5.5	3.5	0.8
1995 : (Projected) Overall	4.8	13.6	11.4	3.1
Slum	0.4	5.9	--	--
Decadal Growth (%)	40.6	19.7	50.6	37.4
Population Structure (%)				
: 0-1 Overall	--	2.0	5.0	3.0
: Slum	4.3	--	5.5	--
: 1-4 Overall	12.0	7.4	8.0	9.0
: Slum	19.7	--	13.7	--
: 5-14 Overall	20.2	23.8	23.5	27.0
: Slum	31.4	--	28.5	--
: 15-44 Overall	--	43.4	50.3	43.2
: Slum	44.4	--	--	--
: 44 + Overall	19.3	18.2	14.2	17.2
: Slum	--	--	--	--

5. ENVIRONMENTAL DATA				
% of Population supplied safe drinking water				
Overall	95.0	80.0	43.0	60.0
Slums	86.0	--	90.8	25.0
% of population covered by sewerage disposal				
Overall	80.0	35.0	90.6	60.0
Slums	10.0	--	33.3	25.0
% of population covere by solid waste disposal			--	--
Overall	75.0	73.9	--	60.0
Slums	15.0	--	--	25.0
% of population covered by sanitary latrines			--	
Overall	85.0	30.0	46.0	60.0
Slums	10.0	--	--	25.0
6. Morbidity Pattern (major causes of Deaths %)				
Respiratory Disease	48.2	11.4	24.6	--
Fevers	21.2	--	1.8	--
Diarrhoeas and Dysentaries	11.0	26.1	11.0	2.0
Accidents	10.4	6.4	--	--
Tuberculosis	9.0	6.7	1.61	15.7
Infective Hepatitis	--	--	--	1.9
6. MATERNAL AND CHILD HEALTH AND FAMILY PLANNING SERVICES				
% of ANC cases registered				
Overall	84.3	--	--	86.2
Slums	80.7	--	71.3	88.7
% of cases receiving ANC	--	--		
Overall	95.4	--	75.0	58.7
Slums	84.3	--	68.9	--
% of Institutional Deliveries				
Overall	63.7	--	65.7	94.8
Slums	85.0	--	72.4	66.0

% of deliveries conducted at home				
Overall	36.3	--	34.3	5.2
Slums	15.0	--	29.6	32.0
% of deliveries conducted by Trained Personnel at home				
Overall	6.5	--	65.9	5.2
Slums	15.0	--	68.7	32.0
% of Children between 1-2 years fully immunized				
Overall	71.4	--	86.3	41.0
Slums	54.2	--	80.0	--
For 1989-90				
% of Family Planning Acceptors (method wise) Conventional contraceptives:	1.4	1.0	9.8	2.5
Oral Pills:	1.0	0.1	0.4	0.9
IUCD:	7.4	1.4	9.1	2.8
Tubectomy/Vasectomy:	37.8	31.8	21.1	43.4
7. EXISTING HEALTH CARE FACILITIES				
Hospitals: Public	16	138	36	31
Private	17	58	--	--
Dispensaries: Public	92	75	367	73
Private	--	--	19	--
Polyclinics: Public	--	27	8	--
Private	10	22	--	--
Paediatric Centres: Public	3	--	41	--
Private	1	--	--	--
Nursing Homes: Public	--	--	--	--
Private	142	--	110	120
Urban family Welfare Centre: Public	37	73	--	34
Private	--	--	--	--
Maternity Homes: Public	31	17	5	10
Private	1	--	--	26
Post-Partum Units: Public	5	--	9	5
Private	--	--	--	--

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

THE NATIONAL FAMILY WELFARE PROGRAM

Section 1: Goals and Achievements

	Goals		Achievement
	1990	2000	1990
Net Reproduction Rate (NRR)	1.17%	1.0%	1.6%
Effective Couple Protection Rate (ECPR)	42.0%	60%	44.1%
Annual Growth Rate of Population	1.66%	1.20%	2.0%
Total Fertility Rate	4.3	2.3	3.9
Infant Mortality Rate	87	below 60	91
Crude Death Rate	10.4	9.0	10.3
Crude Birth Rate	27.4	21.0	30.6
Young Child Mortality (0-4 years)	15 - 20	10	35.2 (1987)
Maternal Mortality	2 - 3	below 2	5-7
Life Expectancy at Birth	56.6	64	55
Babies with birth weight below 2500 grams	18.0%	10%	25%
Pregnant mothers receiving ante-natal care	60 - 75%	100%	40%
Deliveries by Trained Birth Attendants	80%	100%	35%
Immunization Status (% covered)			
• TT (for pregnant women)	100%	100%	65%
• TT (for children)	100%	100%	65%
• DPT (children below 3 years)	85%	85%	80%
• BCG (infants)	80%	85%	80%
• Polio	70%	85%	76%
Subcenter	1 for every 5,000 population 1/		
Primary Health Center	1 for every 30,000 population		
Community Health Center	1 for every 100,000 population		
Health Guide	1 for every village		
Trained Dai	1 for every village		

NA = Not available.
1/ 3,000 in tribal and remote areas.
Source: Ministry of Health and Family Welfare; Sample Registration System.

Section 2: Schemes which Make up the National Family Welfare Program

The 26 Schemes which make up the National Family Welfare Program can be categorized as follows:

(a) **Family Welfare Services** including for Family Planning (i) sterilizations (vasectomy, tubectomy), (ii) IUD insertions; (iii) free distribution of oral pills and conventional contraceptives (condoms, jelly creams, foam tablets, diaphragms) and for MCH, (iv) immunization of pregnant women and children (tetanus, DPT, Polio, BCG and measles), (v) prophylaxis against nutritional anemia among women and children and against blindness due to Vitamin A deficiency; and (vi) Oral-rehydration therapy.

(b) **Facilities to deliver these services:** construction, furnishing and equipping (vii) under the Minimum Needs Program, Community Health Centers (CHCs), Primary Health Centers (PHCs) including operation theaters, and Sub-centers including quarters for Female Health Workers: (viii) Post-Partum Centers at district and sub-district Hospitals and selected Medical Colleges; (ix) sterilization beds; (x) IUD Rooms at Rural Family Welfare Centers; and (xi) Health Posts in urban slums under the Urban Revamping Scheme;

(c) **Improving the Quality of Services** delivered through the appointment of new and upgrading of new and existing workers through specialized training programs for (xii) Female Health Workers; (xiii) Female Health Assistants; (xiv) Nursing Tutors and Public Health Nurses; (xv) former Unipurpose workers to become Multipurpose Workers (Male Health Workers and Assistants); (xvi) Dais (traditional birth attendants) and (xvii) Village Health Guides;

(d) **Improving the Management and Operation Systems** through ensuring the supply and distribution of (xviii) vaccines, (xix) cold-chain equipment, (xx) vehicles; (xxi) contraceptives; and (xxii) undertaking demographic research and evaluation; and

(e) **Increasing the Demand for these services** from the public by (xxiii) Information, Education and Communication programs (IEC); (xxiv) increasing the involvement of Private Voluntary Organizations (PVOs) in the program; (xxv) social marketing of contraceptives (pills and condoms) and (xxvi) supporting family welfare programs in the organized sector (Railways, Defense, Labor, etc) and private sector companies.

Section 3: Family Welfare Statistics (in millions)

INDIA	1986-87	1987-88	1988-89	1989-90	1990-91
Sterilisations	5.04	4.94	4.68	4.18	4.12
IUD insertions	3.94	4.36	4.85	4.94	5.32
Oral Pills Users	1.83	2.06	2.42	2.74	2.49
Conventional Contraceptive users	9.83	11.34	12.42	14.19	14.71
NEW DELHI (In actual numbers)					
Sterilisations	26,901	28,971	31,456	31,917	33,368
IUD insertions	61,699	64,246	69,402	70,630	71,454
Oral Pills Users	1,768	2,509	3,328	3,484	5,612
Conventional Contraceptive users	205,134	235,737	370,217	318,301	298,883
CALCUTTA (In actual numbers)					
Sterilisations	29,248	34,621	26,159	26,244	23,307
IUD insertions	10,655	13,342	12,740	14,170	13,621
Oral Pills Users	56,386	44,638	33,401	25,044	18,212
Conventional Contraceptive users	11,531	35,739	12,973	15,391	28,960
HYDERABAD (In actual numbers)					
Sterilisations	28,991	27,881	28,605	27,437	30,133
IUD insertions	6,545	7,554	7,385	7,151	7,874
Oral Pills Users	1,751	1,671	2,283	3,456	3,780
Conventional Contraceptive users	6,911	6,968	10,933	13,498	13,986
BANGALORE (In actual numbers)					
Sterilisations	31,393	25,118	16,289	10,833	20,208
IUD insertions	17,489	16,673	16,878	18,661	18,767
Oral Pills Users	3,312	4,357	4,731	3,452	3,811
Conventional Contraceptive users	4,223	10,963	11,601	9,370	11,433

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

ORGANIZATION AND MANAGEMENT OF FAMILY WELFARE PROGRAMS

BANGALORE

1. The Bangalore City Corporation (BCC) functioning under the Karnataka Municipal Corporation Act 1976, is a local self Government with an elected Mayor/Administrator at the head of the administrative structure/policy making body viz. the City Corporation Council. The Commissioner is the executive head of BCC, and is assisted by 3 Deputy Commissioners. The Health Department of the BCC, under the supervision of a Health Officer is responsible for providing health and FW services, environmental sanitation health licenses, vital statistics, and health education. Administratively the area under the BCC is divided into 6 zones - North, South, East, West, Central and South-west. Each of these 6 zones are supervised by 6 Deputy Health Officers (DHO's) who report to the Additional Health Officer (General). Each zone is further divided into two ranges, which is supervised by a Medical Officer Health (MHO) each, and corresponds to a Karnataka Legislative Assembly Constituency. The principal task of the MOH is environmental sanitation. However DHO's and MOH's also supervise the Assistant Surgeons who look after the maternity homes, dispensaries and sub-health offices. BCC is divided into 87 divisions, each represented by a Municipal Councilor. For the maintenance of sanitation and other public health programs, one or two Junior Health Inspectors are appointed for each division of BCC. Senior Health Inspectors supervise 3 to 4 Junior Health Inspectors who work under the supervision of MOH.

2. One DHO designated as Headquarters Assistant, assists the Health Officer in administrative work, also implementing the PFA Act. There is a separate Surgeon MC with an MOH (MC), Entomologist, 5 Unit Officers, 25 Junior Health Officers, 25 Head gangmen, 300 gangmen looking after malaria control. An Assistant Surgeon is in charge of the 23 Dispensaries which provide curative services, and 12 sub health offices which are involved in the Public Health work like anti-rabies, cholera, leprosy, T.B. control, 5 Mobile Dispensaries 2 ISM, and 1 T.B. Dispensary. One Surgeon (FP) is working as Project Officer under UBSP scheme.

3. One MOH (MCH) is in charge of the City Family Welfare Bureau, and is responsible for Family Welfare and MCH activities. She supervises 30 MCH Centers and 19 Urban Family Welfare Centers (UFWC's). Of these, 16 are attached to maternity homes and 3 are independently based. The 30 maternity homes together have 754 beds. They are staffed with 30 surgeons (Lady doctors), 30 staff nurses, 13 LHV's and 169 ANM's). The UFWC's have 16 assistant surgeons, 2 extension educators, 19 LHV's, 57 ANM's, one statistician and one lab assistant. One Additional Health Officer (FP and MCH) performs the overall supervision of FP and MCH functions.

4. The Corporation has a referral hospital with 30 beds functioning under the supervision of a Medical Superintendent who has one pediatrician, one obstetrician, one assistant surgeon, one staff nurse and 2 ANM's to assist. Besides this, referrals are also made to the 16 government hospitals and 17 private hospitals in the city.

5. 50% of all ANMs, LHV's and assistant surgeons are on deputation from the State Government. The DHO's, surgeons and MOH's are Corporation employees. The Health Officer has conventionally also been a State Government employee on secondment. They all function under the overall charge of the Commissioner who is invariably from the administrative service on secondment.

CALCUTTA

1. The CMDA shares the responsibility with the State Government in the implementation of the health and family welfare program. The Calcutta Corporation plays a major role in this as provided under the Calcutta Municipal Corporation Act 1980.

2. The Calcutta Metropolitan Area (CMA) is composed of three Municipal Corporations, (Calcutta, Howarah and Chandhan Nagar), 31 Municipalities, 2 Notified Area Authorities, 70 Non-Municipal Urban Units and 390 rural mouzas.

3. At present there are 138 hospitals with 23,112 beds available in the CMA area which gives a bed ratio of about 2 beds per thousand population. Facilities for referral services are mostly located in the city of Calcutta and some in the Municipal towns. In addition there are 75 dispensaries and 73 clinics (T.B., Leprosy, MCH and Family Welfare Clinics and 5 Polyclinics available in the CMD area. The hospitals include non-allopathic systems -- Ayurvedic 3, Homeopathic 4, other systems 8.)

4. The Department of Health and Family Welfare headed by the Health Secretary, with a Directorate of Health Services is chiefly responsible for Health and Family Welfare services. The Health Unit of the CMDA co-ordinates the delivery of Health, FW, MCH and Environmental Services in the three corporations, 31 municipalities and the 2 notified areas.

5. The Corporation area is divided into burroughs and wards. Each ward has an elected councilor. These councilors take interest in the day-to-day supervision of their areas. The concentrated participation of the elected representative is a unique feature of Calcutta and is due to the ruling political party with a well-developed cadre at the local level.

6. The Health Unit of CMDA functions under the Director, Health Program Unit which is under the overall charge of the Chief Executive Officer. The Director is assisted by the Deputy Director and four Assistant Directors looking after Implementation, Financing, MIES and Supplies. The Assistant Director, Implementation has one Sr. Assistant, Establishment and 1 Sr. Accounts Officer to assist him. The Assistant Director, Training is assisted by 1 Sr. Training Officer, 1 Jr. Training Officer, 2 Nutritionists and 1 Projectionist. The Assistant Director, MIES has two statisticians for support. There is a Planning Directorate under a Director-General of Planning and Development, a Socio-Economic Planning Unit and an Appraisal Monitoring and Evaluation Unit.

7. In the CMC, the Health Unit functions directly under the supervision of the Chief Municipal Health Officer who reports to the Commissioner. he is assisted by the Deputy Chief Municipal Health Officer and two Senior Medical Supervisors. One of these SMS supervises the HAU's with the help of two Junior Medical Supervisors. The SMS supervises stores.

DELHI

1. There is a multiplicity of authorities that are providing health care services in Delhi. These are the Municipal Corporation of Delhi (MCD), New Delhi Municipal Committee, Delhi Cantonment Board, Delhi Administration and the Central Government. Of these, the largest areas is covered by the Municipal Corporation of Delhi. However, the Directorate of Health Services, Delhi Administration has the responsibility of directing, coordinating and monitoring these services.

2. Health care services in Delhi are provided through a network of Hospitals and Dispensaries, Tuberculosis and Leprosy Treatment Centers. There are 417 Dispensaries, 50 Hospitals, 12 T.B. Units, 6 STD Units and 8 Leprosy Units being run by the government. Besides these, the government manages 182 dispensaries and hospitals in the Indigenous Systems of Medicine. The Voluntary Sector runs 8 hospitals, 121 dispensaries, 15 ISM dispensaries, 1 ISM hospital, 194 Family Welfare Centers, 3 PP units, 1 Maternity hospital, 5 T.B. and one STD clinic. The private sector provides services in 110 Nursing Homes and a number of clinics through 4,500 (approx.) Private Medical Practitioners (PMPs) who are registered with the Delhi Medical Association. However, the number of unregistered practitioners and Registered Medical Practitioners (RMP's) providing health service is unknown. In addition to this, for the delivery of Family Planning and MCH the government is running 144 MCH centres, 10 Polyclinics, 60 Urban Family Welfare Centres, 29 Health Post, 27 Post Partum units, 3 Maternity hospitals. Nine APEX Hospitals which are mainly teaching and training institutions are being run by the Central Government. Among these are the All India Medical Institute, the Jayaprakas Narayan Hospital and the Sanjay Gandhi Memorial Hospital.

3. The MCD being the largest provider of health services manages 9 hospitals, 50 dispensaries, 9 T.B. Clinics, 104 I.S.M. Dispensaries and Hospitals, 17 Maternity Homes, 102 Family Welfare Centers and 38 Sub Centers. The Health and Family Welfare services in the MCD are being managed by the Health Unit which functions under the Municipal Health Officer who reports to the Corporation Commissioner. He has two Deputy Municipal Health Officers reporting to him, one of whom manages the delivery of Public health and the other who looks after the Hospitals, Dispensaries and special Clinics. There is a separate D.H.O. who manages maternal and child health services, Family Planning, ICDS, Immunization and Nutrition. There are separate D.H.O.'s looking after Anti-malaria and T.B. Control Programmes. The entire area is further sub-divided into Zones. There are 10 urban zones and 2 rural zones each of which functions under the supervision of a Zonal Health Officer.

4. The Delhi Administration coordinates and monitors the health services being provided by the MCD and other Government and voluntary agencies in Delhi. The Medical and Public Health Department is headed by the Secretary, Medical who supervises the work of the Director Health Services who is assisted by an Additional Director Health Services, Headquarters and an

Additional Director, Health Services/Family Planning. For administrative services, the city is divided into 4 zones - North, East, West and South. Each zone has 45-50 dispensaries and is managed by a Medical Officer who is assisted by an Additional Medical Officer, 2 Pharmacists, 1 ANM and 1 staff Nurse. All the Medical Officers report to the Chief Medical Officer, in charge of Zones, who is supervised by the Additional D.H.S. Headquarters. The Additional D.H.S. Family Welfare coordinates Family Planning and MCH services with the help of an Assistant Director and an EPI Officer.

HYDERABAD

1. The Municipal Corporation of Hyderabad functions at present under the over-all control of the Special Officer who is the Principal Secretary to the Government in the Department of Municipal Administration and Urban Development. The elected Mayor who held office until a few months ago, completed his tenure and the State government has yet to announce the dates for the next elections. The Corporation is headed by the Commissioner who has 5 Additional Commissioners to assist him in looking after general administration, Accounts, accounting, etc. There is a separate Additional Commissioner for Secunderabad and one for the ODA project. The Commissioner also supervises the Engineering Wing consisting of the Chief Engineer, 3 Superintending Engineers and 10 Executive Engineers; a divisional Forest Officer, Chief City Planner, Chief Horticulturist and the Chief Medical Officer of Health.

2. The Health Unit of the MCH under the Chief Medical Officer of Health is responsible for providing health, family welfare, MCH and environmental sanitation services. The area is divided into 6 circles, each supervised by an Assistant Medical Officer of Health. Secunderabad has a separate Medical Officer. These circles are further sub-divided into 23 wards each having 8-12 blocks in it. These are supervised by 66 Sanitary Supervisors who have 342 sanitary Jawans, 4,900 Sweepers and 641 Scavengers to assist them in keeping the city clean. Besides this, there is an Entomologist looking after malaria control and he is assisted by 3 senior entomologists, 9 sanitary inspectors, 5 health sub-inspectors, 85 field assistants, 225 field workers and 9 insect collectors. There is a separate Medical Officer, Cholera Control who has a staff of 9 Health Supervisors and 2 ANM's to assist him.

3. The Health Care services of the city are provided by government Hospitals and Dispensaries as well as private practitioners. There are 12 Teaching Hospitals (with 5,559 beds), 8 non-teaching hospitals (449 beds), one ESI hospital (300 beds), 1 RTC hospital (70 beds), 5 PP units (70 beds). In addition, there are 3 hospitals run by the Railways, Defence and CRPF (140 beds).

4. The FP and MCH services are under the charge of the Additional District Medical and Health Officer who is in charge of the City Family Welfare Bureau. There are 15 Family Welfare Centres and 19 Child Welfare Centres where the Ante-natal and Post-natal services are available. Of these centres, 13 are attached to Maternity Hospitals under the government, 12 are under the control of the Municipal Corporation and 6 are with Non-governmental Organizations. The government also manages 34 Dispensaries and 33 ESI Dispensaries while PMP's run 1,200 dispensaries and 120 Nursing Homes.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

STATUS OF BASIC EDUCATION FOR FEMALES

Table 1: Percentage of Literate Population (Aged 7 and Above in India, 1991) 1/

Literate	India	AP	Delhi	Karn	WB
Total	52.1	45.1	76.0	55.9	47.1
Male	63.8	56.2	82.6	67.2	67.2
Female	39.4	33.7	68.0	44.3	47.1

Table 2: Primary School Enrollment (Total and girls) in India, 1986 2/

Lower Primary(I-V)	India	AP	Delhi	Kar	WB
	----------Millions----------				
Total	85.91	6.22	0.81	5.06	6.83
Girls	35.91	2.68	0.37	2.27	2.97
% of Girls	41%	43%	46%	45%	43%
Upper Primary(VI-VIII)					
Total	27.27	1.62	0.47	1.47	1.85
Girls	9.63	0.58	0.18	0.59	0.71
% of Girls	35%	36%	45%	40%	39%
Total Primary School Enrollment (I-VIII)					
Total	113.18	7.84	1.22	6.53	8.68
Girls	44.69	3.26	0.55	2.86	3.68
% of Girls	39%	42%	45%	44%	42%

1/ Source: Census of India 1991, (series 1), p. 67.
2/ Source: Fifth All India Educational Survey, 1986, pp. 67-68.

SECTION 2: DETAILED FEMALE EDUCATION PROPOSALS

A. BANGALORE:

1. It is estimated that there are 48,000 girls in the age group 5-11 living in slums. Assuming that 25% are not attending schools, 12,000 girls would be provided "incentives" to attend school or provided with functional literacy. However, the Baseline Survey which has already been initiated, will reveal the number of boys and girls in the age group 5-11 not attending primary school. The Municipal Corporation will provide "incentives" such as books and school uniforms to induce the girls to attend school. The Corporation will also supplement "incentives" with grants to Private Voluntary Organizations to provide functional literacy to girls in the ages 5-11 residing in slums and not attending schools. As a part of Innovative Scheme Program, PVOs would be encouraged to promote vocational training and upgradation of skills among adolescent girls and women in slum areas.

B. CALCUTTA:

2. The average female illiteracy rate in the low income settlement is 40%. The reasons for relatively low levels of enrolment and high drop-out for girl students include the following: (a) girls are to share household responsibility of looking after their younger brothers and sisters and to do the household work. The parents, therefore, are unwilling to send them to the school; (b) girls in poorer families are employed as house-maids and sending them to the school would deprive the parents of earnings; (c) women having secondary role in the socio-economic scene are ignored in preference to their male counter-parts. This also reflects in providing education to children; (d) the school environment in many cases, is not comfortable for the girl students. For instance, toilets for girl students are not available at many schools; and (e) parents find that the type of education imparted in the school does not help the girl in her future life either for work, or rearing a family and caring for children.

3. The strategy for improving female education would be to address the problem in a comprehensive manner by providing: (a) early child care; (b) primary education; (c) non-formal education for adolescent girls; and (d) adult education.

4. The State Government has recently undertaken a massive program for the eradication of illiteracy in the entire State. The existing schools under the Local Authorities, State Education Department and under non-governmental organizations are trying hard to impart education at the pre-primary and primary levels both for men and women in different areas. To improve female education both in qualitative and quantitative terms, the present project will include the following actions: (a) the HHWs will be trained to motivate the beneficiaries of the health program to promote education of the girls in their families; (b) the IEC activities in the project shall include special programs to make the community aware about the need and importance of female education; (c) essential repair including provision of toilet facilities for girls would be undertaken in the schools; (d) incentives would be provided to the girl student in form of supply of school uniform, books for library, stationery,

stipends and scholarships; (e) at the Block and Sub-block levels, efforts will be made to link the women beneficiaries under the project with the Adult Literacy program run by various organizations; and (f) efforts will be made as part of the program to provide vocational training to entrepreneurs for income generation.

5. Non-formal Education for Girls in the Age Group 7-14 years and Illiterate/"Below Primary" Adult Women to be organized by Local Bodies. The main objectives of the project in Calcutta include raising the health status of women and children and supporting the National Family Welfare Program among the economically weaker sections. Efforts to raise the literacy status of women living in slum areas would go a long way towards meeting these objectives. The educational levels in the slum areas are generally low. All the surveys and studies for slum areas undertaken recently, suggest that female literacy rates are far below the overall literacy rates. Because of the lack of education, women belonging to poor households are often not in a position to benefit from the ongoing welfare activities undertaken by Government, different NGOs and other welfare agencies. The success of the Project hinges on effective communication with mothers and generating awareness among women. Raising the literacy levels of women would greatly facilitate this task.

6. The State Government has launched an ambitious project for eradication of illiteracy in the State. But it will take time before the gains of the project are adequately stabilized. Some limited attempts to raise the literacy status of women in the project area are proposed as a part of Innovative Schemes. Illiterate women, women who do not have "primary level" of education, and girls in the age group 7-14 years who do not go to school would form the target group. The program will be implemented through local bodies situated in CMDA and benefit 25,000 women/girls in 5 years. The task of teaching will be entrusted to honorary teachers to be recruited by respective local bodies. Classes would be held either in the courtyards attached to houses or in some local institution. While designing the program efforts have been made to keep the costs low so that some of the local bodies could replicate the model from their own resources. The expenditures would include teachers, training costs, payment of token honoraria to teachers, costs of teaching equipments/facilities, providing learners with some reading/writing materials and supervision costs. The program will be planned, implemented and monitored in a decentralized manner. There will however, be some competent specialists in the project to guide the local bodies and facilitate monitoring. The methodology is outlined below.

Target	-	25,000 learners in 5 years.
Duration	-	12 months each.
Methodology	-	250 honorary teachers to work with groups of 20 learners - under supervision of local bodies - classes to be held in household courtyards or premises to be made available by the community.

7. Vocational Training to Women - to be organized by Local Bodies. Enough data are available to suggest that the extent of unemployment and underemployment in the slums of CMDA are high. Recently, some efforts have been made by Government and Non-Government Organizations to generate skills among slum dwellers and assist them in obtaining credit from financial

institutions to establish small enterprises. Whatever income opportunities were created appear to have been usurped by the men. Unemployment and under-employment among women are considerably higher than those for the overall population.

8. The Project gives considerable emphasis to the motivation of women belonging to the target group, and their participation in the planning and implementation of the project. It will be extremely difficult to achieve this unless certain steps are taken to improve the economic status of women.

9. With a view to generating appropriate skills among women in poor households and creating income opportunities for women, vocational training courses would be organized by local bodies. Training in appropriate skills would be imparted by master craftsmen and reputed training institutions under the supervision of local bodies. During the project period 10,000 women entrepreneurs/artisans/prospective entrepreneurs are expected to benefit from this scheme. NGOs and PVOs would remain closely associated with this program not only in conducting the program, but also in the identification of trainees in post-training follow-up work. Although vocational training courses would be organized in a decentralized ways, a small group of experts will be included in the project organization to guide the training curriculum, locating master craftsmen and organizing post-training follow-up work.

Target - 10,000 women entrepreneurs/artisans/prospective entrepreneurs @ Rs. 2,300/- per trainee (includes remuneration of master craftsman, conveyance charges, raw materials, tools and equipment).

10. Renovation of Schools for Girl Students. The objective of women's education will be supported by adding to the existing infrastructure facilities. It has been ascertained from the local bodies that about 100 schools, both primary and secondary, situated in the project area are in urgent need of renovation/extension to facilitate women's education. Toilets for girl students will be constructed wherever needed. The average cost of renovation/extension of schools has been worked out as Rs. 100,000.

C. DELHI:

11. At present, Municipal Corporation of Delhi (MCD) operates 1655 schools with a total enrolment of more than 700,000 children. Out of these, 426 schools are situated in J.J. clusters and slum areas with a strength of 300,000 children out of which 140,000 are girls. In order to enroll 100% girls in primary schools, to retain them up to Class-V, and to improve their achievement levels, the following are proposed under the project:

12. Opening of New Nursery Sections. At present, MCD runs 34 Nursery schools and 735 sections attached to primary schools. However, there are thousands of girls between 3-5 years of age who are not provided pre-school education. It is proposed to open 100 new sections in schools situated in J.J. Clusters and Slum Areas.

13. Free Uniforms. School uniforms are supplied free of charge to poor and needy children. At present MCD is spending Rs. 10.0 million under this Scheme. Nonetheless, there are thousands of girls who do not get uniforms under this scheme. It is proposed to cover an additional of 100,000 girls.

14. Creation of Awareness. Mass media i.e. radio. T.V., wall posters, hoardings, banners and literacy marches will be used for creating awareness among the parents about the education of their children specially the girls.

15. Early Child Care/Creche Program. It is proposed to identify Juggi Jompri Bastees where the enrollment rate is lower and dropout rates are higher than the average especially for the female child. It is proposed to open 300 new creches in the catchment areas of primary schools in JJ clusters. Each Creche looking after 40-50 children, will be manned by one Nursery trained teacher and 2 Ayas. Approximately 3 creches will be attached to one Primary school which will serve as Resource Center for creches. Anganwadis/Balwadies, both present and prospective, will also be brought under this program to avo overlapping of functions and responsibilities.

16. Early Childhood Education for Children in the Age Group of 3-6 Years. To promote School going habits in the slum children, 100 pre-primary sections are proposed to be opened in Primary schools located in the vicinit of JJ Clusters for children in the age group of 3-6 years. Each pre-primary section consisting of 30-40 pre-school children will have one teacher and one Aya. Flexible curriculum which will be activity and play-based instruction will be adopted.

17. Primary Education. Many of the schools situated in the vicinity of JJ clusters are at present without proper toilet facilities. This is a great handicap for the girl child attending school. It is proposed to provide 20 toilets in these schools.

18. Non-formal Education Centers. It is proposed to open 100 non-formal education centers in the primary schools and other schools in the vicinity of JJ clusters. These new centers will have the benefit of flexible hours, provision of trained instructors and suitable teaching material. Proper supervision/monitoring will be done through the Principal/Headmaster of the school who will also be paid honorarium.

19. Special Training Centers for Awareness, Skill Upgradation and Income Generation Programs. Three centers - one in the first year and two in the second year - will provide training to the girls in areas of legal rights, social issues, small family norms, safe motherhood, first aid, home economy, nutrition, food hygiene, etc., and related topics. Skill upgradation and entrepreneurship training for starting self-employment programs will be given in different trades like cutting and tailoring, knitting and bag making, food preservation, etc.

D. HYDERABAD

20. Adult Literacy Program. Under this program, one women will educate ten women. This innovative program started in October 1990, is to be continued for about one and half years. There are 757,754 illiterate females as per 1991 census in Hyderabad City. The dropout rate amongst girl students at the primary level is very high. Only 42 out of every one hundred enrolled in class one reach class five. Parents assign domestic responsibilities to girls at a very young age and they believe that education is of little value to girls as their life is going to be devoted to marriage and motherhood. There is also child labor in the slum communities.

21. Primary Schools. The majority of schools have one or two rooms and do not have ancillary facilities such as drinking water, urinals and lavatories. This is one of the main barriers to girls having access to education. At present, the State Government does not provide any incentive to encourage female education. The majority of slum women work in the unorganized sector like household work, daily wage earnings in beedimaking. As a part of Community Needs Assessment Study, it is proposed to undertake a special study to formulate Action Plans for female education with the involvement of the Education, Women's Welfare and Adult Education Departments.

Extension Educator	-	1	1
PHN	1	1	1
Statistical Assistant	1	1	1
Computer	-	1	2
UDC-cum-Store keeper	-	1	1
LDC-cum-typist	1	1	2
Attendant	1	1	2

5. The Scheme was reviewed in December, 1985, under the Chairmanship of Union Health Secretary and it was decided to impose a ban on filling up of the posts of Multi-purpose worker (male) and discontinuation of payment of honorarium to Voluntary Women Health Worker.

6. In a meeting held under the Chairmanship of Joint Secretary (S) on September 26, 1991, it was decided that:

(a) only 'D' type Health Posts would be established in future for a population of 50,000 and at least 40% of this population should be slum or belonging to weaker section of the society;

(b) the existing Urban Family Welfare Centers are to be re-organized into 'D' type Health Posts and the staff would be adjusted in the newly established 'D' type Health Posts;

(c) instead of appointing 6-8 Multi-purpose workers/ANMs (3-4 male and 4 females) at the `D'type Health Posts only 5 MPW (F)/ANMs would be appointed at each Health Post, in addition to one LHV/PHN/Health Assistant (F);

(d) a total of 1-3 posts of MPW (male) will not be required;

(e) 2 posts of Sweeper-cum-Chowkidar would be created in order to look after the cleanliness/security of premises of Health Post; and

(f) the male MPWs already appointed would be transferred to the sub-center functioning in rural areas.

PART B: URBAN REVAMPING SCHEME AND PROJECT INSTITUTIONS

URS	BANGALORE	CALCUTTA	DELHI	HYDERABAD
'D' type Health Post	97 Health Centers	109 Health Administrative Units	25 Health Centers	70 Health Centers
'C' type Health Post	---	---	---	---
'B' type Health Post	---	763 sub centers	650 Health Posts	---
Other Facilities	24 Maternity Homes	18 Expanded Special Outpatient Departments 12 Maternity Homes	6 Upgraded Health Centers	17 Upgraded Health Centers

PART C: THE OUTREACH SYSTEM

	BANGALORE	CALCUTTA	DELHI	HYDERABAD
Community Contact	Link Worker 1 per 5,000 population	Honorary Health Worker 1 per 1,000 population	Bustee Sevika 1 per 1,000 population	Link Worker 1 per 1,000 population
Supervision 1st Level	Auxiliary Nurse Midwife	First-Tier Supervisor	ANM	ANM
2nd Level	Public Health Nurse (PHN) Lady Health Visitor (LHV)	Second-Tier Supervisor	PHN/LHV	PHN/LHV
3rd Level	Lady Medical Officer at Health Posts (Health Center)	2 Part-Time Medical Officers - 1 per Health Administrative Unit (HAU) and 2 Part-Time Specialists per ESOPD	Lady MO at Health Center	Lady MO at Urban Health Posts
Management/ Administration	Senior Lady Medical Officer (at upgraded Health Center) Medical Officer (FP/MCH) in Urban Family Welfare Bureau	Local Authority Medical Unit CMDA Health Program Administrative Group	Deputy Health Officer Municipal Health Officer	Senior Medical Officer Deputy Director, Urban Health Service Additional Director, Urban Health Chief Medical Officer

Health Administrative Unit (HAU)

It is an administrartive unit for delivery of primary health care services including outreach activities.

Features:

(a) Coverage: Each unit will cover about 35,000 beneficiaries of target population residing in areas under control of the Calcutta Municipal Corporation and local bodies.

(b) Administrative Control: Elected local representatives of the Local Authorities.

(c) Responsibilities: (i) Identification of beneficiaries; (ii) Primary selection of Honorary Health Workers (HHW); and (iii) Overall administration, supervision and monitoring of the program.

(d) Functions: (i) to act as administrative office to all health activities except treatment of patients; (ii) storage facilities for immunization materials, common drugs, family folders, etc; (iii) compilation of monthly reports.

Sub-Center

It is an intermediary tier for service delivery and a nerve center for delivering outreach services.

Features:

(a) Coverage: 5,000 beneficiaries (i.e., seven sub-centers under each HAU)

(b) Administrative Control: One first tier supervisor recruited from among the Honorary Health Workers (HHW) to supervise activities of 5 HHWs

(c) Functions: (i) Medical check-up and immunization; (ii) Growth monitoring and distribution of nutrition packets; and (iii) Maintenance of eligible couples and children register.

Block

It is a well degined grass root level project area.

Features:

(a) Coverage: 1,000 beneficiaries

(b) Incharge: Honorary health workers (HHW)

(c) Functions: (i) Linkage between HHW and PVO belonging to the community; and (ii) Organizing community awareness and participation.

Extended Specialized Out Patients' Department (ESOPI)

It will be an adjunct to existing hospitals or maternity homes.

Services to be rendered:

(a) Phase I - Medicine, surgery, obstetrics and gynecology and paediatrics

(b) Phase II - Ophthalmology, ENT, Dermatology and Dental surgery

Advantages:

(a) Will reduce overcrowding at existing Government Hospitals

(b) Will minimize travel distance and time spent on travelling and waiting by patients.

Regional Medical Store: It is decentralization of Central Medical Store ensure steady and regular supply of drugs.

Need: Due to increased number of indenting units namely HAUs, ESOPD and Maternity homes.

Type 'B' Health Post

Functions:

(a) To identify eligible couples and to motivate them toa ccept family planning

(b) List and motivate eligible children under UIP

(c) Follow up and motivate non-acceptors of family planning and immunization

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

BILATERAL AND MULTILATERAL ASSISTANCE TO HEALTH AND FAMILY WELFARE

Donor	Amount	Period	Program
WHO	US$30.0 Mn.	1984-87	Biennium Program: provision of general medical supplies equipment, educational activities, including training of Indian experts, supporting research projects.
	US2.08 Mn.	1988-89	For research under Human Reproduction Program
	US$0.3Mn.	1990-91	FW/MCH Services in Urban Areas
UNICEF	US$9.44 Mn.	1980-86	Support to MCH and Immunization program
	US$29.0 Mn.	1985-90	Support to health programs, particularly Expanded Proram of Immunization (EPI), Sexually Transmitted Diseases (STD), Oral Rehydration (ORT) and Primary Health Care, support to health worker training, and provision of vehicles, syringes, needles and vaccines.
UNFPA	US$184.0 Mn.	1974-90	Promotion of cash and kind to support Family Welfare Schemes, manufacturing of contraceptives, development of population education programs, strengthening program management, training lower-level Health Workers, and introducing innovative approaches in FP and MCH.
	US$50.0 Mn.	1980-86	AREA PROJECT: Rajasthan (4 districts), Bihar (11 districts)
	US$14.05Mn.	1989-94	Area Project Phase II Rajasthan (13 districts)
DANIDA	DK.2.0 Mn.		Support to Leprosy Control Program.
	US$ 30.0 Mn.	1981-86	AREA PROJECT: Madhya Pradesh (8 dists) Tamil Nadu (2 dists).
	Dk.126.56 Mn.	1989-92	Area Project Phase II: Madhya Pradesh, Tamil Nadu. No new districts added.
ODA	Pd.Stg.170,000	-	Experts to support various health institutions.
	US$15.2 Mn.	1981-86	AREA PROJECT: ORISSA (5 districts)
	Pd.Stg.20 Mn.	1989-94	Area Project Phase II: Orissa (5 districts)
SIDA	SK 125.0 Mn.	1984-89	Equipment and other support for TB, Leprosy and Malaria Control Programs.

Donor	Amount	Period	Program
NORAD	NK.378.5 Mn.	1969-88	Support to post partum program in Urban and Semi-Urban areas.
	NK.90Mn	1988-91	Training and Management activities under Post Partum Program
USAID	US$ 20.0 Mn.	1981-	Strengthening private and voluntary sector to expand and improve basic and special preventive health, family planning and nutrition programs.
	US$33.0 Mn.	1980-86	AREA PROJECT: Punjab(3 dists), Haryana (3 districts), Himachal Pradesh(3 dists), Maharashtra (3 districts)
	US$47.0 Mn.		Development of a Contraceptive Marketing Organization.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

IDA-ASSISTED POPULATION AND NUTRITION PROJECTS

Credit No.	Name of project	Description	Effective Date	Closing Date	Total Project Cr.	IDA Disbursement 04/10/92
					(In Millions of US$)	
CR.312	1st Population	U.P.(6 dists) Karnataka(5 dists) a)expansion of health infrastructure; b)provision of additional supplements and testing alternative patterns; c)creation of two population centres to design a MIES, evaluate performance, and recommend changes; d)technical assistance; and e)creation of population units in two established management institutes.	05/73	05/80	--	21.20	21.20
CR.981	2nd Population	A.P.(3 districts) U.P.(6 districts) Project was based on GOI Model Plan(Area Projects Program). Included a)construction of facilities; b)provision of staff; c)training; d)IEC;and e)monitoring and evaluation.	07/80	03/88	96.0	46.0	38.8

Credit No.	Name of project	Description	Effective Date	Closing Date	Total Project (In Millions	IDA Cre.	Disbursement 04/10/92 of US$)
CR.1426	3rd Population	Karnataka(6 dists.) Kerala(4 dists.) a)Civil works in selected districts and on broader state perspective; b)training; and c) monitoring & evaluation.	05/84	03/92	123.5	70.0	82.14
CR.1623	4th Population	West Bengal(4 dists.) a)Civil works in selected districts and on a state-wide basis; b)training; c)monitoring and evaluation;d)demand generation; e)service delivery, and f)development of a State Institute of Health & Family Welfare.	12/85	08/93	89.9	51.0	42.52
CR.1931	5th Population	Bombay and Madras a)construction of new and rehabilitation of existing health posts; b)development of outreach programs; c)reorganization of Family Welfare Bureaus; d)trg of all cadres of family welfare workers; and e) increasing PVO and private sector participation in family welfare through grants-in-aid and innovative schemes.	12/88	12/95	78.2	57.0	37.3

Credit No.	Name of project	Description	Effective Date	Closing Date	Total Project Cre. (In Millions	IDA	Disbursement 04/10/92 of US$)
Cr.2057 LN.3108	6th Population	Andhra Pradesh, Madhya Pradesh, and Uttar Pradesh. a) const. furnishing, and equipping of SIHFW, Divisional (Regional) Training Centers and District Training Teams; b) strengthening Directorates of Health and Family Welfare through creation of Human Resource Development Cells, instituting Personnel Management Information Systems; c) rehabilitating and building new pre-service training institutes for Male and Female Health Workers; d) training of trainers and development of training materials; and e) upgrading facilities, equipment & vehicles at PHCs and sub-centers.	02/23/90	03/97	182.0	124.6	26.55
Cr.2133 Ln.3199	7th Population	Bihar, Gujarat Haryana, Jammu & Kashmir, Punjab a) increasing the supply of services through upgrading and expanding the number of Primary Health Centers and Subcenters, and increasing the supply of medicines, equipment and supplies for family planning and maternal and child survival strategies; b) increasing demand through the expansion of the Social Marketing of Contraceptives, increasing the involvement of PVOs in the FWP, and strengthening	03/19/91	06/98	141.5	86.7 10.0	11.55

Credit No.	Name of project	Description	Effective Date	Closing Date	Total Project Cre. (In Millions	IDA	Disbursement 04/10/92 of US$)
(cont.)		the IEC efforts in each of the States; c) improving the quality of family welfare services by upgrading the training of all levels of family welfare workers; and d) improving management through the strengthening of each State's Directorate of Health and Family Welfare, upgrading of MIEPMS, and expanding demographic and operational research directly relevent to program management and implementation.					
Cr.1580	Second Tamil Nadu Integrated Nutrition	Tamil Nadu a) Service Delivery to increase the range coverage and quality of nutrition and health services to the target groups through improvements in the design of software systems, provision of nutrition and health education and of health referral services, supply of therapeutic food to the malnourished, increasing the availability of equipment and drugs for maternal and child health, and training for health and nutrition workers and traditional birth attendants; b) communication and community participation, to stimulate demand for project services, improve child feeding and care practices and promote community involvement, through support for insitutional development, provision of communciaitons equipment and materials, and support for formation of women's groups and community education; and c) project management and evaluation, to expand and strengthen TINP I's PCO, to expand and strengthen the existing monitoring and	12/05/90	12/97	139.1	95.8	6.83

Credit No.	Name of project	Description	Effective Date	Closing Date	Total Project (In Millions	IDA Cre.	Disbursement 04/10/92 of US$)
(cont.)		evaluation system, to develop a new apex institution for nutrition communications and training activities in the state and to provide support for operations research.					
Cr.2173 LN.3253	First Integrated Child Develop. Scheme	Andhra Pradesh Orissa a) service delivery, to increase the range, coverage and quality of nutrition and health services to target groups through improvements in the design and implementation of software systems, training for health nutrition workers, provision of nutrition and health education and health referral services, increasing the availability of drubs and equipment for maternal and child health and the supply of therapeutic supplementary food to malnourished beneficiaries, and construction of village nutrition centers, offices and residences for key field staff; b) communications to stimulate demand for project services and improve child feeding practices and care through production and dissemination of media messages, provision of equipment and materials and training; c) community mobilization to increase local participation in and support for project services and activities through testing of innovative women's development activities including activation of village women's groups, development of income-generating activities, non-formal study courses for women and development of training programs for adolescent girls; and d) project management and evaluation to manage, monitor and evaluate the project and conduct operations research to analyze and improve aspects of project design.	01/28/91	12/97	157.5	96.0 10.0	8.55

Credit No.	Name of project	Description	Effective Date	Closing Date	Total Project (In Millions	IDA Cre.	Disbursement 04/10/92 of US$)
Cr.2300	Child Survival and Safe Motherhood Project	The Project would support enhancement & expansion of GOI's MCH Program for the 1991-95 period. It would cover the incremental costs associated with the program. It would be national in scope, but with an emphasis on specific districts where maternal and infant mortality rates are higher than the national average. Its specific objectives would be to enhance child survival, prevent maternal mortality and morbidity, and increase the effectiveness of service delivery.	03/05/92	09/30/95	329.58	214.53	17.95

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

PROJECT OBJECTIVES AND COMPONENTS, INDICATORS OF PROGRESS AND TARGETS

SECTION 1: PROJECT OBJECTIVES AND COMPONENTS BY CITY

PROJECT COMPONENTS	BANGALORE	CALCUTTA	DELHI	HYDERABAD
SERVICE DELIVERY EXPANSION	Upgrade the level of family welfare services by establishing 60 new Health Centers, strengthening 37 existing Health Centers and upgrading 24 Maternity Homes to upgraded Health Centers, construction of staff quarters for 7 upgraded Health Centers.	Opening of 763 subcenters; 18 Expanded Special Out-Patent Departments (ESOPDs) at existing Maternity Homes or Hospitals; renovation of 25 existing Maternity Homes to include satellite units (neo-natal center and Post-Partum Centers); and two Regional Medical stores.	Opening 125 subcenters ('B' type health posts), 19 Health Centers of which 6 would be upgraded Health Centers, and provision of 31 Mobile Health Clinics (vans).	Renovation of 10 existing Health Centers, and construction of 36 new 'D' type Health Centers; establishing 12 new and strengthening 4 existing upgraded Health Centers.
QUALITY IMPROVEMENT	Training of over 3,000 health personnel including Medical officers, health workers members of the Slum Clearance Board, link workers and about 300 Private Medical Practitioners, through orientation, induction and recurrent in-service programs.	Training of over 6,000 staff, of which about 75% would be para-technical women trained as Honorary Health Workers. The curriculum and training design differs from the traditional Health Center/Hospital referral system by emphasizing outreach and promotive health.	Training of about 1,600 medical officers and staff, primarily ANMs, Dais and Bustee Sevikas and (Link Workers). These staff would be trained mainly on the job.	Training of 3,500 staff through orientation and refresher courses including 400 ANMs, 1,000 Dais, 600 PMPs, 350 Trainers. About 3,500 local leaders and 200 NGOs will also be trained. These staff would be trained at institutions and through programs established in Andhra Pradesh under the Sixth Population Project but adapted to urban slum health problems.
DEMAND EXPANSION	Appointment of link workers (10 per health center and ANMs (3 per health center); enlist services of 13 identified PVOs; establishment of 'SHE'/PVO clubs at slum level (1 per 1,760 households) covering 376 slums; enlist services of private medical practitioners; offer support for the organization of community involvement activities (incentives, grants, honoraria, supplies, personnel); enlist assistance from established Joint Women's Program and Registered Societies; formulation of Joint management arrangements.	Expansion of present activities under CUPD III; appointment of Honorary Health Workers in slums (1 HHW per Block-1,000 persons/200 families); organization of link-ups between HHWs & grass-root PVOs; enlist services of PMPs; use of elected Local Authorities to decentralize control; enlist support from block level Women Advisory Committees/-Mahila Samiti and Corporation Maternity Homes; offer support for the organization of community involvement activities (incentives, kits, training); coordination with other government departments.	Use of female health workers (Bustee Sevikas) as health educators and links (1 per 2000) concentrating on community mobilization activities; use of trained birth attendants (1 per Jhuggie Cluster); use of ANMs (1 per 10,000 to supervise 5 Bustee Sevikas and 5 Dais); use of private medical practitioners and identified (neighborhood committees) and Bustee Vikas Mandals (to work in partnership with PVOs (PMPs); use of orientation workshops for staff on CP; regular meetings with target communities; PVOs, IMA, PMPs; representations of community on Project Advisor/Coordinating Committee.	Appointment of 1 ANM per 10,000 persons & 1 Women Health Volunteer/Link worker for every 2000 population; enlist services of PMPs + PMP/Nursing homes (100 per year) and existing corporation Maternity Centers (12); training of NGOs (200) and local leaders (3,500) for community activities; organization of slum development committees plus Health and family welfare committees at local levels; use of existing neighborhood and bustee level committee system; use of existing Mahila Mandals, Youth Organizations and OTCs; offer support for the organization of community involvement activities (incentives, fees, grants, kits, supplies, training); coordination with other Government departments.
	Establish IEC Unit in Project Management Team (PMT) under Project Officer. Appoint Communications expert in community health programs.	Overall IEC responsibility will rest with State Mass media Division and Central IEC will be set up with 5 other units, 3 on East, and 2 on West Bank. Central level coordination by CMDA and Health Dept. jointly. Municipal level responsibility will be with local authorities.	Establish IEC Unit in MCD under project Director, staffed by communications officer, health educator and other staff. Mass media Campaign.	Annual IEC plans to be prepared at Corporation level. At CFWB/-Project Management Unit Level an IEC cell headed by an IEC officer will be established.
	Using PMPs as resources for the delivery of health services to the community.	Use of PMPs to deliver health services to the slum community.	Use of PMPs as health educators and motivators.	Use of PMPs and PVOs to deliver health services to slum population through a grant-in-aid scheme.

PROJECT COMPONENTS	BANGALORE	CALCUTTA	DELHI	HYDERABAD
MANAGEMENT IMPROVEMENT	Conversion of the City Family Welfare Bureau into an Administrative and Monitoring Unit, establishing IEC and Training Units, reorganizing the management information system, and coordination of MCH & FW services with other health services like environmental sanitation, control of communicable diseases, licensing of food etc. at the level of the range Medical officers of health. Formation of an Implementation Committee under the chairmanship of the Mayor to review progress, the State Monitoring Committee under the chairmanship of the Chief Secretary to approve Plan of Action, and Local Committees under the chairmanship of the Local Councillors to facilitate community participation.	Strengthening the Health Unit in the Calcutta Metropolitan Development Authority (CDA) into five groups - Health Program Administrative Group, Planning Monitoring and Evaluation Group, Engineering Construction Group, Information, Education and Communication Group and Training Group. A State Project Advisory Coordination Committee under the Chairmanship of the Secretary Health & FW, and the Local Committees under the Chairmanship of the Local Authorities or nominated representative.	Reorganizing and strengthening of the Directorate of Health Services, Delhi Administration. Establishment of a Project Coordination, training, MIS, IEC and Project Administration & Planning, Grants, Accounts & Auditing Cells in the Division of Public Health of the Health Department of Municipal Corporation of Delhi. A Steering Committee with the Chief Secretary as its Head and a Project Advisory and Coordination Committee under the Corporation Commissioner would be established.	Strengthening of the City Family Welfare Bureau in the Health Unit of the Corporation into 5 sections - one each for Administration, Accounts & Finance, MIES, IEC/ Training and MCH and Public Health Nursing. Two Advisory Committees would be established - one at the State Level headed by the Chief Secretary and the other at the Corporation level headed by the Corporation Commissioner.
INNOVATIVE SCHEMES	Nutrition awareness for Pregnant and lactating mothers and children 0-3 years; Intensive Health Education among Urban Poor; Promotion of Women's Education in Minority Community focussing on drop-outs; Sanitation drive with Community involvement; Health and Family Welfare Education amongst adolescent girls, non-formal education program; Education Program for Men on Women's problems and importance of girl child.	Nutrition awareness for children between 0-5 years; Environmental Sanitation Program for upkeep of facilities and cleanliness; anti-larval program; creche program to be attached to HAUs. Promotion of basic and non-formal education for girls, non-formal/ vocational training and income generation.	Sanitation program with community participation. Strengthening of existing strategy for control of gastroenteritis. Non-formal education for adolescent girls.	Nutrition awareness program for pregnant and lactating mothers and toddlers; integration of services of ANMs and Anganwadi workers; study of fertility behavior among minority groups; sanitation drive in community; income generation among Women in slums; clean hut competition; well baby clinics; study of the incidence of Sexually Transmitted Diseases (STD). Basic education for young and adolescent girls.

SECTION 2: INDICATORS OF PROJECT PROGRESS

A. BANGALORE

Table 1: Number and Percentage of Couples Effectively Protected Due to Family Planning Methods

	Eligible Couples	% Protected due to sterilization	% Protected due to IUCD	% Protected due to CC	% Protected due to OP	% Effecttively Protected
1989	583,600	37.8	7.4	1.4	1.0	47.6
1995	731,700	40.0	13.0	4.0	3.0	60.0

Note: The number of eligible couple in 1990 is low due to limited coverage of urban family welfare centers. The existing 37 centers cover only 44% of the population of Bangalore Urban agglomeration.

Table 2: Mortality figures in Different Age Groups

	INFANT MORTALITY			AGE 0-4 MORTALITY			AGE 16-35 MORTALITY		
	Deaths per 1000 Birth			Deaths per 1000 Birth			Deaths per 1000 Births		
	Male	Female	TOTAL	Male	Female	TOTAL	Male	Female	TOTAL
1990	56.05	49.17	53.04	67.70	61.17	64.52	19.13	13.47	16.37
1995	46.17	40.96	43.63	53.91	48.42	51.23	14.06	9.36	11.77

Note: The data presented in this table refer to Bangalore city. Simialr information is not available for separately for slums. The proposed Base Line Survey is expected to fill the gap. The estimate of infant mortality from civil registration system for 1990 is 26.7 which is an underestimate as compared to Sample Registration Scheme. The estimates of mortality for 1990 are based on SRS estimate of infant mortality of 53 for urban Karnataka for 1989. The SRS estimate of infant mortality approximately corresponds to life expectancy of 68.5 for males and 72.5 for females. The deaths for other age groups have been derived from South model Life Tables. The projections for 1995 are based on life expectancy of males 71.0 for males and 75.0 for females and South Model Life Tables.

B. CALCUTTA

Table 1: Number and Percentage of Couples Effectively Protected Due to Family Planning Methods

	Eligible Couples	% Protected due to sterilization	% Protected due to IUCD	% Protected due to CC	% Protected due to OP	% Effecttively Protected
1991	1,560,000	31.8	1.4	1.0	0.1	34.3
Projected 1997	1,820,000	47.0	6.0	3.0	4.0	60.0

Table 2: Mortality figures in Different Age Groups

	INFANT MORTALITY			AGE 0-4 MORTALITY			AGE 16-35 MORTALITY		
	Deaths per 1000 Birth			Deaths per 1000 Birth			Deaths per 1000 Births		
	Male	Female	TOTAL	Male	Female	TOTAL	Male	Female	TOTAL
1991	52.0	48.0	50.0	18.5	15.8	17.2	1.7	1.9	1.8
Projected 1997	25.0	23.0	24.0	13.0	11.0	12.0	1.4	1.5	1.4

Note: 1991 figures have been worked out by using the concerned statistics given in the "Seclected population: Demographic & Socio-economic Indicators, West Bengal State Profile Series - 17" by S.K. Alok, Study Director, MOHFW, Government of India (Jan. 1990) and in the Census 1991 and CMDA Surveys.

C. DELHI

Table 1: Number and Percentage of Couples Effectively Protected Due to Family Planning Methods

	Eligible Couples	% Protected due to sterilization	% Protected due to IUCD	% Protected due to CC	% Protected due to OP	% Effecttively Protected
1992	1,517,400	21.1	9.1	9.8	0.4	40.4
Projected 1995	1,750,000	31.0	14.0	12.5	2.5	60.0

Table 2: Mortality figures in Different Age Groups

	INFANT MORTALITY			AGE 0-4 MORTALITY			AGE 16-35 MORTALITY		
	Deaths per 1000 Birth			Deaths per 1000 Birth			Deaths per 1000 Births		
	Male	Female	TOTAL	Male	Female	TOTAL	Male	Female	TOTAL
1989	23.98	16.04	40.02	29.92	28.89	58.81	23.34	15.07	38.41
Projected 1995	NA	NA	NA	NA	NA	NA	NA	NA	NA

D. HYDERABAD

Table 1: Number and Percentage of Couples Effectively Protected Due to Family Planning Methods

	Eligible Couples	% Protected due to sterilization	% Protected due to IUCD	% Protected due to CC	% Protected due to OP	% Effecttively Protected
1991	560,919	43.45	2.82	2.55	0.93	49.71
Projected 1995	573,711	45.0	5.0	5.0	5.0	60.0

Table 2: Mortality figures in Different Age Groups

	INFANT MORTALITY			AGE 0-4 MORTALITY			AGE 16-35 MORTALITY		
	Deaths per 1000 Birth			Deaths per 1000 Birth			Deaths per 1000 Births		
	Male	Female	TOTAL	Male	Female	TOTAL	Male	Female	TOTAL
1990	14.43	10.03	24.46	17.98	12.97	30.95	14.68	11.59	26.27
Projected 1995	NA	NA	NA	NA	NA	NA	NA	NA	NA

Source: V.S. Section, MCH, Hyderabad 1992.

Note: 1990 totals - Events registed are reported in Table 2 ???
1 M.R. Registered rate (1990), 24.55 per 1,000 L.B.

SECTION 3: PROJECT OBJECTIVES, TARGETS AND PROCESS INDICATORS BY CITY

	BANGALORE			CALCUTTA		
OBJECTIVES	ACTIVITIES	TARGET	INDICATORS	ACTIVITIES	TARGET	INDICATORS
SERVICE DELIVERY EXPANSION	Establishment of new health centers	60	No. of new centers established	Open subcenters	763	No. of centers opened
	Strengthen existing health centers	37	No. of centers strengthened	Expanded Special Outpatient Dept. (ESOPDs) at MH	18	No. of ESOPDs at maternity homes
	Upgrade maternity homes to upgraded health centers	21	No. of maternity homes upgraded to upgraded health centers	Renovate existing maternity homes	25	No. of renovated maternity homes
				Establish Regional Medical Center (RMC)	2	No. of RMC established
QUALITY IMPROVEMENT	Training of medical officers, health workers, members of the slum clearance board	2,400	No. of persons trained.	Training of paratechnical women as HHW	4,400	No. of women trained as health workers.
				Training of staff including medical officers.	1,200	No. of staff trained.
	Training of Private Medical Practioners	300	No. of PMPS trained.	Training Block Level Community Leaders	3,800	No. of leaders trained.
MANAGEMENT IMPROVEMENT	Conversion of the City Family Welfare Bureau into an Administrative and Monitoring Unit		Establishment of Admin. and Monitoring Unit	Strengthening of the Health unit in the CMDA into 5 groups by establishing Health Program Administrative Group		Health Unit strengthened HPA Group established.
	Establishment of IEC and Training Unit		Establishment of IEC and Training Unit	Formation of Planning Mornitoring and Evaluation Group		Planning & Monitoring & Evaluation Group formed.
	Formation of an Apex Committee		Apex Committee formed	Establishment of IEC Group		IEC Group established.
				Formation of Training Group		Training Group established.
	Formation of a coordinator committee		Coordination committee formed	Establishment of Engineering Construction Group		Engineering Construction Group established.
				Formation of Project Advisory Coordination Committee		Project Advisory Coordination Committee formed.
				Formation of Local Committees		Local Committees formed.
DEMAND EXPANSION	Use of link workers from the community		No. of days in a month services of link workers used	Use of community based Honorary Female Health Workers		No. of days in a week the services of HHW used
	Building health centers in the slums		No. of health centers built in the slums	Involving local bodies/ slum bustee groups in the outreach services		No. of local groups involved; level of motivation, level of changed impact on each service

OBJECTIVES	BANGALORE			CALCUTTA		
	ACTIVITIES	TARGET	INDICATORS	ACTIVITIES	TARGET	INDICATORS
DEMAND GENERATION (continued)	Employment of local residents in the health centers		% of local residents employed	Use of organized "sarsandana" (voluntary labor)		No. of days in a week voluntary labor used
	Organization of health education activities with the community		No. of groups organized for health education	Building HAUs in the community		No. of HAUs built
	Upgrading community-based maternity homes		No. of community-based maternity homes upgraded	Use of community development workers		No. of days the services used; at the level other services used
	Expansion of neighborhood committee scheme beyond the 28 which presently exist		No. of committees formed and functioning	Use of informal, functional groups of user families for joint management and feedback on each of the specific health service activities planned for the project		No. of times in a month these informal groups meet with government staff/ appointed volunteer workers to give feedback
	Analysis of local health needs using the neighborhood committees		No. of surveys completed	Involving local bodies/ groups in the outreach services		No. of local groups involved; level of motivation, level of change/impact on each service
	Selction of one initial problem/issue (as demonstration) for committee action		List of the issues selected and the actions planned	Use of elderly women from the community to bring patients to the center for prophylaxis		No. of accompanied visits in a month;
	assignment of responsibilities for various activities to community persons		Lists of persons accepting responsibility and kinds of No. of activities	Organizations of space for preparation of supplementary nutrition packets and family planning discussions		No. of elderly women who have taken such action
	Organization of informal meetings of families		No. of meetings held			No. of spaces made available on a continous basis
	Orbanization of local spots for "IEC shows"		No. of performances, discussions, presentation held in a month	Organization of space for creche program		No. of creche programs carried out in donated places
	Extension of the UBSP scheme of Karnataka		No. of low income neighborhoods added to the program	Donation of food and toys for creche program		The extent of donations on an ongoing basis
	Use of the ICD scheme and extension of such		No. of anganawadi workers and centers used	Identification of troubled area for the anti-larval service		No. of unsolicited reports received from the citizens
	Involvement of existing grassroots organizations and non-government support organizations		No. of organizations agreed to participate in the project	Dissemination of the anti-larval information by community leaders		No. of informal meetings held/speeches given in a month; the level of awarenes
				Dissemination of information regarding the use of maternity homes/hospitals		Survey of the No. who receive care and their sources of information regarding such
				Minor repairs of sanitation equipment		No. of repairs done, level of reporting regarding repairs necessary
				Organization of space for training on health issues		No. of organized training sessions and their locale

OBJECTIVES	BANGALORE			CALCUTTA		
	ACTIVITIES	TARGET	INDICATORS	ACTIVITIES	TARGET	INDICATORS
DEMAND GENERATION (continued)				Study to identify ways in which the community may collaborate with public authorities		Completion and utilization of the study, use of citizens to undertake parts of the survey and numbers invoved
				Involvement of existing grassroots organizations and non-government support organizations		No. of organizations with agreements to participate in the project
	Using FHPs as resources for the delivery of health services to the community		No. of days in a month services of FHPs used	Using FHPs as resources for the delivery of health services to the slum community		No. of days in a month services of FHPs used
INNOVATIVE SCHEMES	Supplementary nutrition for pregnant and lactating mothers		Number fo LBW babies	Supplimentary Nutrition for children between 0-5 years		% of malnouriced children
(Creche)	Nutrition progrm for children 0-3 years		No. of malnourished children	Environmental and Sanitation Program		% of population covered with toilet, drainage, solid waste disposal and safe drinking water facilities
	Health Education among urban poor		% of urban population received health education; No. of talks given	Creche program		% of children covered under creche program
	Promotion of women's education in minority community		Literacy rates among minority women			
	Sanitation drive with community involvement		No. of drives undertaken			
	Health and family welfare education amongst adolescent girls on NFE Program		No. of adolescent girls covered with health and family welfare education			
	Education program for men and women's problems		No. of education talks			
	Importance of female child		Female child mortality rate			

OBJECTIVES	DELHI			HYDERABAD		
	ACTIVITIES	TARGET	INDICATORS	ACTIVITIES	TARGET	INDICATORS
SERVICE DELIVERY EXPANSION	Opening of health post	125	No. of health posts opened	Renovation of existing health centers	10	No. of existing health center renovated
	Opening health centers	19	No. of health centers opened	Construction of new health centers	36	No. of new health centers constructed
	Upgraded health centers	8	No. of health centers upgraded	Establishing upgraded health center	12	No. of upgraded health centers
	Mobile Health Clinic (vans)	19	No. of mobile health clinics in use	Strengthening existing upgraded health centers	4	No. of upgraded health centers strengthened
QUALITY IMPROVEMENT	Training of medical officers and FHPs	300	No. of medical officers and FHPs trained	Training of medical officers	170	No. of MOs & staff trained
				Training of FHPs	600	No. of FHPs trained
	Training of ANMs and link workers	1,900	No. of ANMs and link workers trained	Training of ANMs and link workers	1,800	No. of workers trained
MANAGEMENT IMPROVEMENT	Reorganizing and strengthening of Health Department of MCD and Directorate of Family Welfare, Delhi Administration		Strengthened and re-organized Directorate and Health Department	Establishment of Units for Administration Accounts & Finance, MIES, IEC/Training and MCH & Public Health Nursing		Administration, Accounts & Finance, MIES, IEC/ Training and MCH & Public Health Nursing Units established.
	Establishment of project Coordination Cell		Project coordinator established	Establishment of a State and a Corporation Project Advisory and Coordination Committees		Project Advisory & Coordination Committees established.
	Establishment of Administration, Training, MIS, IEC and Monitoring & Evaluation, Grants & Accting and Auditing Cells		Administration+Planning, Training, MIS, IEC Cells established			
	Formation of Steering and Advisory and Coordination Committees		Steering and Advisory Committees formulated; No. of meetings held			
DEMAND EXPANSION	Involvement of Bustee Vikas Kendras for organization of social programs in jhuggies		No. of Bustee Vikas Kendras involved	Use of link workers/ Dais from the community		No. of link workers/ dais used
	Construction of local garbage dhallaus		No. of garbage dhallaus constructed	Building upgraded and other health centers in community		No. of upgraded and other health centers built
	Organization of Multi-purpose cooperational societies		No. of societies organized			
				Use private medical practitioners (as Volunteers)		No. who serve as volunteers
	Use of community based volunteer female health workers (Bustee Sevikas)		No. of days used Bustee Sevikas used	Involvement of Mahila Mandalis, youth organizations and religious organizations (existing)		No. who undertake a new slum-dwellers oriented activity

	DELHI			HYDERABAD		
OBJECTIVES	ACTIVITIES	TARGET	INDICATORS	ACTIVITIES	TARGET	INDICATORS
DEMAND EXPANSION (continued)	Use of trained local dais in training program		No. of trained dais used	Use of OTC (orientation training camps) and their leaders as community educators		No. of camps which address the projects' issues
	Selection/Recruitment of ANMs from slums		% of ANMs from the slums			
				Use of existing schools for health and adult education programs		No. of classes held
				Involvement of existing grassroots organizations and non-government support organizations		No. of organizations with agreements to participate in the project
	Use of PHPs as health educators and motivators		No. of PHPs used; No. of people motivated	Use of PHPs and PVOs to deliver health services to slum population through a grant-in-aid scheme		No. of PHP & PVOs used
INNOVATIVE SCHEMES	Sanitation Program with Community participation		% of population covered with clean toilet, drainage solid waste disposal and safe drinking water facilities	Supplementary nutrition program for pregnant and lactating mothers		No. of LBW babies
	Effectively Control Gastroenteritis		No. of people with gastroenteritics	Supplementary nutrition program for toddlers		No. of cases of moderate and severe malnutrition in children under-five years
				Integration of services of anganwadi workers and ANMs		Services integrated
				Study of fertility behavior among minority groups		Fertility rates among minority groups
				Sanitation Drive in Community		No. of sanitation drive
				Income generation activities among slum women		% of women employed in gainful employment
				study of the incidence of sexually transmitted disease (STD)		% of men/women with STD

ANNEX 11

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

CIVIL WORKS PROGRAM

Type of Institution	Bangalore		Calcutta		Delhi		Hyderabad	
	TOTAL	FIRST 2 YRS	TOTAL	FIRST 2 YRS	TOTAL	FIRST 2 YRS	TOTAL	FIRST 2 YRS
Construction of Health Centers	60	45	109	25	19	5	36	32
Renovation of Existing Health Centers	37	22	-	-	-	-	34	30
Construction of Health Post	-	-	-	-	125	30	-	-
Construction of Quarters for Upgraded H.C.	7	5	-	-	-	-	-	-
Construction of UHC (Maternity Homes)	-	-	-	-	6	4	2	1
Renovation of Maternity Homes	21	17	25	6	-	-	10	8
Construction of ESOPD	-	-	18	2	-	-	-	-
Construction of Training Center	1	-	-	-	-	-	-	-
Construction of Regional Stores	-	-	2	-	-	-	-	-
Improvements to Schools	-	-	50	-	200	-	-	-

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

ANNUAL TRAINING PLAN AND CALENDAR BY CITY

Table 1: Ingredients of a Comprehensive Training Program

	Bangalore	Calcutta	Delhi	Hyderabad
Management, Coordination and Monitoring Plan	I	C	C	C
Training Needs assessment (Compares performance with job) requirement and previous training)	I	I	I	I
Comprehensive Training Plan				
Process of training				
* Categories & numbers to be trained	I	I	I	I
* Trainers training	I	I	I	I
* Methodology (Lecture, Demonstration, Field Work)	F	I	I	Inc
* Development & curriculum/ instructional materials	Inc	I	Inc	Inc
* Training impact	Inc	Inc	I	I
* Venue for training/facilities	C	C	I	I
* Training support (Housing, TA/DA)	C	C	I	I
Types of Training				
* Pre-service	I	I	I	Inc
* Induction/Orientation	I	C	I	I
* In-service (recruitment) Institutional	I	C	I	Inc
On the job	I	C	I	I

Content of Training				
* Project goals/objective	I	I	Inc	I
* Management/supervisory skills	I	I	I	I
* Clinical skills	I	I	Inc	Inc
* Communication skills (including motivation)	I	I	I	I
* Record keeping statistical skills	I	I	I	I
Adequate Budget	Inc	I	I	Inc
Feedback Loop	I	I	I	I

C - initial plan completed
I - in process
Inc - needs further study

B A N G A L O R E

Annual Training Plan/Calendar

					Number to be trained						
Type of Traing. (P=Pre Service O= Orien-tated; I=In-Service (OST)	Of Staff Categories to be trained	Location of Training	Curriculum Content Topics	Duration of Course (days)	19 92/ 93	19 93/ 94	19 94/ 95	19 95/ 96	19 96/ 97	19 97/ 98	Total No. to be trai-ned
O	1. Proj. Ed. Stf.	NIHFW ✓	Planning, Mgment.	3	12						12
O	2. Munic.Councillors	BCCTC	Outreach	1	43	44					87
(O)	3. Sr. Med.Officers	HFWTC ✓	Health Ser.Admn.	2	24						24
–	4. Gynaecologists	BCCTC	Planning,Org.	2		24					24
I	5. Pedaetricians	BCCTC	Planning,Org.	2		12					12
I	6. Extd.Educ.Offcrs.	BCCTC	Planning. Org.	2		4					4
I	7. Lady Medical Officers	BCCTC	Supervision, Clinical	5		37	30	15	15		97
I	8. Staff Nurse	BCCTC	Supervision, Clinical	5		38	30	16	12		96
I	9. LHV/PHN	BCCTC	Supervision Clinical	5		37	30	15	15		97
I	10. ANM/MPW	BCCTC	Communication, Outreach, Clinical	5		111	90	45	45		291
O	11. PMP	BCCTC	Outreach	1		120	90	45	45		300
I	12. Computers/clark	BCCTC	Statistics	5	-	34	28	12	10		84
P	13. Link Workers	H.C./ BCCTC	Outreach Communication Referral	(25) 5		370	300	150	150		970
O	14. NGOs	BCCTC	Orientation, outreach	1		90	50	30	30		200
O	15. Local Leaders	BCCTC	Orientation, outreach	1		150	120	63	65		400
O	16. Anganwadis	BCCTC	Outreach, Communication, Health promotion	5		76	60	35	30		200
1	17. Lab Tech.	BCCTC	Lab. management	5		9	8	7			24
O	18. School Teachers	BCCTC	Extension approach	1		50	50	50	50		200

Type of Training (P=Pre Service O=Orientated; I=In-Service (OST)	Of Staff Categories to be trained	Location of Training	Curriculum Content Topics	Duration of Course (days)	Number to be trained						Total No. to be trained
					1992	1993	1994	1995	1996	1997	
	19 Trainers	Apex Inst.	Training Strategies Materials, Measurement	15	12						12
GRAND TOTAL											3,152

1/ Orientation Training provided at the Project Launch

2/ In-service provided annually.

C A L C U T T A

Annual Training Plan/Calendar

					Number to be trained						
Type of Training (P=Pre Servce O= Orientation I=In Servce (OST)	Of Staff Categories to be trained	Location of Training	Curriculum Content Topics	Duration of Course days	19 92/ 93	19 93/ 94	19 94/ 95	19 95/ 96	19 96/ 97	19 97/ 98	Total Number to be trained
1	2	3	4	5	6	7	8	9	10	11	12
P	H H W	Hau/Municipal Office	- Objective and goals - Role & Job responsibilities - Methodology - Communication	10 weeks	880	1320	1540	660	-	-	4400
P	1st Tier Supervisor	-do-	- Job responsibilities - Leadership motivation & skill - Monitoring & Supervision	3 weeks	150	230	260	123	-	-	763
P	2nd Tier Superviser	-do-	-do-	2 weeks	45	65	75	35	-	-	220
O	Elected representatives of Local Authorities (Chairman + one Commissioner to be nominated by Chairman)	C T C	- Objectives and goals - Role - Monitoring and Supervision	2 dys	20	30	35	15	-	-	100
O	- Health Officer - Medical Officer (Part time) - Specialists of ESOPDS	HAU/Municipal Office	- Objectives & goals - Communication - Administrative Skill - Monitoring & Supervision	3 dys	85	130	150	65	-	-	430

O	- Representatives of PVO's - Representatives of Local Advisory Commi-tees	-do-	- Objectives & goals - Communica-tion -Supervision	2 dys	960	1440	1680	720	-	-	4800
O	- Executive & Finance Officers of Local Autho-rities - Asst. Chiefs of CMDA Projects - Project IEC Officers of the Mass Media Wing of Health Deptt. GOWB	C T C	- Objective and goals - Communica-tion - Coordina-tion	2 dys	20	30	35	15	-	-	100
O	High level officers of CMDA + Health Deptt.	C T C	- Objectives and goals - Coordina-tion	1 dys	25	-	-	-	-	-	
I	H H W	HAU/Mu-nicipal Office	- Tools & Techniques - Monitoring Feedbacks - Communica-tion skill	1 wk	-	800	1000	1000	800	400	4000
I	- 1st Tier Supervisors - 2nd Tier Supervisors	-do-	- do -	4 dys	-	150	190	190	150	83	743
I	- Health Officer - Medical Officer (Part time)	-do-	- Adminis-trative skill - Monitoring feedbacks	2 dys	-	60	70	70	55	25	280
I	- Nurse - ANM - Pharmacist	-do-	- Technical skill - Communica-tion - Monitoring & Feedbacks	3 dys	-	5	15	15	10	5	50
I	- CMDA Staff - HAU Staff - Local Authority Staff	C T C	- Accounting & financial mgmnt - Adminis-trative skill - Monitoring feedbacks	4 dys	-	40	50	50	40	20	200
I	- CMDA Project Officers - Project IEC Officers	C T C	- Supervi-sory skill - Monitoring feedbacks	2 dys	-	-	5	5	5	5	
I	Training of Trainers	C T C	- Skill up-gradation - Communica-tion	2 dys	50	120	120	150	60	-	
	Grand Total										16,65

D E L H I

Annual Training Plan/Calendar

					Number to be trained						
Type of Training (P=Pre Servce O= Orientated; I=In Servce (OST)	Of Staff Categories to be trained	Location of Training	Curriculum Content Topics	Duration of Course days	1992	1993	1994	1995	1996	1997	Total Number to be trained
0	1. Proj. Hd. Stf.	MCD	Mgmt. Eval.	2	25		25		25		75
0	2. Munic. Ldr.	MCD	Urban Hlth.	1	100		100		100		300
1	3. Sr.Med.Offcrs.	MAMC	Management	5		1	2	3	6	6	18
1	4. Gynaecologists	MAMC	Outreach Technology	5		1	2	3	6	6	18
1	5. Pedaetricians	MAMC	Outreach Technology	5		1	2	3	6	6	18
1	6. Lady M.O.	MAMC	Urban Hlth. Care,Strategy	5	2	12	24	36	50	50	174
1	9. LhV/PHN	MAMC	Supervision Clinical	5	1	6	12	18	25	25	87
1	10. ANM/HPW	Type D Hlth Post	Outreach phc	5	8	10	83	136	200	200	642
0	11. PMP	MAMC	Fld. Outreach	1	10	20	20	50	100	100	200
1	12.Computers	On job	MIES	2	5	5	5	5	5	5	30
1	13. Stat. Asst.	On job	MIES	2	5	5	5	5	5	5	30
P, (1)	14. Dais (link workers)	Type D Hlth. Post	Orientation ANC, PNC	30	25	150	300	450	625	625	2,175
0	15. NGO	MCD	Outreach	1	3	3	3	3	3	3	18
0	16. Local LDR	MCD	Objectives progress	1	100	100	100	100	100	100	600
0	17. Angan.	Type D Hlth. Post	Outreach Referral	30	25	150	300	450	625	625	2,175
1	18. Trainers	MAMC	TOT	4	2	10	12	12	14		50

					Number to be trained						
Type of Training (P=Pre Servce O= Orientated; I=In Servce (OST)	Of Staff Categories to be trained	Location of Training	Curriculum Content Topics	Duration of Course days	1992	1993	1994	1995	1996	1997	Total Number to be train
	19. Others - 1st Tier Sup. - 2nd Tier Sup. - NGOs - KSCB	MCD	Outreach Clinical	5 1	 5	1 10	2 16	3 22	6 30	6 30	18 11
O	20. Teachers		Prim.Health								
I	21. Indian Tours		Service Lib.								
I	22. International Tours		Management Health Service								
GRAND TOTAL											6,1

H Y D E R A B A D

Annual Training Plan/Calendar

					Number to be trained						
Type of Training (P=Pre Service O= Orientated; I=In Service (OST)	Of Staff Categories to be trained	Location of Training	Curriculum Content Topics	Duration of Course (days)	1992	1993	1994	1995	1996	1997	Total Number to be trained
I	1. Proj. Hd. Stf.	NIHFW	Management/Coor.	14	20		20		20		60
O	2. Munic. Ldr.	Directorate	Orientation	1	25	25	25		25		100
I	3. Sr. M.O.	NIHFW	Supervision Health Services	14	5		5		5		15
I	4. Gynaecologists	Med.Sch.	Clinical	14	5		5		5		15
I	5. Pedaetricians	Med.Sch.	Clinical	14	8		6		6		20
I	6. Ext.ed.off		Outreach	5	8		6		6		20
I	7. Lady M.O.	CHC	Supervision, Clinical	5	40		40		40		120
I	8. Stf. Nurse	CHC	Clinical	10	25	20	20	20		20	105
I	9. Lhv/PHN	H.O.	Supervision, TOT Clinical	10	30		30		30		90
I	10. ANM	H.O.	TOT Clinical Hlth. Educ.	10	100		140		140		380
O	11. PMP	C.H.C.	Clinical Refresher	2	200		200		200		600
(P) I	12. Dais (link workers)	On the job	Outreach Referral	12	250	250	250	250			1,000
O	13. NGO	H.O.	Outreach	1	50	50	50	50			200
O	14. Local LDRs	H.O.	Promotive Health	1	1000	500	500	500	500	500	3,500
O	15. Anganwadi/Sup	H.O.	Outreach	2	100	100	100	100			400
I	16. Lab. Tech.	CHC	Technical	10	5		5		5		15
I	17. Pharmac.	CHC	Drug Management	5	5		5		5		15
P	18. Trainers	APEX	Methods/Materials	15							30
O	19. Others	Various	Various	1	100		100		150		350

Type of Training (P=Pre-Service O=Orientated; I=In Service (OST)	Of Staff Categories to be trained	Location of Training	Curriculum Content Topics	Duration of Course (days)	Number to be trained						Total No. to be trained
					1992	1993	1994	1995	1996	1997	
GRAND TOTAL											7 12

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

SECTION 1: OPERATIONALIZING COMMUNITY PARTICIPATION

The following tables reflect how each city plans to "operationalize community participation" for this project. Six main strategies have emerged. The "x" indicates information in the final proposal submitted.

Key: B = Bangalore; C = Calcutta; D = Delhi; H = Hyderabad

Table 1: Persuasion as a Community Involvement Strategy

Strategy Proposed:	PERSUASION	B	C	D	H
	· The use of public relations to convince the urban poor strata of: the need to become responsible for the delivery of their local health care services; the need to address government-identified health care changes (e.g. family planning methods, environmental sanitation); and the need to accept government policies (e.g. Marriage Restraint Act), and female literacy/education programs.	x	x	x	x
Implementation Methods Identified:	· Mass media information campaigns.	x	x	x	x
	· Organization of National Population Commission and complimentary State Commissions.				
	· Outdoor publicity activities and follow-up.			x	x
	· Joint Women's Programs.	x		x	
	· Use of incentive payments to "acceptors".	x		x	x
	· Use of "SHE" clubs.	x			
	· Use of private medical practitioners.	x	x	x	
	· Enumeration of female children.			x	x
	· Use of folk/traditional media.			x	x
	· Organization of training camps to create political will.			x	x
	· Use of incentive payments to "motivators" for permanent methods.			x	x
	· Use of special incentives for employees (e.g. one increment in pay scale for permanent birth control methods.			x	x
	· Use of grant of special causal leave for adoption of family planning method.				x
	· Use of "special" subcommittee to review compensation / incentives.				x
	· Enhancement of motivators fee.				x
	· Organization of Health Education and Information Centres.				x
	· Registration of marriages.			x	x

Government Inputs:	· IEC Cells/Units		x	
	· IEC materials and equipment		x	
	· IEC cells - use of on-going/established.		x	
	· Rupee payments for incentives.	x	x	
	· Financial support to PVO's (e.g. SHE clubs).	x	x	x
	· Free family planning supplies, equipment and materials to PMP's.	x		
	· Establishment of new IEC unit, personnel, equipment, vans, furniture.	x	x	x
	· Development of new IEC materials/software	x	x	x
	· Payments to professional organizations for the development of IEC materials/films.	x		
	· Incentives for literacy for girls in form of books, uniforms, supplies.	x	x	
	· Grants to PVO's for literacy teaching to females not in school.	x		
	· Use of ICD units and family welfare staff.			
	· Motivator fees.			
	· Review of present compensation/incentive system for upward revisions and temporary methods.			
	· Costs for organizing Information Centres.			
	· Marriage registration incentive for records.			
	· ANMs and PVOs	x	x	
Community Inputs:				
Joint Management Structures:	· "Coordination Cell" for IEC			
	· Use of Monitoring Cell/Media studies			
Problems/Issues/Risks Associated:	· Negative political reaction if the community perceives it is being manipulated on a particular topic/issue.			
	· Benefits of the program are not clearly visible to the slum dwellers.		x	
	· Materials may be improperly designed and inappropriate.			
	· Use of incentives (for permanent methods)	x		
Requirements to Increase Demand:	· Further change in government authority's orientation regarding the concept of community participation.	x		
	· Review of government document terminology (e.g. "to get people to cooperate", beneficiaries, targets, etc.).	x	x	
	· Base program on identified needs and background of the people (e.g. check assumptions).			
	· Vital statistics system.			
Benefits Noted:	· Does not raise community leaders expectations of participating in the planning process.			
	· Allows for gradual change in thinking and project approaches by government sectors.			
	· "Fringe slums" receive some benefits from "targeted" slums' project.			
	· Assumed	x	x	x

		B	C	D	H
Evaluation Indicators Noted:	· Number of public reached in relation to the total the project is to affect.	x		x	
	· Measurement of increased comparative.			x	x
	· Number of citizens with positive attitude towards project information.	x		x	
Additional Funding Requirements:	· Materials production - part of IEC costs.				x
	· Government officers training. ✓	x	x	x	
	· Attitudinal survey for evaluation purposes.	x	x	x	x
	· Needs identification process - focus groups.	x		x	x

Table 2: Education as a Community Involvement Strategy

Strategy Proposed:	EDUCATION	B	C	D	H
	· The use of information dissemination and general instruction to create an awareness of the health issues and changes desired by the project.	x	x	x	x
Implementation Methods Identified:	· Involvement of private medical practitioners for specialization backup.		x		x
	· Use of IEC cells/units.		x	x	x
	· Use of ANM training schools and Corporation Maternity Homes.		x	x	x
	· Use of Mahila Swasta Sanghas/use of other agencies' departments.			x	x
	· Use of "volunteer trainers" to go into communities to deliver messages/Honorary Health Workers/Link workers/dais/Bastee Sevikas. ✓	x	x	x	x
	· Group presentations by link workers and counselling sessions.			x	x
	· Use of voluntary and philanthropic organizations.		x	x	x
	· Use of "SHE" clubs. ✓	x			
	· Use of health centre and referral centre staff/PHP's. ✓	x	x	x	x
	· Use of special environmental health and hygiene programs (well baby and clean hut). ✓	x	x	x	x
	· Use of ANMs/HHWs. ✓	x	x	x	x
	· Counselling couples bedside/maternity centres.		x	x	x
	· Treatment of minor ailments, as a "bait" for preventive health services.		x	x	x
	· Use of training needs surveys.		x	x	x
	· Use of health and family welfare committees (local).				x
	· Use of OTC trained leaders.				x
	· Use of upper primary students as "education task force".				x

Education Strategy (continued)

Government Inputs:	· Staff (Health Education Coordinator/Communications Officers) salaries.	x		x	
	· Professional artists contracted/employees newsletters.			x	
	· Leadership by medical officer to oversee IEC activities.		x	x	x
	· Educational kits including audio visual materials for outreach.	x	x	x	x
	· Training for staff, NGO and local leaders/assessment of.	x	x	x	x
	· Orientation (camps) with link workers and community leaders.			x	x
	· Grants-in-and to voluntary institutions to educate and supplement government activities.			x	
	· Training from "Shramika Vidhy Peeth".			x	
	· Set up residential training centre - the staffing of such.	x	x	x	
	· Development of training course materials.	x	x	x	x
	· Honoraria as incentives to outreach workers.	x	x	x	x
	· Salaries of ANMs.	x		x	x
	· Honoraria to trainers.	x		x	
	· Board and lodging for trainers/allowances.	x		x	x
	· Marriage guidance and marriage counselling services.		x	x	x
	· Training surveys by identified organizations.		x	x	x
	· Pre-testing of IEC kits.			x	x
	· Fertility behaviour rapid surveys.				x
	· Prizes as awards.				x
	· Training cell			x	
Community Inputs:	· Mahila mandals/Mohila Samriti		x	x	x
	· Youth organizations.				x
	· Time and space.		x	x	x
Joint Management Structures:	· Integration of services of ANM's and anganwadi workers for coordination.		x	x	x
	· Use of a project administration and management committee (PAMU/PACC).	x	x	x	x
Problems/Issues/Risks Associated:	· Technical information may not be properly communicated for ease of understanding, thus limiting awareness levels.	x			x
	· Use of honoraria.	x	x	x	x
	· High awareness levels by the citizens may create additional, administrative demands on the bureaucrats.	x			
	· Increased project costs for print/visual materials and equipment for presentation (extensive investment).	x	x	x	x
	· A long term strategy for results, thus time is an issue to address.				
Requirements to Increase Demand:	· Involve education institutions (universities) in the training process (e.g. Regional Institute for Urban and Developmental studies).	x	x	x	x
	· Greater use of the local government system.	x		x	
	· Easily accessible materials/information from national ordering location.	x	x		
	· Increase standards for those working with slum dwellers.	x	x	x	x
	· Focus on integration of services (literacy, water supply).				
	· Community development activities described in "neighbourhood terms" versus region/city/country descriptors.	x		x	x

Education Strategy (continued)

Benefits Noted:	· Creates a foundation for increased involvement by the urban poor in the future.	x	x	x	x
	· Enhances the effectiveness of existing government programs of public relations.		x	x	x
	· Strengthens environmental consciousness leading to community change (e.g. simple garbage projects).		x	x	
	· Educators/educator groups/associations can be easily identified and trained to form a part of delivery system and network.	x	x	x	x
	· Promotion of Basti Sevikas to ward ayahs.			x	
Evaluation Indicators Noted:	· Amount of time actually spent by educators (groups) in delivering the information.				
	· The actual behaviourial change which occurs in a defined region/community active targets.	x	x	x	
	· Increased use of (government) health services.	x	x	x	x
	· Response from focus groups (in UBS project).		x		
	· Test for "understanding" of the messages.	x	x	x	
	· Display of performance statistics.			x	x
	· Development of performance skills.		x	x	x
Additional Funding Requirements:	· Administration system for coordination.		x		x
	· Periodic message understanding tests.	x	x	x	x
	· Recordings of behaviour change in slum regions (e.g. videos).	x		x	
	· Measurement of use of health services by slum groups.				
	· Materials - part of IEC costs.				
	· Professional fees.	x			

Table 3: Information Feedback as a Community Involvement Strategy

Strategy Proposed:	INFORMATION FEEDBACK	B	C	D	H
	· The distribution of information regarding a health-related policy or government position or management scheme in order to allow local leaders and citizens or staff to react; to gain feedback.	x	x	x	x
Implementation Methods Identified:	· Use of project monitoring cells.			x	
	· Use of neighbourhood committees.	x	x	x	x
	· Household committees offer "single line contact" to women in the slums - gender awareness.	x	x	x	x
	· Vital statistics by dais.			x	x
	· Use of SHE clubs.	x			
	· Revamping of MIS for quicker action.	x		x	
	· Periodic surveys for impact of training.	x		x	
	· Surveys for FW & MCH content and targets.	x	x	x	
	· Use of Slum Development Committees.			x	x
	· Upgrading of MIES and design of service delivery booklet.			x	x
	· Use of family folders.		x	x	x

Government Inputs:	· Basic funding to committees.			x
	· Vital events honorarium.			
	· CMDA Project Directorate/MCD.		x	x
	· Outside expertise fees for MIS assistance.	x		
	· Outside consultancy fees for surveys.	x		x
	· MIS equipment and software.	x		x
	· Rapid Low Cost Studies.			x
Community Inputs:	· Time for committee work.	x	x	x
Joint Management Structures:	· HAU		x	
	· Decentralized institutional framework.		x	
	· Project Advisory & Coordinating Committee	x	x	x
Problems/Issues/Risks Associated:	· Individuals/bureaucrats are required to both distribute and evaluate the publics responses.	x		x
	· Improper systems for recording inputs of the public.	x		
	· Presentation of the information to the slum dwellers has to be organized in such a manner as to receive "useful" feedback.	x		x
	· Failure to acknowledge in a demonstratable manner how the slum dwellers and their leaders did affect the final policy and planning process can jeopardize the project and next phase working relationships.			
Requirements to Increase Demand:	· Allow a suitable and adequate time commitment to receive feedback and process the results.			
	· Demonstrate and communicate the results of the feedback (not necessarily the findings, but always the results).	x	x	x
Benefits Noted:	· Provides proof of "government listening".	x		x
	· Creates acceptance of the final decisions regarding the projects.	x		x
	· Improves management decisions of authorities.	x	x	x
Evaluation Indicators Noted:	· Frequency of contact (numbers of meetings, telephone calls, reports).		x	x
	· Measurement of local persons attitudes towards perceived influence over government policy (sample survey).			
	· Impact surveys.	x	x	x
Additional Funding Requirements:	· Information mechanism for feedback loops to slum citizens.	x		x
	· Survey.			
	· Clerical assistance.			x
	· Outside expertise fees.			
	· Extra slum committee financial assistance.	x	x	x

Table 4: Consultation as a Community Involvement Strategy

Strategy Proposed:	CONSULTATION · The use of formal dialogue between health authorities and the slum dwellers; to establish mutually accepted objectives; to develop the overall frame of reference for the project and to select "participation methods" appropriate to the region and the project.	B x	C x	D x	H x
Implementation Methods Identified:	· Use of ward level committees to bring slum committees together and support local leadership. · Use of "SHE" committees/Bustee Vikas Mandals. · Use of elected Local Authorities.	 x	x x	x x x	x
Government Inputs:					
Community Inputs:	· Committee members. · Identification for new facility sites. · Financial support of new clubs.	 x	x x	x x x	 x x
Joint Management Structures:	· PACC's	x	x	x	x
Problems/Issues/Risks Associated:	· Organized pressure groups may be favoured. · Lack of slum dwellers understanding as to their exact roles and limits. · If ideas collected during community workshops & seminars are unacknowledged, repetition may occur. · Dwellers and leaders may not be "listened" to.	x x x x	 x x	x x x	x x x x
Requirements to Increase Demand:	· Ongoing information/communication with the citizens about decisions regarding the project. · Recognition of the significant time commitment to obtain slum dwellers input. · Use of NGO Sector Department program of MOFHW.	x x	 x	x x	 x x
Benefits Noted:	· Local leaders are involved from the initial stages. · Establishes a system to begin participatory planning. · Some departments have a long history working in slums thus raising confidence levels of health authorities. · Local leadership is supported through committee efforts. · Innovative workshops will (continue to) be implemented, (e.g. listening workshops).	x x x x x	x x x x	x x x x x	x x x x x
Evaluation Indicators Noted:	· Frequency of contact between leaders and authorities. · Output of the consultative process (e.g. project plan).	x	x x	x	x
Additional Funding Requirements:	· Trained facilitators for workshops with public. · (Additional) training workshops on participatory consultation.	x x	x x	x x	x x

Table 5: Joint Planning of Design as a Community Involvement Strategy

Strategy Proposed:	JOINT PLANNING OF DESIGN	B	C	D	H
	· The use of share decision-making since the local slum dwellers are, in this strategy, represented on planning committees, given voting authority, and issue authority.	x	x	x	x
Implementation Methods Identified:	· Build on ODA Slum Improvement Project/Urban Community Development organizations/CUPD models.		x		x
	· Use of existing Urban Family Welfare Centres structures (e.g. 34 Hyderabad) with the management of six by voluntary agencies.			x	x
	· Use of organized Registered Societies, NGOs in slums for large regions.	x	x	x	
	· Encouragement through Neighbourhood Infrastructure Committees (young men).				
	· Use of Monitoring and Coordinating Committees at State government levels.	x	x	x	x
	· Use of Neighbourhood Committees (UBSP scheme/CUPD).	x	x	x	x
	· Use of "SHE" clubs of slums.	x			
	· Use of issues-oriented workshops and in-house staff meetings.		x	x	x
	· Micro planning joining ANMs and the anganwadi workers for services.		x	x	x
Government Inputs:	· Training for reorientation.			x	
	· Financial support to clubs.	x		x	
	· Assistance (by UCD staff) for local committee representation selection.		x		x
Community Inputs:	· Slum committee members' time.	x	x	x	x
	· Community organizer/facilitator for committee units.				
Joint Management Structures:	· Coordination through slum committees.	x			
	· Past project structures.		x	x	x
Problems/Issues/Risks Associated:	· Clear definitions of the organizational setups and roles of government departments responsible for project; flexibility.	x	x		x
	· Development of appropriate materials for use by all the committee members (slum dwellers' leaders) for meetings and planning.	x			
	· Little government experience working with NGO's/PVO's.				
	· Use of incentives for PVO's.	x			
	· Slums are not homogeneous; some are 30 to 40 years old and as such cannot be treated as same.	x	x	x	x
	· Lack of formalization of known and existing coordination mechanisms.	x			
	· Men stopping women from representation on the community development unit committees.	x			
	· Improper nomination of committee representative.	x	x	x	x
	· Multiplicity of agencies and government departments in field.				
	· Linking of action plans to recurrent funds and striving to meet year-end quotas.				
	· Vested interests prevent people from coming together.				
	· Barriers of caste, religion, language, and education prevent openness.				

Joint Planning Strategy (continued)

Requirements to Increase Demand:	· Acceptance of consensus building process by authorities.				
	· Recognition by government department responsible for this strategy of time commitment required for results.			x	
	· Proper representation on the committees so the recommendations are not questioned.	x	x	x	x
	· Creation of high visibility of the committee' representation and its responsibilities for final acceptance by public of recommendations.			x	
	· Greater involvement of focal NGO's (e.g. Rotarians and Red Cross).	x	x		
	· Create linkages to National Commission on Urbanization.				
	· Use of MOHFW's NGO Sector program funds.	x	x	x	x
Benefits Noted:	· Joint management is realized for inter sectoral cooperation	x	x	x	x
	· Sensitivity to community problems and knowledge of community constraints in solving problems is demonstrated.	x	x	x	x
	· Limited media-oriented investment.				
	· High involvement of women at neighbourhood trustee committee level (potential).	x	x	x	x
	· UBS staff can be used as trainers.			x	
	· Forced government team-planning in order to integrate approaches.	x	x	x	x
	· Able to build on the capacity of other community systems and schemes (e.g. Scheme of Urban Wage Employment - Nehru Rozgar Yojana).			x	
	· Training available for facilitators.			x	
Evaluation Indicators Noted:	· The degree to which the slum dwellers actually perceive they had a voice via their representatives.	x	x	x	
	· Recording of examples of committee's self-perception.				
	· Design and implementation of a joint management plan.	x	x	x	x
	· Sites purchased by government as identified by locals.			x	x
Additional Funding Requirements:	· Training seminars - part of training costs.	x	x	x	x
	· Joint management costs.	x		x	x
	· Outside consultant fees for cooperation in building.				x

Table 6: Delegated Authority as a Community Involvement Strategy

Strategy Proposed:	DELEGATED AUTHORITY	B	C	D	H
	· The use of existing elements of self-help within the urban poor communities in order to transfer responsibilities normally associated with the authority to urban poor groups or to another level of government (local).	x	x	x	x
Implementation Methods Identified:	· Use of the participatory model (Workshop series in slums involving NGO's local clubs, government representatives; synthesization of ideas through use of bustee leadership discussion groups; organization of an agreed-upon project package; preparation of project documents).	x	x	x	x
	· Creation of slum dweller cooperatives (for 1,000 population).				
	· Involvement of registered Non-Government organizations in citizen coops as institutional members.	x		x	
	· Use of RCV (Resident Community Volunteer) Committees for geographical areas.		x		
	· Use of Final Tier and Second Tier Supervisors.	x	x		
	· Use of "SHE" clubs/Mahila Mandals.	x		x	
	· Addition of more health officers to expand responsibilities into community groups.	x	x	x	
	· Use of creche scheme at slum level.	x	x	x	
	· Vocational training (tailoring/knitting) schemes.	x	x	x	x
	· Availability of Revolving Fund Projects.	x	x	x	x
	· Use of ODA health services base.				x
	· Use of NGO special registers for future project involvement.		x	x	
	· Distribution of nutrition supplements by health workers (volunteer/Department).		x	x	x
	· Child to child programs (i.e. fly collection project).				x
	· Use of youth organizations/Balwadi Teacher.			x	x
	· Use of female liaison officers/Bustee Vikas.	x	x	x	
	· Use of regional medical stores/Central Store systems.		x	x	
	· Use of ESOPDs.		x		
	· Use of income-generation schemes.		x	x	
	· Expanded anti-laraval program.		x		
	· Use of mobile units (re cancer detection).		x		
	· Add to Implementation Methods			x	
	· Use of Training Cell			x	
	· Use of 'house to house' surveys			x	
	· Use of disabled persons support/NGO's				

Delegated Authority Strategy (continued)

Government Inputs:	· Limited management assistance to citizens coops.	x			
	· Equipment, medical supplies and expertise; supply of tools; audio visual materials; medical personnel, training materials.	x	x	x	x
	· Referral services (professionals).		x	x	x
	· Equipment - special (e.g. solar water heater).	x		x	
	· Waste management materials for health centres and people of slums (trippers/dustbins).	x	x	x	x
	· Financial support to clubs.	x		x	
	· Buildings and furniture for facilities of the health centres/maternity homes.	x	x	x	x
	· Staff quarters (e.g. for nurses and chowkidars.)	x		x	x
	· Salary for additional health officers and staff associated and furniture and equipment.	x		x	x
	· Costs for creche scheme.	x	x	x	
	· Cost for vocational training program as submitted by PVOs.	x		x	
	· Availability of Revolving/Development Funds matching grants.	x		x	
	· Identification and registration of Grass Roots NGOs in each community.	x	x	x	x
	· Nutrition packages.		x	x	x
	· Remuneration to children as incentives.				x
	· Local malaria lab.				x
	· Vocational Training Centre.				x
	· Women entrepreneurs programs.		x	x	
	· Supply of medicines to regional medical stores.		x	x	
	· Costs of larvicide and equipment.		x		
	· Establishment of an "Aids Cell", or Aids project.		x	x	
	· Costs for labs, mobile units, staff and equipment.		x	x	
Community Inputs:	· Land maintenance; labour; garbage scheduling; scramdans; food, donations, emergency assistance.	x	x	x	x
	· Committee/Club membership (people)	x	x	x	x
	· SHE Club subscription.	x			
	· Parent payment for creche programs.	x		x	
	· Volunteer labour.	x		x	x

Delegated Authority Strategy (continued)

Joint Management Structures:	. Joint monitoring of supplies and distribution.		x	x	x
	. Joint training of traditional birth attendants.			x	
	. Informal functional groups of user families.				
	. NGO's for remuneration to Bustee Sewika.				x
	. Use of Deputy City Family staff in micro work.	x			
	. SHE Committees.	x	x	x	x
	. PVO representation on Project Advisory Coordinating Committees (PACCs).	x	x	x	x
	. Slum organization representation on PACCs.			x	x
	. Voluntary Organizations Management of Urban Family Welfare Centres.		x	x	x
	. Coordination with other government departments (on water projects and conservancy education).	x	x	x	x
	. Coordination with Women Welfare Department, Adult Education Revenue Department (intra-sectoral).		x	x	
	. CMDA Project Directorate/MCD.			x	
	. Use of SCERT & NCERT.			x	
	. Use of NF Education Centre.			x	
	. Use of Habitat Polytech (Construction).			x	
	. Use of KVIC (Khadi Village Industries).			x	
	. Policy Review & Steering Committee.			x	
Problems/Issues/Risks Associated:	. Accountability regarding finances (funds) and materials.	x	x	x	x
	. Threat to existing administrative structures with loss of authority.				
	. Lack of government representatives in cooperatives.	x	x	x	x
	. A mechanism to improve the quality of the project is needed.	x	x	x	
	. Less than clear understanding of the "partnership" between community and government departments to implement the project.				
	. Organizations may continue to try 'to do' for the community rather than facilitate community to do for self.	x	x	x	
	. Lack of project organization skills.				
	. Lack of information.	x	x	x	
	. Acknowledgement of migration.	x	x	x	x
	. Need to acknowledge qualitative indicators.				
Requirements to Increase Demand:	. Link to existing successful schemes already in slum areas.	x			
	. Administrative and support staff to assist.		x	x	
	. Development of appropriate application forms for registering coops.	x		x	x
	. NGO training workshops are required in most areas (Calcutta has made a beginning).	x	x	x	x
	. Continued decentralization (HAU).				
	. Strengthening referral services.				x
Benefits Noted:	. Release of rights to land (e.g. UNICEF/Hyderabad) thus ownership of needs established.			x	x
	. A business agreement (consortia between government and community) established.				
	. Sharing of solutions by slum leaders of day-to-day problems (reaching beyond local area).	x	x	x	x
Evaluation Indicators Noted:	. Whether the project meets its objectives.				
	. Frequency of acceptance of responsibility for problems by slum dwellers and their leaders.				

Delegated Authority Strategy (continued)

Additional Funding Requirements:	· Tools, supplies - part of funds allocated for equipment, etc.	x			
	· Training - part of training costs.	x	x	x	x
	· Administration costs for innovative solutions.	x	x	x	x
	· Land rights costs.			x	
	· Flexibility of Revolving Fund.	x			
	· Coordination mechanism costs for departments/personnel to assist.	x	x	x	x
	· Innovative scheme fundings.	x	x	x	x

SECTION 2: TECHNICAL ASSISTANCE ON COMMUNITY PARTICIPATION

Background: Concern with local development activities is not new.

1. **Community Development:** Though community development initiatives can be traced to the 1920's, it was the Etawah pilot project in India that brought community development (CD) into prominence in the post colonial era. CD programs were introduced to the developing world during the 1950's and were for the most part abandoned by the 1960's after a long list of documented failures (i.e.targets were formulated centrally with little regard to the willingness of the people to respond; little attention was given to institutional linkages/policies which influenced village self-help activities).

2. **Popular Participation:** In the early 1970's popular participation became a priority in development as a response to the failure of the "trickle down" theory. In this scheme, projects were/are aimed at providing services to the poor as quickly and directly as possible through government funded and administered extension services. This approach also has recorded a long list of failures:

(a) plans stressed popular participation but, in reality this was largely precluded by the planning procedures themselves;

(b) there was little or no accountability to the people who have a direct interest in the actual outcomes; and

(c) 'Blueprint projects' emerged with key decisions regarding services, facilities, inputs, schedules and outcomes which were centrally determined by experts who generally lacked the incentive and means to obtain inputs from the poor beneficiaries. Therefore, the only form of participation for the poor, was in providing free labor or materials to implement decisions in which they had no part.

3. **Decentralization:** Decentralization schemes emerged with their emphasis on implementing national programs through local administrative units, with efforts consisting largely of providing grants to local bodies, to be used for small scale local projects. As with the other schemes, this decentralized approach retains central control and 'community dependence' on central funding. There is little commitment to political and administrative reforms which might lead to self - managing local communities.

4. **Lessons learned:** None of the approaches which were aimed at stimulating local initiative, challenge the idea that the government does development for the people who are then expected to respond with acceptance to whatever guidance, information and assistance the government chooses to offer. None confront the basic issue of local control and responsibility. **There is, therefore, first, a need to apply the lessons learned from community development, popular participation and decentraliation schemes, and second, there is a need to seek alternatives.**

5. **Introduction to one alternative - Community Management:** Community management is different in concept and practice from community development and

popular participation endeavors. The term `community' refers to an interacting population living in a common location. A `community management system' therefore may be comprised of any number of different social units including households, small companies, kinship groups, factions, local voluntary organizations & local government bodies. The term 'community management', therefore, is normally applied when management control is broadly distributed among the `system'. It is not applied when resources are being managed `for' the community by groups outside its boundaries, or by a small local elite group.

6. **Community management has several generic features:**

(a) assistance to each individual community group is designed and managed as a discrete project activity. It has its own timetable and is responsive to the particular situation of that group. It is based on a careful study of existing practices, technical capacities, resources available, and power structures;

(b) the emphasis is on community control and management of its resources. Every project intervention is geared to this outcome including even legal confirmation of resource ownership and recognition of the community group as a body with legal rights;

(c) actual project design does not take place until the constituents are fully prepared to make their needs and priorities known. Project implementation does not begin until the design is formally accepted by some association of the constituents;

(d) project organizing takes account of the existing community structures, and builds on individual citizen strength - from the bottom up - to insure broad-based participation and to avoid domination by traditional leaders or corruption;

(e) incentive systems are structured so as to strengthen accountability of project staff to community groups; and

(f) long term, systematic attention is given to debureaucratizing agency systems and building their capacities to work flexibly as service agencies.

7. It is evident that a commitment to the community management approach is not to be taken lightly by a public agency. Programs should not readily adopt a community management label without such a commitment, as they are likely to suffer all the deficiencies of past community development, popular participation & decentralization schemes. **Yet, there remains, at the same time, the need to begin to examine such alternative approaches, as they appear to hold promise of more positive results.**

8. **Objectives of the Technical Assistance Program are to:**

(a) examine new project approaches and new organizational structures or arrangements which encourage local initiative, accountability and self regulation;

(b) provide a needed reorientation in thinking in order to better

appreciate and understand the significant impact local self-help actions can have on a projects's outcomes;

(c) to understand more fully the broad range of resources that local communities are able to bring to bear in addressing their needs, and the complex social dynamics that serve to both enable and constrain local activities; and

(d) to examine the potential and limitations of government in implementing projects intended to strengthen community capacities.

9. **Methodology**

(a) **Training Workshops: In country series**

Sessions - 5

Durations - 3 days

Locations - 4 Municipal Corporations (Delhi, Hyderabad, Calcutta and Bangalore)

Numbers - 50 per session

Expatriate Trainers - 3 - P. Randall, R. McCarney, M. T. Fuerstein.

Local trainers -3- To be decided plus national NGO'S (eg. UNICEF).

(b) **External Fellowships:**

Duration - 20 days

Locations of projects - Thailand, Philippines, Bangladesh, Kenya, Nepal +(emphasis on Asia)

Numbers - One selected per each Training Workshop (Total 5)

(c) **Internal Fellowships:**

Duration - 6 days

Locations - to be decided

Numbers - 2 selected per Training Workshop (total 10)

(d) **National Conference**

Topic: Demand Expansion through Active Community Involvement and Government Commitment.

Duration - 3 days

Location - New Delhi

Numbers - 400

Recommended keynote speakers - D. David Korten & D. Norman Uphoff

Special workshop series could include: BRAC (Bangladesh Rural Advancement Committee), a PVO ; UNDP/PROWESS; D. David Drucker; Kenya's National Environment Secretariat.

(e) **Development Film/Video (for training)**

Co-sponsorships a possibility

10. **Time Frame:** 1992 - 1993 inclusive

11. **Budget**

- The total budget is US $ 565,400 (a 10% contingency should also be added)

- Budget breakdown is given in Table 1.

12. **References**

- Korten, D.C. Community Management - Asia Experience. Perspectives. Kumarian Press, 1987

- Midley, J. Community Participation, Social Development and the State, Methuen, 1986.

- Indian Society of Health Administrators, Community Participation in Health, family welfare: Innovative experiences in India 1990

Table 1: Budget Breakdown

Item	Preparation & Training Workshop	Internal Fellowships	External Fellowships	National Conference	$ U.S. Totals
FEES					
· local consultants (3)	24,600	1,200	0	12,000	37,8
· expatriate consultants (3)	86,000	0	22,000	32,600	140,6
· administration (2)	10,800	600	4,000	29,900	45,3
· guest speakers	0	0	0	12,000	12,0
DISBURSEMENTS					
· travel					
- guest speakers	0	0	0	35,000	35,0
- delegates	15,000	7,000	25,000	20,000	67,0
- consultants local	2,100	700	0	0	2,8
- consultants expatriate	27,300	0	6,500	12,600	46,4
- administration	9,600	0	0	9,600	19,2
· food and accommodation					
- local consultants	9,000	900	0	1,350	11,2
- expatriate consultants	18,000	0	3,000	4,500	25,5
- administration	4,500	0	0	3,000	7,5
- delegates	0	9,000	15,000	2,700	26,7
- guest speakers	0	30,000	0	0	30,0
· transportation (ground)	100	100	300	50	5
· materials					
- regular	11,000	0	0	5,000	16,0
- video	30,000	0	0	0	30,0
· other					
- entertainment, reception, equipment, supplies	0	50	200	3,500	3,7
- room(s) rental	0	0	0	5,000	5,0
· communications	500	50	2,000	500	3,0
TOTAL	248,500	49,600	78,000	189,300	56

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

MANAGEMENT AND INITIAL LISTING OF PRIVATE VOLUNTARY ORGANIZATIONS TO BE INVOLVED IN PROJECT IMPLEMENTATION

Management of PVO Involvement

1. The Government of India has evolved a standard system for bringing Private Voluntary Organizations (PVOs) into its social service programs. Selected PVOs, which must be registered under an appropriate State or national Act regulating PVOs in order to qualify for Government funding, are contracted to provide certain services. In return, they receive a "grant-in-aid", which covers part or all of their operating costs. All PVOs receiving grants-in-aids are inspected, their performance monitored and their accounts audited at regular intervals. At present neither selection procedures nor contract formats nor monitoring procedures have been standardized, though work on this is currently underway. The following paragraphs give details of how each municipality proposes to implement PVO participation in project activities within the framework of the existing Government system:

2. Bangalore. Bangalore envisages a two-stage involvement of PVOs. In the first phase, existing PVOs registered under the Karnataka Societies Act, 1954 have been shortlisted and then invited for exploratory discussions to ascertain their background and experience and interest in the project. A verificatory workshop was then held to assess their capacity, interest and desired area of operation. They would be deployed on the basis of their interests and strengths. Contracts would be entered into only when the project flow-of-funds is in place, but model contracts are under preparation. PVO accounts would be audited by registered chartered accountants and furnished annually to the BCC. PVO performance would be monitored through periodic reports, monthly and quarterly review meetings, and workshops; the LMO would function as a first-level supervisor. A leading role of these existing PVOs would be to help slum dwellers set up and launch their SHE (Social, Health and Environmental) clubs, which would be associations of project service beneficiaries for every identified slum.

3. In the second phase, the SHE clubs would themselves register as new PVOs and seek grants-in-aid under the same system to support their social, health and environmental activities. SHE management committees would be elected by the members, with the local Lady Medical Officer as an ex-officio member. The club would also have the option to co-opt PVO staff as committee members.

4. Calcutta. In the existing health programs in Calcutta under CUDP III, PVOs are not being directly utilized. However such a process has started under a similar ODA-funded program in the slums. Their involvement there is mainly in training, and they are paid on a fee-for-service basis. For this project, PVOs working in the health/family welfare area have been identified through a survey. Their services will be utilized as and when necessary under the normal financial procedures followed by the State government in its own employment of PVOs.

5. Hyderabad. In Hyderabad, lists of PVOs for the project areas have already been prepared. Final selection will be based on past experience, credibility and capabilities; they must also be registered under the Society Registration Act, with a specific set of objectives and headed by a board of management capable of delivering the required activities. All the PVOs listed are already in receipt of grants-in-aid and hence subject to periodic audits and independent inspection. This would continue under their funding from the project, in which their role will be to employ and manage community link workers.

6. Delhi. Under Delhi's current procedures for utilizing PVOs, applications of PVOs are invited through press advertisements. The credentials and background of applicants are examined, with particular reference to the type of services provided and their field of operation. Guidelines to be followed and basic requirements to be met in the final shortlisting and selection process are laid down in a brochure produced by the Delhi Administration. Selected PVOs seeking grant-in-aid assistance must enter into a written undertaking with the Delhi Administration/ Municipal Corporation to abide by the terms and conditions mutually agreed upon for implementation of specific tasks or programs with specific targets. They then receive grants-in-aid to make up any deficit in their core operating budgets, particularly for staff salaries, and also to fund part of the salaries of staff employed in the specific tasks and programs assigned to them under the written undertaking. Their accounts are subject to both internal and external audit. Action can be, and has been, taken against PVOs who fail to perform satisfactorily.

7. Under this project, a new set of procedures will be introduced for PVO selection, specification of the services they are to provide, type of assistance they will receive, etc. Work is underway on preparation of these new procedures, which are expected to be more flexible in their operation.

Initial Listing of PVOs to be Involved in Project Implementation

8. The following table lists identified PVOs (aided and non-aided), by project city, which are likely to be involved in the project. These PVOs have already been associated with government-sponsored health/family welfare programs in each city.

BANGALORE	CALCUTTA	HYDERABAD	NEW DELHI
Centre for Research and Development of Dalits.	Aided R.K. Miosion Sava Pratisthan	Indian Red Cross Association	Lok Kalyan Samiti (1)
Need Trust	F.P. Association of India	Andhra Mahila Sabha	Rotary Club, Panchsheel Park (1)
Shramika Vidya Peeta	Marwari Relief Society	Family Planning Association of India	SECH (1)
Shishuraksha FHP	Birla S.W. Scheme (Ultadanga)	Marie Stopes Association of India	Love and Care (1)
Rayapuram Slum Development Society	Birla S.W. Scheme (Dhakuria)	Indian Medical Association	Privar Seva Kendra (1)
Charistian Children's Fund	N. & S. Gandhi Peace Foundations	Lion's Club of Hyderabad	Indian Red Cross - Delhi (1)
CMAI	N. & S. Marie Stopes Society	Rotary Club of Hyderbad	Family Planning Association, Delhi (1)
Bosco Yuva Sangha	Paschim Banga Samaj Seva Samity (B.T. Road)	Voluntary Health Association of India	Parivar Kalyan Kendra (1)
Deena Seva Sangha	Paschim Banga Samaj Saeva Samity (E.R. Avenue)	Vasoda	ASHA (2)
Women's Voice	Bangal Social Service League	Giants International	SHARAN (2)
Sumanhally Centre	Prosenjit Mem. Com. H. Centre	Health Action	Deepalaya (2)
Joint Women's Programs	Soroj Nalini Dutt Assoc.	*Vidyanagar (AMS)	WAFD (2)
Bagpiakers Education	Crused	*Basheerbagh	CASP Plan (2)
Note: Some 13 groups given in proposal development scheme, but 37 groups was the seminar number quoted for involvement.	Vivakananda Sava Samity	*Begumpet	SEWA - Bharti (2)

BANGALORE	CALCUTTA	HYDERABAD	NEW DELHI
	Harmony	*Sanatnagar FPA1	HARSHA
	Matiabruj Seva Samity	*Dr. Paul Das Centre Rc Socy.	Virendra Gupta (2)
	S.V.S. Marwari Relief Society	*Lady Baston Centre Rc Socy.	Guild of Services (2)
	RMC S Beniapokur	* Denotes Voluntary organization managing an urban family welfare centre.	A.V. Baliga Memorial Society (2)
	RMC S Sastitala		Delhi Catholic Archdiocese (2)
	RMC S Duff Street		ANKUR (3)
	RMC S Sokul Boral Street		KATHA Educ. (3)
	RMC S R.K. Bose Street		Rajir Neelu Kachwaha Trust (3)
	Non-Aided Florence Day Centre		Butterflies (3)
	Islamia Hospital		Street Survivors (3)
	Bam India		Sulabh Intl. (3)
	R.K. Mission Sevashram		Nirman Bazdoor Panchayat Sangam (3)
	R.K. Sarada Mission Matri Bhava		Action India (3)
	Lion's Multipurpose Clinic		NGO Centre for Training (3)
	Child Health Centre		SACH (3)
	Calcutta F.P. Centre		Jan Madhyancy (4)
	Assoc. Medl. Women Institute		Tamana (4)
	Souch Cal Child & Gari Society		Sahan (4)
	Society for Com. Dev. Project		Spastic Society (4)

BANGALORE	CALCUTTA	HYDERABAD	NEW DELHI
	All India Women's Conference		Akshaya Pratisthan (4)
	Cathadral Relief Society		Handicapped Welfare Fed. (4)
	Lt. Amritalal Gupta Char Disp.		Blind Relief Assoc. (4)
	Church Aux for Social Action		Joint Women's Program (5)
	Sidhaswari Seva Protisthan		SAHELI (5)
	Kothari Foundation		Mahila Dakshta Samiti (5)
	Janata Medical Service		VHAI (5)
	Bengal Rural Welfare Service		VHAI Delhi (5)
	Inner Wheel Club of Calcutta		Vivekanand Kendra (5)
	Calcutta Social Project		Ford Foundation (5)
	Rotary Club of Cal Dn. Town		Yuva Prayas (5)
	Vishudhyananda Hospital		Project Smita (5)
	Medical Bank		
	Sea Right Hospital		
	Thakurpukur M.C.H. Centre		
	Bakhrahat		
	Himoabty Association		
	Mohananda Bramhachari		
	Lohia Matri Sadam		
	Matri Mongal Pratisthan		
	Satya Sai Seva Samity		
	Kusua Kumari Databya		
	Inst. of Child Health		
	Kumartuli Seva Samity		
	Mat. & Ch. Welfare Advisory Clinic		

BANGALORE	CALCUTTA	HYDERABAD	NEW DELHI
	Cal. National Welfare Organization		
	Selimpuz Nursing Home		

Notes Re New Delhi:

(1) Refers to those NGO's presently running health posts.
(2) Refers to those NGO's involved at present in health care delivery and integrated health programs.
(3) Refers to those NGO's engaged in specific activities (e.g. education, construction of latrines).
(4) Refers to those NGO's working for the disabled.
(5) General NGO's.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

INFORMATION, EDUCATION AND COMMUNICATION

A. BACKGROUND

1. An IEC program can be the catalyst for community and client involvement and acceptance of key project interventions to improve opportunities for urban slum populations e.g. increasing demand and utilization of a wide range of health services; improved education for girls; delaying the age of marriage. However, IEC programs can be effective only in an environment in which: (a) promoted program services are available at the level and quality necessary for utilization by client and community; (b) IEC implementing organizations have the resources and ability to plan and conduct necessary program activities; and (c) the felt needs of beneficiaries are given priority by program planners and implementors.

2. Proposals from Bangalore, Calcutta, Delhi, and Hyderabad indicate an appreciation of the need for these prerequisites to be developed under the project and have outlined IEC activities aimed at addressing problems which hamper institutional capabilities to undertake effective IEC programs at three critical service levels: (a) the service center (including, PVO and public sector hospitals, health centers and health posts); the client; and (c) the community.

3. On the supply side or service center level, training is needed in communication skills to new outreach workers e.g. link workers in Bangalore, Hyderabad and Calcutta and ANMs in Delhi, and the communication skills of existing program staff and service delivery workers have to be upgraded. New and existing cadres of care givers in all the municipalities require a variety of IEC materials to: upgrade their knowledge of health technology; support their interpersonal communication and motivation efforts with clients; and support their promotion of new and existing services available in targeted slum communities.

4. At the client level, ignorance about the range of health services available through the public health system; apathy regarding the need to utilize such services in an appropriate and timely manner; pervasive perceptions about the quality of care at public sector health institutions, and concerns about poor service provider attitudes and behavior remain real barriers to increased client utilization of services and program participation.

5. At the community level, IEC programs have to facilitate the involvement of community-based organizations in program planning and implementation. There is also to requirement to increase the knowledge of health issues by opinion leaders and where necessary, change negative attitudes and behavior so that these leaders can support the program and its objectives.

B. GOI's IEC STRATEGY FOR SLUMS

6. The GOI's Mass Education and Media (MEM) Division has determined that the IEC strategy in slum areas has to be achieved through a mix involving the electronic media, folklore through the song and drama, and print including items such as innovative stickers and posters. The analysis, pre-testing, development, implementation and revision of new materials will be undertaken as part of the process of developing prototype material by the center. Regionally sensitive variations in terms of culture and language for the four cities would also be adapted from these prototypes.

7. An IEC infrastructure exists and State Media Officers, Exhibition Officers, editors, audiovisual officers, painters, and photographers are already available in each State. States also have basic media and audiovisual equipment and offset printing presses for the production of regional materials. The additional personnel which would be created under the project, has been done in consultation with the State Media Officers. The Department of Audiovisual Productions also organizes exhibitions in different places. These exhibitions are funded by MOHFW would be organized in the slum areas at appropriate times. Similarly, song and drama programs, screening of films on 16 mm projectors would also be organized in consultation with State Media Officers. The State Media Officer is also on the Inter-Media Publicity Coordination Committee where Doordarshan, All India Radio and other media personnel are members.

8. Inter-personal communication is critical in the GOI plan. Under the project, link workers (volunteers) would work in every 20 households. Their training should be organized and they will be equipped with flip books and other materials to enable them to be more effective.

9. Communication research indicates that IEC activities should be entertaining as well as educational. A base of the program will be entertainment. There is therefore a need to produce good music and films and funds will be provided for this. Entertainment and education will be provided also by Mahila Swasthya Sang which are women's health education groups. They meet as an executive body once a month and organize innovative programs on target groups such as youth, children, mothers and daughters-in-law, and husbands. Some immediate funds are given for the monthly meeting and a one-time small non-recurring grant for buying musical instruments. The women functionaries of different departments are members of this executive body such as ICDS workers, rural health volunteers, lady teachers, and traditional birth attendants. There are also 10-15 influential and important women who are elected by the community.

10. Training is an important activity. Under the MEM's plan, all health functionaries must be trained in communication. IEC officials will also be trained. Portable simple educational materials would have to be provided to all field workers. Distance, group and traditional training would have to be undertaken. Audiovisual vans will be an asset in carrying this program from door to door and also to make it a success. Song and drama programs, like puppet shows, street plays, magic shows, song and dances are also required.

C: THE IEC PLAN

11. Countering the low demand for temporary methods of contraception, poor utilization of existing public sector health services, and client ignorance and apathy regarding healthful behaviors which can save lives, would be the focal points of the IEC efforts in the four municipalities. To achieve these goals, IEC programs will aim at changing negative health related client and community attitudes and behaviors and promote greater demand for new and existing health and social services. The plan will be to: (a) supplement efforts aimed at improving the quality of FW and MCH services provided at various public and private health centers/posts by; (i) increasing service provider (e.g. private medical practitioners, link workers, ANMs), skills in interpersonal communication and client motivation techniques through enhanced training and use of specialized IEC materials, (ii) promoting and enhancing new and existing health services also enhanced health care activities, e.g. outreach services and worker routines for slum dwellers; and (b) generate increased demand and use of municipality health services and special programs by; (i) changing health related attitudes and behaviors among providers that are barriers to client health compliance; and (ii) producing media materials for client health and family welfare information and educational needs. IEC activities will utilize interpersonal communication approaches reinforced by use of various mass media for:

A: Advocacy and Awareness Creation of:
- the project and its special programs;
- the availability of new and existing health services in the project area;
- the presence of new health functionaries, e.g. link workers, their work routines and schedules;

B: Demand creation for utilization of:
- specialized health services;
- new and/or upgraded services e.g.primary education, literacy programs, provided under the project.

C: Behavior and attitude change for:
- the adoption of modern temporary contraceptive methods;
- improved MCH health compliance;
- greater community involvement and support to health care and special social service programs promoted under the project;
- prompt action by clients in seeking curative health care;
- improved client use of existing health facilities;
- increasing the age of marriage.

12. General target audiences for IEC efforts in the four municipalities will be:

At the health facility level:

- Medical officers
- Private medical practitioners

- ANMs
- link workers; Basti Sevikas;HHWs
- dais
- IEC Unit staff

At the community level:

- local leaders
- NGO, PVO community
- cooperative members etc.

At the client level:

Identified slum populations with emphasis on:

- adolescent girls (13-16)
- women of fertile age
- mothers-in-law/sais
- males in general

13. Key project inputs include:

(a) Staff and consultants

(b) Research and evaluation activities; e.g.Communication Needs Assessments and process evaluation activities;

- to explore client and community perceptions, attitudes and practices about specific health related issues
- for creative media program and materials development
- to evaluate the efficacy and impact of IEC interventions

(c) Training

- IEC curriculum development for various lacunae e.g link workers
- training of IEC staff and manpower development
- training for local leaders through OTCs and camps
- communications training for health service delivery workers

(d) Material development

- for use in lacunae training
- for service provider client counseling and motivation activities
- for client use
- for program advocacy efforts

(e) Special campaigns and program activities

(f) Hardware and supplies e.g. vehicles, audiovisual equipment etc.

(g) Technical assistance

- for materials development
- for conducting research and evaluation activities
- assisting with training and other specialized program needs.

D. ORGANIZATION

14. In Calcutta and Hyderabad the proposed apex planning and implementation organization for IEC under the project is the State Mass Education and Media Unit within the State's Central Health and Family Welfare Department. In Hyderabad the existing Mass Media Unit in the Family Welfare Bureau will be strengthened and its activities integrated with the Training Cell in the Project management unit. Calcutta has a well developed IEC Unit which was strengthened under IPP POP IV. Under this project, IEC operations will be decentralized to the East and West Banks of the city by establishing small scale IEC Units in these areas. The State MEM Units and the various collaborating public sector, private voluntary organizations and community service provision agencies involved in the municipalities' projects will work together under the auspices of an IEC program planning and implementation committee. Terms of reference and scope of work of each municipality IEC program planning and implementing committee will be defined individually by each municipality.

15. Neither Delhi or Bangalore municipalities have an IEC system for primary health care and family welfare programs. These municipalities will establish IEC Units to facilitate program implementation (Para 3.16 of SAR). In this regard, the projects proposed IEC program planning and implementation committees will provide a preliminary institutional base until such time as explicit IEC Units are established in the two municipalities.

16. In Delhi the Publicity Wing within the Directorate of Family Welfare organizes and coordinates some IEC activities for the Corporation. However, such activities are related primarily to publicity of family planning program activities. The Delhi Administration proposes the establishment of an IEC Cell in the Directorate of Health Services. The Delhi Cell will have forty-three (43) new staff positions which will include helpers who will work out of Health Posts in JJ clusters. The functions of this Cell will include assessments of health education and other communication needs at Health Posts, message and materials development, campaign implementation and evaluation activities.

17. Bangalore will establish and equip a new IEC Unit under the control of the Corporation's Additional/Deputy Health Officer and the addition of seven (7) new posts. Currently the State provides the municipality with two Health Extension Officers. Four fully equipped mobile audio visual vans will be provided to support IEC outreach efforts in Bangalore.

18. All IEC Units will be responsible for collaborating with the various project Training Wings to develop integrated communications training plans for in-house staff and peripheral workers who will be trained under the

project. Training of workers will be undertaken collaboratively by State MEM staff. Additional training of service providers and other health cadres will be undertaken at regional Training centers. (See Paras. 3.09-3.10, Training).

19. Ongoing IEC research, monitoring and evaluation activities will be developed jointly by IEC and Management Information Systems staff. A strateg will be to develop, as part of the project's MIES system, in-house activities and simple program assessment instruments that could be used by IEC staff and select health functionaires to monitor the performance and impact of IEC activities on key segments of the target audience. Wherever needed, local consultant firms from the private sector will be recruited to assist in the design and implementation of necessary impact studies and evaluation activities.

IEC PLANS BY MUNICIPALITY PROPOSALS

PROGRAM AREAS	BANGALORE	CALCUTTA	DELHI	HYDERABAD
Research	♦ Assessment of communications/IEC needs as part of baseline training assessments ♦ Conduct ongoing impact studies	♦ Assessment of communications/IEC needs as part of baseline/ communication and training assessments	♦ Conduct communications needs assessment ♦ Medical officers prepare community profiles for health posts	♦ Conduct communications/IEC needs assessment
Training	♦ Train key categories, e.g. link workers, health workers, extension educators, LHVs, LMDs, PHNs, and top level officers in motivation and communication techniques.	♦ Train HHWs, HFOs and first tier supervisors in IEC skills and techniques.	♦ Re-train and reorient training staff in IEC skills. ♦ Training for all categories of program staff, e.g. medical officers, in the planning and implementing of IEC activities, also in assessing impact of activities ♦ IEC training for NGOs, PMPs, and community groups.	♦ Provide training for ANMs in principles of Health Education ♦ Conduct periodic IEC seminars for critical program and service delivery staff.
Strengthening IEC, Institutions	♦ Development of Annual IEC Action Plans. ♦ Establish an IEC Unit in PMT under project coordinator.	♦ Development of annual IEC action plans. ♦ Decentralize the IEC program to East and West Banks through establishment of small scale IEC units.	♦ Development of annual IEC action plans. ♦ Establish an IEC cell within coordination cell of the IPP VIII Project. ♦ Recruit 43 new staff for IEC cell.	♦ Development of Annual IEC action plans. ♦ Establish IEC and Training cell in CFWP project management unit.

PROGRAM AREAS	BANGALORE	CALCUTTA	DELHI	HYDERABAD
Strengthening IEC Institutions (cont.)	♦ Recruit 7 new personnel for unit. ♦ Purchase 4 audiovisual vans (fully equipped).	♦ Coordinate IEC activities of government departments, local bodies, NGOs and PVOs.	♦ Undertake ongoing impact assessments of IEC activities. ♦ Purchase vehicles, audiovisual equipment and software for IEC cell. ♦ Decentralize communication planning and include all levels of MOs, slum community groups and PVOs. ♦ Monitoring cell to develop IEC monitoring system for IEC cell.	
Promoting Services /Demand Generation	♦ ANMs to provide health, FP and nutrition education at health centers ♦ ANMs and health workers educate and motivate community groups and clients on nutrition, HE and FP. ♦ S.H.E. Clubs to promote awareness of MCH and FW programs and services	♦ Outreach on environmental sanitation, personal hygiene; nutrition; MCH. ♦ Client information and motivation on FP methods and MTP. ♦ Nutrition education for pregnant and lactating mothers. ♦ Health education for baby care. ♦ HHWs to educate mothers on use of ORT.	♦ Basti Sevikas to conduct 3 hour per day health education talks, mobilize and motivate clients for MCH, FW, immunization methods, FP. Also importance of breastfeeding, ORT weaning and use of supplementary foods.	♦ ANMs, WHVs and Dais provided with medical and educational kits and materials for their outreach work. ♦ Increased client education on nutrition, FP and PHC also environmental sanitation offices. ♦ Group meetings/OTC's.

PROGRAM AREAS	BANGALORE	CALCUTTA	DELHI	HYDERABAD
Promoting Services /Demand Generation (cont.)		♦ Educate community about new and existing services.	♦ Promote participation of males in the adoption of contraceptives, generally promote advantages of small family norms and preventive/ promotive health; generate demand for services. ♦ Trained dais to provide health education, also educate mothers on care of newborns and promote breast feeding. ♦ Medical officers to organize communication and media activities; govern group meetings and other health campaigns.	♦ One-on-one counselling/ motivation. ♦ Organization of well baby clinics.
PVO Involvement	♦ PVO involvement in: - Organizing and implementing health education programs - Promotion of MCH and FW programs ♦ Non-formal education programs for out-of-school girls ♦ Through Joint Women's Programme educate slum parents on the dangers of early marriage.	♦ PVO implementation of IEC component.	♦ Involve PVOs in awareness campaigns against prostitution and to counter spread of HIV/AIDS. ♦ Involve PVOs in planning of IEC activities.	♦ Private medical practitioners to undertake increased IEC IHE activities with clientele. ♦ Organization of IEC Seminars and workshops for PVOs.

PROGRAM AREAS	BANGALORE	CALCUTTA	DELHI	HYDERABAD
Community participation	♦ Awareness creation by S.H.E. Clubs. ♦ Community involvement in MCH, FW programs, environmental hygiene	♦ Promote among formal and informal opinion leaders positive attitudes towards MCH, immunization, and nutrition	♦ Promotion of community participation in IEC and Training programs. ♦ ANMs, VHWs and Dais to motivate local leaders for involvement in the health care of the community. ♦ Propagation and strengthening of women's organizations.	♦ Formation of HFW committees. ♦ OTCs to involve community in planning and execution of IEC activities. ♦ Involvement of Local Dais and community medical practitioners in IEC activities. ♦ Involvement of Mahela Mandals, influential women, religious, youth and professional organizations in conducting IEC activities.
Child Marriage Restraint Act	♦ IEC unit staff to educate urban poor on ill effects of early marriage	♦ Conduct media and community-based campaign to increase the awareness of the ill-effects of early marriage		♦ Develop comprehensive educational and motivation programs to inform and persuade slum-dwellers and community leaders about hazards of early marriage and benefits of delaying marriage
Innovative Schemes	♦ Environmental health, sanitation and hygiene awareness program.	♦ Nutrition Awareness program.	♦ Awareness campaign to promote early detection of cervical and breast cancer. ♦ Formulation of IEC/Health Ed squads comprising upper primary school students.	

PROGRAM AREAS	BANGALORE	CALCUTTA	DELHI	HYDERABAD
Female Education-	♦ S.H.E. Clubs to organize non-formal education for girls not in school.	♦ IEC activities to promote community awareness about the need and importance of female education.	♦ Utilize mass media, wall posters to create awareness and motivate parents re: need for early child care for females, primary school enrollment for girls, etc. ♦ Utilize traditional art forms and folk theatre for field based IEC activities.	♦ Education of adolescent girls/ counselling practices scheme.
Campaign /Material Production	♦ Development of local language videos and films, educational games, film slides, flip charts, printed materials, etc.	♦ Utilize mass media, community education and involvement techniques for FW acceptance. ♦ Utilize communication efforts of other departments, e.g. social welfare, education, etc. to convey health and FW messages. ♦ Develop a comprehensive mix of IEC materials.	♦ Conduct specific HE campaigns/ camps. ♦ Implement state level health competitions. ♦ Utilize traditional art forms, folklore, free publicity and interpersonal communication at cluster level. ♦ Develop mix of media materials and audiovisual aids in a decentralized manner.	♦ Development of display kit and educational materials aimed at educating slum dwellers about hazards of early marriage and benefits of delaying marriage. ♦ Develop special kits for use by Dais and WHVs. ♦ Develop kits for use by ANMs. ♦ Develop kits to contain educational and essential health materials for OTCs. ♦ Screening of films and video shows. ♦ Exhibitions.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

SCHEDULE OF APPOINTMENT OF ADDITIONAL STAFF

DESIGNATION TITLE OF STAFF	TOTAL TO BE APPOINTED	1992	1993	1994	1995	1996
BANGALORE						
Health Centers/Health Posts	60	25	20	8	7	-
Lady Medical Officers	12	4	4	2	2	-
Paediatricians	47	12	20	8	7	-
LHVs/PHNs	58	-	30	16	8	4
Staff Nurse	11	-	-	-	11	-
ANMs	970	370	300	150	110	40
Link Workers (Volunteers)	24	9	8	4	2	1
Lab Technicians	24	9	8	4	2	1
OT Attendant	24	9	8	4	2	1
Anaestheologist (part-time)	1	1	-	-	-	-
Project Coordinator	5	5	-	-	-	-
Program Officers	1	1	-	-	-	-
Training Director	4	4	-	-	-	-
Training Officer	1	1	-	-	-	-
IEC Director	4	-	2	2	-	-
Training Officers	4	-	2	2	-	-
Extension Educator	1	-	1	-	-	-
Photographer	4	-	1	3	-	-
Driver/projectionist	2	-	1	1	-	-
Demographer/Statistician	1	-	1	-	-	-
Secretary cum Steno	2	-	2	-	-	-
Administrative Assistants	1	1	-	-	-	-
Driver	44	20	14	6	4	-
Clerk	65	30	20	8	7	-
Sweeper/Watchman						
NEW DELHI						
Health Centers/Health Posts	77	10	27	27	13	-
Medical Officers	24	12	6	3	3	-
Staff Nurses	200	25	75	75	25	-
ANMs	6	2	2	2	-	-
Lab Technicians	51	11	20	20	-	-
Pharmacists	625	125	200	200	100	-
Basti Sewikas (Volunteers)	6	0	4	2	-	-
Statistical Assistant	6	0	4	2	-	-
Lab. Technician						

DESIGNATION TITLE OF STAFF	TOTAL TO BE APPOINTED	1992	1993	1994	1995	1996
N E W D E L H I (continued)						
Health Centers/Health Posts						
Lab. Assistant	6	0	4	2	-	-
Safai Karamchari	37	8	12	8	9	-
Chowdikar	25	5	8	5	7	-
Ward Ayah	12	2	5	5	2	-
Clerk	6	1	2	2	1	
Driver		1	2	2	1	
Coordination Cell						
Project Director	1	1	-	-	-	-
Office Superintendent/ Head Clerk	1	1	-	-	-	-
Stenographer	1	1	-	-	-	-
U.D.C.	1	1	-	-	-	-
Driver	2	2	-	-	-	-
L.D.C.	2	2	-	-	-	-
IEC Cell						
Communications Officer	1	-	1	-	-	-
Media Accountant	1	-	1	-	-	-
Health Education Officer	3	-	1	-	-	-
Extension Educator	1	-	1	-	-	-
Projectionist	2	-	2	-	-	-
Electrician		-	1	-	-	-
Driver	2	2	-	-	-	-
LDC cum Storekeeper	1	1	-	-	-	-
Training Cell						
Training Program Officer	1	-	1	-	-	-
Health Education Officer	3	1	2	-	-	-
Medical Officer	1	-	1	-	-	-
Extension Educators	1	-	1	-	-	-
U.D.C.	1	1	-	-	-	-
Driver	1	1	-	-	-	-
Monitoring & Evaluation Cell						
Medical Officer	1	-	-	-	-	-
Research Officer	1	-	1	-	-	-
Systems Analyst	2	-	2	-	-	-
Programmers	2	-	2	-	-	-
Operators	4	-	4	-	-	-
Statistical Officer	1	-	1	-	-	-
Statistical Assistant	1	-	1	-	-	-
Stenographer	1	1	-	-	-	-
Accounts Cell						
Account Officer	1	1	-	-	-	-
Accountant	3	-	1	2	-	-
U.D.C.	2	1	1	-	-	-
L.D.C.	1	1	-	-	-	-

DESIGNATION TITLE OF STAFF	TOTAL TO BE APPOINTED	1992	1993	1994	1995	1996
H Y D E R A B A D						
Health Centers/Health Posts						
City F.W.Officer-Jt.Dir.	1	1	-	-	-	-
Program Officers	3	-	3	-	-	-
Lady Medical Officer	26	10	10	6	-	-
Senior Medical Officers	5	2	2	1	-	-
Gynaecologists	2	-	2	-	-	-
Paediatricians	3	2	1	-	-	-
Anaesthetists	2	2	-	-	-	-
LHVs/PHNs	60	20	20	20	-	-
Staff Nurses	20	10	10	-	-	-
ANMs -	172	35	50	75	12	-
Lab Technicians	5	3	2	-	-	-
Operation Theatre Attendants	5	2	3	-	-	-
Link Workers (Volunteers)	690	150	200	200	140	-
Accounts Officer	1	1	-	-	-	-
Senior Accountant	2	1	1	-	-	-
Cashier (U.D.C)	1	1	-	-	-	-
Typists	2	2	-	-	-	-
Computer Program Assistant	1	1	-	-	-	-
Program Officer (Training and Nursing Superviser)	2	1	1	-	-	-
Projectionist cum Operator	1	1	-	-	-	-
C A L C U T T A						
Project Director	1	1	-	-	-	-
Chief	2	1	1	-	-	-
Deputy Chief	4	1	2	1	-	-
Assistant Chief/Sr.Trg.Off.	9	2	5	2	-	-
Nutritionist/Project Officer	8	2	4	2	-	-
Training Officer	4	1	2	1	-	-
Accounts Officers/Accountant	2	-	1	1	-	-
Stenographer	5	2	2	1	-	-
Senior Accounts Assistant	2	1	1	-	-	-
Accounts Assistant	1	1	-	-	-	-
Program Assistant	1	1	-	-	-	-
Cashier	1	1	-	-	-	-
Typist cum Clerk	13	3	8	2	-	-
Clerk cum Storekeeper	6	2	3	1	-	-
Attendant	19	6	8	5	-	-
Packer	6	2	3	1	-	-

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

INNOVATIVE SCHEMES

A. BANGALORE

1. The main objective of innovative schemes in the project is not only to supplement but also to strengthen sustainability of the project. Promotion of the status of women is given importance under these schemes. To make the schemes more effective, it is proposed to generate a "Revolving (Development) Fund" at slum levels with full participation of beneficiaries and benefactors. Four schemes are proposed initially and are outlined below:

2. Social Health and Environmental Clubs - SHE Clubs in Slums. Under the project, to promote effective community participation, "Social Health and Environmental" clubs - "SHE" clubs would be formed in each of the slums. Slum dwellers would be enrolled as members through the collection of a monthly subscription of Rs. 5 per family. A Management Committee consisting of 5 members, of whom at least 3 will be women, with two member retiring every two years. The Committee can coopt members of PVOs. The club will also be treated as PVO and is eligible to receive financial support. SHE Clubs will: (a) create awareness of environment hygiene and develop coomunity-based sanitation programs; (b) prepare a plan of activities for the health centre based on the needs of the community; (c) coordinate with the health centre to ensure availability of services; particularly free medical aid to the needy; (d) discourage child marriage and early motherhood; (e) organise non-formal education for out-of-school girls; and (f) maintain the funds of the clubs for the benefit of the community. A Lady Medical Officer will be an ex-officio member of the Committee.

3. Establishment of Creches in Slums. These will be promoted by health centres and established by PVOs and SHE clubs. BMC is presently running 10 creches and experience indicates that creches could be run effectively or economically by PVOs or by slum dwellers themselves. It is proposed to cover 250 children per year in about 5-7 creches. The creches would be located either at the health center, schools or in buildings owned by BMC in the slum areas.

4. Vocational Training. Tailoring and knitting seem to be more popular schemes among the women of slums. Adolescent girls and women are receptive to such skill upgradation programs. SHE clubs and PVOs will be encouraged and financed to organise programs for targeted groups. The estimated cost per candidate for 12-15 weeks training programme is Rs. 1000/- and on an average 1000-1500 candidates will be trained every year.

5. Revolving Fund/Development Fund. The sources identified for generation of Revolving Fund/Development Fund at slum level would be: (a) monthly subscription to SHE club at five rupees per family per month; (b) contribution of parents leaving children at the creche at ten rupees per month; (c) matching grants to the slum from Bangalore Municipal Corporation, State and Central Governments.

B. CALCUTTA

6. As a part of innovative schemes, certain non-medical services would be taken up under the project to supplement the main efforts under MCH. The following are the supplementary programmes designated as innovative schemes.

7. Nutrition Awareness Program. The main purpose of this scheme would be to generate awareness amongst beneficiaries about the need for taking a locally available low-cost nutrious diet, rather than merely feeding nutritious food. The scheme will help demonstrate among the target beneficiaries that with cheaper local good grains, a nutrious and affordable diet can be made. It is proposed that food packets of 500 gms, each containing 400 gms of a roasted whole wheat flour and 100 gms of green gram, will be prepared and distributed amongst the eligible mother and children. While the children would receive one food packet every week, eligible women would be provided with two food packets each week. This would provide 250 calories to a child and 500 calories to a pregnant and lactating mother per day. A similar program under CUDP-III has been quite successful in generating nutrition awareness among the women beneficiaries and has been able to demonstrate that it is feasible to prepare food packets of sufficient nutritional value at a relatively low and affordable costs. What is important to do under this scheme, is to establish a mechanism by which mothers can evaluate and see for themselves the improvement in health standards of their own and of other children. To do this, it will be necessary to maintain and monitor records of weight, height, measurement of arms, preparation of charts etc. It is also necessary to ensure that the beneficiaries themselves can prepare such nutrious foods with locally available cheaper ingredients. PVOs/Local Clubs would be involved in implementing this Nutrition Awareness Program. The HHWs who will have direct contact with the beneficiaries will, however, be responsible to inform the latter about implementation of the NAP through concerned PVOs/Local Clubs. The Nutrition Awareness Program shall be run at sub-centre level in the present program. It is proposed that during the project period the nutrition program shall be run only at 300 sub-centres.

8. Creche Program. It has been observed that in low income settlements, children of working mothers are left uncared for during the period their mothers are engaged in work. This has resulted in various health and social problems for the children. It is proposed to set up creches at the block level, with direct involvement of the PVOs. This will provide an opportunity for the PVOs to monitor the various health measures envisioned for the children. The main purpose of creche, however, would be to keep the children in a congenial environment during the time their mothers will be in work. Under the CUDP-III Health Program, 6 creches have been established and are already functioning. The experience has been good in that such facilities have been appreciated by the community. The Creche Program will be run at 200 sub-centres.

9. Anti-Larval Program (ALP). The Anti-Larval Program component has been envisaged for upgrading and expanding the Mosquitoes Control Program. This is particularly significant in view of the rising incidence of malaria, filaria and encephalities in the urban areas of CMA. The prevailing measures have been found to be ineffective in controlling mosquitoes, especially in the municipal areas. The Government of West Bengal has taken up a program called

Malaria Eradication Program (MEP), to achieve the objectives of elimination of deaths from malaria; reduction in the malaria morbidity; and maintenance of the gain achieved earlier by reducing transmission wherever possible. The following steps have been taken in the context of ALP: (a) areas where API is more than 2 - Regular insecticide a spray with 2 rounds of DDT & 3 rounds of BHC. Active and passive surveillance and presumptive and radical treatment of cases; (b) areas where API is less than 2 - only focal spraying where Falciparum cases are detected. Surveillance and treatment of cases; (c) urban areas - intensive Anti-Larval Measures and drug treatment. This is done by the Municipalities and Corporations. For containment of filaria, the following measures have been instituted as anti-mosquito measures: (a) Anti-Larval Measures - Recurrent Anti-Larval measures in endemic urban areas including an extra 3km peripheral belt: (b) Anti-Adult Measures - Pyrethrum space sprays as the vector have become resistant to DDT and BHC.

10. In order to expand the scope, coverage and efficacy of the above noted programs, the following items would be included in the Anti-Larval Program (ALP), as a part of the project: (a) training of the existing manpower of the local bodies where they can, organize intensive anti-larval measures; (b) supply of material like Abate (Temephos, Baytex (Fenthiion) Pyrosense Oil - E etc. so that the corporations and municipalities can use these in a proper manner and frequency to eliminate mosquitoes; and (c) in urban areas, along with Anti-Larval Measures, it is necessary to take action against adult mosquitos where vector density is high. Thus, Malathion and Fogging Machines may be supplied to the corporations so that they can participate in effective vector control.

11. All the measures mentioned above would be carried out by the Government directly through the local bodies with logistical support in the form of radicals in chemicals. The Municipal Authority will be responsible for executing the works envisaged under this scheme. The program will be run from the municipalities. For Calcutta Municipal Corporation and Howrah Municipal Corporation, there will be need for more than one unit. The total number of units for all the municipal areas and the corporations taken together would be 50.

12. Environmental Sanitation Improvement Program. To engage local communities in the maintenance of infrastructural assets and services within the low-income settlements, the HHWs and PVOs will be authorized to register complaints with the Municipal Authorities in cases of breâk down of services. For minor repairs which do not require much of skill and expertise, the local community shall put in voluntary labour to overcome the problem. The scheme aims to undertake the following services with the help of voluntary labor from the community: (a) effect minor repairs of tubewells; (b) replace missing taps to prevent wastage of piped water supply; (c) cleaning of open drains to prevent breeding of flies and mosquitoes through organized "Sramdan" (voluntary labour by the community); (d) disposal of garbage; and (e) introduce cheaper variety of smokeless chullies (ovens).

13. Organization of the activities under the scheme would be left to PVOs. The PVOs will have to maintain records and registers necessary for carrying out the activities. The scheme is expected to have important impact on the health condition of the people living in low income settlements. The records and registers maintained by the PVOs will provide an opportunity to evaluate

the performance of the scheme at the later stage. During the project period, the program would be implemented at 300 sub-centres out of a total of 763.

14. Program for Early Detection of Uterine and Breast Cancer. It is a felt need of the low-income group of women in the proposed project areas in CMD area, that for generating awareness against cancer & early detection of Uterine Cancer and Breast Cancer some activities be included in the project. An overall scientific guidance, a regular feed back, continuous updating of project personnel and involvement of the community in the general could provide a cost effective cancer control service. It is proposed that local voluntary organizations which have credibility and expertise on this subject would be inducted in the program and entrusted with the task. Financial assistance would be given as a grant to that organization to cover equipment and staff cost, for the effective implementation of this program.

15. The principal characteristics of the program will consist of:

(a) preliminary training of MOs, HHWs and supervisory staff of HAUs, ESOPDs and maternity homes;

(b) Cystotechnician Training: a suitable group of laboratory and sub-centre related individuals would be given training in collection of clinical smears. A major element in the mass screening program is collection of samples for investigation. Whereas the specimen collection protocol is a simple one to be learnt by any woman it has to be carried out with care and integrity. Therefore, training exposure would have element of examination of the proficiency in collection samples. This program will be continuous and would generate a sufficient number of trained technicians in the community;

(c) Mobile Units with Cystologist: The mobile unit with cystologist, cystotechnicians and mass instruction personnel will visit various sub-centres under the program to generate direct interaction between the community and the reference laboratory. This approach is expected to (i) maintain the quality of service offered at community level, (ii) expose the workers in practice to the specialists, and (iii) increase confidence of the community;

(d) a central static and two mobile units with mammographic equipment will be established for mammographic screening of project beneficiaries;

(e) the facility will consist of (i) a Central Reference Laboratory under the direct supervision of cystologist, and (ii) Regional Laboratories on either side of the Hooghly River. Following a preliminary screening, all doubtful specimens would be placed before the cystologist in any of the three laboratories. Preliminary screening will be carried out by the cystotechnician under the guidance of the pathologist with primary observations and clinical record;

(f) cases would be referred from the health centres and brought directly by the health workers in cases of suspected malignancy. A detail record will be prepared with particular emphasis on the probable causative factors. Such records will be in a computer coded form so that proper statistical analysis and data retrieval would be possible;

(g) an in-depth investigation would be carried out on patients detected with early signs of malignancy. The process of follow-up will be maintained;

(h) awareness campaigns and continuous data processing techniques are expected to provide guidance for further action. Awareness of prevention of cancer and early detection will be created by personal contacts, meetings, seminars, workshops with HHWs, MOs and specialist doctors. Peoples' representatives and opinion leaders will also be involved in these awareness campaigns;

(i) cancer tests of all referred cases by MOs of HAUs, ESOPDs and maternity homes under the project will be carried out and strengthened by feed-back reports;

(j) prospective follow-up studies to evaluate the project will be undertaken;

(k) epidemiological data about environmental/genetic/other factors as causes of uterine and breast cancer can also be utilized for the purpose of both basic and applied research in the future for national interest; and

(l) as a back-up service for detected cases, arrangements, would be made for the reservation of a few beds at the Cancer Home.

16. Women Employment/Entrepreneurship Development. To promote increased and effective participation of women in the family welfare programme, a supplementary programme for development of women employment or entrepreneurship will be undertaken. Provision of employment leading to a reasonable earning can effectively bring down the fertility rate amongst women leading to birth control. CUDP-III is running a programme of small-scale enterprises, and the Calcutta Slum Improvement Project under the ODA Program, also provides for employment and income generation activities. Under the project, it is proposed to expand this program. This is specifically desgined to attract women functionaries from low-income communities.

D. DELHI

17. A Revolving Fund of Rs. 2.1 crores will be established in the project for funding of innovative schemes, PVOs and PMPs and the promotion of community participation. Innovative Schemes are proposed to be implemented through (a) different Departments of Delhi Administration and Municipal Corporation Delhi such as UBSP, Social Welfare, Community Services Dept of MCD; and (b) NGOs/PVOs and community organisation at slum Bastee levels.

18. The project Director will interact with Social Welfare and other Departments as well as NGOs/PVOs and community organisations to guide and motivate them to prepare the different innovative schemes. Specific model schemes and grants will also be prepared in consultation with relevant agencies. After obtaining the proposals from a Departments and NGOs, the Project Director will submit them to PACC for approval. The specific conditions and guidelines for grants under this schemes will be prepared after

obtaining the views of the concerned Departments, NGOs and slum communities.

The Revolving Fund will be operated by the Project Director. The process of submission, review and approval of innovative schemes shall be as follows:

(a) either specific schemes will be prepared by Coordination Cell in consultation with various specialised institutions, and PVOs and other agencies will be involved in their implementation; or

(b) PVO & other Delhi Administration or MCD agencies may develop their own schemes and funding support shall be provided through the Revolving Fund of the project.

19. The following agencies will be associated with the program:

(a) Shramik Vidyapeeth (Workers' Education Centre) Ministry of Human Resource Development: This organisation is engaged at present in training of the slum population in Delhi in various skills such as tailoring, carpentry, plumbing, electrician, making of candles and aggarbatties etc. are taught.

(b) Khadi & Village Industries Commission (KVIC): This is an autonomous organisation created by a special act of Parliament. Its mission is to create employment opportunities for the non-farm sector which are, at least, comparable to the prevailing levels of wages in farm sector. It aims to produce saleable articles, and to provide services for which there is effective demand. The obejectives are to:

(i) ensure employment at the doorsteps;
(ii) encourage production by masses;
(iii) harness humane technology;
(iv) preserve employment;
(v) impart dignity of labour;
(vi) manage with low capital;
(vii) promote decentralised economic activities;
(ix) invite participation of women in economic activity.

20. Some of the schemes under the purview of KVIC which are directly relevant for women in the urban informal sector are as follows:

(a) Group I: **Mineral based industry** - including slate and pencil making manufacture of paints, pigments, varnishes and distemper;

(b) Group II: **Forest based industry** - such as hand made paper, manufacture of kattha, bookbinding, paper cups, paper plates, bamboo & cane work;

(c) Group III: **Agro based industry** - fruits and vegetable processing, preservation and canning including pickles;

(d) Group IV: **Polymer and chemical based industry** - manufacture of shampoos, detergents and washing powders;

(e) Group V: Engineering and non-conventional energy, carpentry, paper pins, safety pins, stove pins;

(f) Group VI: Textile industry, hosiery, surgical bandages, readymade garments; and

(g) Group VII: Service industry, laundry, masonry.

21. The KVIC provides training and marketing support for all these activities as well as financial assistance. Large number of women in JJ clusters come from rural areas and have many traditional skills which can be easily utilised if financial and marketing support is organised by utilizing the network of KVIC.

22. Habitat Polytech (Under Ministry of Urban Development). This institution is concerned with improving the skills of construction workers. Training may be imparted to large number of women in JJ clusters working in Construction Industry to upgrade their skill and thereby increase their income opportunities and promote their status.

23. Environmental Sanitation and Personal Hygiene. An epidemic of gastroenteritis took place in slums of Delhi in the summer of 1988. Since then, large investments have been made by MCD in the provision of safe drinking water through piped water supply and India Mark-II hand pumps to population of slum bastees including JJ clusters. Though further epidemics have been successfully averted in subsequent years, diarrhoea and scabies continue to be an epidemic especially in the population of JJ clusters. Though no investment is proposed in infrastructure of safe drinking water, latrines and garbage collection through this project, a special component for community mobilisation, promotion of environmental sanitation and personal hygiene is being provided. It will consist of: (a) provision of water testing kits for testing the safety of potable water at community level; (b) promotion of the community and schools personal hygiene, especially the use of soap for hand washing; (c) community mobilisation and collective incentives through grassroot organisation/PVOs for maintenance of clean toilets and internal garbage collection.

24. Early Child Care. Large numbers of women are forced to seek employment outside the bastees and their children tend to get neglected in the process. Provision of Creche facilities is important for the welfare of women and children. Individual women will be motivated and trained to organise creche facilities for working women in slums on a payment basis. Suitable one-time support shall be provided to them from the Revolving Fund for necessary furniture/equipment. Alternatively, NGOs will also be motivated to take up this activity in JJ clusters.

25. Prevention of Alcoholism and Drug Abuse. The slum population, especially males, have a high prevalence of alcoholism and drug abuse which is a major cause of economic and social disability. The voluntary organisations will be involved in prevention and eradication through community mobilization and other specific interventions.

26. Prevention of Prostitution and AIDS. The women in Jhuggie Bastees become involved in prostitution because of economic and social pressures. Though no specific data exist about its actual prevalence, this also makes them vulnerable to the spread of AIDs. PVOs will be involved in national and state programs to help the women in distress, and community mobilization activities to increase awareness against prostitution and the danger of the spread of AIDs.

27. Formation of Mahila Mandals. Support will be provided to PVOs involved in the stimulation of group activities for women and the formation of women's organisations or Mahila Mandals.

28. Early Detection of Cancer. Support will be provided to NGOs for developing and implementing awareness campaigns among women for the early detection of cervical and breast cancer.

29. Community Based Rehabilitation. There are a large number of disabled persons in Jhuggie Bastees. Support will be provided to NGOs which take-up community-based rehabilitation programs for the disabled in JJ clusters.

D. HYDERABAD

30. Registration of Birth and Deaths. At present, no accurate statistics regarding births and deaths among the slums and pavement dwellers. Local Dais would be paid a modest honorarium for reporting these events to the Registrar of the local area.

31. Marriage Registration. At present, no statistical data is available particularly in the slum community, with regard to the marriages and the ages of the married couples. With a view to enforcing the Child Marriage Restraint Act, local PVOs and the leaders would make informal registration of marriages in their organisations indicating the names of bride and bridegrooms, their parents and the ages of the couple as per birth registration document. It would be possible to collect this data by offering incentives to those individuals or institutions who undertake the registration.

32. No Pregnancy Incentive. Observance of contraceptive practices by women in slum areas is usually far below the accepted average. A program of motivation is needed to convince these women of the benefits of family planning to them especially through the adoption of spacing methods either IUDs or oral pills. Local Mahila Mandals and women health volunteers would be encouraged to maintain proper documentation in a confidential manner to ensure postponement of pregnancies and also birth reduction. Incentives would be offered to those institutions which will undertake counselling.

33. Construction of Soakage Pits. The most common scene in the slum areas is the flow of used sullage water which has stagnated leading to mosquito breeding. The community would be motivated to construct soakage pits depending on the nature of the soil and its percolation capacity.

34. Depots of distribution of Chloroquine Tablets for Fever Cases and Collection of Blood Smears. There has been in increase in the instance of fever cases among slum dwellers. One member of one of the many local youth

organizations or a Balwadi Teacher in the community would be identified to collect smears and administer chloroquine or any other drug given by local malaria unit. The identified worker could be trained in the collection of blood smears by the local unit officer-in-charge of the malaria program.

35. Education of Adolescent Girls and Counselling Practices. Girls in the age group of 16-18 years identified by local mahila mandals and/or health functionaries, will be educated with regard to health habits, home economics, preparation of weaning foods and diets, child health care, personal hygiene and coaching habits. This type of work can be carried out with the help of the Women Welfare Department, NSS volunteers, and the staff of the Home Science College.

36. Literacy Component Among Women. Most of the women in slum areas are illiterate. The local children, especially the adolescent girls who are studying in high schools, can be identified and motivated to work as adult education teachers and organise literacy campaigns. The use of resources of the Adult Education Department, NSS units and the University's Adult Education Wing would be explored.

37. Innovative Schemes for Income Generation. In order to alleviate the suffering of women, a few income-generation activities in association with the local industrial units, State Government undertakings, and self-employment units in the community would be undertaken. The activities/training programs would include:

(a) tailoring and dress making;
(b) silk screen printing;
(c) toy manufacturing;
(d) soap manufacturing;
(e) organisation and women's cooperatives;
(f) establishment of canteens;
(g) preparation of domestic necessities and kitchen/food materials like jams, pickles, nut powder;
(h) preparation of agarbatties, envelops (paper cover), carpets with coil fibre or cotton including carpet weaving with wool, sweater making;
(i) Apiary (bee hives).

38. The duration of the training will vary from 1 to 6 months. The Women Welfare Department, Urban Community Development, Andhra Mahila Sabha and other associations connected with women care, will be involved and will work out the details of the scheme. Periodical evaluation/review of the program will be undertaken by the community. A large number of organisations are actively associated at present in the implementation of such income-generating programmes and they are working with the Department of Women Development and Child Welfare. To plan and organise these activities, a special cell would be established under the control of Project Director, IPP-VIII and include the following: (a) Liaison Officer (Female Literacy Education) on deputation from Department of School Education/Adult Education; and (b) Liaison Officer (Women Welfare) on deputation from the Women Development and Child Welfare.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

WOMEN IN DEVELOPMENT (WID) ASPECTS OF THE PROJECT

A. BACKGROUND

1. Women's roles in Indian society are shaped by sex-gender systems that place women in subordination to men. These systems influence the very ability of women's access to social services as well as the types and quality of social services offered to them. Therefore, Indian women's access to goods and services, to productive assets, and to markets (including the right to sell their own labor) is conditioned in a way that men are not. Variations, however, exist in women's access to resources by States, region, social class and caste. Socio-cultural factors dictate that women remain in the private sphere ("inside") because of their reproductive and nurturing roles, while men deal with the public ("outside") sphere -- governments, markets, and courts, etc. Women retain the traditional responsibilities for child rearing and the welfare of the family; they are responsible for processing foodcrops, preparing food, and have a heavy workload of domestic tasks, including the time-consuming burdens of fetching fuelwood and water. 1/ In general, women tend to control fewer productive resources than men, they are engaged in a wider range of activities in the working day, and they enjoy less mobility.

2. Nevertheless, despite the inside/outside dichotomy, women contribute significantly to India's economic and social development, but in ways that are not captured in the national accounting system. They tend, therefore, to be largely "invisible," often overlooked, undervalued, or taken for granted. When female contributions in dairy, poultry or production of family food crop are added to those in the conventionally defined labor force, their participation rate totals 51% -- only 13 percentage points below the rate for men. 2/ Evidence indicates that women who work for wages take the burden of double shifts of work, both in the household and outside, while men do not. The contribution of women to India's economic and social development is made in the face of severe cultural, institutional, physical, and economic constraints.

3. Although women contribute substantially to India's socio-economic development, the gender specific differences in human capital investments, such as health and schooling, still remain discriminatory. Lack of access to adequate health care and other resources, is reflected in continued high levels of female mortality and morbidity, exacerbated by repeated pregnancies and heavy work burdens, which also limit their opportunities in economically

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1/ For an elaborate discussion on how assigned gender roles in Indian society limit women's access to resources, such as health, education etc., see Gender and Poverty in India: A World Bank Country Study. Washington, D.C.: The World Bank, 1991.

2/ Ibid.

productive activities. Studies show that there is systematically higher malnutrition and morbidity among female children; boys receive favorable treatment relative to girls in the allocation of nutrients; and urban medical care facilities are used more for male children compared to female children in the event of illness or injury. It is argued that differential mortality rates between males and females is the major factor in female/male sex ratio in India. Demographic data shows that there is a steady decline in this ratio which has fallen from .970 at the beginning of the century, to .929 in 1991 (Table 1). This shortfall of females cannot be explained away as being caused by differences in sex-ratio at birth, migration rates, or that females are grossly undercounted. Similarly, the age-specific mortality rates shown in Table 2 reveal that female death rates are substantially higher than those for males. Data on sex specific infant mortality rates (Table 3) indicates that the probability of survival of a male child is much higher by several years when compared to a female child. Evidence also suggests that there is an overwhelming preference for male children and that the bias against female children is leading, in some States in India, to the growing incidence of sex determination tests followed by abortion of the female foetus.

4. Gender based differences are also observed in literacy, enrollment, educational attainment and achievement rates as well as the quality of education provided for females as opposed to males. In general, women are more likely to be illiterate as adults than men (illiteracy rate is 61% for women as against 36% for men), while the enrollment of females is about one half that of males at all levels (Table 4). The gender gap in the educational attainment is also evident at all levels (Table 5). Women are at a particular disadvantage with respect to their legal status. Laws are often inconsistent or in conflict with customary practices or simply not applied. Further, women often cannot take advantage of the legal system to protect their rights because of the lack of information and education.

5. In summary, the major constraints limiting the productivity and contribution of women to India's economic and social development are: (a) low levels of literacy and education; (b) limited access to and the poor quality of basic health services; (c) early marriage; (d) the lack of knowledge regarding legal rights as well as the ambiguity of their legal status; (e) the lack of political power; (f) the burden of household and farming chores; (g) the lack of access to employment and to productive assets, notably credit; and (h) violence against women in the family and the community. Traditional male attitudes toward the role and place of women in society also constitute an impediment to expanding and improving women's lives.

B. GOVERNMENT POLICY

6. The Government of India (GOI) has shown its concern about women's issues through a number of initiatives. In 1974, as a part of wider attack on poverty, it produced The Report of the Committee on the Status of Women in India (CSWI), which presented the generally disadvantaged socio-economic position of women. Since then several major Commissions and Reports have made policy recommendations on women's issues. In 1990, a National Commission for the Indian Women was established to monitor and speed up the process of equal representation for women; to enforce all legislation for women's rights including labor laws, and to check discrimination at all levels. Specific functions of the Commission as an advisory committee are the following:

suggest remedial legislative measures to meet gaps and shortcomings in existing laws; address violation of the provisions of the Constitution and other laws relating to women; examine specific problems arising out of discrimination and atrocities against women; identify the constraints and recommend strategies for removal of such. The Commission has been entrusted with the power to make periodical reports on any issue concerning women, to recommend strategies and corrective measures to formulate further policies and programs, and to improve women's accessibility to the law by funding litigation involving women's issues. The reports of the Commission would be placed before the State legislatures, so as to, make the executive accountable to the representatives of the people in cases of non-implementation of the recommendations of the Commission.

7. Recently, the Government has also decided to amend existing laws concerning women following a detailed scrutiny of the Dowry Prohibition Act and the Commission of Sati (Prevention) Act. The Immoral Traffic (Prevention) Act and the Indecent Representation (Prohibition) Act are also being examined to rectify the loopholes. The amendments to these Acts would remove the basic weaknesses and will make them more effective at the implementation level. Progress has also been made in the field of research and data collection where women's contribution to socio-economic development is taken into consideration.

8. The National Health Policy enunciated in 1982, identified goals for the reduction of mortality among different age groups, though not separately specified for males and females. The target is to bring down the infant mortality rate from about 125 per thousand to 60 per thousand; the crude death rate from 14 to 9 per thousand; and the maternal mortality rate from over 400 per 100,000 live births to under 200 by 2000. All pregnant women are to receive antenatal care, and all deliveries are to be conducted by trained birth attendants. All the pregnant women and school children are to be immunized against tetanus, and 85% of the relevant target groups are to receive DPT, Polio, BCG and DT immunizations. It is expected that as a result of these improvement in health, life expectancy for both males and females would increase to 64 years by the year 2000. The goal of a net reproductive rate (NRR) of 1 and a crude birth rate (CBR) of 21 per 1000 by the year 2000 has also been established. It is expected that the average number of children per family would decrease from about 4.4 in 1975 to 2.3 in 2000 in order to stabilize the population.

9. If the goals of the National Health Policy are to be achieved, there is a need to work on both the supply and demand sides to improve women's access to health care. Increasing women's access to health services is critical for the achievement of the mortality, morbidity and fertility reduction goals. The policy to increase women's access to health and family welfare services call for a woman-centered approach in its delivery system.

C. GENDER ANALYSIS AND THE ROLE OF WOMEN IN THE PROJECT

10. To deliver the services effectively and generate demand among the target/beneficiary groups, the States/municipalities must analyze gender issues in the project. Gender analysis is a systematic process of identifying gender patterns for the purpose of understanding their implications for the

design and implementation of the Eighth Population Project. 1/ The gender analysis framework relies on four components as illustrated in Figure 1 below. 2/ First is the analysis of the activities which identifies the activities that males and females do, and where and when they do them. Second is the analysis of access and control which asks questions on what resources people use to accomplish their tasks and what gender patterns exist for access to and control over such resources. The division of labor within the family and the community, how and where people spend their time, and the resource base they rely on, their assets and security, directly affect the effectiveness of the project delivery system. These factors also indirectly affect the family decisions that people make. The decision-making process, in turn, affects the design of a project delivery system.

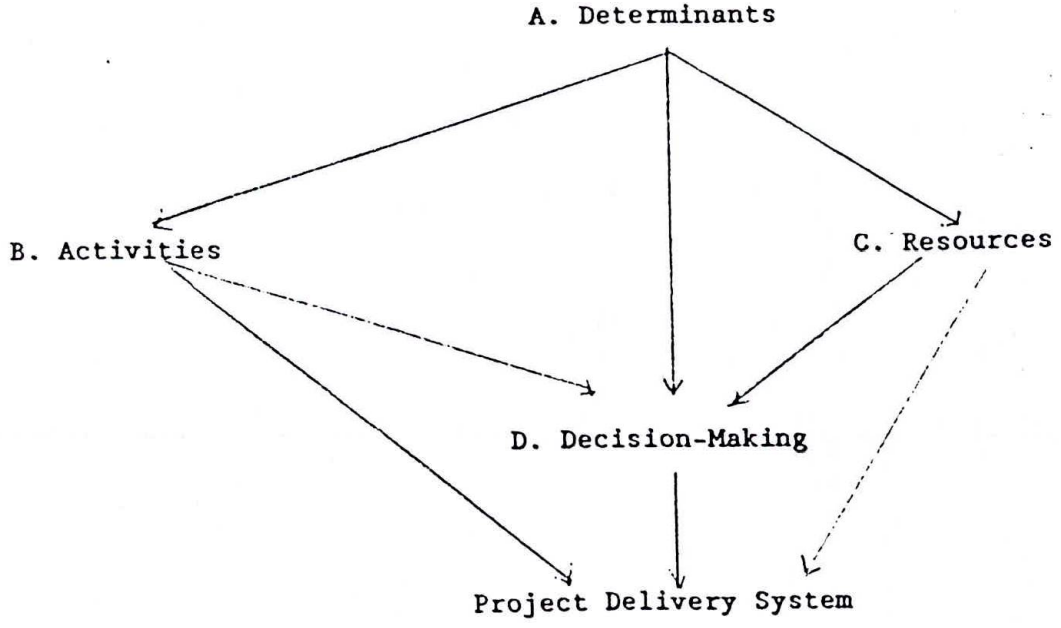
11. However, the context in which activities are carried out, is the most important factor which influences the success of the project. These determining factors fall into four categories: (a) cultural; (b) economic; (c) political; and (d) demographic. It is, therefore, important to know which determinants are strong in the slums and how they shape components. The effect of the determining factors on project design and vice versa is through effects on activities, on access and control pattern, or on decision-making.

12. In this project, the intended clients are slum women and children. The activities analysis (i.e. who does what? where, when and how long do they perform these activities? why do they do what they do?), assist us to know where and when women and children can be reached. From this analysis, the daily tasks of women can be understood and the problems they will have if they must travel long distances or wait in long lines can be anticipated. It is also critical to understand the times of day, or the days of the week, when women can and cannot avail themselves of health and family welfare services. It is not sufficient, however, to identify only female activities, since gender interrelationships exist and can affect or be affected by the project. Male activities must also be specified. The baseline survey and beneficiary/community needs assessment are designed to address these concerns and to plan the project accordingly. The access to and control over resources by women, affect their status, and status influences their health and family welfare. In project planning, attention has been paid to gender patterns of access to and control over resources, because the use of a resource is often decided by the group who controls it rather than by those who use it.

1/ Table 6 reflects why and how gender analysis will be incorporated in various stages and components of the Project.

2/ The Gender Analysis Framework is adapted from UNFPA, Gender Analysis for Project Design: UNFPA Training Manual. Prepared for UNFPA by J. E. Austin Associates and the Collaborative for Development Action, Inc., 1989.

Figure 1: APPLYING THE GENDER ANALYSIS FRAMEWORK



Source: UNFPA, Gender Analysis for Project Design, p. 2.

13. Because of the diverse roles women play in family welfare, they will be involved in all aspects of the project decision making. The evaluation report of CUDP-III by WHO indicates the importance of involving women in decision-making positions. Their participation at the community-level in the type, design, quality, and other aspects of welfare services will be crucial for the effectiveness and sustainability of services. Therefore, in formulation of policies and programs for women, their active participation as planners, managers, and staff has and will continue to be sought. Mechanisms through which women can voice their needs and their expectations of different levels of services will also be critical. These mechanisms not only incorporate systematic information gathering efforts, but the organization of fora, including street discussions, user group meetings and other participatory occasions, that would allow women to benefit from others' view and to mobilize themselves in a search of solutions to their problems. These activities would be supported under the project.

14. Health care and family welfare services will be provided to women and children in slums by establishing Health Posts, Health Centers, Maternity Homes, Expanded Specialized Outpatient Departments, and other facilities, and by using female doctors, female supervisors (Lady Health Visitors, nurses), female health workers (ANMs) and female volunteer health workers (link workers, Bastee Sevikas). The objective of the project is to deliver services in the slums where women can be easily reached. This indicates that the project is gender sensitive. The project also takes into consideration the fact that poor slum women often do not avail of existing health services provided in publicly-financed/Government clinics and health centers. If

health and family welfare services are located in clinics requiring travel of a long distance from home, and if transportation costs are high, then these services will be "out of the reach" of poor slum women. Second, the fact that all volunteer link/health workers will be female and will be selected from the slum community, demonstrates that the project will be sensitive to the cultural constraints women experience in India. Women link workers will have easy access to clients' domestic setting for demand generation and service delivery. Third, the supervision of link workers by ANMs, LHVs, and female medical officers indicates that women will be actively involved in the project implementation and supervision. Fourth, the inclusion of local women in training programs and their recruitment as project personnel, acknowledges that women will be contributors to the family welfare services rather than mere beneficiaries of project resources. At the decision making level, the participation of female-led PVOs and community groups in Project Advisory and Coordinating Committees (PACC) at both the Center and State levels and in Project Implementation Committees (PICs) at municipal level would ensure that the concerns of women are expressed and taken into consideration in project planning, implementation and supervision.

15. Bangalore, Calcutta, Delhi and Hyderabad are also aware of the lack of access to resources such as education and employment by women. At present, the low demand for contraception and utilization of existing health services in the municipalities is largely influenced by slum women's low level of education. Similarly, there is a correlation between access to income and fertility. As families become better off, they often decide to have fewer children because they do not need to rely on them for old-age security. And as they have fewer children, families are in a position to offer better education, food and medical facilities for their children. The project, therefore, incorporates female education and employment generation activities under the Innovative Schemes component.

16. A project designed to serve women will be more successful when it uses a "woman to woman" approach or involves women's groups in designing and implementing the project. The example of the Family Planning Project by Gujarat State Crime Prevention Trust, a women non-governmental organization in Ahmedabad, India indicates that this approach strengthens the project by responding to the real needs of women clients as well as by developing a skilled cadre of women managers, supervisors and field workers. Slum women when given accurate and culturally appropriate information and support, accept family planning as a way of improving their lives and those of their families. The desire to offer family planning services, coupled with the commitment of the PVO to the community, compensates for its lack of experience. Lessons learned from Rajasthan indicates the importance of women's group formation for building collective strength to gain access to and control of resources. Further, the report (Sramshakti) of the National Commission on Self-employed Women and Women in the Informal Sector as well as the workshop on "Gender and Poverty in India" suggest the importance of the organization of women's group for demand generation. The Eighth Population Project, is committed to involving female-led PVOs and the female community groups in service delivery and demand generation. Although Staudt1/ points

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1/K. Staudt, "Sex, Ethnic and Class consciousness in Western Kenya" Comparative Politics, Vol 14, No. pp. 149-167, 1988.

out that working with women's group does not automatically guarantee that women will be empowered and that women's organizations which are dominated by elite women may be insensitive to the economic needs of the poor, nonetheless, working with existing women's groups has been an important factor in the success of projects.

17. The powerlessness of women, and especially poor women, is a political reality.1/ Even when women's organizations are powerful by their numbers, with very few exceptions, the support of local officials (usually men) is imperative if women's integration into development is to be realized. For this reason men and also women (because women in higher positions often do not understand how gender relations affect women's lives) are needed to be sensitized regarding gender issues. The project will include periodic gender sensitization training for all the project personnel, government officials as well as for slum population.

1/S. E. Charlton, Women in Third World Development. (London: Westview Press, 1984).

Table 1: Sex Ratio, Percent of Literates and Life Expectancy at Birth in India, 1891-1991

Year	Sex Ratio[a] (females/ males)	Percent of Literates[b]			Period	Life Expectancy at Birth[c]		
		Males	Females	Difference		Males	Females	Difference
1891	n.a.	n.a.	n.a.	n.a.	1881-90	24.6	25.5	-1.1
1901	0.972	9.9	0.7	9.2	1891-00	23.6	24.0	-0.4
1911	0.964	10.6	1.1	9.5	1901-10	22.6	23.3	-0.7
1921	0.955	12.2	1.8	10.4	1911-20	19.4	20.9	-1.5
1931	0.950	15.6	2.9	12.7	1921-30	26.9	26.6	0.3
1941	0.945	n.a.	n.a.	n.a.	1931-40	32.1	31.4	0.7
1951	0.946	27.1	8.9	18.2	1941-50	32.5	31.7	0.8
1961	0.941	40.4	15.3	25.1	1951-60	41.9	40.6	1.3
1971	0.930	46.0	22.0	24.0	1961-70	49.4	44.7	1.7
1981	0.933	56.4	29.8	27.4	1971-80	52.0	50.6	1.4
1991[d]	0.929	63.9	39.4	24.5	1981-90	n.a.	n.a.	n.a.

Note: n.a.: Not available

Sources: a. ICSSR (1983), p.3 for the years 1901-1971. Computed from Census reports. For 1981 computed for Census of India, 1981. 1991 figures are provisional based on press reports.

b. ICSSR (1983) for 1901-1931 (includes population aged 0-4).
U.N. (1982) for 1951-1971 (excludes population aged 0-4).
Census of India, 1981, for 1981 (excludes population aged 0-4).
1991 figures are provisional (excludes population aged 0-6).

c. U.N. (1982), p. 137 for the years 1881-1970

d. Provisional, excluding Jammu and Kashmir.

Table 2: RATIOS OF AGE-SPECIFIC DEATH RATES, ALL INDIA, 1984

Age Group,	Female/Male Ratios			Rural/Urban Ratios		
	Rural	Urban	Combined	Male	Female	Person
0- 4	1.09	1.05	1.09	1.96	2.03	1.99
5- 9	1.29	1.31	1.28	2.56	2.52	2.61
10-14	1.29	1.08	1.25	1.42	1.69	1.58
15-19	1.43	1.38	1.40	1.31	1.36	1.39
20-24	1.40	1.33	1.39	1.43	1.50	1.44
25-29	1.52	0.96	1.36	1.26	2.00	1.64
30-34	1.09	1.05	1.09	1.59	1.65	1.68
35-39	1.04	0.60	0.95	1.07	1.88	1.35
40-44	0.86	0.65	0.82	1.02	1.36	1.13
45-49	0.67	0.52	0.65	1.02	1.33	1.10
50-54	0.69	0.72	0.70	1.18	1.12	1.15
55-59	0.76	0.66	0.74	0.95	1.10	0.99
60-64	0.86	0.76	0.84	1.03	1.16	1.08
65-69	0.84	0.76	0.83	0.98	1.10	1.03
70+	0.94	0.89	0.93	1.08	1.14	1.11
All Ages	1.04	0.94	1.03	1.53	1.69	1.60

Source: Calculated from Sample Registration Bulletin XXI. No.1. Office of the Registrar General, Minsitry of Home Affairs, New Delhi, 1987.

Table 3: Sex-Specific Infant Mortality Rates in India 1970-1978

Year	Males	Females	Females-males Difference
1970	131	126	-5
1971	129	129	0
1972	132	148	16
1973	132	135	3
1974	128	119	-9
1975	140	140	0
1976	124	134	10
1977	126	135	9
1978	123	131	8

Source: Sample Registration System.

Table 4: Percent of Boys and Girls Enrolled in Schools by Levels in India 1950-51 to 1986-87

Year	Primary (class I-V)			Middle (class VI-VIII)			Secondary (class IX-XI)		
	Boys	Girls	Difference	Boys	Girls	Difference	Boys	Girls	Difference
1950-51	60.6	24.8	35.8	20.6	4.6	16.0	8.7	1.5	6.2
1960-61	82.6	41.4	41.2	33.2	11.3	21.9	18.0	4.4	15.6
1970-71[a]	95.5	60.5	35.0	46.3	19.9	36.4	26.8	9.8	17.0
1980-81	95.8	64.1	31.7	54.3	28.6	25.7	23.1	11.1	12.0
1986-87	111.8	79.2	32.6	66.5	38.9	27.6	29.8	14.4	15.4

Note: a. Percent exceeds 100 because of repetition by some children

Source: Education in India (various years), Ministry of Education and Culture, Government of India.

Table 5: Completed Level of Education of Men and Women Aged 25 -59, India 1981

Level	Male	Female	Difference
1. Illiterate	47.35	78.47	-31.12
2. Literate below primary	10.92	4.96	-5.96
3. Primary	15.06	7.79	-7.28
4. Middle	9.58	3.87	-5.71
5. Secondary	12.78	3.44	-9.34
6. Graduate and above	4.31	1.22	3.09

TABLE 6: GENDER ANALYSIS OF THE PROJECT

Strategies	Implementation Activities
Project Component: Design	
* Analyze determinants: · Cultural factors: social norms, traditions, religion, organizational and institutional arrangements; · Economic factors: The general level of poverty, inflation rates, infrastructure, the quality of land and/or other environmental conditions, economic organization; · Political factors: power relationship and control, government bureaucracy, legal systems, systems for collective decision-making; and · Demographic factors: migration pattern, life expectancy, infant mortality, etc. * Analyze Activities: · Who does what? Identify the production job that both male and female do which can affect project design in the slums; · Identify who in the family does the household production tasks, i.e., building houses and repairing, food preparation, laundering clothing, fuel and water collection, child bearing and rearing, providing family health care and the like; · Identify gender-based division of activities in social, political and religious unctions, e.g., arranging and conducting special traditional ceremonies and festivities, engaging in volunteer community project and others. · Identify where activities are done; when they are done; (what time of day, during what part of a year?). How much time does each job take? From activities analysis, identify where and when should the project services be delivered? who should deliver project services? what project content would be most useful for the clients (e.g., sterilization, injections with longer term effectiveness, or provision of larger supplies of pills or condoms)? * Analyze access to and control of resources: · Identify the basic resources which people use; identify the gender patterns of access to and control over these resources; · Analysis of access to resources would again influence location and time of project design. (For example, if the family welfare services are in a clinic requiring travel and transportation costs, the poor slum women may not use the services. The analysis of access to resources would help to identify whether women have access to technologies, such as radio and TV through which women can be reached with IEC programs. Do women have the right to choose a program, or do men always have the right to listen? Who will hear about family welfare services if it is advertised on the radio? If it is announced in written form? The issue of advertising the services to be delivered in ways that reach the intended participants is just as important as reaching them with the actual service.)	* Baseline survey and beneficiaries/community need assessment are underway in four municipalities to disaggregate information by gender and age; to identify income generating activities; to identify household production activities; to identify tir and place of the activities; to identify number of female headed households; to identify women's access to resources and technology, i.e. radio, TV, etc.; to gather data on income by gender. * Identified women's accessibility to existing health care institutions; * Identified slum women's needs for different kin of health services to be delivered; * Taken measures to use flexible timing to reach beneficiaries with services. * Identified the location of the service delivery. * Used feedbacks from women to plan and design the project components.

Strategies	Implementation Activities
Project Component: Service Delivery Expansion	
* Establish health care facilities within the reach of poor slum women and create outreach programs; * Use female link/health workers, honorary health workers, female Doctors and nurses.	* Construction of New Health Centers/HAU in slums; Construction of Upgraded H.C.; Extension of upgraded H.C.; Construction of maternity homes; Construction of E.S.O.P.D.;Construction of Collapsible H. Posts in slums; * Use of female doctors, female supervisors (Lady Health Visitors, Nurses), female health workers (ANM) and female volunteer health workers, dais from slums to provide services effectively.
Project Component: Quality Improvement	
* Arrange both technical and Gender sensitization training of link/health workers, Anganwadi workers, ANMs, medical officers, Private Medical Practitioners and PVOs. * Arrange training of female staff in formulation an design of activities as well as in continual managerial and operational functions.	* Training needs assessment underway in four cities; * IEC training for project personnel; Pre-service training; Induction/orientation training; In-service training; On-the-job training; * Identified the number of project personnel who will be trained by categories; * Gender sensitization training for all the project officials and slum population, local leaders, bustee committees, etc., through periodical group discussions, seminars, workshops, field visits, distributing literature etc.; * Taken measures for training of females in designing activities as well as for managerial and operational skills.
Project Component: Management Improvement	
* Involve women in higher levels of decision making, supervision, monitoring and evaluation positions; * create "WID cell" for effective implementation of monitoring and evaluation of the project where necessary; or "main-streaming" gender concerns in planning and management in a routine and systematic manner.	* Special Committee, Advisory committees (Block and sub-center levels) comprising of women members will be established to screen the decisions to be taken by the managers; * Women's representation will be ensured in Project Advisory and Coordination Committees; Project Monitoring and Evaluation Unit will periodically meet the women Advisory Committees to collect information; * Measures will be taken to ensure women's involvement in the decision-making positions i.e. in Apex Committees, Project Implementation Committees, etc.; * Provision has been made to monitor and evaluate the impact of the project on women by creating WID cell.

Strategies	Implementation Activities
Project Component: Demand Generation	
* Disseminate information regarding the health and family welfare services to women. * organize IEC programs at a time and place where women can be reached; * Use "woman-to-woman" approach where necessary; * Organize women into groups or social network for demand generation; * Develop income generation activities to increase women's access to services including making them responsible for the delivery of health-care services; * Increase female education; * Introduce time-saving devises (i.e., fuel efficient stoves, communal wells, etc.) to enable women to avail family welfare services or attend IEC programs; * Establish a mechanism through which women can express their needs and their expectations of different levels of services. (These mechanism should not only incorporate systematic information gathering efforts, but the organization of street discussions, user group meetings and other participatory occasions, that would allow women to benefit from others' views and mobilize themselves in search of solutions to their problems.) * Take measures to reduce violence against women in the family and the community so that women can avail the services.	* Use of Mahila Mandals, neighborhood committees, teachers of Balavadis, Anganwadi workers for demand generation; * Formation of women's groups to demand services, to reduce violence against women, and to create awareness of women's rights; * Use of Link workers for motivation; * Use of female-led PVOs, community development workers, local bodies, groups for outreach services; * Study to identify ways in which the community may collaborate with public authorities; * Involvement of existing grassroots organizations and non-government support organizations; * Use of female PWPs as resources for the delivery of health services to the slum community; * Use of OTC (orientation training camps) and their leaders as community educators; * Use of existing schools near slums for health and adult education programs.
Project Component: Innovative Programs	
* Identify women's needs in the community regarding nutrition, environmental sanitation and water, creche programs and the like and involve community to meet such needs with project support.	* Education programs for slum women and girls; * Provisions for women's employment/entrepreneurship development program; * Sanitation program with community participation; * Provisions for control gastroenteritis effectively; * Supplementary nutrition program for pregnant and lactating mothers; * Supplementary nutrition program for toddlers; * Integration of services of anganwadi workers and ANMs; * Study of fertility behavior among minority groups; * Sanitation drive in Communities; * Study of incidence of sexually transmitted disease (STD); * Health and family Welfare education amongst adolescent girls; * Education program for men and women's problems; * Importance of female child; * Creche program.

TABLE 7: STRATEGIES TO INVOLVE WOMEN IN THE PROJECT

A. PROJECT DESIGN

STRATEGY

1. Analyze determinants

   (a) Cultural factors: customs, traditions, religion, social norms etc.;
   (b) Economic factors: general level of poverty, inflation rates, economic organization etc.;
   (c) Political factors: government bureaucracy, legal systems etc.;
   (d) Demographic factors: life expectancy, infant mortality, migration.

2. Analyze activities

   (a) Identification of production jobs that both males and females can do and which can affect project design;
   (b) Identification of distribution of household production tasks between males and female;
   (c) Identification of gender based division of activities in social, political and religious functions;
   (d) Identification of place and time of activities and thereby convenience of place, time and content of project services.

3. Analyze access to and control of resources.

   Identification of gender patterns of access to, and control of basis resources which will influence location, time and type of project design, so as to reach the beneficiaries appropriately.

ACTIVITIES

(a) Baseline survey;
(b) Beneficiary/community needs assessment;
(c) Identification of location of service delivery;
(d) Information about income by gender;
(e) Identification of women's movement in development of various components.

B. SERVICE DELIVERY EXPANSION

STRATEGY

(a) Establishment of health care facilities within the reach of poor slum women, including outreach activities;
(b) Make services more acceptable to the beneficiaries.

ACTIVITIES

(a) Development of infrastructure, e.g. construction of new health posts, upgrade/expand health centers, etc;
(b) Use of female doctors, supervisors, lady health visitors, ANM, female honorary health workers, dais etc;
(c) Identification of acceptable type and time of service delivery.

C. QUALITY IMPROVEMENT

STRATEGIES

(a) Technical and gender sensitization training of all health personnel;
(b) Training of female staff in formulation of a design of activities and in continual managerial and operational functions.

ACTIVITIES

(a) Training needs assessment;
(b) IEC training;
(c) Pre-service, induction, in-service and on the job training.

D. MANAGEMENT IMPROVEMENT

STRATEGIES

(a) Involvement of women in higher levels of decision making, supervision, monitoring and evaluation;
(b) Creation of "Women in Development (WID) cells.

ACTIVITIES

(a) Formation of Apex Committee/Project Implementation Committee/Steering Committee;
(b) Establishment of project coordination committee, training, MIS, IEC and monitoring and evaluation cells.

E. DEMAND GENERATION

STRATEGIES

(a) Dissemination of information regarding health and family welfare services by IEC programs, woman approach etc;
(b) Organization of women into groups or social network;
(c) Development of income generation activities to increase women's access to services and to make them responsible for delivery of health care services;
(d) Increasing female education;

(e) Establishment of mechanism through which women can express their needs and be protected against violence, e.g. street discussions, user group meetings etc.

ACTIVITIES

(a) Use of neighborhood committees, link workers, mahila mandals, PVOs, local bodies etc for motivation;
(b) Identification of methods for collaboration between community and public authorities;
(c) Use of female PMPs for delivery of health services and orientation training camps (OTC) leaders as community educators;
(d) Use of existing schools for health and adult education programs.

F. INNOVATIVE SCHEMES

STRATEGIES

(a) Identification of women's needs regarding nutrition, safe drinking water supply, environmental sanitation, creche programs etc;
(b) Involvement of community to meet their needs with project support.

ACTIVITIES

(a) Environmental sanitation program;
(b) Income generation activities;
(c) Integration of services of anganwadi workers and ANMs;
(d) Creche program;
(e) Supplementary nutrition etc.

	Activities	B	C	H	D
A.	**PROJECT DESIGN**				
1.	Baseline survey	X	X	X	X
2.	Beneficiary needs assessment	X	X	X	X
3.	Identification of location of service delivery		X	X	
4.	Information about income by gender				
5.	Identification of women's involvement in development of various components		X	X	
B.	**SERVICE DELIVERY EXPANSION**				
1.	Construction of "D" type health posts			X	
2.	Construction of "B" type health posts				X
3.	Upgrade maternity centers	X		X	X
4.	Use of female doctors LHV/ANMs/HHV	X	X	X	X
5.	Use of dais			X	X
6.	Construction of ESOPD (Extended) specialized out patient department)		X		
7.	Health administrative unit		X		
C.	**QUALITY IMPROVEMENT**				
1.	Training needs assessment	X	X	X	X
2.	IEC training	X	X	X	X
3.	Pre inducting, in-service and on the job training	X	X	X	X
D.	**MANAGEMENT IMPROVEMENT**				
1.	Involvement of women in project management positions	X	X	X	X
2.	Formation of Advisory/Apex Committee	X	X	X	X
3.	Establishment of MIS, training, IEC and monitoring and evaluation cells	X	X	X	X
E.	**DEMAND GENERATION**				
1.	Use of mahila mandals			X	X
2.	Use of balwadi and anganwadi teachers			X	X
3.	NHC, female volunteers	X	X	X	X
4.	Involvement of PVOs/PMPs	X	X	X	X
5.	Involvement of OTC trained teachers			X	
6.	Female education	X	X	X	X
7.	Formation of social health and Environment (SHE) clubs	X			

F. INNOVATIVE SCHEMES

	Activities	B	C	H	D
1.	Registration and detection of vital events			X	
2.	Marriage registration			X	
3.	Family formation practices and fertility behavior			X	
4.	No pregnancy incentive			X	
5.	Integration with ICDS			X	X
6.	Community sanitation programs	X	X	X	X
7.	Kitchen gardens				
8.	NFE for adolescent girls		X	X	X
9.	Female literacy	X	X	X	X
10.	Income generation activities	X	X	X	X
11.	Creche programs	X	X		
12.	Revolving fund	X			
13.	Support to community based rehabilitation for disabled in slums				X

B = Bangalore
C = Calcutta
D = Delhi
H = Hyderabad

SUMMARY

A. BANGALORE

The project is aimed predominantly at females and administered by females. The project beneficiaries are children, unmarried girls and married women residing in slums and they account for over 40% of total beneficiaries. The majority of personnel involved in service delivery at the top, middle and junior management levels, and also at supporting paramedical and construction workers levels, are females. Posts of LMO, PHN, ANM and link worker would be filled through appointment of women. Social Health and Environment clubs - "SHE" clubs-at slum levels provide for women's participation in management council. Workshops will be conducted to familiarize municipal staff with the needs of poor women. The Project Management Committee is responsible for monitoring impact of the project on women.

B. CALCUTTA

In the implementation of the project, women will play pivotal roles from the grass-root level where community-based health workers will be only women up to the level of health administrators and managers. The majority of trainers for training of personnel at different levels will be drawn from practitioners or operating staff, and these are mostly women. At both block and sub center levels, an Advisory committee comprising women beneficiaries will be set up to screen the decisions taken by managers. The Project Monitoring and Evaluation Unit would periodically meet Women Advisory Committees at sub center units and collect feedback from them. Women will be the beneficiaries in programs connected with primary and adult education, entrepreneurship development and nutrition awareness. In running creche programs, PVOs would engage women drawn from local communities. Among the beneficiary population, the majority will be women.

C. DELHI

For implementing the project, Bastee Sevikas, Trained Dais and ANMs will all be women. Half of the doctors are expected to be women and 40% of the construction workers will be women. Formation of Mahila Mandals and Bastee Vikas Mandals would directly benefit women. Specific provisions, have been made to ensure female participation in the management positions of the project. Women's Organizations, Women's NGOs and Mahila Mandals will be given representation in Project Advisory and Coordination Committee (PACC). Special indicators will be developed in management information system to monitor the impact of the project on women.

D. HYDERABAD

The target beneficiaries under the project would be females living in the slum areas and therefore involvement of beneficiary community in every component of the service delivery system would be guaranteed. The personnel/staff at Health Posts and Upgraded Maternity Centers would be women. There would be 750 women health volunteers with project with each covering 2,000 population exclusively in the slum communities. Training officers will be preferably women officers. Women belonging to the slums will be given preference in civil construction works at worker level. In addition to women health volunteers, teachers of Balavadis, Anganwadi workers and other functionaries in ICDS project would help in organizing women's groups, demand generation and the delivery of services. Awareness of the needs of poor women would be created through periodical group discussions, seminars and workshops among project personnel.

Increased female participation in project management positions at City Family Welfare Bureau level and in special units like IEC and training would be ensured. In all urban Health Posts and upgraded Maternity Centers, services will be provided exclusively to women and children. It is proposed to constitute a special committee to supervise and monitor the impact of project on woman. Apart from the project management staff, the special committee will associate representatives of local community, PVOs, PMPs and members of local Mahila Mandals. The Chairperson and member secretary of the proposed committee will also be female.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

PROJECT COSTS

TABLE 1. SUMMARY COSTS BY COMPONENT AND TIME

(RS '000)

	Base Costs							Total	
	92/93	93/94	94/95	95/96	96/97	97/98	98/99	RS	(US$ '000)
A. INCREASE SUPPLY OF FAMILY WELFARE SERVICES									
1. BANGALORE	10,449.2	24,429.8	33,241.1	32,759.2	23,016.6	18,830.6	15,081.1	157,807.6	5,844.7
2. CALCUTTA	18,500.2	40,706.1	75,338.4	87,090.2	78,672.9	58,452.9	76,036.8	433,597.6	16,059.2
3. DELHI	8,870.0	41,870.2	61,769.7	73,795.7	68,963.3	46,900.0	41,044.0	343,212.9	12,711.6
4. HYDERABAD	7,843.4	18,008.2	26,970.9	30,268.1	29,981.2	20,033.8	27,717.8	169,823.3	6,282.3
Sub-Total INCREASE SUPPLY OF FAMILY WELFARE SERVICES	45,662.8	125,014.3	197,320.1	224,713.2	200,634.0	150,217.3	159,879.6	1,104,241.3	40,897.8
B. IMPROVE QUALITY OF FAMILY WELFARE SERVICES									
1. BANGALORE	1,445.9	5,888.7	12,722.6	10,776.6	7,605.6	5,888.1	314.0	44,561.5	1,650.4
2. CALCUTTA	2,175.5	7,263.4	16,233.8	23,880.8	30,336.8	33,136.1	38,187.8	151,214.3	5,600.5
3. DELHI	914.0	2,010.0	3,812.0	5,999.4	7,875.3	9,671.4	9,671.4	39,953.6	1,479.8
4. HYDERABAD	2,255.1	3,749.8	4,812.0	6,196.7	5,847.3	5,847.3	5,847.3	34,555.5	1,279.8
Sub-Total IMPROVE QUALITY OF FAMILY WELFARE SERVICES	6,790.6	18,911.9	37,580.5	46,853.4	51,664.9	54,483.0	54,020.6	270,284.8	10,010.5
C. INCREASE DEMAND FOR FAMILY WELFARE SERVICES									
1. BANGALORE	7,110.5	10,041.0	9,646.7	9,644.9	9,644.9	9,644.9	9,644.9	65,377.7	2,421.4
2. CALCUTTA	11,378.3	12,841.2	10,734.3	8,608.0	7,503.2	7,503.2	6,468.4	65,126.5	2,412.1
3. DELHI	6,528.2	14,358.1	12,199.5	12,199.5	7,288.5	5,242.2	5,242.2	63,058.3	2,335.5
4. HYDERABAD	2,626.8	4,163.1	4,231.9	4,231.9	4,231.9	3,100.8	3,100.8	25,687.3	951.4
5. CENTER	2,782.2	4,703.6	4,703.6	4,703.6	4,159.7	3,897.8	3,697.4	28,637.8	1,060.7
Sub-Total INCREASE DEMAND FOR FAMILY WELFARE SERVICES	30,426.0	46,107.0	41,516.0	39,467.9	32,833.2	29,388.8	28,153.7	247,887.7	9,181.0
D. MANAGEMENT IMPROVEMENT									
1. BANGALORE	2,380.1	2,031.0	307.2	307.2	307.2	307.2	307.2	5,954.9	220.6
2. CALCUTTA	2,222.1	3,502.5	2,221.3	3,905.6	3,248.0	3,248.0	3,248.0	21,675.4	802.8
3. DELHI	2,096.0	4,260.3	3,004.9	3,004.9	3,004.9	3,004.9	3,004.9	22,101.1	821.5
4. HYDERABAD	1,417.1	2,624.6	2,651.1	1,832.9	1,649.1	1,649.1	1,580.5	13,404.3	496.5
5. CENTER	-	7,008.3	7,008.3	4,333.3	2,157.8	1,070.0	-	21,577.6	799.2
Sub-Total MANAGEMENT IMPROVEMENT	8,923.4	19,426.6	15,192.8	13,463.8	10,366.9	9,279.2	8,140.6	84,793.3	3,140.5
E. INNOVATIVE SCHEMES									
1. BANGALORE	1,722.4	2,583.6	2,583.6	2,583.6	2,583.6	2,583.6	2,583.6	17,224.3	637.9
2. CALCUTTA	3,268.8	11,311.6	14,650.0	18,433.6	18,535.7	28,473.5	27,000.9	123,682.0	4,580.8
3. DELHI	5,293.4	15,880.1	15,880.1	15,880.1	-	-	-	52,933.7	1,960.5
4. HYDERABAD	1,566.9	2,350.4	2,350.4	2,350.4	2,350.4	2,350.4	2,350.4	15,669.3	580.3
Sub-Total INNOVATIVE SCHEMES	13,851.5	32,125.7	35,472.1	39,247.8	23,469.7	33,407.5	31,934.9	209,509.3	7,759.6
F. PREPARATION OF FUTURE PROJECTS									
1. CENTER	87,602.9	128,335.9	-	-	-	-	-	215,938.8	7,997.7
Sub-Total PREPARATION OF FUTURE PROJECTS	87,602.9	128,335.9	-	-	-	-	-	215,938.8	7,997.7
Total BASELINE COSTS	193,257.2	370,721.4	327,081.6	363,746.1	318,968.7	276,750.8	282,129.4	2,132,655.2	78,987.2
Physical Contingencies	14,550.2	27,863.1	25,924.8	28,137.4	23,557.7	20,158.2	20,201.3	160,400.7	5,940.8
Price Contingencies	18,544.6	69,662.9	89,252.0	130,107.6	137,643.3	145,601.4	169,501.2	760,413.0	11,645.9
Total PROJECT COSTS	226,360.0	468,247.4	442,258.4	521,991.1	480,169.7	442,510.4	471,831.9	3,053,468.9	96,573.9
Taxes	7,599.2	14,671.3	13,120.9	15,462.5	13,634.2	13,281.7	13,967.7	91,737.4	2,908.7
Foreign Exchange	24,241.2	52,594.8	45,531.7	51,745.4	39,399.2	34,518.4	36,313.2	284,343.9	9,084.0

TABLE 2. SUMMARY COSTS BY CATEGORIES OF EXPENDITURE AND TIME

	Base Costs (RS Million)								Foreign Exchange	
	92/93	93/94	94/95	95/96	96/97	97/98	98/99	Total	%	Amount
I. INVESTMENT COSTS										
A. CIVIL WORKS	18.7	78.1	106.2	94.7	61.6	21.2	25.5	406.1	11.2	45.4
B. FURNITURE	4.4	8.5	15.5	17.1	7.4	5.8	6.1	64.8	9.2	5.9
C. VEHICLES	11.2	14.1	9.8	7.8	2.8	1.2	-	46.8	9.1	4.3
D. EQUIPMENT	40.5	60.6	22.8	23.3	11.2	7.1	6.7	172.4	35.4	61.0
E. MCH MATERIALS	9.3	16.7	19.6	28.1	31.7	44.7	40.3	190.3	20.3	38.6
F. PROFESSIONAL FEES	3.3	3.4	3.3	3.1	3.1	-	-	16.3	0.0	0.0
G. LAND	2.4	12.6	17.2	17.2	17.2	3.8	7.0	77.3	0.0	0.0
H. DRUGS	3.7	8.8	22.8	34.3	45.1	48.0	51.8	214.4	10.2	21.8
I. LOCAL FELLOWSHIPS	4.2	7.1	6.3	6.3	5.0	5.0	3.0	36.9	0.0	0.0
J. LOCAL ADVISERS	45.0	70.3	12.7	10.0	9.8	9.8	9.8	167.4	0.0	0.0
K. FOREIGN FELLOWSHIPS	0.1	2.8	2.8	2.8	0.8	-	-	9.2	90.2	8.3
L. FOREIGN ADVISERS	0.6	2.2	2.2	2.2	1.1	0.6	0.4	9.2	90.2	8.3
M. BOOKS AND TRAINING MATERIALS	0.7	1.3	1.3	1.0	1.0	1.0	1.0	7.3	0.0	0.0
N. DEPARTMENTAL CHARGES	8.7	8.7	8.7	8.6	7.6	3.4	-	45.8	0.0	0.0
O. CONTRACT FOR INNOVATIVE SCHEMES	13.6	28.3	28.3	28.3	12.5	12.5	12.5	136.1	0.0	0.0
P. LOCAL TRAINING	8.2	12.3	-	-	-	-	-	20.4	5.1	1.0
Total INVESTMENT COSTS	174.6	335.6	279.4	284.8	218.0	164.0	164.1	1,620.5	12.0	194.7
II. RECURRENT COSTS										
A. SALARIES OF ADDITIONAL STAFF	16.0	27.9	33.3	54.9	67.9	75.2	76.3	351.4	0.0	0.0
B. HONORARIUM	2.2	5.7	12.0	20.5	28.4	32.9	36.5	138.3	0.0	0.0
C. OPERATION AND MAINTENANCE OF VEHICLES	0.0	0.2	0.6	0.9	1.1	1.2	1.2	5.2	5.1	0.3
D. OTHER OPERATION AND MAINTENANCE	0.2	0.3	0.4	0.8	1.4	1.4	1.4	5.8	5.1	0.3
E. RENT OF HEALTH CENTER	0.2	0.9	1.4	1.9	2.2	2.2	2.6	11.4	0.0	0.0
Total RECURRENT COSTS	18.7	35.1	47.7	78.9	101.0	112.8	118.0	512.1	0.1	0.6
Total BASELINE COSTS	193.3	370.7	327.1	363.7	319.0	276.8	282.1	2,132.7	9.2	195.2
Physical Contingencies	14.6	27.9	25.9	28.1	23.6	20.2	20.2	160.4	11.6	18.6
Price Contingencies	18.5	69.7	89.4	130.1	137.6	145.6	169.5	760.4	9.3	70.5
Total PROJECT COSTS	226.4	468.2	442.4	522.0	480.2	442.5	471.8	3,053.5	9.3	284.3
Taxes	7.6	14.7	13.1	15.5	13.6	13.3	14.0	91.7	0.0	0.0
Foreign Exchange	24.2	52.6	45.5	51.7	39.4	34.5	36.3	284.3	0.0	0.0

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TABLE 3. SUMMARY COSTS BY COMPONENT AND CATEGORIES EXPENDITURE

(RS Million)

	MANAGEMENT IMPROVEMENT					INNOVATIVE SCHEMES				PREPARATION OF FUTURE PROJECTS		Physical Continsencies	
	BANGALORE	CALCUTTA	DELHI	HYDERABAD	CENTER	BANGALORE	CALCUTTA	DELHI	HYDERABAD	CENTER	Total	%	Amount
INVESTMENT COSTS													
A. CIVIL WORKS	-	-	-	-	-	-	-	-	-	-	406.1	10.0	40.6
B. FURNITURE	0.1	1.5	1.0	0.2	-	-	0.4	-	-	-	64.8	10.0	6.5
C. VEHICLES	-	-	0.6	2.0	-	-	-	-	-	12.3	46.8	10.0	4.7
D. EQUIPMENT	1.7	1.0	3.3	0.7	-	-	0.6	-	-	61.7	172.4	10.0	17.2
E. MCH MATERIALS	1.4	2.1	1.5	1.4	-	-	68.8	-	-	7.2	190.3	10.0	17.0
F. PROFESSIONAL FEES	-	-	-	-	-	-	-	-	-	-	16.3	10.0	1.6
G. LAND	-	-	-	-	-	-	-	-	-	-	77.3	0.0	0.0
H. DRUGS	-	-	-	-	-	-	-	-	-	-	214.4	10.0	21.4
I. LOCAL FELLOWSHIPS	2.2	2.5	-	-	5.4	-	-	-	-	-	36.9	5.0	1.8
J. LOCAL ADVISERS	-	-	-	0.6	5.4	-	-	-	-	96.0	167.4	5.0	8.4
K. FOREIGN FELLOWSHIPS	-	-	-	-	5.4	-	-	-	-	-	9.2	5.0	0.5
L. FOREIGN ADVISERS	-	-	-	-	5.4	-	-	-	-	-	9.2	5.0	0.5
M. BOOKS AND TRAINING MATERIALS	-	-	-	-	-	-	-	-	-	-	7.3	10.0	0.7
N. DEPARTMENTAL CHARGES	-	-	-	-	-	-	-	-	-	-	45.8	10.0	4.6
O. CONTRACT FOR INNOVATIVE SCHEMES	-	-	-	-	-	17.2	50.2	52.9	15.7	-	136.1	5.0	6.8
P. LOCAL TRAINING	-	-	-	-	-	-	-	-	-	20.4	20.4	5.0	1.0
al INVESTMENT COSTS	5.4	7.1	6.4	4.9	21.6	17.2	120.1	52.9	15.7	197.6	1,620.5	8.4	135.4
. RECURRENT COSTS													
A. SALARIES OF ADDITIONAL STAFF	0.6	14.6	12.6	8.1	-	-	-	-	-	18.4	351.4	5.0	17.6
B. HONORARIUM	-	-	-	-	-	-	3.6	-	-	-	138.3	5.0	6.9
C. OPERATION AND MAINTENANCE OF VEHICLES	-	-	0.1	0.3	-	-	-	-	-	-	5.2	5.0	0.3
D. OTHER OPERATION AND MAINTENANCE	-	-	0.8	0.1	-	-	-	-	-	-	5.8	5.0	0.3
E. RENT OF HEALTH CENTER	-	-	2.2	-	-	-	-	-	-	-	11.4	0.0	0.0
al RECURRENT COSTS	0.6	14.6	15.8	8.5	-	-	3.6	-	-	18.4	512.1	4.9	25.0
al BASELINE COSTS	6.0	21.7	22.2	13.4	21.6	17.2	123.7	52.9	15.7	215.9	2,132.7	7.5	160.4
Physical Continsencies	0.5	1.3	1.3	0.9	1.1	0.9	9.7	2.6	0.8	14.9	160.4	0.0	0.0
Price Continsencies	1.3	8.0	7.7	4.6	6.4	6.3	54.9	13.8	5.8	33.1	760.4	7.2	54.6
al PROJECT COSTS	7.7	31.0	31.2	18.9	29.0	24.4	188.2	69.4	22.2	263.9	3,053.5	7.0	215.0
Taxes	0.4	0.4	0.6	0.4	-	-	7.8	-	-	9.4	91.7	9.1	8.3
Foreign Exchange	1.2	1.2	2.1	1.0	13.2	-	23.4	-	-	31.0	204.3	8.7	24.8

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TABLE 3. SUMMARY COSTS BY COMPONENT AND CATEGORIES EXPENDITURE

(Continuted)

(RS Million)

	INCREASE SUPPLY OF FAMILY WELFARE SERVICES				IMPROVE QUALITY OF FAMILY WELFARE SERVICES				INCREASE DEMAND FOR FAMILY WELFARE SERVICES				
	BANGALORE	CALCUTTA	DELHI	HYDERABAD	BANGALORE	CALCUTTA	DELHI	HYDERABAD	BANGALORE	CALCUTTA	DELHI	HYDERABAD	CENTER
I. INVESTMENT COSTS													
A. CIVIL WORKS	62.5	150.7	115.9	35.9	8.1	2.3	-	-	-	10.2	20.5	-	-
B. FURNITURE	4.3	45.5	8.0	1.2	2.0	0.3	-	0.1	0.1	0.1	-	-	-
C. VEHICLES	6.1	10.7	9.5	1.4	0.5	-	0.3	-	2.3	-	1.0	-	-
D. EQUIPMENT	19.1	51.7	10.6	2.8	1.0	0.3	1.0	2.1	0.1	4.2	5.2	5.1	-
E. MCH MATERIALS	5.8	-	42.6	1.6	10.4	-	0.5	1.2	0.9	30.8	3.5	-	10.7
F. PROFESSIONAL FEES	3.1	5.0	5.8	1.8	0.4	0.1	-	-	-	-	-	-	-
G. LAND	-	40.8	25.3	-	-	3.2	-	-	-	-	-	-	-
H. DRUGS	-	-	-	-	13.8	140.2	30.1	25.1	5.2	-	-	-	-
I. LOCAL FELLOWSHIPS	-	-	-	-	5.6	-	1.1	1.9	12.9	-	-	-	5.4
J. LOCAL ADVISERS	-	-	-	-	-	-	-	1.4	40.9	17.1	-	-	6.0
K. FOREIGN FELLOWSHIPS	-	-	-	-	-	-	1.0	-	-	-	-	-	2.7
L. FOREIGN ADVISERS	-	-	-	-	-	-	-	-	-	-	-	-	3.8
M. BOOKS AND TRAINING MATERIALS	-	-	-	-	0.5	-	-	-	1.7	-	4.1	1.0	-
N. DEPARTMENTAL CHARGES	7.5	12.0	18.5	3.2	-	0.3	-	-	-	0.9	3.3	-	-
O. CONTRACT FOR INNOVATIVE SCHEMES	-	-	-	-	-	-	-	-	-	-	-	-	-
P. LOCAL TRAINING	-	-	-	-	-	-	-	-	-	-	-	-	-
Total INVESTMENT COSTS	108.5	324.5	236.3	47.9	42.4	146.6	34.1	31.8	63.9	63.3	37.5	6.2	28.6
II. RECURRENT COSTS													
A. SALARIES OF ADDITIONAL STAFF	33.0	11.9	89.4	107.4	1.1	0.7	3.0	2.6	1.4	1.8	25.4	19.5	-
B. HONORARIUM	12.8	87.9	15.5	11.5	0.6	3.6	2.8	-	-	-	-	-	-
C. OPERATION AND MAINTENANCE OF VEHICLES	0.5	1.1	2.0	0.3	0.1	0.3	0.0	-	0.1	-	0.2	-	-
D. OTHER OPERATION AND MAINTENANCE	2.9	-	-	1.7	0.3	-	-	0.0	-	-	-	-	-
E. RENT OF HEALTH CENTER	-	8.2	-	0.8	-	-	-	0.2	-	-	-	-	-
Total RECURRENT COSTS	49.3	109.1	106.9	121.7	2.1	4.6	5.9	2.8	1.5	1.8	25.5	19.5	-
Total BASELINE COSTS	157.8	433.6	343.2	169.6	44.6	151.2	40.0	34.6	65.4	65.1	63.1	25.7	28.6
Physical Contingencies	13.3	32.6	26.4	10.8	4.1	14.6	3.6	3.1	3.8	5.6	5.0	1.6	2.0
Price Contingencies	57.3	158.7	128.6	67.7	16.0	71.1	18.8	14.3	24.0	21.5	20.7	9.2	10.5
Total PROJECT COSTS	228.5	624.9	498.3	248.1	64.6	236.9	62.4	52.0	93.1	92.2	88.8	36.5	41.2
Taxes	6.6	16.9	12.6	2.2	3.1	15.7	3.6	3.1	0.8	4.1	2.0	0.7	1.1
Foreign Exchange	22.7	61.2	41.1	7.8	7.5	22.9	6.9	5.4	1.4	12.6	6.7	2.6	11.4

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INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

TABLE 1: FINANCING PLAN BY COMPONENTS

(US$ '000)

	INTERNATIONAL DEVELOPMENT AGENCY		GOVERNMENT OF INDIA		Total				
	Amount	%	Amount	%	Amount	%	For. Exch.	Local (Excl. Taxes)	Duties & Taxes
A. INCREASE SUPPLY OF FAMILY WELFARE SERVICES									
1. BANGALORE	5,650.5	78.0	1,596.4	22.0	7,246.9	7.5	737.9	6,292.5	216.5
2. CALCUTTA	14,326.5	73.8	5,095.2	26.2	19,421.6	20.1	1,917.2	16,971.9	532.6
3. DELHI	11,446.4	72.6	4,109.7	26.4	15,556.1	16.1	1,286.9	13,875.9	393.3
4. HYDERABAD	5,618.2	72.8	2,097.3	27.2	7,715.5	8.0	257.7	7,334.9	72.9
Sub-Total INCREASE SUPPLY OF FAMILY WELFARE SERVICES	37,041.6	74.2	12,898.5	25.8	49,940.1	51.7	4,199.7	44,525.1	1,215.3
B. IMPROVE QUALITY OF FAMILY WELFARE SERVICES									
1. BANGALORE	1,845.4	89.7	212.2	10.3	2,057.6	2.1	237.3	1,721.5	98.8
2. CALCUTTA	6,299.6	87.8	876.0	12.2	7,175.7	7.4	721.9	5,979.0	474.8
3. DELHI	1,657.2	87.7	233.4	12.3	1,890.6	2.0	214.4	1,567.6	108.6
4. HYDERABAD	1,436.3	88.9	179.3	11.1	1,615.6	1.7	169.4	1,349.2	97.0
Sub-Total IMPROVE QUALITY OF FAMILY WELFARE SERVICES	11,238.5	88.2	1,501.0	11.8	12,739.4	13.2	1,343.0	10,617.2	779.2
C. INCREASE DEMAND FOR FAMILY WELFARE SERVICES									
1. BANGALORE	2,867.7	97.6	71.6	2.4	2,939.3	3.0	43.9	2,868.2	27.2
2. CALCUTTA	2,700.3	90.8	274.7	9.2	2,975.0	3.1	408.8	2,433.2	133.0
3. DELHI	2,208.0	77.1	654.0	22.9	2,862.0	3.0	222.1	2,574.2	65.7
4. HYDERABAD	866.1	74.9	290.1	25.1	1,156.2	1.2	83.4	1,049.2	23.6
5. CENTER	1,251.0	96.1	50.4	3.9	1,301.4	1.3	364.5	901.6	35.3
Sub-Total INCREASE DEMAND FOR FAMILY WELFARE SERVICES	9,893.1	88.1	1,340.9	11.9	11,234.0	11.6	1,122.7	9,826.4	284.9
D. MANAGEMENT IMPROVEMENT									
1. BANGALORE	241.6	91.7	21.9	8.3	263.5	0.3	39.7	211.6	12.1
2. CALCUTTA	758.3	77.6	219.2	22.4	977.5	1.0	41.4	923.4	12.6
3. DELHI	657.6	66.2	335.2	33.8	992.9	1.0	73.4	897.2	22.3
4. HYDERABAD	456.9	75.7	146.5	24.3	603.4	0.6	33.8	555.4	14.2
5. CENTER	945.2	100.0	-	-	945.2	1.0	428.6	516.5	-
Sub-Total MANAGEMENT IMPROVEMENT	3,059.7	80.9	722.7	19.1	3,782.4	3.9	617.0	3,104.2	61.2
E. INNOVATIVE SCHEMES									
1. BANGALORE	692.4	90.0	76.9	10.0	769.3	0.8	-	769.3	-
2. CALCUTTA	5,160.5	89.4	609.0	10.6	5,769.5	6.0	704.7	4,829.3	235.5
3. DELHI	2,075.0	90.0	230.6	10.0	2,305.6	2.4	-	2,305.6	-
4. HYDERABAD	629.9	90.0	70.0	10.0	699.8	0.7	-	699.8	-
Sub-Total INNOVATIVE SCHEMES	8,557.7	89.7	986.5	10.3	9,544.2	9.9	704.7	8,604.0	235.5
F. PREPARATION OF FUTURE PROJECTS									
1. CENTER	8,740.0	93.6	593.7	6.4	9,333.7	9.7	1,076.9	7,904.3	352.6
Sub-Total PREPARATION OF FUTURE PROJECTS	8,740.0	93.6	593.7	6.4	9,333.7	9.7	1,076.9	7,904.3	352.6
Total Disbursement	70,530.5	81.3	16,043.3	18.7	86,573.9	100.0	9,084.0	84,581.2	2,908.7

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TABLE 2: FINANCING PLAN BY CATEGORIES OF EXPENDITURE

(US$ Million)

	INTERNATIONAL DEVELOPMENT AGENCY		GOVERNMENT OF INDIA		Total		For. Exch.	Local (Excl. Taxes)	Duties & Taxes
	Amount	%	Amount	%	Amount	%			
I. INVESTMENT COSTS									
A. CIVIL WORKS	17.0	90.0	1.9	10.0	18.8	19.5	2.1	16.2	0.6
B. FURNITURE	2.7	90.0	0.3	10.0	3.0	3.1	0.3	2.7	0.1
C. VEHICLES	1.9	90.0	0.2	10.0	2.1	2.2	0.2	1.8	0.1
D. EQUIPMENT	7.0	90.0	0.8	10.0	7.8	8.1	2.7	4.3	0.8
E. MCH MATERIALS	8.2	90.0	0.9	10.0	9.1	9.4	1.9	6.6	0.6
F. PROFESSIONAL FEES	0.7	90.0	0.1	10.0	0.7	0.8	-	0.7	-
G. LAND	-	-	2.5	100.0	2.5	2.5	-	2.5	-
H. DRUGS	9.2	90.0	1.0	10.0	10.2	10.6	1.1	8.5	0.7
I. LOCAL FELLOWSHIPS	1.6	100.0	-	-	1.6	1.7	-	1.6	-
J. LOCAL ADVISERS	7.3	100.0	-	-	7.3	7.5	-	7.3	-
K. FOREIGN FELLOWSHIPS	0.4	100.0	-	-	0.4	0.4	0.4	0.0	-
L. FOREIGN ADVISERS	0.4	100.0	-	-	0.4	0.4	0.4	0.0	-
M. S AND TRAINING MATERIALS	0.3	90.0	0.0	10.0	0.3	0.4	-	0.3	-
N. THENTAL CHARGES	-	-	2.1	100.0	2.1	2.2	-	2.1	-
O. CT FOR INNOVATIVE SCHEMES	5.4	90.0	0.6	10.0	6.0	6.2	-	6.0	-
P. LOCAL TRAINING	0.9	100.0	0.0	0.0	0.9	0.9	0.0	0.8	-
Total INVESTMENT COSTS	63.0	85.8	10.4	14.2	73.4	76.0	9.1	61.4	2.9
II. RECURRENT COSTS									
A. SALARIES OF ADDITIONAL STAFF	11.1	70.0	4.8	30.0	15.9	16.5	-	15.9	-
B. HONORARIUM	4.4	70.0	1.9	30.0	6.3	6.5	-	6.3	-
C. OPERATION AND MAINTENANCE OF VEHICLES	-	-	0.2	100.0	0.2	0.2	0.0	0.2	-
D. OTHER OPERATION AND MAINTENANCE	-	-	0.3	100.0	0.3	0.3	0.0	0.3	-
E. RENT OF HEALTH CENTER	-	-	0.5	100.0	0.5	0.5	-	0.5	-
Total RECURRENT COSTS	15.5	67.0	7.7	33.0	23.2	24.0	0.0	23.2	-
Total Disbursement	78.5	81.3	18.0	18.7	96.6	100.0	9.1	84.6	2.9

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ANNEX 21

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

INCREMENTAL COST ANALYSIS

TABLE 1: STATE FAMILY WELFARE EXPENDITURES 1985-91 AND PROJECTED (Rs MILLIONS

STATES	1985-86	1986-87	1987-88	1988-89	1989-90	1990-91	PROJECTED 1998/9
KARNATAKA	251.06	250.85	318.58	293.16	333.83	353.84	513.06
WEST BENGAL	248.57	267.21	305.60	329.64	380.89	507.05	731.5
DELHI ADMINISTRATION	246.19	276.63	278.38	280.80	372.12	410.62	595.4
ANDHRA PRADESH	-	339.03	386.42	438.83	514.91	738.31	1,070.5

TABLE 2: RECURRENT COSTS OF PROJECT IN FINAL YEAR OF PROJECT
(RS million)

CITY	1998/99
BANGALORE	24.4
CALCUTTA	65.1
DELHI	78.3
HYDERABAD	52.0
MOHFW	2.8
TOTAL	222.6

TABLE 3: IMPACT OF PROJECT RECURRENT COSTS ON PROJECTED STATE AND MUNICIPALITY BUDGET

A. Project as % of Projected Karnataka Family Welfare Budget = 4.7
B. Project as % of Projected West Bengal Family Welfare Budget = 8.9
C. Project as % of Projected Delhi Administration Family Welfare Budget = 13.1
D. Project as % of Projected Andhra Pradesh Family Welfare Budget = 4.8

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

SECTION 1: SUPERVISION PLAN

1. IDA

Since the Project incorporates several new elements which were not included in previous IDA-assisted Population Projects, IDA staff will closely monitor (supervise) the progress and impact of these elements. Community participation in project implementation, female education and gender analysis, the use of Revolving Funds for special studies, PMPs, PVOs, and Innovative Schemes, will require expertise in these areas to be included in supervision missions from time to time. The expected skill requirements and staff inputs are summarized in Table 1.

2. Borrower

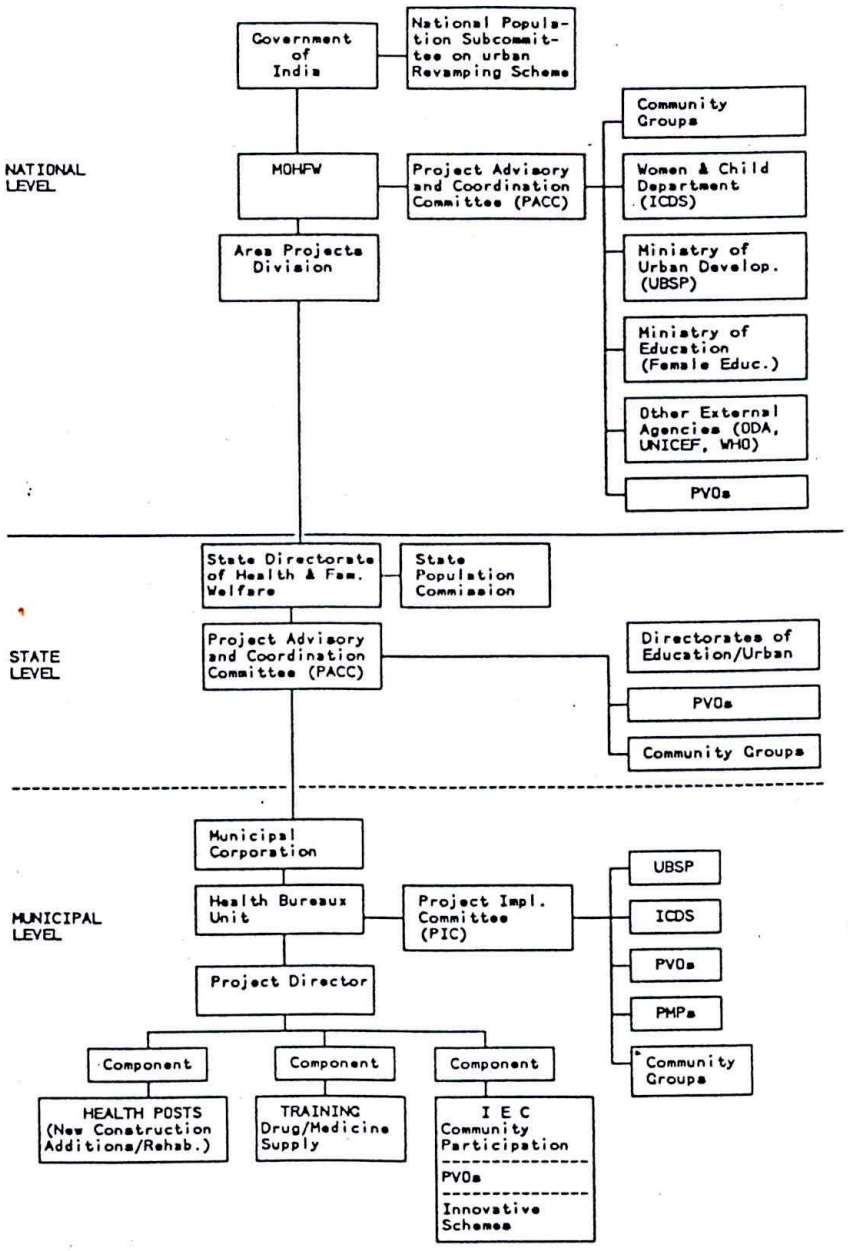
To supplement IDA staff supervision efforts, MOHFW, the States and Municipalities would prepare semi-annual reports (Part 2 of the Annex) under the coordination of the MOHFW Area Projects Division. Semi-annual reports will be submitted by the municipalities and States and consolidated by the Area Projects Division. These reports will provide data on progress in implementing inputs i.e. civil works, materials, training, financial outlays and expenditures, procurement of goods and services, etc. The States will also form PACCs and the municipalities will form Project Implementation Committees to assist in the planning, management and monitoring of Health Posts, Maternity Homes, and Upgraded Urban Family Welfare Centers. These tasks to be undertaken by these entities, will allow IDA staff to focus supervision missions on implementation progress at the three levels and on the major policy and program issues.

Supervision Outline

Approximate Dates	Activity	Expected Staff Requirements	Staff Weeks Estimates
FY 93 (1)	Supervision Mission (Initial Start-up)	Task Manager/Economist Architect/Engineer Public Health Spec./MD Women's Dev. Spec. Community Participation Training/IEC Specialist	24
FY 93 (2)	Supervision Mission	Population Specialist Public Health Spec. Health Economist	10
FY 94 (1)	Supervision Mission	Population Specialist Architect Engineer Community Participation Specialist Medical Education/ Training Specialist	12
FY 94 (2)	Supervision Mission	Public Health Spec./MD Women's Dev. Spec. IEC Specialist	12
FY 95 (1)	Supervision Mission	Population Specialist Architect Engineer Community Participation/ Public Health Specialist	12
FY 95 (2)	Supervision Mission	Medical Education/ Training Specialist Women's Dev. Spec. Monitoring and Evaluation Specialist	12
FY 96 (1)	Supervision Mission	Population Specialist Architect/Engineer Community Participation Spec. Public Health Specialist	10

FY 96 (2)	Supervision Mission (Mid-term Review)	Population Specialist Architect/Engineer Public Health Spec./MD Women's Dev. Spec. Medical Education/ Training Spec. Community Participation Specialist	24
FY 97 (1)	Supervision Mission	Task Manager Public Health Spec./MD Health Economist	12
FY 97 (2)	Supervision Mission	Monitoring and Evaluation Specialist Demographer Community Participation Specialist	12
FY 98 (1)	Supervision Mission	Population Specialist Women's Dev. Spec. Community Participation Specialist Public Health Spec./MD	12
FY 98 (2)	Supervision Mission	Women's Development Public Health Spec. IEC Specialist	12
FY 99 (1)	Supervision Mission	Population Specialist Public Health Spec./MD Health Economist	12
FY 99 (2)	Supervision Mission (Project Completion Report Preparation)	Population Specialist Public Health Spec./MD Architect/Engineer Women's Dev. Spec. Monitoring/Eval. Spec. Med./Training Spec.	20

SCHEMATIC ORGANIZATIONAL CHART



SECTION 2: OUTLINE OF PROGRESS REPORT

1. Key Indicators are divided into two categories: (a), overall project impact on the beneficiaries; and (b), project objective/activity achievements.

(a) Beneficiary Impact indicators would be:

- contraceptive prevalence rates by method, source and prevalence, including decreasing extrinsic incentives;
- immunization coverage;
- ante-natal care provided;
- post-natal care provided;
- institutional delivery/delivery by trained personnel;
- growth monitoring;
- births by percentages of birth orders;
- female literacy;
- numbers paying for some services;
- age of marriage increase.

(b) Project objective/activity achievement indicators would be:

1. Service Delivery Expansion: numbers of:
   * health centers/posts opened/upgraded;
   * maternity homes/PP Centers upgraded/provided;
   * Outreach Services increase.

2. Quality Improvement: numbers of:
   * persons trained, by category, topics, duration, frequency;
   * increase in quantity/quality/availability of drugs/medicines/supplies.

3. Increasing the demand for services: the kinds and extent of:
   * community participation in project activities, management and assessment;
   * PVO involvement;
   * PMP participation;
   * IEC activities;
   * female education.

4. Management Improvement: Actions taken to:
   * strengthening the health department;
   * improving the MIS and use as a management tool;
   * monitoring and evaluation data and refinement of project policies/practices.

5. Innovative Schemes: funding of and application of findings.

6. Female Involvement and Measurable impact: women advisory committee frequency of meetings and agendas related to improvement of services.

2. Progress Reports will be prepared by each City (Bangalore, Calcutta, Delhi and Hyderabad) on a semi-annual basis. Submission should be to the GOI/MOHFW and the World Bank by January 15 for the six month period ending December 31, and by July 15 for the six month period ending June 30. The reports should compare progress against the targets developed each year in the required Annual Action Plans to be submitted to the World Bank by January 31 each year. These reports should be an integral part of the management/MIS system for implementing the project rather than as a separate activity. The reports are intended to :

(a) document progress in achieving Project Goals and Objectives;

(b) identify problems and constraints; and

(c) outline recommendations, policies and practices to be incorporated for solving the problems encountered.

3. Since the Project has five major components, the Reports should be organized into five discrete chapters, including tables and annexes as appropriate. A sixth Chapter should be added to summarize the financial aspects of the project such as budget allocations, expenditures and submission of withdrawal applications. Information on contracts awarded or in process may also be mentioned.

4. The Chapters should begin with a statement of the objective, the project activities by which the objective would be achieved and the ways of determining progress in meeting identified and time bound targets. The following is the proposed outline.

OUTLINE FOR SEMI-ANNUAL PROGRESS REPORTS

CHAPTER I

OBJECTIVE: EXPAND THE SUPPLY OF FAMILY WELFARE SERVICES

1. This would be achieved by:

Bangalore
(a) establishment of new Health Centers/Health Posts;
(b) strengthening existing Health Centers;
(c) upgrading Maternity Homes to upgraded Health Centers;
(d) expanding the Outreach Program through link workers and community participation.

Calcutta
(a) opening of new subcenters/Health Administrative Units;
(b) increasing the number of "Expanded Out-Patient Departments" (ESOPDs) at existing Maternity Homes/Hospitals;
(c) renovation of existing and construction of new Maternity Homes to include satellite units (neo-natal and PP Centers)
(d) construction of two Regional Medical Stores;
(e) expanding the outreach program through Honorary Health Workers and local committees.

Delhi
(a) opening of 650 Health Posts;
(b) establishment of 25 Health Centers, including 6 upgraded;
(c) provision of 19 Mobile Health Clinics (Vans);
(d) expanding the outreach program through Link Workers and local cooperatives.

Hyderabad
(a) construction of 56 new Health Centers;
(b) renovation of 14 existing Health Centers;
(c) establishment of 13 new and strengthening 4 existing upgraded Health Centers;
(d) expanding the outreach program through community based Link Workers.

2. The Implementing Authority should report on each of these listed activities. Progress should be measured against Annual Targets which will have been developed by January 31 of each year. Charts and Tables should be used whenever possible. For example a Table could be developed as follows:

Bangalore: Establishing, Strengthening, Upgrading Health Centers, Maternity Homes

	Total in Project	Total in 1993	Achievement as of 6/30/93	% annual achiement
established	60	15	8	53%
strengthening	37	20	25	120%
upgraded (Mat.)	24	16	12	75%

3. A Table should also be created showing the appointment of staff for the expansion of outreach capacity. These data may be cross-referenced with other chapters such as Training for greater detail.

4. The Chapter should conclude with two or more paragraphs, (a) problems encountered, and (b) proposed solutions to be taken during the next period.

CHAPTER II

OBJECTIVE: IMPROVING THE QUALITY OF FAMILY WELFARE SERVICES

1. This would be achieved by:

Bangalore, Calcutta, Delhi and Hyderabad ---
(a) Training all categories of Family Welfare Workers, including Community Volunteer Workers, PVOs and PMPs; and,
(b) Improving the supply, variety, budget, and distribution of drugs, medicines, and supplies.

2. This Chapter should provide information on all the training activities being undertaken by the Project. Annex 12 outlines an Annual Training Plan format with targets for the number of persons to be trained each year, the areas in which they are to be trained, and the location and duration of training. This draft plan should be revised and updated as an essential feature of the Annual Training Plan.

3. The reporting which will be undertaken semi-annually should be measured against the targets established for the Annual Training Plan and an appropriate Table should be included showing the annual training levels proposed compared to actual achievements.

4. This Chapter also should indicate efforts taken to recruit and train Trainers, progress in developing curricula and instructional materials, and collaboration with PVOs, Medical Schools, and other public or private training institutions.

5. This Chapter should describe efforts taken to improve the supply, budget, variety ,and distribution of drugs, medicines, and supplies. It initially might include the standard lists of medical stores and subsequently indicate revisions and improvements in the system.

The Chapter should conclude with Problems and Proposed Solutions.

CHAPTER III

OBJECTIVE: INCREASING THE DEMAND FOR FAMILY WELFARE SERVICES

1. This would be achieved in Bangalore, Calcutta, Delhi and Hyderabad by:

(a) community participation, including
* community's involvement in the project's designated activities
* organization and implementation of community-designed activities
* community's involvement in the project's management and on-going assessment;

(b) involvement of PVOs, including steps taken to increase numbers of PVOs participating in the project,

(c) involvement of Private Medical Practitioners, including the process to increase numbers participating, the kinds of activities they have undertaken, and the role of the IMA or other professional organizations;

(d) information, education and communication programs, including the specific IEC intervention and target audience to be addressed, and how results of the program were measured andrevised where appropriate;

(e) female education, including specific program elements in
* early child care/creches (open centers, materials, train workers)
* primary education (renovation, construction, stipends, free uniforms,teacher training, textbooks and supplies)
* non-formal education (open centers, skill training, self-employment).

2. The Reports should include information on each of the activities outlined above, with cross references to other Chapters and Annexes where indicated. It is also important to reference the civil works/construction which is to br undertaken for facilities in Chapter 1.

3. The Chapter should conclude with Problems encountered in each activity ,and the proposed Solutionsto be employed during the next reporting period.

CHAPTER IV

OBJECTIVE: IMPROVING THE MANAGEMENT OF FAMILY WELFARE SERVICES

1. This would be achieved by:

Bangalore

(a) conversion of the City Family Welfare Bureau into an administrative and Monitoring unit;
(b) establishing IEC and Training Units;
(c) reorganizing the MIS;

(d) formation of an Apex Committee under the chairmanship of the Mayor and a Coordination committee under the Corporation Commissioner to review progress of the Project.

Calcutta
(a) strengthening the Monitoring and Computer Cell in the Health Unit in the Calcutta Metropolitan Development Authority (CMDA);
(b) establishment of 109 Health Administrative Units (HAUs);
(c) formation of an Implementation Committee, Zonal Coordination Committees for Municipalities, and Local Committees at the Ward level.

Delhi
(a) --to be determined at appraisal---

Hyderabad
(a) establishment of a Project Implementation Unit in the Health Unit of the Corporation;
(b) establish three units in the PIU for Service Delivery, Training, and Monitoring and Evaluation;
(c) formation of a Project Implementation and Coordination Committee under th Chairmanship of the Corporation Commissioner.

2. Each City should report on the progress in establishing their respective units, cells and committees. This can be shown by appointment of staff as outlined in Annex 16. The reports also should include detailed information on the activities of the units, cells and committees.

3. The functioning, activities and results of the MIS, monitoring and evaluation should be described and compared to the Annual Plans prepared for that year. The use of Rapid Low Cost Studies (RLCS) should be reported upon, particularly how the studies are being used in planning, management and evaluation in the project.

4. The Chapter should conclude with descriptions of major Problems encountered and the proposed Solutions to be employed during the next reporting period.

CHAPTER V

OBJECTIVE: INNOVATIVE SCHEMES

1. This Objective would be achieved by:

Bangalore
(a) supplementary nutrition for pregnant and lactating mothers and children 0-3 years of age;
(b) intensive Health Education among the urban poor;
(c) promotion of women's education in the minority community, focussing on drop-outs;
(d) community involvement in sanitation drives;
(e) Health and Family Welfare Education among adolescent girls in a non-formal education setting;
(f) an education program for men on women's problems and the importance of the girl child.

Calcutta
(a) supplementary nutrition for children between 0-5 years;
(b) sanitation program upkeep and cleanliness of facilities;
(c) anti-larval program;
(d) creche program to be attached to HAUs.

Delhi
(a) sanitation program with community participation;
(b) strengthening program for control of gastroenteritis.

Hyderabad
(a) supplementary nutrition program for pregnant and lactating mothers and toddlers;
(b) integration of services of ANMs and Anganwadi workers;
(c) study of fertility behavior among minority groups;
(d) sanitation drive in community;
(e) income generation among women in slums;
(f) clean hut competition;
(g) well baby clinics;
(h) STD studies.

2. Each City should describe how its Revolving Fund for supporting innovative schemes is administered, including the review process, grant procedures and a listing of all schemes funded and to whom, and for what purpose and duration. The frequency and amounts of replenishing the Revolving Fund also should be reported.

3. Each City should describe fully activities completed in each innovative scheme, and how effectiveness was or is being measured. Exemplary scheme's results should be analyzed and reported upon fully, and schemes lacking effective results and abandoned also should be described.

4. This Chapter should conclude with a description of Problems encountered and Solutions to be employed for remediation.

SECTION 3: SPECIAL STUDIES

1. Special studies which are separate from the regular ongoing monitoring and evalution activities would be undertaken. They may be based on further anlysis if data exists or involve limited new data collection. Special studies will be finalized after the study of the results from the four initial Baseline Survey, which by themselves provide rich data source for analysis. The list below is illustrative of the kinds of special studies the project municipalities would pursue:

(a) determinants for Child Marriage;

(b) determinants of enrollment and retention of girls in school;

(c) operational research, evaluating the proposed strategy of PVO identification and training of PMPs;

(d) KAP of birth spacing;

(e) cultural/social practices influencing maternal and child health with special emphasis post-partum call and child rearing;

(f) male KAP of MCH and family planning; and

(g) Mother-in-law KAP of MCH and family planning.

ANNEX 23

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

FORECAST OF ANNUAL EXPENDITURES AND DISBURSEMENTS

IDA FISCAL YEAR	EXPENDITURES		DISBURSEMENTS	
	SEMESTER	CUMULATIVE	SEMESTER	CUMULATIVE
	(US$ MILLIONS)			
FY 93				
1st -Jul 92 - Dec 92	---	---		
2nd -Jan 93 - June 93	4.15	4.15	8.00 /a	8.00
FY 94				
1st -Jul 93 - Dec 93	4.15	8.30	2.50	10.50
2nd -Jan 94 - June 94	8.05	16.35	6.90	17.40
FY 95				
1st -Jul 94 - Dec 94	8.05	24.40	6.90	24.30
2nd -Jan 95 - June 95	7.25	31.65	5.90	30.20
FY 96				
1st -Jul 95 - Dec 95	7.25	38.90	5.90	36.10
2nd -Jan 96 - June 96	8.25	47.15	6.60	42.70
FY 97				
1st -Jul 96 - Dec 96	8.25	55.40	6.60	49.30
2nd -Jan 97 - June 97	7.30	62.70	5.80	55.10
FY 98				
1st -Jul 97 - Dec 97	7.30	70.00	5.80	60.90
2nd -Jan 98 - June 98	6.50	76.50	5.20	66.10
FY 99				
1st -Jul 98 - Dec 98	6.50	83.00	5.20	71.30
2nd -Jan 98 - June 99	6.75	89.75	5.50	76.80
FY 2000				
1st -Jul 99 - Dec 99	6.85	96.60	2.20	79.00

/a Includes Special Account and Retroactive Financing.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

SECTION 1: RATIONALE FOR RECOMMENDED METHODS OF PROCUREMENT OF SELECTED DRUGS

1. Generally the normal Bank methods and thresholds required for projects in India will be applicable to this project. Some exceptions are warranted, however, because of the special nature of drug (vaccine, medicine and vitamin) manufacture and supply.

2. Vaccines. There is an economic reason why it is unlikely that foreign manufacturers would be interested in entering the Indian market for these vaccines. There is no "natural" demand for these items. In contrast to other pharmaceuticals where there is some demand in the private sector, the vaccines needed for the project, like all preventive medicines, do not combat illnesses that are considered an immediate threat to life and they are included only in government programs aimed at improving the general level of health in the population. Governments typically target the poorest level of society for these programs with the result that, even in the developed world, prices tend to be controlled and profit margins very slim. Therefore, there is usually little idle manufacturing capacity available because manufacturers are not inclined to invest in plant to produce these vaccines when other items can be more profitable. For this reason and those relating to logistics, WHO recommends that governments establish either a local or a regional manufacturing capability for all vaccines that are on the WHO "essential" list.

3. Logistics are a key factor in deciding what procurement approach is appropriate. Use of local sources to the maximum extent is justified by the need to reduce the risk of loss during transport alone. The vaccines covered by the project must be shipped in a refrigerated state and even a brief exposure to heat can either drastically reduce its shelf life or destroy it completely. In addition, the Government controls which are imposed, combined with monitoring by WHO, ensure that the required quality standards are kept and that the prices charged are reasonably related to actual cost.

4. The market situation affecting each vaccine and each has been considered previously by IDA [Child Survival and Safe Motherhood Project (Cr. 2300-IN) of September 1991].

(a) Oral Polio: There are three existing local suppliers of oral polio vaccine which do not as yet meet all of MOHFW's needs. These firms are (i) a Central Government enterprise (Babcock) which has a collaboration and imports the raw material it needs in bulk from Russia; (ii) a State Government enterprise (Haffkine) which procures its raw material from various foreign sources selected through competitive bidding; and (iii) a private sector company (Radicula) which has a foreign collaboration with and obtains its raw materials from an Italian firm. The shortfall of less than 10% is covered by imports purchased by UNICEF's Copenhagen office using their global competitive bidding

procedures and offered to the Ministry on a grant basis. There are delivery losses with some of these imports because of failures in maintenance of the "cold chain." The use of the existing LCB procedure regardless of estimated contract value has been accepted by the Bank under the CSSM Project because of the importance of minimizing the distance between supplier and end-user.

(b) DPT and TT: There are five or six WHO-approved local suppliers respectively for these vaccines. All have proven that they can deliver acceptable quality vaccines with a minimum of loss due to refrigeration problems during delivery. The use of LCB procedures regardless of the estimated contract value has been accepted by the Bank, for the same reasons as for the polio vaccine.

(c) BCG: There is only one WHO-approved source of BCG supply in India: BCG Laboratories India, Guindi, and only nine others in the world. There is a current shortage of supply worldwide. Procurement of BCG by direct contracting from BCG Laboratories India has been accepted by the Bank because of delivery problems. In any event, given the world supply situation, ICB would be unlikely to result in lower costs. Any shortfall in supply should be made up by international shopping.

(d) Measles: There are two strains of measles vaccine in the world, E-Z and Schwartz. WHO recommends use of E-Z in India because it can be administered to children younger than 9 months. There are only two manufacturers of the EZ strain in the world: a Yugoslavian firm and the Indian firm preferred by MOHFW which has a collaboration with this Yugoslavian firm. To avoid delivery problems the Bank has previously agreed to procurement by direct contracting from any Indian manufacturer.

5. Vitamin A. MOHFW has opted for ease of administration to young children and to achieve better overall compliance, to dispense the Vitamin A covered by the project during clinic visits in liquid form. The most common alternative, soft gelatin capsules which are generally used in the West are prone to degradation under the extreme temperatures prevailing during much of the year in India with consequent loss of potency. Vitamin A in liquid formulation is not available elsewhere in the world. The Bank has previously agreed to the use of LCB for procurement of Vitamin A from all approved local manufacturers.

SECTION 2: LCB PROCUREMENT: DEFINITION OF ROLES AND RESPONSIBILITES BETWEEN MINISTRY OF HEALTH AND FAMILY WELFARE (MOHFW) AND DIRECTORATE GENERAL OF SUPPLIES AND DISPOSAL (DGS&D)

Pre-Procurement Activities

1. Schedule of requirements	MOHFW
2. Technical specifications	MOHFW
3. Packaging specification	MOHFW
4. Dose specifications	MOHFW
5. Delivery schedules	MOHFW
6. Post qualification technical criteria	MOHFW
7. Quality parameters	MOHFW
8. Preparation of bid documents	DGS&D
9. IFB	DGS&D

Procurement Processing

Relase of tenders	DGS&D
Bid opening	DGS&D
Comparative analysis of bids	DGS&D
Bid evaluation - MOHFW to be involved in technical evaluation	
Tender award	DGS&D
Follow up of supplies	DGS&D
Dispute resolution	DGS&D

Post Procurement

Inspection	MOHFW
Quality testing and sampling	MOHFW
Receipt and verification	
Distribition	MOHFW

DGSD has the necessary expertise in procurement and dispute resolution and can, exercise leverage on suppliers because of its special role as the GOI's principal procurement organization.

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

SELECTED DOCUMENTS AND DATA AVAILABLE IN THE PROJECT FILE

A. GENERAL REPORTS, STUDIES AND DATA COLLECTIONS

A-1 Health and the Cities: A Global Overview. WHO, Geneva, May 1991.

A-2 Health of the Underprivileged. Country Paper India. WHO Geneva, July 1990.

A-3 Evaluation of the Health Program of the Calcutta Metropolitan Development Authority; a Component of the World Bank supported Calcutta Urban Development Project III (CUDP III). Evaluation Team led by the World Health Organization with participation of the World Bank (Third Draft) - December 1991.

A-4 Report of the Interregional Meeting on City Health: The Challenge of Social Justice Co-Sponsored by Aga Khan University, FINNIDA; METROPOLIS, UNICEF, UNDP, WHO. Division for strengthening of Health Services, WHO Geneva. November 1989.

A-5 World Health Quarterly - Volume 42, No.4, 1989 - WHO, Geneva.

A-6 World Health Quarterly - Volume 43, No.3, 1990 - WHO, Geneva.

A-7 Urban Basic Services Programme in Andhra Pradesh - Ganesan, N.; Regional Center for Urban and Environmental Studies, Osmania University, Hyderabad.

A-8 Special Study - Reaching Urban Women with Family Planning Services in Ahmedabad, India; The Center for Development and Population Activities; October 1991.

A-9 National Workshop on UBS Implementation: Ministry of Urban Development, UNICEF, New Delhi, December 1989.

A-10 Report of The National Commission on Urbanization - Volume 1, August 1988.

A-11 Early Childhood Mortality and Perinatal Period Management in Urban Poor. Report submitted to the Ministry of Health and Family Welfare (under USAID Child Survival Programmes) by Department of Pediatrics, Maulana Azad Medical College, New Delhi, September 1991.

URBAN BASIC SERVICES

A-12 Urban Basic Services for Poor: Selection Process for Appointment of APOs and COs. Hyderabad Field Office, UNICEF, February 5, 1992.

A-13 Urban Basic Services Program: A Reference Manual - National Institute of Urban Affairs in Cooperation with UNICEF, New Delhi, July 1989.

A-14 Process of Community Mobilization: The Hyderabad Experience, UNICEF, New Delhi, 1990.

A-15 The Efforts of UCD Project, Municipal Corporation, Visakhapatnam, to Improve the Health and Socio-Economic Conditions of Urban Poor through Neighbourhood Committees with Emphasis on Development of Women and Children in Visakhaptnam City - Future Visions and Plans, A Profile and Case Study, Subba Rao, D.V.

A-16 Case Studies in Bihar - Urban Basic Services for Poor, Department of Urban Development, Government of Bihar, Patna.

A-17 Accessability and Utilization of Basic Services in Selected Urban Slums with Special Reference to Women and Children: Summary Report - Operations Research Group, Baroda, 1988.

A-18 Urban Basic Services program in Bhilwara and Banswara Districts - An Assessment, UNICEF.

A-19 Accessability to Basic Services in Slums of Five Urban Centers - with Special Reference to Women and Girl Child, Bhawanipatna, Kanpur, Kumbakonam, Madanrting and Raykot - Operations Research Group, January 1990.

B. REPORTS AND STUDIES RELEVANT TO THE PROJECT

BANGALORE

B-1 Plan for Delivery of Family Welfare Services in Urban Slums based on the Needs Assessment of Beneficiaries (Slum Dweller), Communications, Training of Staff and KAP Study of Private Practitioners in Urban Slum of Cities with more than Five Lakh Population - National Institute of Health and Family Welfare, New Delhi, August 1991.

B-2 Plan for Delivery of Family Welfare Services in Urban Areas - Bangalore Summary Report - N.I.H.F.W., New Delhi, July 1991.

B-3 Proceedings of the First Meeting held with World Bank mission at Mayo Hall, Bangalore, August 8, 1991.

B-4 Plan for Delivery of Family Welfare Services in Slums based on Need Assessment of Slum Dwellers in Bangalore city, Department of Health, Bangalore City Corporation, October 12, 1991.

B-5 Plan for Delivery of Family Welfare Services in Slums based on Need Assessment of Slum Dwellers in Bangalore City, Department of Health, Bangalore City Corporation, October 30, 1991.

B-6 Additional Information/Clarifications for Eighth Population Project - Department of Health, Corporation of City of Bangalore, November 30, 1991.

B-7 World Bank Aided Eighth India Population Project: Bangalore, Municipal Corporation, Feburary 1992.

CALCUTTA

B-8 Background Paper on IPP VIII for Calcutta Metropolitan District over a period of 5 years. Calcutta Metropolitan Development Authority - July 1990.

B-9 Integrated Health Programme for Calcutta Metropolitan Area (Proposed IPP VIII) Project Proposals; Calcutta Metropolitan Development Authority for Health Department, Government of West Bengal; September 1991.

B-10 Integrated Health Programme for Calcutta Metropolitan Area (Proposed IPP VIII). Supplementary input to project proposal of September 1991; Calcutta Metropolitan Development Authority for Health Department, Government of West Bengal; November 1991.

B-11 India - Eighth Population Project in Calcutta Metropolitan District - Government of West Bengal - Health Program Unit.

B-12 Integrated Health Program for Calcutta Metropolitan Area (Porposed IPP VIII) Final Project Report - Calcutta Metropolitan Development Authority for Health Department, Government of West Bengal, February 1992.

DELHI

B-12 Primary Health Care for Urban Poor - Delhi - A Project Proposal; Medical and Public Health Department, Delhi Administration, October 1991.

B-13 Delhi-Plan for the Delivery of Family Welfare Services in Urban Slums Based on Need Assessment of Beneficiaries (Slum Dwellers Communication, Training of Staff and KAP Study of Private Practitioners in Urban Slums with Cities with more than 5 Lakh Population. NIHFW, Delhi, July 1991.

HYDERABAD

B-14 Assessment of Family Welfare and Primary Health Needs and Formulation of Proposals for their Strengthening in Hyderabad City. Supplement to Revised Proposals: Directorate of Family Welfare, September 1991.

B-15 Assessment of Family Welfare and Primary Health Needs and Formulation of Proposals for their Strengthening in Hyderabad City. Supplement to Revised Proposals: Directorate of Family Welfare, A.P. and Municipal Corporation of Hyderabad, November 1991.

B-16 Strengthening of Family Welfare and Primary Health Care Services in Municipal Corporation, Hyderabad. India Population Project VIII: Final Proposals - Municipal Corporation of Hyderabad, February 1992. Supplement to Final Proposals, Municipal Corporation of Hyderabad, February 1992.

B-17 Hyderabad Slum Improvement Project - Implementation Manual (O.D.A (UK Govt. Funding)) T. Rajagapala, Consultant. Hyderabad, 1990.

B-18 Report on Health Education Workshop for ODA Slum Improvement Programs. Regional Center for Urban and Environmental Studies, Osmania University - April 1991.

B-19 Report, Recommendations and Follow-up Actions on Workshops for Health Personnel by V.K. Consultants - Hyderabad Slum Improvement Project: Mathur, O., Reddy, S.

B-20 Report on Assessment of Family Welfare and Primary Health Care Needs and Formulation of Proposals for their Strengthening in Hyderabad City - Raju, R.S., *. Director of Medical and Health (DEMO), Directorate of Family Welfare. Hyderabad, July 1991.

B-21 Hyderabad Slum Improvement Project III - Baseline Survey (sponsored by the Municipal Corporation of Hyderabad and the ODA, UK). Regional Center for Urban and Environmental Studies, Osmania University, Hyderabad, 1991.

CHART 1

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

MATERNAL AND CHILD HEALTH SERVICES BENEFICIARIES
IMMUNIZATION PROGRAM (1970-1989)

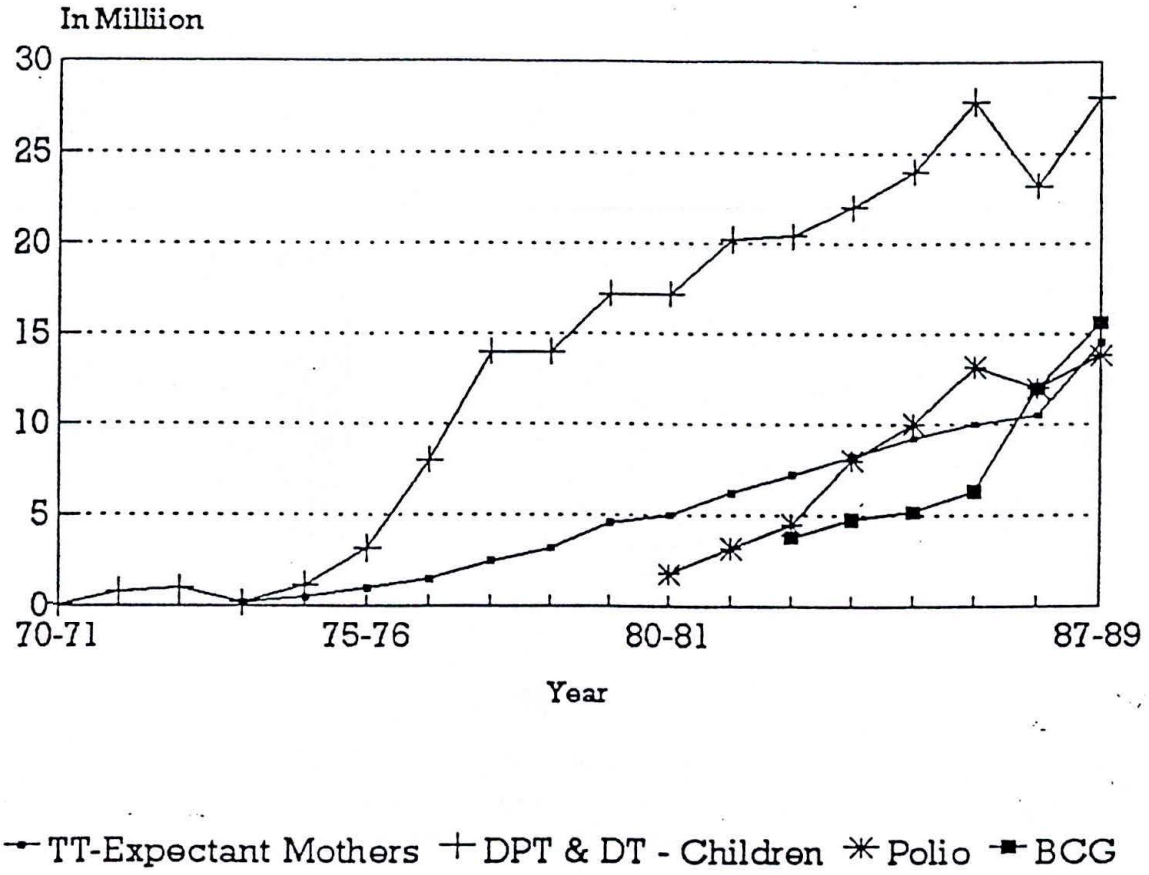
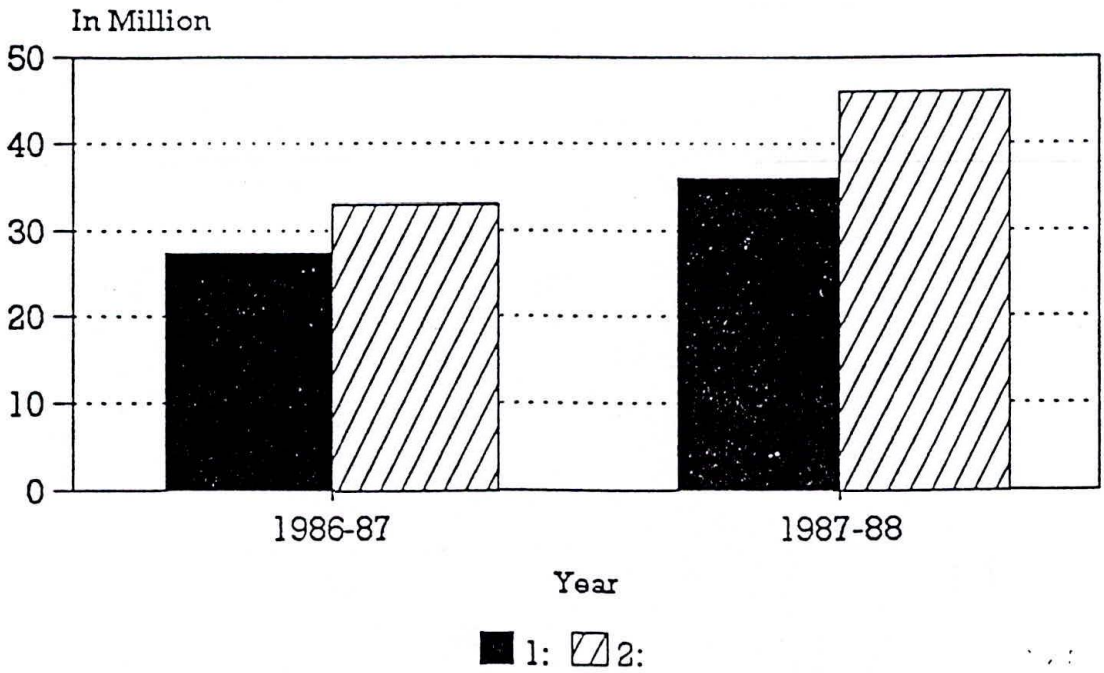


CHART 2

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

MATERNAL AND CHILD HEALTH SERVICES BENEFICIARIES
PROPHYLAXIS PROGRAM (1986/87-1987/88)



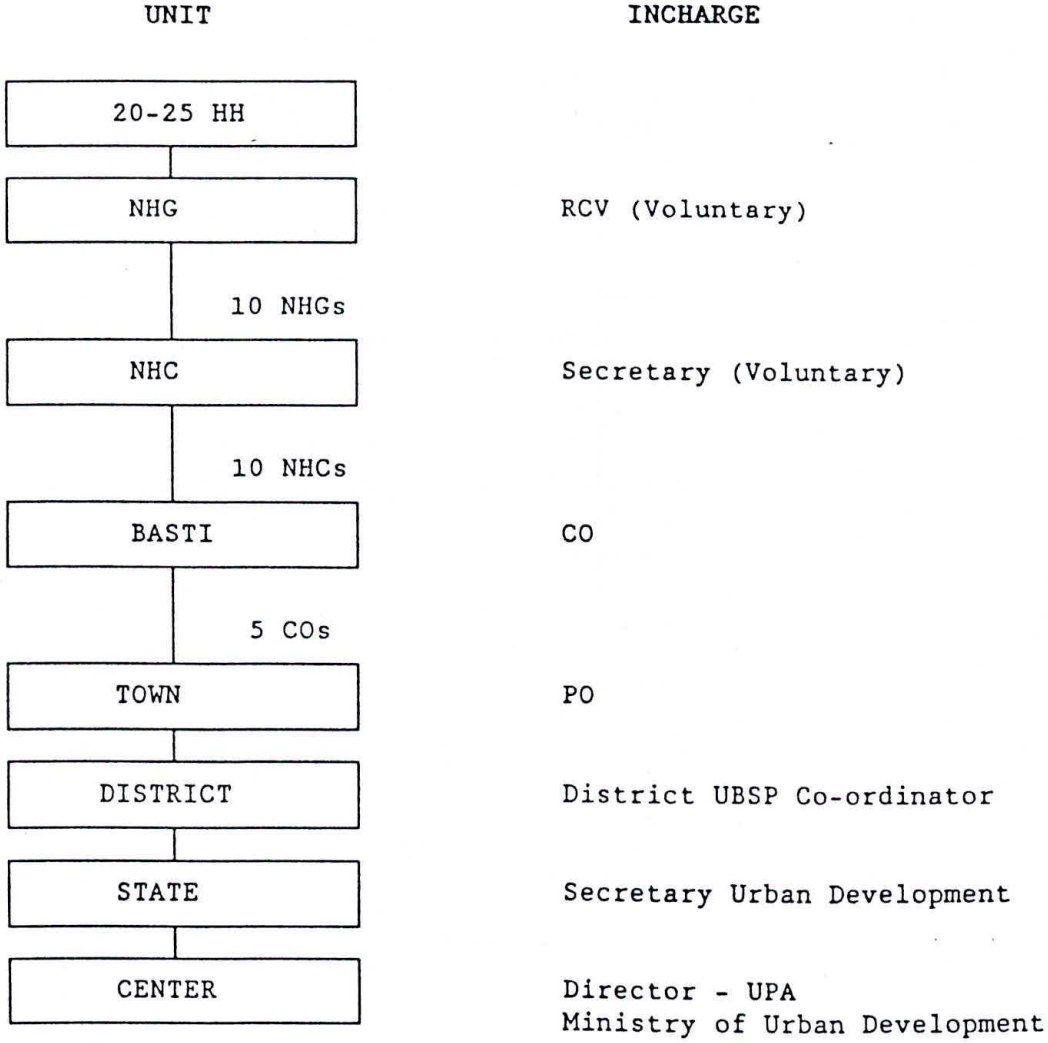
1:Against Nutritional Agaemia among mothers & children (completed)
2:Against Blindness-Children-Vit. A Def.

CHART 3
Page 1

INDIA

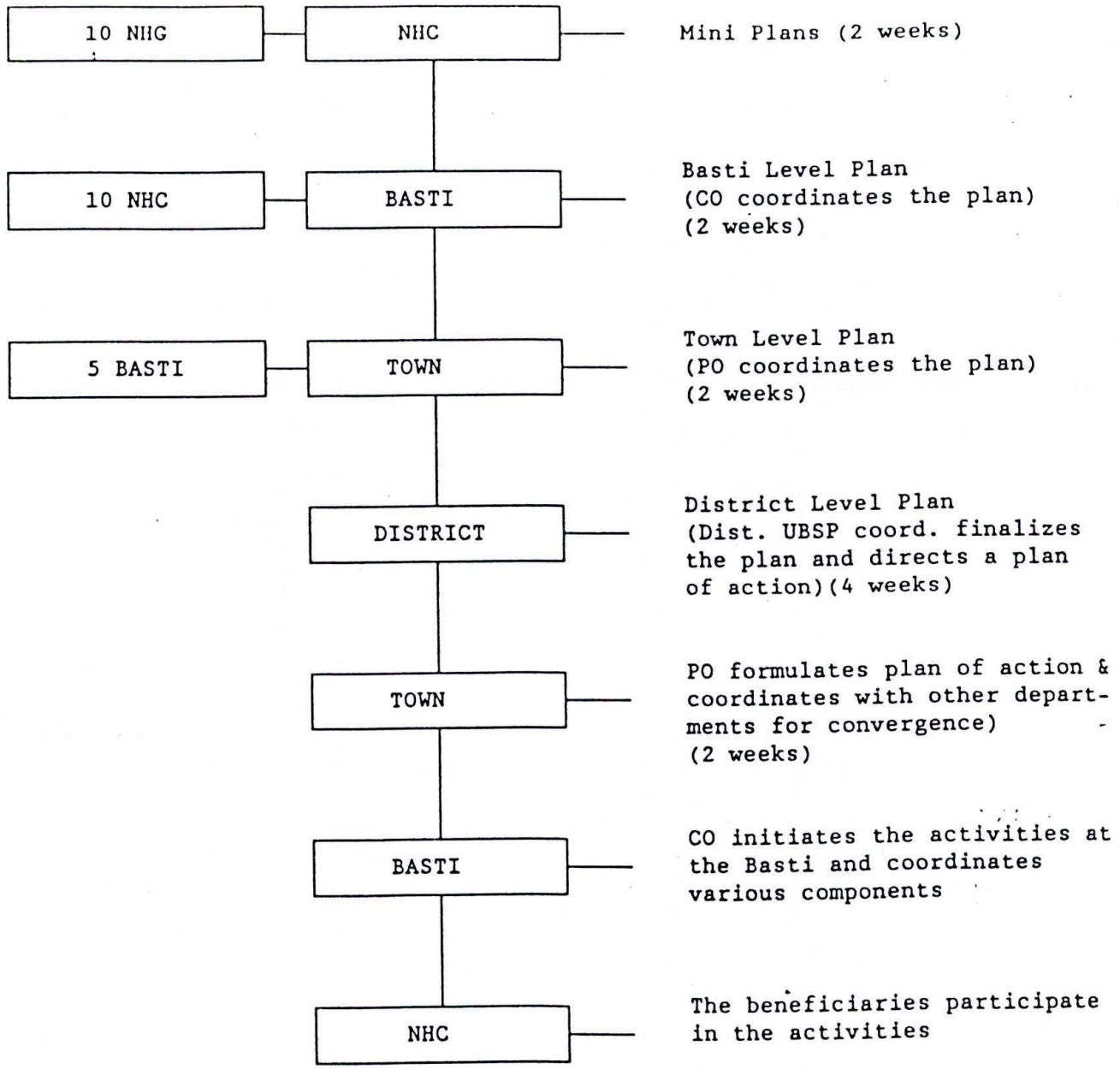
FAMILY WELFARE (URBAN SLUMS) PROJECT

ORGANIZATIONAL STRUCTURE OF THE URBAN BASIC SERVICES FOR POOR PROGRAM



UBSP - Urban Basic Services for the poor
HH - Households
NHG - Neighborhood Group
NHC - Neighborhood Committee
CO - Community Organizer
PO - Project Officer

ACTION PLAN FOR UBSP ACTIVITIES



Total estimated time taken from formulation of mini plans to the beginning of activities - 12 weeks.

CHART 4

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

BANGALORE: PROJECT IMPLEMENTATION ORGANIZATION

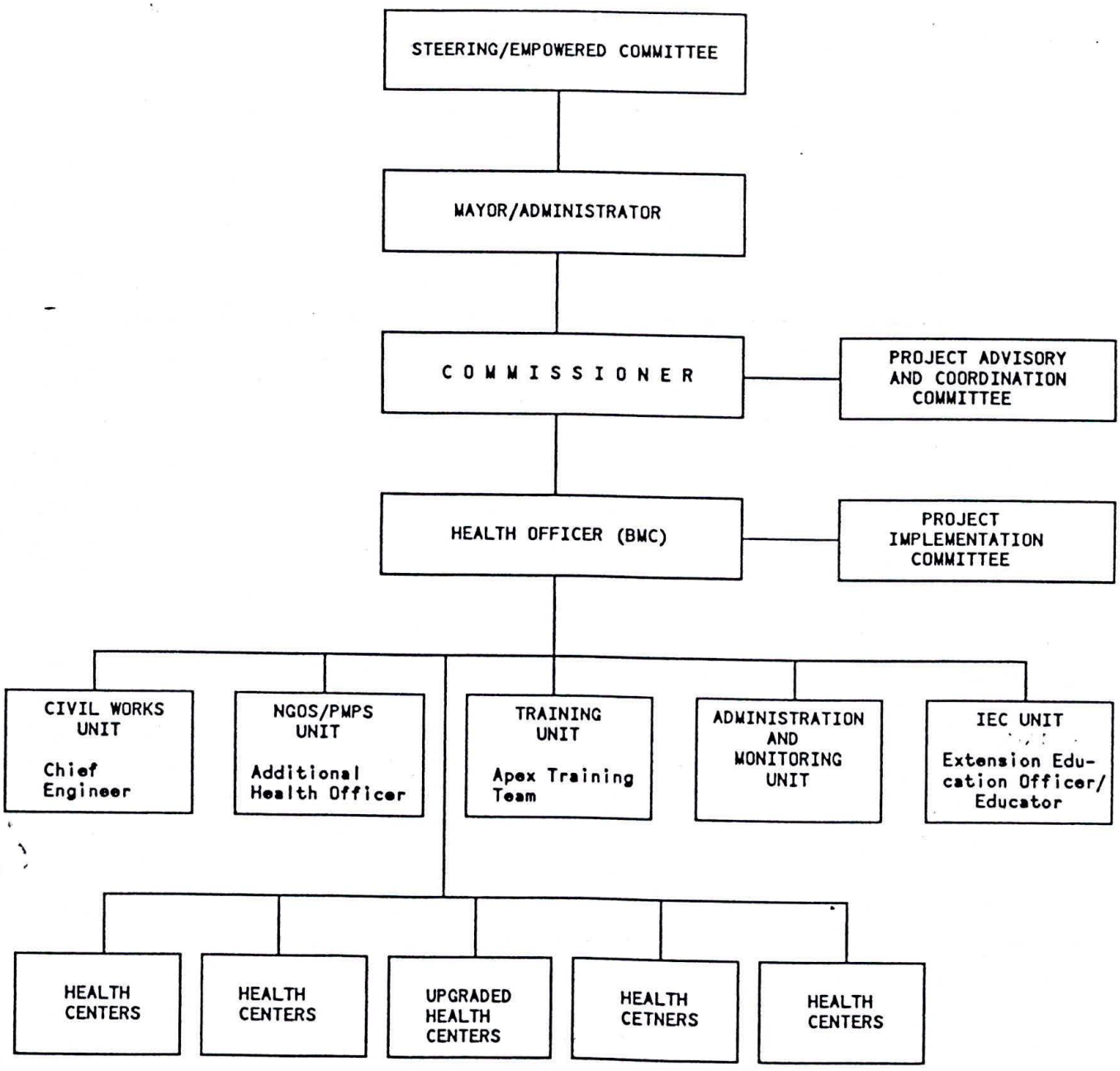


CHART 5

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

CALCUTTA: PROJECT IMPLEMENTATION ORGANIZATION

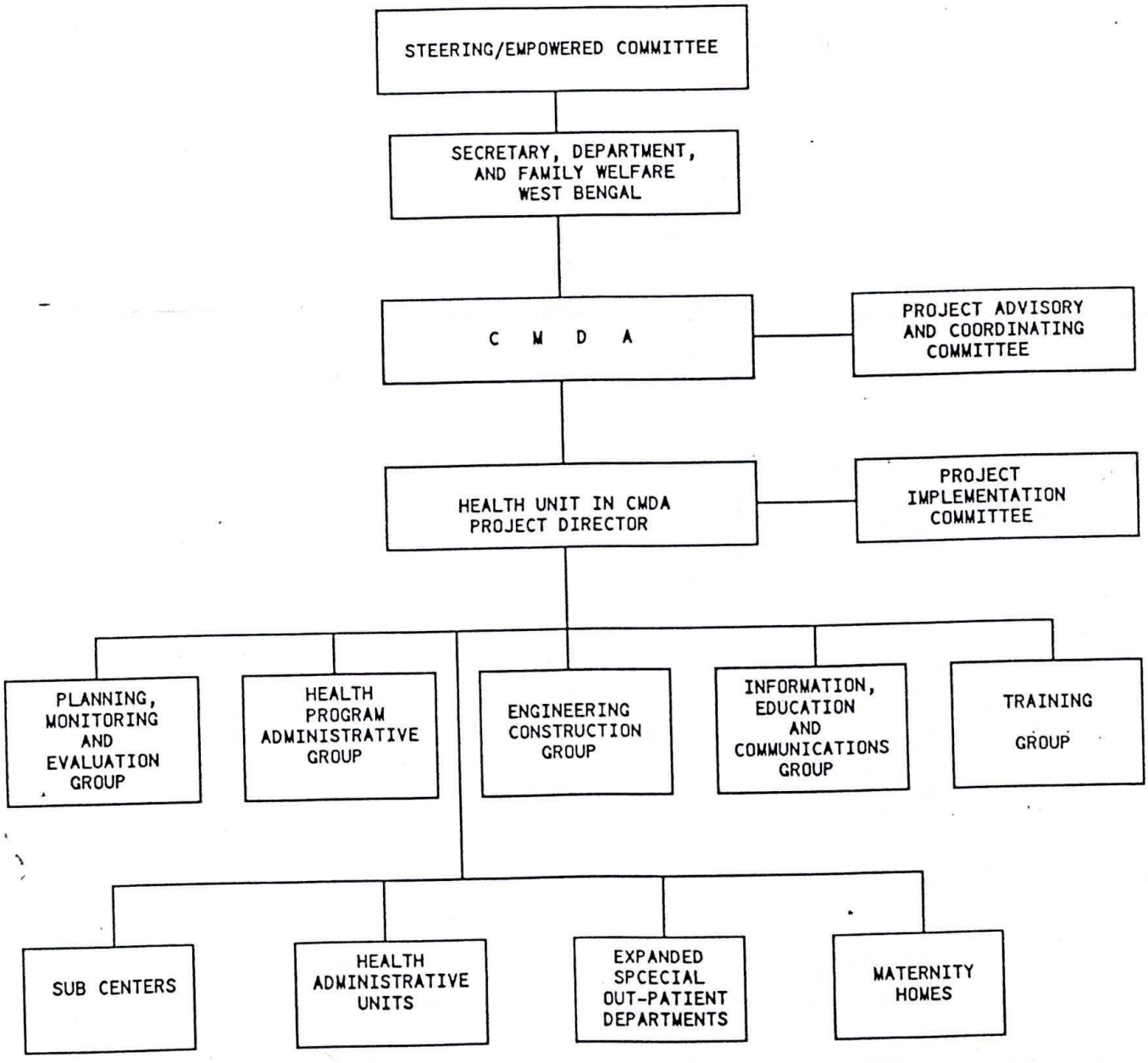


CHART 6

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

DELHI: PROJECT IMPLEMENTATION ORGANIZATION

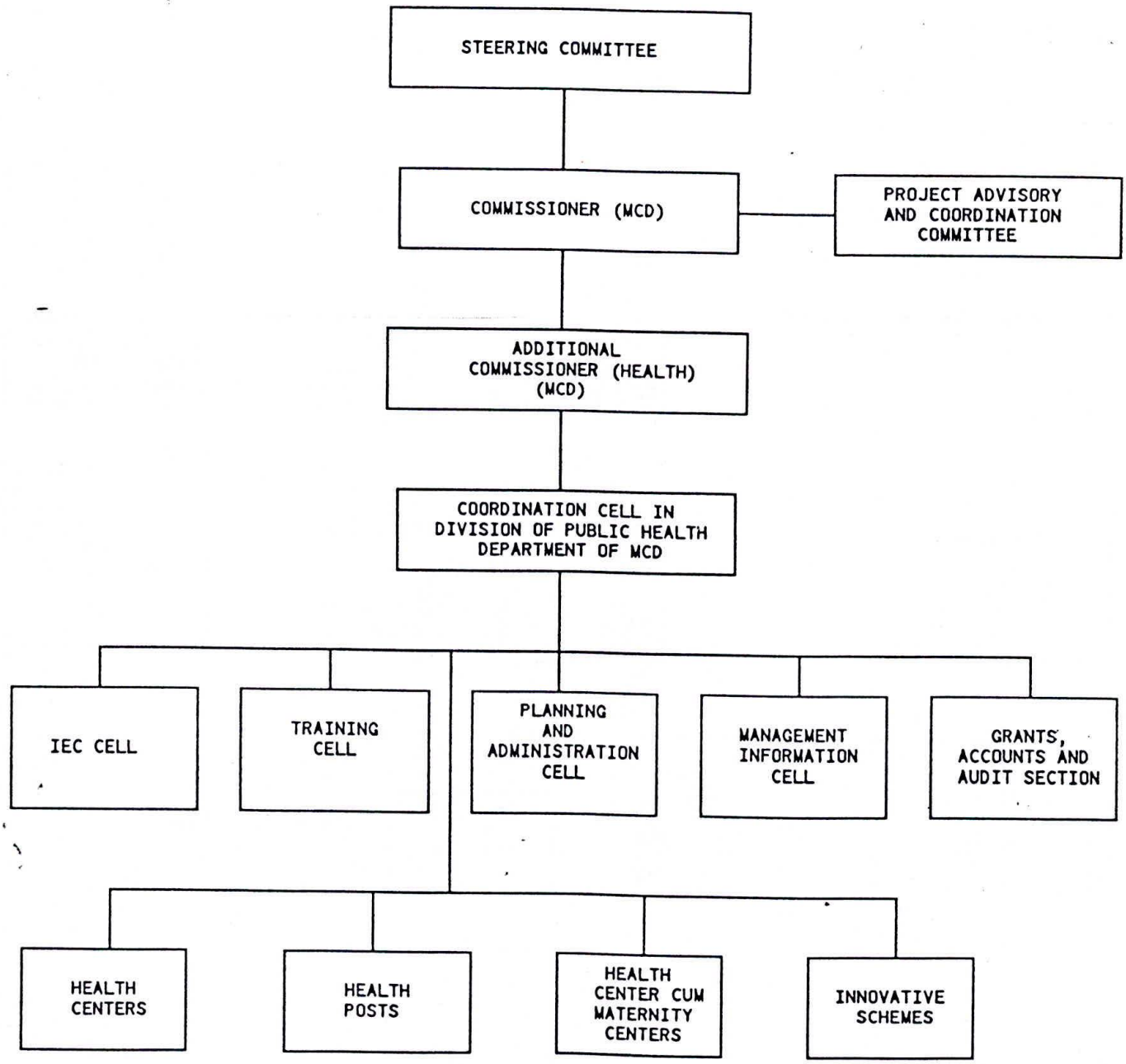


CHART 7

INDIA

FAMILY WELFARE (URBAN SLUMS) PROJECT

HYDERABAD: PROJECT IMPLEMENTATION ORGANIZATION