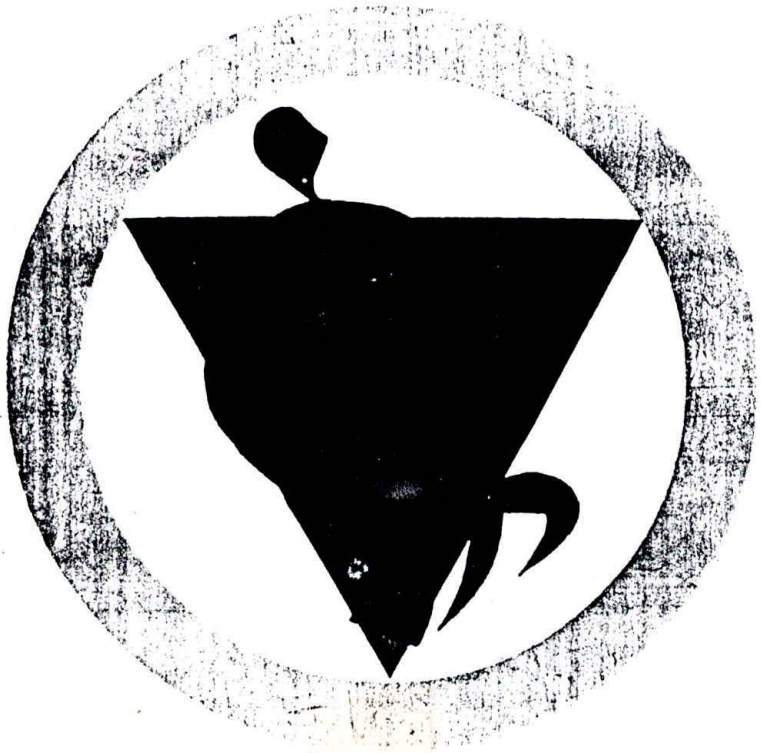
Dr. Mira Shiva

REPRODUCTIVE AND CHILD HEALTH PROGRAMME

Schemes for implementation

October, 1997



DEPARTMENT OF FAMILY WELFARE
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

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REPRODUCTIVE AND CHILD HEALTH PROGRAMME

1. The Family Planning Programme was started in 1951 as a purely demographic programme. Subsequently the element of public education and extension was included to facilitate outcomes under the Family Planning Programme. During the seventies, the Family Planning Programme was focused mainly on terminal methods and the Programme received set back due to rigid implementation of a target based approach. The Programme has, however, remained fully voluntary and the main effort of the Government has been to provide services on the one hand and to encourage the citizen by information, education and communication on the other hand to use such services. The experiences gained, within the country and outside, had amply established that health of women in the reproductive age group and of small children (upto 5 years of age) is of crucial importance for effectively tackling the problem of growth of population which led to the change in approach from Family Planning to Family Welfare. Since the Seventh Plan implemented during 1984-89, the FW Programmes have evolved with the focus on the health needs of the women in reproductive age group and of children below the age of 5 years on one hand and on the other hand to provide contraceptives and spacing services to the desirous people. The main objective of the Family Welfare Programme for the country has been to stabilise population at a level consistent with the needs of national development.

2. The Universal Immunization Programme (UIP) aimed at reduction in mortality and morbidity among infants and younger children due to Vaccine Preventable Diseases was started in 1985-86. The Oral Rehydration Therapy (ORT) was also started in view of the fact that diarrhoea was a leading cause of deaths among children. Various other programmes under Maternal and Child Health (MCH) were also implemented during the 7th plan. The objectives of all these programmes were convergent and aimed at improving the health of the mothers and young children and to provide them facilities for prevention and treatment of major disease conditions. While these programmes did have a beneficial impact but the separate identity for each programme was causing problems in its effective management and this was also reducing somewhat the outcomes. Therefore, in nineties i.e. in the 8th plan, these programmes were integrated under Child Survival and Safe Motherhood (CSSM) Programme and which was implemented from 1992-93.

3. Various programmes have led to very substantial improvement in health indicators. The achievement with regard to some prominent health and population indicators is depicted in the table (next page).

4. However, the position is not uniform all over the country. Whereas the

states like Kerala, Tamil Nadu, Goa, Maharashtra and Punjab have achieved a considerably higher level, the states like U.P., M.P., Bihar. Rajasthan, J&K, Assam and Orissa are performing at levels much below the national level. This has been a matter of great concern because these states also happen to be very populous and unless performance in these states improves, the national performance will continue to remain depressed. The results at ground level are influenced by a number of factors like investment for the programme at national/state level, efficiency of the state health system and response of the people. The deficiencies in implementation of the maternal and child health services have been responsible for a high incidence of maternal mortality and child/infant mortality and low health status of women and children. Poor prospect of health and life of the children is one of the prominent factors leading to birth of more children per family. The present position vis-a-vis to past levels of various RCH and population indicators is given in the following table:

ACHIEVEMENTS AND GOALS

Indicator	Past levels/achvt.	Current level
Infant Mortality Rate	146(1951-1961	72(1996)
Crude Death Rate	25.1(1951)	8.9(1996)
Maternal Mortality Rate	NA	4.37(1992-93)*
Total Fertility Rate	6.1(1951)	3.5(1993)
Life Expectancy at Birth (Years):		
Male	37.1(1951)	61.5(1996)
Female	36.1(1951)	62.1(1996)
Crude Birth Rate	40.8(1951)	27.4(1996)
Effective Couple Protection Rate	10.4(1970-71)	46.5(1996)
Immunization status (% Coverage)		
TT (for pregnant women)	40(1985-86)	76.73(1996)
Infant (BCG)	29(1985-86)	93.12(1996)
Measles	44(1987-88)	78.91 (1996)

* National Family Health Survey 1992-93

5. The Approach Paper to the Ninth Plan brought out by the Planning Commission has brought out the inadequacy of the investment made for Family Welfare. This is a severe handicap particularly when it is noted that

in almost all respects, the health care system needs upgradation and it needs to reach out to many more people for the national goals to be achieved. While there is a steady improvement due to economic development, spread of education/literacy and empowerment of citizens, substantial problems in regard to educational literacy particularly among the weak performing states and in regard to empowerment particularly of women, remain.

6. The process of integration of related programmes initiated with the implementation of the CSSM Programrne was taken a step further in 1994 when the International Conference on Population and Development in Cairo recommended that the participant countries should implement unified programmes for Reproductive and Child Health (RCH). The RCH approach has been defined as **"People have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancies is successful in terms of maternal and infant survival and well being and couples are able to have sexual relations free of fear of pregnancy and of contracting diseases"**. This concept is in keeping with the evolution of an integrated approach to the programmes aimed at improving the health status of young women and children which has been going on in the country. It is obviously sensible that integrated RCH Programme would help in reducing the cost of inputs to some extent because overlapping of expenditure would no longer be necessary and integrated implementation would optimise outcomes at the field level. During the 9th Plan, the RCH Programme, accordingly, integrates all the related programmes of the 8th Plan. The concept of RCH is to provide to the beneficiaries need based, client centred, demand driven, high quality and integrated RCH services. The RCH Programme is a composite programme incorporating the inputs of the Government of India as well as funding support from external donor agencies including World Bank and the European Commission.

7. It is a legitimate right of the citizens to be able to experience sound Reproductive and Child Health and therefore, the RCH Programme will seek to provide relevant services for assuring Reproductive and Child Health to all citizens. However, RCH is even more relevant for obtaining the objective of stable population for the country. The overall objective since the beginning has been that the population of the country should be stabilised at a level consistent with the requirement of national development. It is now well established that parents keep the family size small if they are assured about the health and longevity of the children and there is no better assurance of good health and longevity of the children than health care for the mothers and for young children. Therefore, RCH Programme by ensuring small families also ensures stable population in the medium and long-term, though in the short-term, population is controlled by use of spacing methods and terminal methods for avoiding unwanted pregnancies. Therefore, the overall strategy of the Government of India (Department of Family Welfare) is to simultaneously strive for obtaining Reproductive and Child Health arrangements for the whole of the country's population and to promote and make available contraceptive/terminal methods for desirous couples. It also needs to be observed that the measures through the health system alone do not and

cannot assure success in either ensuring Reproductive and Child Health or in controlling population. These objectives are determined concurrently by the following:

(i) Policy support expressed publicly by opinion leaders in different sectors of the national system and by the community at large. Without this kind of support, the receptivity of the people to make use of even available services cannot be ensured;

(ii) Adequate resources for making available Reproductive and Child Health services of all rural and urban communities in the country;

(iii) Accountability of performance among the health workers and efficiency of the health system. Without such efficiency the quality of services to citizens or even effective access to health services cannot be ensure;

(iv) Literacy among women and educational status of families. Similarly improvement in economic status of families, the educated and economically well-of families can more rationally assess the options before them and acquire capability/willingness to assess consequences of their present actions for future. Therefore the effort of the Department of Family Welfare is to collaborate for seeking support of their Programmes for the Family Welfare programmes. This in turn will similarly improve the outcomes of related Programmes of those Departments as well.

8. The RCH programme incorporates the components covered under the Child Survival and Safe Motherhood Programme and includes two additional components, one relating to sexually transmitted diseases (STD) and other relating to reproductive tract infection (RTI). The main highlights of the RCH Programme are:

(i) The Programme integrates all interventions of fertility regulation maternal and child health with reproductive health of both men and women;

(ii) The services to be provided will be client centred, demand driven high quality and based on the needs of the community arrived at through decentralised participatory planning and the target free approach;

(iii) The Programme envisages upgradation of the level of facilities for providing various interventions and quality of care. The First Referral Units (FRUs) being set up at sub-district level will provide comprehensive emergency obstetric and new-born care. Similarly RCH facilities in PHCs will be substantially upgraded;

(iv) The Programme will improve access of the community to various services which are commonly required. It is proposed to provide

facilities for MTP at the PHCs, counselling and IUD insertion at SCs in a phased manner and

(v) The Programme aims at improving the out-reach of services particularly for the vulnerable groups of population who have till now substantially been left out of the planning process e.g.

- Special Programmes will be taken up for urban slums, tribal population and adolescents;
- Non-Governmental Organisations will be involved in a much larger way to improve out reach and make it people's programme;
- Skills of practitioners of ISM will be upgraded by training and research & development in ISM will be supported to improve the range of RCH services and
- Panchayati Raj System will have a greater role in planning, implementation and assessment of client satisfaction.

PROGRAMME INTERVENTIONS

9. The RCH programme will be implemented based on differential approach. Inputs in all the districts have not been kept uniform because efficient delivery will depend on the capability of the health system in the district. Therefore, basic facilities are proposed to be strengthened and streamlined specially in the weaker districts as the better-off districts already have such facilities and the more sophisticated facilities are proposed for the relatively advanced districts which have acquired the capability to make use of them effectively. All the districts have been categorised into categories A (58), B (184) and C (265), on the basis of Crude Birth Rate and Female Literacy Rate which reasonably reflect the RCH status of the district. The districts will be covered in a phased manner over three years. The nationally uniform and differentiated RCH interventions would be as given on page 6.

FUNDING OF THE RCH PROGRAMME

10. The estimated cost of the RCH Programme will be Rs. 5112.53 crore during 9th Plan starting 1997-98. The RCH initiatives in the form of nationwide programmes will cost Rs. 4565.03 crore during the Ninth Plan. This would be supplemented by 24 District Projects in 17 States costing Rs. 283.88 crore which will be strengthened by inputs for infrastructure and facilities to bring them up to the State level. The outlays for RCH Programme also includes the expected IDA assistance of about US$ 250 million in the form of RCH-II which will be available after the satisfactory implementation of first two years of RCH Programme subject to performance review. Some more District Projects (Rs. 263.62 crore) will be taken up during World Bank assisted RCH-II.

Interventions in All Districts	Interventions in Selected States/ Districts
* Child Survival interventions (as available under CSSM Programme) * Safe Motherhood interventions (as available under CSSM Programme) * Facilitation for operationalisation of Target Free Approach * Institutional Development * Integrated training package * Modified Management Information System * IEC activities & counselling on health, sexuality & gender * Urban & Tribal Areas RCH package * District sub-projects under Local Capacity Enhancement * RTI/STI Clinics at District Hospitals (where not available) * Facility for Safe abortions at PHCs by providing equipments, contractual Doctors etc. * Enhanced community participation through Panchayats, Women's Groups and NGOs * Minor civil works * Provision for Lab Technicians for laboratory diagnosis of RTI/STI & EOC * Adolescent health and reproductive hygiene	* Screening and treatment of RTI/STI * Emergency Obstetric Care at selected FRUs by providing Drugs * Essential Obstetric Care by providing Drugs and PHN/Staff Nurse at PHCs * Additional ANM at sub-centres in the selected districts for ensuring MCH care * Improved delivery services and emergency care by providing Equipment kits, IUD insertions and ANM kits at sub-centres. * Rental to contracted PHNs/ANMs, not provided Govt. accommodation. * Facility of Referral transport for pregnant women during emergency to the nearest referral centre.

ASSISTANCE FOR DIRECTION AND ADMINISTRATION-STATE LEVEL AND DISTRICT LEVEL OFFICES

11. Government of India has been assisting the States for the approved number of posts in the Directorate of Family Welfare at the State level and in the District Family Welfare Bureaus. In addition, posts of Cold Chain officers at State level assisted by a few other staff and of Cold Chain mechanic at District level is being supported by the Govt. of India. For District Training Centres and IEC set up, a number of posts have been sanctioned for 200 districts under the various externally funded projects implemented in past

years in various States. Many States have represented that some of the posts sanctioned from national level by the Government of India in the past do not answer the state's specific needs. Also, some of the posts have become redundant now because of the change in technology relating to IEC and office management. Also a number of new districts have been created in many States for the last few years which have not been provided with posts at par with old districts. Therefore, henceforth (from Ist April, 1998) States with more than one crore population will be entitled to receive from the Government of India financial assistance up to 8% of the grants given by the Department of Family Welfare for direction and administration of Family Welfare Programmes in the State. However, in this calculation the funds channelised to the States for externally aided projects including for the RCH Programme and kind assistance will not be taken into account. For State, having population less than one crore (according to census) the assistance will be 12%. Such assistance for direction and administration will be subject to actual expenditure as would be ascertained by the Accountant General of the State. The items on which funds cannot be spent under this scheme are purchase of vehicles, maintenance of vehicles, construction activities etc. While remaining within these admissible limits, the States will be able to create District Family Welfare Bureaus, training bureaus, IEC unit and Cold Chain staff where it is not already available. In order to provide flexibility to the States so that the actual needs of the Programme can be best served, it has also been decided that within the above mentioned limits, the States will be able to create or abolish posts on the basis of their assessment of needs, subject to the assurance that they provide for at least the following posts:

I. **State Level :**

(1) Addl./Joint/Deputy Director for Maternal Health.
(2) Addl./Joint/Deputy Director for Child Health.
(3) Addl./Joint/Deputy Director with qualifications in Population Science/ Statistics for monitoring, evaluation and statistical analysis.
(4) Addl./Joint/Deputy Director for administration/personnel matters.
(5) Addl./Joint/Deputy Director for financial matters.
(6) Addl./Joint/Deputy Director for population control measures.
(7) Engineer/Asstt. Engineer level officer for State Cold Chain.
(8) State Media Officer

In smaller States, posts at S. Nos. 1 & 2 can be combined and similarly posts at S. Nos. 4 & 5 and 3 & 6 can also be combined.

11.2 The creation and existence of these posts in direction and administration is an essential condition for the grant and if any of these posts is not created at the State level or in any of the Districts, not only this will reduce the admissibility of grants to the State/UTs to that extent, but the average annual cost of such posts will be deducted from the overall grant payable to the State/UTs. This will be to ensure that availability of these essential posts is assured for reasonably efficient implementation of Family Welfare Programmes.

II. District Level :

11.3 The States should ensure that one District Health & Family Welfare Officer assisted by one Gazetted Officer for RCH matters, one for population control methods, one for training and one Refrigeration Mechanic for Cold Chain maintenance are in position in each district. Additional posts required will be for new districts created before Ist April, 1997 (other than 466 districts). It will be the responsibility of the States to ensure that adequate technical and clerical assistance is provided to all the officers so that they can perform their work competently.

11.4 As in the past, the grant for direction and administration will be released to the States on the basis of assessed requirement for the year and subsequently on production of audited statements by the State/UT Government the final adjustments will be made.

11.5 State/district level staff appointed specifically for Area Projects shall not be brought under "Direction and Administration" on the completion or termination of the Area Project.

III. SCOVA :

11.6 For RCH implementation and flow of funds, the States who have established their ability for expeditious utilisation of funds and based on their preference, will be provided funds through State Finance Departments as at present. Otherwise, funds will be routed through a State Committee On Voluntary Action (SCOVA) which will be a registered society with State Chief Secretary as Chairman and State Health Secretary as Vice-chairman. These SCOVAs are proposed to be strengthened with the provision of contractual staff. For this, one Accounts Clerk and one Statistical Assistant will be provided for the project in order to strengthen implementation, management and monitoring. The number of Consultants in large States viz. Andhra Pradesh, Uttar Pradesh, Madhya Pradesh, Rajasthan, Maharashtra, Bihar and Tamil Nadu will be 8 (eight) each, in the medium States viz. Assam, Punjab, Haryana, Himachal Pradesh, J&K, Kerala, Orissa, Gujarat, Karnataka, West Bengal, Delhi will be 5 (five) each and small States/UTs viz. Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Tripura, Manipur, Sikkim, Pondicherry, Chandigarh, Goa, A&N Islands, Lakshwadeep. Daman & Diu, Dadar & Nagar Haveli will be 3 (three) each. Total - 153 will be appointed. These experts may be in any of the subject areas mentioned in "Para 10-I State level" but within these subject areas flexibility will be available to the States. These will be appointed by State Governments for the project period as per the requirement. In case, the funds to the State is being routed through State budget, the services of Account clerk and Statistical Assistant will not be available, however, services of Consultants will be available. The payment of honorarium to Account Clerk and Statistical Assistant will be Rs. 5000 per month each while that of RCH Consultant can be between Rs. 8000-12000 depending upon qualifications and experience for the retired Government officer whereas the outside experts can be paid honorarium upto Rs. 18000

per month. The above appointments will be on contract basis and as per World Bank procedure.

DISTRICT PROJECTS

12. 24 District Projects have been prepared and approved under the World Bank RCH project in Phase-I of the World Bank Project (Annexure-A). Some more District plans will be taken up in Phase-II of the World Bank Project. At that stage, the priority will be given to those States which have not been covered by District Projects under Phase-I.

District Project Implementation Plan (DPIP) for each of the District Project have already been made by the States and these have been approved by the Government of India and the World Bank. These projects specify the annual phasing of the expenditure under each area project. The Govt. of India (Department of Family Welfare) will release grants for implementation of these area projects equivalent to the first years assessed expenditure worked out in the District PIP. These funds will be released on receiving a letter of request from the concerned State Government informing that the arrangements for efficient implementation of the District projects have been made by the State Government. The funds will be released to the State Government or the State SCOVA as the case may be and they will transfer funds in turn to the designated District authorities for implementation. The next lot of funds for the District Projects will be released after the States report expenditure of at least the 75% of the previous instalment of grant. Thus the Government of India will be releasing annual grants for the District Projects; the instalment of release from the Government of India being equal to the corresponding year's requirement of the District Project as reflected in the District PIP. The States, which manage to implement the PIP items faster can therefore, receive subsequent grants earlier than those envisaged in the PIP.

IMMUNIZATION

13. The Universal Immunization Programme (UIP) will continue to provide vaccines for Polio, Tetanus, DPT, DT, Measles and TB. The vaccination coverage under these Programmes achieved so far is 80-90% in different parts of the country. The objective in 9th Plan is that 100% coverage should be achieved for all these vaccine preventable diseases. As a supplement of the UIP, the Pulse Polio Immunization campaign has been taken up for eradicating Polio by the year 2000. After about 95% immunization coverage is achieved for these vaccines nationally, special campaigns like PPI may be taken up later in the 9th Plan for achieving near zero incidence for Tetanus among pregnant women/newborns and for Measles.

Inputs for immunization & related programmes of CSSM

i. For supporting Immunization Programme a Cold Chain has been created covering all PHCs in the country. The Cold Chain staff has

already been given to all States to ensure that the cold chain is managed well. The present equipment for the cold chain is about 10 years old and has already outlived its normal life. Therefore, to prevent excessive break downs the cold chain will be renewed by replacing equipment in phases during the 9th Plan. At this stage, a need based assessment for deep freezers and ILRs will also be made and where necessary they will be provided in additional places. The assistance to be available to States/UTs for renewal of Cold Chain will form part of the sanction for Population Control Programme which will be issued as a separate scheme to States/UTs.

ii. The assistance for the following items is being provided under the CSSM Programme. This will continue at the level of norms indicated against each item below :

(a)	Vaccines (BCG, OPV, Measles, DPT, TT & DT	:	As per the number of beneficiaries in each state/UT.
(b)	Cold Chain Items	:	The cold chain established so far will be maintained and additional items will be provided to new health facilities e.g. PHCs.
(c)	Repair of cold chain	:	Rs 500 per PHC per year.

Release of Assistance

i. The assistance for these items will continue to be released to the States/UTs on the basis of number of PHCs and Cold Chain data available with the Ministry.

ii. From 1st April, 1998, the salary of staff created under UIP/CSSM would not be separately provided to the States/UTs. It will get adjusted in the other staff covered under sub-item of the scheme under Direction/Administration. Similarly, POL for vehicles provided under UIP/CSSM will also be get adjusted in the expenditure on maintenance of Family Welfare vehicle.

iii. Assistance for reporting fee for TBAs and Mother's Meetings will be phased out as no longer relevant but the States/UTs can continue these if they so desire as their liability.

iv. Also the Government of India would not be making any payment for contingencies for stores/kerosene oil because it is a very small item and it is legitimately the responsibility of the State/UT Governments.

v. Dai kits where being given to the TBAs when they were trained. This will continue to be provided by the institutions imparting training to TBAs and the expenditure would become part of the cost of training.

vi. From 1st April, 98, the needles and syringes will be provided as part of drug/equipment kits at various levels.

vii. The Department of Family Welfare is also assisting the States/UTs for procurement and supply of Disposable Delivery Kits. This assistance will continue till the system of Supply Depots at Divisional level in States is set up. At that stage delivery kits will be procured centrally and will be made available for use of the district health set up from the Divisional Supply Depots.

Procedure for sanction/conditions regulating grants

It is expected that the States/UT Governments will apportion this grant to Districts where it should be kept by the District Health & Family Welfare Officer in a separate Bank Account so that for prompt utilisation when the need arises becomes possible. The States/UTs will have the flexibility to increase or reduce grants to any individual district depending on their own assessment of needs for repairs, maintenance etc. in that district. The District Health & Family Welfare Officers must be instructed to adhere to the flexible approach depending on the local situation for prompt and adequate maintenance of the Cold Chain i.e., they should supplement the district Cold Chain mechanism with contract assignment for break downs or by obtaining the services of locally available mechanics/workshops.

DRUG AND EQUIPMENT KITS

14. Following drug and equipment kits were being supplied under CSSM programme at various levels:

Sub-Centre level	PHC level	CHC/FRU level
Drug Kit-A Drug Kit-B Mid-wifery Kit Sub-Centre- -Equipment Kit	PHC Equipment -Kit	Equipment Kits Kit-E to Kit-P

The items in each kit are mentioned in the **Annexure I to Annexure VI.**

These kits will continue to be supplied and those FRUs and PHCs which have not been covered so far, will be covered under the RCH Programme. In addition, a drug kit for essential obstetric care with items mentioned in the **Annexure VII** will be supplied to PHCs in category C districts. The composition of the drug and equipment kits will be reviewed from time to time.

Procedure for Sanction/conditions regulating assistance

It needs to be, however, noted that the supply of these inputs in the form of kits has the inherent weakness that such supplies presume uniform scale of requirement all over the country which in reality is not the case. Because of this, some items fall short of requirement in some places and some items in excess of

actual requirement get supplied. There have also been instances where the same equipment has got provided under different programmes leading to duplication.

To eliminate this, the Department is attempting to set up a system at Divisional level (1 divisional supply depot for each cluster of 6-10 districts) where suppliers will supply each individual item in reasonably large packing. The District/ FRUs/PHCs will be able to get individual items issued to them as per their entitlement under the scheme in any number of installments throughout the year. This is expected to minimise wastage of these costly inputs. The effort of the Department is to operationalise these Depots by end of 1998.

ESSENTIAL OBSTETRIC CARE (Es.O.C.)

15. Essential Obstetric Care includes those items of obstetric care which any pregnant woman requires if there is no complication during pregnancy or delivery. These items basically include registration of pregnancy in the first 12-16 weeks of the pregnancy, at least 3 pre-natal check-ups by ANM or in dispensary for providing check-ups of essential body parameters and counselling and includes detection of complications and reference to PHCs/FRUs in cases of complication. It also includes assistance during delivery and 3 post-natal check-ups with similar testing of basic body parameters and identification of complications including reference to PHCs/FRUs in the case of complications.

Inputs

i. Many of these inputs are provided by ANM and her capability in this regard will continue to be augmented by training and by provision of equipment/drugs. In PHCs equipments will continue to be provided where they have not been provided so far.

ii. In addition, in all Category C districts and Category B districts including in State Health Systems Project States, the essential obstetric care, drug kit will also be provided (with items in the **Annexure-VII**) subject to availability of required infrastracture. In Category A districts, the provision of this drug will be the responsibility of the State/UT Government. In Madhya Pradesh, Es.O.C. drugs will be made available to block PHCs only, as such facilities are not available in other PHCs.

iii. On the same rationale, the PHCs in Category C districts will be able to engage Public Health Nurse/Staff Nurse on contract basis during the RCH Project or till the State Government is able to make a regular arrangements. In such cases, the Staff Nurse would be paid a lump-sum monthly honorarium equal to the pay at the minimum of the pay scale in the State plus dearness allowance plus Rs. 400/- for HRA. No other allowances/increment will be paid for the duration of the contract. Reimbursement to States for this expenditure will be available in addition to the expenditure on Direction & Administration.

iv. In Category C districts the status of RCH is poor and this is accompanied by low awareness, low educational status and frequently lower economic status as well. The infrastructure, roads and electricity is also generally weak in these districts, therefore, the responsibility of ANM is more difficult to discharge efficiently. Therefore, in all Category C districts of 8 States of U.P., Bihar, M.P., Orissa, Harayana, Assam, Nagaland and Rajasthan in 30% of the Sub-Centres which reasonably qualify to be categorised as 'remote Sub-Centres', one additional ANM will be provided on contract basis. To qualify being categorised as remote, each of these Sub-Centres will have to be at least 5 Kms away from the Block headquarters. This input can also be considered for Delhi wherein 140 ANMs can be appointed on contract basis for extending services to slum areas through attachment with existing government dispensaries. On the request of Rajasthan, it is agreed to extend the scheme of Jan Mangal for CBD in lieu of additional ANMs wherein a Sahayika (lady helper) will be provided to each ANM for conducting deliveries with assistance of Sahayika. Each Sahayika will be paid Rs. 300 per month through selected NGOs. The performance of this shceme will be reviewed on the basis of number of deliveries conducted by ANMs in their area.

v. On an average each sub-centre caters to the requirement of 5-6 villages and the services to these villages need to be provided by ANM through the village visit every week. The mobility of ANM has been found to be one of the reasons for the poor services to villages at distance from Sub-centre village. Therefore, in order to cater to the RCH & FP requirement of far-flanged villages, the mobility needs to be improved. Accordingly, loan will be provided for purchase of moped out of the corpus funds provided under the Programme. Under the project period, it is proposed to provide loan for upto 25% of ANMs, funds for purchase of Moped.

Procedure for sanction/conditions regulating assistance

i. For getting assistance for PHNs, the State Government will be required to authorise a Committee consisting of District Family Welfare Officer, Civil Surgeon/CMO and District Magistrate/his representative and President of District Chapter of IMA to make appointments without seeking any further approval of the State Government.

ii. The provision of drugs and PHN/Staff Nurse will be available at the PHCs having the suitable infrastructure with delivery room, operation theatre and 25 bedded ward with residential quarters and deliveries being already conducted. It is expected that these facilities will be available in about 25% of PHCs in "C" category districts & in about 50% in "B" category districts. However, SSN districts may also have about 50% PHCs having the required infrastructure.

iii. Whereever additional ANM are being provided on contract basis, the

State/UT Government will be expected to divide the jurisdiction of the existing ANM into two and to assign one part of the divided area to the additional ANM so that the responsibility of the existing and new ANM will remain clear. In regard to honorarium for the additional ANM and the method of selection/appointment, the mechanism specified in regard to Staff Nurse earlier in this sub-item will apply.

iv. The drug kits will be procured centrally and supplied to the States in kind. Funds for Staff Nurse and Additional ANMs will be placed with the SCOVAs/State Governments on the basis of district-wise requirements estimated by the State/UT Governments and intimated to this Ministry. Funds for the first year will be given in advance. For the subsequent years, funds will be released based on actual requirements subject to adjustments based on audited statements of account received from time to time.

v. The Government of India will release funds for being used by the State Governments for extending loans to ANMs for procurement of mopeds to increase their mobility. Whether the loan will be interest-free or not will be decided by State Government. There will be no interest subsidy from Government of India. This will enhance the capability of ANMs to tour the villages in their jurisdiction more regularly and therefore the effectiveness of their work will improve. The State Governments will work out the list of remote PHCs (a remote PHC should be at least 10 K.M. away from a District and Sub-divisional head quarters) and therefore, the number of ANMs eligible for such loans which should not exceed more than 25% of the total ANMs in the State. On the basis of such number the State Government will request the requirement of funds to the Central Government. The banks or State Cooperative Banks, the arrangements for receiving the money from Government of India and the Corpus Fund out of which loans will be sanctioned by their branches to the ANMs. The State Government will also have to obtain its decision for extending interest subsidy to ANMs. The number of ANMs to be covered, the size of Corpus Fund required, the decision to provide interest subsidy and copy of the MOU finalised with the bank should be furnished to the Government of India for securing release of funds for the purpose. The State Governments will also have to decide to authorise Drawing and Disbursing Officer for the salary of ANMs to recover the instalment of loan out of their salary.

After the ANMs in the identified remote PHCs have been covered, the recovery from loan to these ANMs will be utilisable for extending loan to other ANMs and para-medical employees of the State Health and Family Welfare Department. After these categories have been covered, the Corpus received from the Government of India can be either refunded back or retained by the State Government for being continued for future years for extending vehicle loans on normal terms through the designated bank.

EMERGENCY OBSTETRIC CARE (Em.O.C.)

16. Emergency Obstetric Care is an important intervention for preventing maternal mortality and morbidity. The complications of pregnancy such as anaemia, haemorrhage, obstructed labour and Sepsis are major causes of maternal mortality and morbidity. If these complications are detected early and managed appropriately, maternal mortality and morbidity can be reduced substantially. If 3 check-ups by ANM at ante-natal and 3 at post-natal stage are ensured by competent supervision, most of such cases of complications can be detected and attended to before they become life-threatening. The ANM is expected to refer cases of complications during pregnancy or at the time of delivery to PHCs/First Referral Units (FRUs).

Inputs

A total of 1748 FRUs were identified and equipped under the CSSM Programme. However, these FRUs have not become fully operational mainly due to deficiency in manpower of Specialists or infrastructure, equipment kits and medicines. The deficiencies are more in Category B & Category C districts than in Category A. Therefore, under RCH Programme, a provision has been kept for strengthening these FRUs through :

i. Supply of drug/medicines;

ii. Provision for appointment of contractual staff;

iii. Provision of Laparoscope at district and Sub-divisional hospitals/FRUs.

iv. Provision for providing Emergency Obstetric Care, requiring surgical interventions, blood transfusion and anaesthesia at the FRU level.

v. Provision for consultant anaesthetists for Emergency Obstetric Care.

vi. Funding training for Diploma in Anaesthesia.

Procedure for sanction/conditions regulating assistance

i. Equipment kits (Kit-E to Kit-P) have been provided to 1748 FRUs (CHCs/PPCs) under the CSSM Programme on the basis of identification by the respective State/UT Government where Operation Theatre, Gynaecologist and Anaesthetist are available in these FRUs. However, in reality this has not been found to be the case and in many places the equipment kits are not getting utilised in the absence of one or more of these inputs. The Government of India will provide such equipment kits to all the remaining CHCs during the 9th Plan but after the concerned State/UT Government is able to assure that the earlier assiated FRUs have become operational with all the three inputs and also after their certification that all the three inputs are available for the proposed FRUs.

ii. Under the RCH Programme drug kit for Emergency Obstetric care **(Annexure VIII)** costing about Rs. 1.65 lakh will be supplied to 3 FRUS in Category C districts and 2 FRUs in Category B districts annually. The State Government are expected to ensure that these drug kits are not asked for in the districts covered by the State Health Systems Project, where similar drug kits are being provided under the ongoing project. 12 FRU drug kits will also be provided to Delhi for 12 hospitals under Delhi Government. In Madhya Pradesh, the selection of FRUs per district will be such that the atleast one FRU is available in each district provided total number of FRUs remain the same in the State.

iii. Under the RCH Project, each district will be assisted to engage 2 Laboratory Technicians for doing routine blood, urine and RTI/STI tests at FRUs if such technicians are not already available. In regard to their honorarium and selection system, the mechanism mentioned for Staff Nurse in the item relating to essential obstetric care will be applicable.

iv. With regard to Anaesthetists, it is necessary to scrupulously follow the qualifications laid down by the Medical Council of India (MCI). MCI has prescribed that the job of Anaesthetist can be performed by a person having MBBS degree and a degree (3 year) or diploma (2 year) in Anaesthesia. It is prudent not to dilute these qualifications because in the case the persons and hospitals may be exposed to claim of damage in a court of law. Since there is a shortage of Anaesthetists in most of the State, it is suggested that State Government may persuade one or more Medical Colleges to start diploma course for anaesthesia for which the assistance will be povided from Government of India under the Training Programme. The States may work out their requirements and make proposals for increasing seats in Medical Colleges for Diploma courses in Anaesthesia in consultation with MCI. These seats should be available to the medical officers in State health services and the officers sponsored for these courses would be required to fill up a bond binding them to serve the State Government for a minimum period of 3/5 years. To tide over the immediate needs, States would be permitted to engage the Anesthetists in the private sector on a payment of Rs. 500 per case and this facility will be available at Sub-district and CHC levels but only for Emergency Obstetric cases.

v. The Department of Family Welfare has been providing Laparoscopes to the State for promoting tubectomy operations by laparoscopic method. Tubal rings are also supplied by the Department of Family Welfare. This method of tubectomy is very popular in many parts of the country. The Department of Family Welfare will supply Laparoscopes to all CHCs which already do not have it and if the State/UT Government concerned makes demand, but it will be conditional that within 6 months of the demand being placed and before actual supply of a Laparoscope, the State Government will have the doctors trained in laparoscopic technique. Facility for training for use of this technique will be available from the Government of India under the

Training Programme being implemented through the National Institute of Health & Family Welfare.

vi. The drug kits will be procured centrally and supplied to the States in kind. Funds for contractual staffs will be placed with the SCOVAs/State Governments on the basis of district-wise requirements estimated by the State/UT Governments and intimated to the Ministry. Funds for the first year will be given in advance. For the subsequent years, funds will be released based on actual requirements subject to adjustments based on audited statements of account received from time to time.

vii. Certain items of drugs and Equipment Kits like Inj. Pethidine, require excise permit at local level. Other items like oxygen and other gases will also need to be replenished at local level. These will, therefore, not be supplied in the kits. The States/UTs will be provided funds for procuring these items based on the actual number of kits to be supplied in each State. Procurement of cylinders will be a one time activity and arrangements for replenishment of gases will have to be made locally depending on the local requirement.

24 HOUR DELIVERY SERVICES AT PHCs/CHCs

17. One of the reasons de-motivating people from seeking deliveries in PHCs/CHCs is non-availability of medical/para medical/cleanliness staff beyond normal working hours and lack of attention to the patients in the dispensaries/ hospitals. Therefore, under the RCH Programme attempt will be made to set up 24 hour delivery services in CHCs/PHCs in as many districts as becomes feasible.

Inputs

The arrangement in this regard would involve a mechanism for the doctor to be available on call, at least one nurse being available beyond normal working hours in the CHC/PHC and cleanliness services being available similarly beyond normal working hours. The later two items can be additionally arranged on contract basis either through some agency or by engaging recently retired persons available in the same locality.

i. It is suggested that State/UT Governments should make project proposals with district as a unit envisaging such facilities in all CHCs/ PHCs. The project should envisage:

- coordination and monitoring by the district RCH officer.
- honorarium to the CHC/PHC doctor at the rate of Rs. 200/- per delivery conducted by him/her between 8.00 p.m. in the evening and 7.00 a.m. in the morning, provided the doctor is not on night shift duty and;
- honorarium to the contractual staff (nurse and cleanliness services).

ii. The Govt. of India is initiating this arrangement for encouraging

institutional deliveries which would have its beneficial impact on maternal mortality and morbidity rate as also on the health and well being of the new born. It is envisaged that after these facilities get fully set up and known to the people and the benefits become apparent to all concerned, the State/UT Governments will take over responsibility for maintaining this facility after the first 5 years.

iii. The State/UT governments are required to send project proposals for this activity. The larger States may initially include upto 4 contiguous districts in the proposal while the smaller States/UTs may submit proposals for one district. While submitting the proposals details of infrastructure in these districts along with manpower (particularly lady medical officers and staff nurses) in position. During the first year, funds will be released to the States/UTs on receipt of these proposals. In subsequent years, the funding for these projects will be regulated on the basis of implementation report for individual districts. In States/UTs where achievement is satisfactory, the coverage of districts will be extended.

REFERRAL TRANSPORT TO INDIGENT FAMILIES THROUGH PANCHAYATS

18. In weakly performing 8 states, particularly in 'C' Category districts of these States the communication infrastructure is weak and the economic status of many families in almost every village is also very low. Because of this, even if there is a complication identified during pregnancy or delivery, the women have the delivery conducted in the village and frequently through untrained persons. This is one of the causes of high maternal mortality and morbidity.

Inputs

i. To assist the referral of women from indigent families; in 25% Sub-Centres of 'C' Category districts of 8 weakly performing states (U.P., Bihar, M.P., Rajasthan, Orissa, Assam, Nagaland and Haryana) a lump sum financial assistance will be made available to Panchayats through District Family Welfare Officers.

ii. In the first year, Rs. 5,000/- will be placed at the disposal of the Panchayats in the beginning of the year, Rs. 4,000/- in the second year, Rs. 3,000/- in the third year, Rs. 2,000/- in the fourth year and Rs. 1,000/- in the fifth year.

iii. The States of Delhi, Karnataka, Maharashtra and West Bengal will be facilitated to develop and implementation of suitable referral system for emergency cases in a phased manner.

Procedure for sanction/conditions regulating assistance

i. The States will be required to submit proposals indicating the name of district, total number of sub-centres and the number of sub-centres

and Panchayats to be included in this activity. On receipt of the proposals, funds for the first year will be placed at the disposal of SCOVA/State Governments who will in turn release it to the Panchayats through the District Family Welfare Officers.

ii. Before releasing the amount for the second year and onwards, the Panchayat will have to give the following details to the District Family Welfare Officers:

* the name of woman assisted;
* the name of dispensary/hospital where delivery was conducted; and
* the amount spent on transport and a valid receipt for payment of transport.

The District Family Welfare Officer will be required to get verification done from hospital records in 10% of cases reported to have been referred to hospitals.

iii This assistance will be used only for procuring and paying for the transport for carrying the women to the PHC/CHC for delivery. It is expected that after the benefit of this scheme is realised by the Panchayat, it will take on the responsibility for maintaining this facility in subsequent years.

BLOOD SUPPLY TO FRUs/PHCs

19. In many cases of Emergency Obstetric Care and in some cases of Medical Termination of Pregnancy (MTP) blood transfusion is needed. At present there is generally no arrangement for regular and reliable blood supply to the CHCs and PHCs for this purpose. As a result even through the infrastructure and the qualified manpower may be available such cases are not handled in these PHCs/CHCs or if they are handled, the mortality and morbidity rates are high.

Inputs

The Department of Family Welfare will be taking up pilot projects with the assistance of European Commission under the RCH Programme for setting up of regular and reliable supply blood to PHCs/CHCs by linking them with the nearest District Blood Bank. These pilot projects will be framed in consultation with the State Governments concerned and if an efficient mechanism gets proven through these pilots projects, the facility will be extended on that basis under the EC funded component of the RCH.

ESSENTIAL NEW BORN CARE

20. Although neonatal mortality is showing a consistent decline, it still contributed to 63.7% of all infant deaths during 1993. The high incidence of low birth weight babies is a common contributory factor in neonatal

deaths. The major causes of neonatal mortality have been identified as Hyperthermia, Asphyxia and infections. Simple, cost effective, indigenous technology is available to provide essential newborn care at the field level to manage the direct causes of neonatal mortality. Provision of essential newborn care will thus not only improve the overall quality of services provided by peripheral health facilities but also contribute to decreasing neonatal morbidity and mortality.

Inputs

i. Under the CSSM Programme essential equipment listed in the **Annexure IX**. has been supplied to the District Hospitals, CHCs/FRUs and PHCs in 26 districts through WHO assistance.

ii. Where deliveries are being conducted regularly in the PHCs this equipment is essential for ensuring care of the new born babies. Therefore, during the 9th Plan under the RCH Programme this equipment will be supplied to all District Hospitals, CHCs including all FRUs and the PHCs at block level.

Procedure for sanction/conditions regulating assistance

These equipments will be provided at the district level on the condition that the State Governments certify that regular deliveries are taking place in the proposed hospitals/CHCs/FRUs and Block PHCs and that at least one lady medical officer/staff nurse are in position in the facility.

MEDICAL TERMINATION OF PREGNANCY (MTP)

21. Medical Termination of Pregnancy (MTP) is permissible under certain conditions laid down in the Medical Termination of Pregnancies Act, 1971. However, MTP should not be a mechanism for restricting family size or for avoiding unwanted births in routine. Although officially the MTPs in the country is only about 6 lakh in a year but various experts/studies have estimated the actual number to be in the region of 4 million or more per year. Such MTPs (unsafe abortions) in unauthorised places where the essential facilities are not available and where sometimes even the person performing MTP is also neither qualified nor experienced are causes of many deaths and morbidity on a much larger scale. Therefore, increasing and improving facilities for MTP is an important component of the RCH Programme.

Inputs

i. Need based training arrangements in MTP are being set up under the training programme being organised through the National Institute of Health and Family Welfare. The State/UT Governments have to ensure that initially at least one team (Medical Officer & Staff Nurse) is trained for every hospital at district and sub-district level.

ii. Under the RCH Programme the Government of India will provide MTP equipments wherever Doctors trained in MTP procedures and operation theatres are available in District Hospitals, CHCs and PHCs.

iii. To supplement these regular arrangements the Government of India will also provide assistance by taking districts as units for engaging Doctors trained in MTP to the PHCs once a week or atleast once in a fortnight on a fixed day for performing MTP. These doctors will be paid at the rate of Rs. 500 per day visit. These doctors will also provide Anto Natal Care and Post Natal Care to the patients during their visit.

iv. In view of the importance of ensuring adequate facilities for MTP in the interest of women's health equipment assistance will be similarly provided to well run and competent medical clinics in the Non-Government sector if they have operation theatre and trained doctors/nurse.

v. In some states like Manipur, Mizoram, Sikkim etc., the facility for provision of MTP services will not be made available below sub-district level and in Madhya Pradesh, the MTP facilities will be made available only in Block level PHCs and not in all PHCs.

Procedure for Sanction/conditions regulating assistance

i. The MTP equipments have already been supplied to a large number of the District Hospitals and CHCs in the past. However, it is not being optimally utilised because trained doctors are not always available in these places. Therefore, on certification from the State or the UT Government concerned that doctors have been trained in MTP procedure. MTP equipment will be supplied :

- In the first stage to all District Hospitals and CHCs where it is not already available;
- After all CHCs in a particular state are covered, MTP equipment will be similarly supplied to PHCs on certification from the State Government that atleast one doctor and one nurse in the PHC has been trained in MTP procedure and operation theatre is available in a functional state; and
- In all these hospitals/dispensaries a board should be prominently put up to inform the people that MTP facilities are available in the hospital/dispensary.

ii. The payment of contractual service fee of Rs. 500/- will, however, not be available to those Government Doctors who are substantively posted in PHCs but are attached to District Hospitals.

iii. The utilisation of this contractual facility will be monitored by the State Government and the Government of India and where the utilisation is found to be only nominal, this input will be stopped subsequently.

iv. The clinics where the MTP equipment is to be provided in the NGO sector, should be under the management of a reputable NGO or a Trust. Their doctors will also be eligible to receive training free for MTP and if they have atleast one doctor and one nurse trained in MTP and they also have a functional operation theatre they can be provided

MTP equipment on the recommendation of the District Family Welfare Officer. Such recommendation should be endorsed by the Civil Surgeon/Chief Medical Officer of the district.

v. The MTP kits will be procured centrally and supplied to the states in kind. Funds for consultants will be placed with the SCOVAs/State Governments on the basis of requirements estimated by the State/UT Governments and intimated to this Ministry. Funds for the first year will be given in advance. For the subsequent years, funds will be released based on actual requirements subject to adjustments based on audited statements of account received from time to time.

REPRODUCTIVE TRACT INFECTION (RTI)/SEXUALLY TRANSMITTED INFECTION (STI) CLINICS

22. The incidence of Reproductive Tract Infections and Sexually Transmitted Infections is very high and according to some small area studies, the incidence is around 20-30% in most parts of the country. They are a cause of considerable morbidity among women and in some conditions they affect the health of the new born also. However, treatment for such conditions has not been set up on a sound basis so far.

Inputs

i. Under the RCH Programme all District Hospitals and three FRUs in category-A districts, two in category-B districts and one in category-C districts will be assisted for setting up RTI/STI clinics. However, this input is not provided to districts in SHS Project State.

ii. The assistance from the Government of India will be in the form of training which is being organised through NIHFW and in the form of a Drug Kit including disposable equipment (items are listed in **Annexure X**).

Procedure for sanction/conditions regulating assistance

i. In order to ensure that there is a bonafide clinic and these facilities for RTI/STI are available to citizens readily, it will be a condition that:

* the hospital will earmark two adjoining rooms, one for Male Doctor and the other for Lady Doctor for attaining to RTI/STI cases;
* two doctors trained in RTI/STI will be made exclusively available for RTI/STI clinic; and
* a board mentioning the RTI/STI clinic, will be put above these rooms.

ii. This arrangement will have to be certified by the State Government before assistance is made available by the Government of India.

iii. State/UT Governments will identify the clinics and the drug kits will be supplied based on the list supplied by them.

CIVIL WORKS

23. Although infrastructure to a large extent has been built up for the District Hospitals, CHCs and PHCs, but small items are lacking in many places or in some of the major constructions, upgradation of facilities to some extent is needed. It is necessary to upgrade these facilities because of the increased sophistication in medical inputs under the RCH Programme so that small deficiencies do not prevent the benefits of RCH Programme reaching to the people.

Inputs

i. A lumpsum financial assistance to the extent of Rs. 10 lakh per CHC (District Hospital will also be provided Rs. 10 lakh) will be provided to every district for constructing operation theatre or labour room, providing water supply or electricity facility where it may not be available or for upgrading these facilities where they require improvement.

ii. The district will have flexibility of providing more amount in a CHC if less than this amount is required for some other CHC. However, the money meant for CHCs will not be diverted for use in District Hospitals.

iii. Similarly a lumpsum of Rs. 10 lakh to each district will be provided for minor civil work providing water supply and/or electricity facility in the PHCs or for their upgradation if it is already provided in part. This money will also be available for upgrading the facilities in labour room or repairs in the PHCs if it is needed.

Procedure for sanction/conditions regulating assistance

i. In all these cases estimates for new facility, upgradation, repair will be prepared for each hospital/dispensary through the authorised agency of the State/UT Government and money will be claimed from the Government of India only on that basis. Proposals for whole district will be submitted in one lot (It will not be necessary to submit copy of estimate to Government of India).

ii. In case of construction of labour room and operating theatres, civil works drawings should be in accordance with the agreed Civil Works Manual. No prior review of drawings by the World Bank would be necessary, but the State would have to certify that the construction is in accordance with the Manual. Civil Works contract estimate to cost more than $25,000, the bid documents for the first three such contracts from each State would require prior review.

iii. The State/UT Government will have to certify while making proposal for the assistance that the amounts are based on the estimates prepared by the authorised agency.

iv. Items which are not to be funded out of the funds indicate at para (iii) of inputs for civil works are given at **Annexure XI**.

INDIAN SYSTEMS OF MEDICINE

24. Considering that about half of the population according to some estimates depends on the Indian Systems of Medicine for health care, the Reproductive & Child Health for the whole population of the country cannot be assured without involving the Indian Systems in a large and meaningful manner. The Ayurveda and Unani Systems in this regard are particularly important. About 5 lakh practitioners of these disciplines mostly in the non-governmental sector are spread out in different parts of the country. These systems have the additional advantage that a large proportion of their practitioners are located in the rural areas where the reach of the modern system is weakest. The Indian Systems are known to have many efficacious practices and remedies for a number of conditions of women and children. These systems generally do not have side-effects also.

There are three specific programmes on ISM which will be implemented under the RCH Programme.

24.1 Training of ISM practitioners

It is neither feasible nor recommendable to create a parallel extensive system of dispensaries and hospitals of ISM to provide RCH facilities through Indian Systems to the citizens. Therefore, the RCH Programme does not seek creation of any posts or proposal for construction of building for ISM dispensaries/hospitals. The RCH programme will confine itself to tapping large resources of ISM practitioners in the non-governmental sector. These persons need to be oriented in RCH concept and framework. Their professional skills also need to be revised and upgraded through training, particularly, in areas relevant to RCH.

Inputs

Short-term training of 2-4 weeks will be provided to ISM practitioners, both in the Government and non-government sector through ISM Medical Colleges which have maintained good standards. These Colleges will be provided financial assistance for imparting these training courses on the basis of norms available for similar scheme under the "Training" head.

24.2 Improving awareness and availability of ISM remedies

The Indian Systems have relied over generations on medicinal plants available in the neighbourhood and knowledge about use of such medicinal plants and other easily available medicinal products (like condiments, herbs, etc.) passed on from generation to generation through the family elders. Because of pressure of population the cultivation of food grains and commercial crops have progressively practically eliminated locally growing medicinal plants and because of the vast changes in the social system, the family traditions have also become weak.

Inputs

i. To address both these problems and to resurrect a highly cost effective preventive health and medical care system, the NGOs will be assisted

for raising nurseries of medicinal plants which are known to grow in that particular area. They will distribute the medicinal plants free of charge to desirous families and village level ISM practitioners.

ii. These practitioners will be encouraged to grow these plants over a somewhat larger piece of land about 1-2 acres (if that can be managed.) This will enable the products of these medicines to be not only readily available but to be available in a pure form.

iii. The NGOs will also be simultaneously assisted to do extension work and educate local population about the uses of locally available medicinal plants for preventive health and for curative purposes.

iv. In order to ensure impact, NGOs will be asked to take up this work on a project basis for a district and only a few of the NGOs with proven larger capability will be assigned more than one district. The items of assistance will be as indicated above.

Procedure for sanction/conditions regulating assistance

i. It is not possible to lay down norms for assistance for each item because area of each district will be different and the programme proposed by the NGO may also differ somewhat from project to project.

ii. However, value of a district project of one year will generally not be more than Rs. 15 lakh.

iii. These projects will be sanctioned by an Expert Committee headed by the Secretary, Department of Family Welfare which will also consider research projects for ISM.

iv. While evaluating the performance of the NGOs, their effectiveness will be adjudged on the basis of their motivation among the people for maintaing these plants for medical purposes.

24.3 Research in ISM

While there is extensive literature going back 2500 years to Charka Samhita mentioning practices and cures, a deficiency of the ISM is that objective data through clinical trials and laboratory work has not been generated to prove the extent of efficacy of individual prescriptions/cures. As a result a large variety of cures and practices are prescribed by the practitioners leading to varying results. It will be beneficial if the cures mentioned in the texts are systematically taken up and subjected to laboratory investigation and clinical trials so that their efficacy is established or disproved. This will allow the most effective cures out of the many recommended for a particular condition to be identified, which then can be propagated for extensive use for the benefit of patients.

Inputs

i. Research projects through ISM research institutions will be supported

financially by the Department in areas of relevance to RCH.

Procedure for sanction/conditions regulating assistance

i. To consider the project proposals and to recommend sanction as well as to monitor progress of the research projects, an expert committee under the Chairmanship of Secretary, Department of Family Welfare will be constituted.

ii. Each research project will be required to associate a researcher familiar with modern research to ensure objectivity.

iii. Each project will be required to volunteer milestones at the end of each year in reference to which the Expert Committee will monitor progress and regulate release of grants for subsequent years.

iv. A research project will envisage assistance for immediate technical project staff but no sanction will be considered for regular posts or buildings. Assistance will also be provided for equipment, consumable, contingencies and expenses on patients in case of clinical trials.

24.4 Vanaspati Van

The forests have been the traditional source of medicinal plants but due to population pressure on the one hand there has been over-exploitation of this resource and on the other hand the forests themselves are shrinking. Therefore, while due to increasing population and increasing population of Indian System, the demand for medicinal plants is growing fast, the availability is decreasing. More than 150 out of about 1200 medicinal plants are already on the endangered list.

Inputs

If Indian Systems have to be utilised in a large manner for RCH, it is necessary to augment availability of medicinal plants in a meaningful manner. It is proposed to do this on a limited scale by taking up one or more plantations of medicinal plants in the form of the 'Vanaspati Van' over wastelands or denuded forest land of 3000-5000 hectares of contiguous area which is available in large measure in most States.

Procedure for sanction/conditions regulating assistance

i Since the forest lands cannot be transferred or sold, it is proposed that the State which agrees to take such development of Vanaspati Van will constitute a state level autonomous body in the form of a society registered under the Societies Registration Act.

ii. The society :

* will be headed by a Forest Officer to ensure cooperation from the State Forest Department. The Society will have one nominee of the Department of Family Welfare and one nominee of the Department of Indian Systems of Medicine and Homeopathy on its Executive Committee.

- It will have a small compliment of staff consisting of Forest, Agriculture, Botany, Ayurveda and Unani professionals. This will generally not be more than 15.

iii. The State will have to identify almost a continuous patch of land over 3000-5000 hectares of denuded or degraded forest land including wastelands. The project will envisage identification of 100 or more medicinal plants which grow naturally in that agro-climatic condition and to raise a sufficiently large plantation of each of these plants in the Vanaspati Van to have impact on availability in the region.

iv. Since many of the Ayurveda medicines are in the form of fruit, roots or bark, the produce will not be available before 5-8 years. In the case of shrubs and leaves the produce may become available in 1-3 years. Therefore, assistance will be provided under the project for 5 years after which the Vanaspati Van will be expected to produce enough of medicinal plants to sell them in the market and to support itself and preferably effect some savings by way of profit.

v. Each Vanaspati Van:

- will be assisted by an Advisory Committee of 1 expert of Ayurveda, 1 of Botany and 1 of Agriculture/Forestry who will visit the Vanaspati Van at least every quarter and provide guidance and supervision.
- Each Vanaspati Van will also require a small compliment of staff headed by a Manager of the rank of a District Officer assisted by about 6 persons of agriculture, management, marketing, accounts and stores.
- In addition, it will have to engage some workers for raising plants and looking after the plantations.
- The Vanaspati Van may require protection by way of fencing along its parameters.

vi. All these inputs will be worked out in the form of a project report which may be prepared by the State Government. It is envisaged that one Vanaspati Van may require upto Rs. 1 crore per year by way of assistance through its 5 year period. Each project proposal will be considered by the Expert Committee constituted for research projects in ISM.

While the primary responsibility for development of Indian Systems of Medicine is of the Department of ISM&H, that Department does not presently have access to resources. Accordingly, it is not able to take up meaningful programmes for harnessing ISM for RCH. Therefore, after the Department of ISM&H is able to develop the full range of programmes, which may be by the end of 9th Plan, some of the foregoing programmes through the Department of Family Welfare can be transferred to the Department of ISM&H in the subsequent Plans.

ADDITIONAL PROGRAMME FOR THE URBAN SLUMS

25. It is estimated that about 9 crore people are residing in urban slums and in some of the towns like Delhi and Bombay the urban slum population is more than 30% of the total city population. It is well known that sanitation and health facilities in urban slums are extremely poor. RCH status of urban slums population is poorer than even the national average. This population is also characterised by large family size, high birth rate and high infant as well as maternal mortality. The incidence of diarrhoea, malnutrition and vaccine preventable diseases is also much higher in this population. Unfortunately, these areas have not received much attention in the past. Even though they are in the urban areas, they tend to be away from the city hospitals and therefore, are effectively not covered by good city health services.

Inputs

In previous Plans, Family Welfare Centres and Urban Posts have been created. The details of the posts available at the Urban Family Centres and the Urban Health Posts are at **Annexure XII**. These are generally not located in the slum areas.

An expert committee has been appointed in the Department of Family Welfare to recommend an appropriate and effective Family Welfare set up for the urban slums. The report of that Committee is expected shorty and the special Family Welfare Programme for urban slums will be worked out on the basis of its recommendations.

SPECIAL PROGRAMME FOR TRIBAL AREAS

26. There are extensive tribal areas in the country. These are generally characterised by low density of population, long distances and small hamlets/ villages. Because of poor communication, lower than average educational participation and generally low economic status of families the RCH status of this population is also generally poor. While the health infrastructure as it exists in other parts of the country has been put in places in tribal areas also because of their special characteristics the benefit of Family Welfare Programmes is not getting passed on to the citizens in the tribal areas to the extent it is happening elsewhere.

Inputs

In view of the extensive tribal area and fairly large tribal population in the country it is necessary to put in places a special programme package for tribal areas so that the Family Welfare Programme can be brought within reach of individual families effectively. A Committee of experts has been constituted in the Department of Family Welfare to work out appropriate package of Programmes for the tribal areas. The report is expected shortly. Based on the recommendations of this Committee the special package of Programmes for tribal areas will be worked out.

SPECIAL PROGRAMME FOR ADOLESCENTS

27. Adolescents constitute a large segment of population which is of special significance for the RCH status of the population at large, more so because adolescents will shortly join the reproductive age group. The special needs of this segment of population have not been addressed adequately in the past. This is an important segment to be addressed because if their needs are adequately provided for, the impact of RCH on population in the reproductive age group will not be much.

A Committee of experts has been constituted in the Department of Family Welfare to work out appropriate package of Programmes and its report is expected shortly. Based on the recommendations of this Committee the special package of Programmes for adolescents will be worked out.

RESEARCH AND DEVELOPMENT

28. The need of Research and Development in areas related to RCH is extensive. Up till now, the research effort in the country has been very modest because the financial support for R&D from the Department has been nominal. The result of this situation has been that practically all drugs and practices relating to RCH have been taken from the western countries as far as Modern System of Medicine is concerned.

The arrangement has been that the Departments relies exclusively on the Indian Council of Medical Research (ICMR) for Research and Development. ICMR takes up research and studies through its own chain of 33 branches/laboratories. Two of these laboratories, one at Hyderabad is focused on nutrition and the other at Bombay is focused on reproduction studies/research. In addition the ICMR entertains proposals from other medical research institutions in the country and funds them for research. While some good research studies have been made in this manner, a common feeling has been that the research has been modest and the research projects have tended to be inconclusive for long years.

Inputs

i. In view of foregoing, the Department of Family Welfare will continue financing R&D through ICMR to the extent R&D projects are taken up in its own laboratories.

ii. Department will also continue to provide financial support for part of the expenditure on headquarters and the two institutes at Hyderabad and Bombay.

iii. In addition to such R&D through ICMR, the Department will entertain proposals in the form of projects from other research institutions in the country in areas relevant for RCH. Dr. Roy Chowdhary Committee

appointed by the Department has recently identified some 80 research areas which will constitute the priority areas of the Department of Family Welfare for research.

iv. In addition, if some other project proposals with important implications are submitted to the Department, these will also be considered.

v. The Department will also consider support to basic research and operations research in areas relevant for RCH though on a limited scale in view of the limited availability of resources.

vi. The conferences and seminars are essential for promoting R&D in the system. They provide opportunity to researchers for presenting the results of their research and studies to the peer group for valuable comments and these forums enable the results of R&D to be disseminated among the participants. Therefore, the Department will extent financial assistance to well established NGOs and research institutions to the extent of upto Rs. 1.5 lakh for seminars/workshops, upto Rs. 3 lakh for national conferences and upto Rs. 5 lakh for international conferences based on their proposals volunteering item wise requirements.

Procedure for sanction/conditions regulating assistance.

i. The ICMR will have autonomy and freedom to take up projects costing upto Rs. 5 lakh in each case through its own internal mechanism though the taking up of the project along with essential details will be communicated to the Department of Family Welfare on a quarterly basis.

ii. The ICMR will also be helped to take up projects beyond this size through its own internal sanctioning mechanism but for each such project the ICMR would furnish a copy of the project proposal mentioning the subject of research, the organisational arrangement for research, duration of the project and financial implications and annual milestones expected.

iii. The project proposals by other Research Bodies will be considered by an Expert Committee headed by the Secretary, Department Family Welfare and consisting of RCH experts. The Committee will also annually monitor the progress of the research projects sanctioned on its recommendations in reference to the milestones volunteered in the sanctioned projects.

TRAINING

29. A fairly large training programme has been going on in the past in various areas resulting in awareness generation and to an extent skill upgradation. Under the RCH Programme, this has to be strengthened to ensure that all priority areas are attended to particularly for skill upgradation of the health functionaries. In addition, emphasis will be placed on training Panchayati Raj functionaries and functionaries of other related departments whose co-operation is necessary for the success of the Family Welfare Programme. An extensive network of Training

Institutions essentially consisting of 513 ANM Training Schools, 45 LHV Training Schools, about 200 District Training Centres, 47 Health and Family Welfare Training Centres besides State and Regional Institutes of Health and Family Welfare, Medical Colleges and National Institute of Health & Family Welfare have been set up and maintained during the last many decades. The training will be conducted in accordance with the guidelines for "Inservice Training for the Family Welfare Programme" brought out by Ministry of Health & Family Welfare in 1996.

The National Institute of Health and Family Welfare (NIHFW) will be nodal agency for co-ordinating all training programmes of the Department of Family Welfare. They will be assisted by 15 collaborating institutions on regional basis for implementation of RCH training. The collaborating institutions will ensure that in the districts where projects are implemented through IPPs, SIFSA, UNFPA and other agencies, the training is in accordance with the overall plan for training under RCH and that there is no duplication. The details of the training component under RCH Programme including responsibilities of NIHFW, collaborating and training institutions are at **ANNEXURE-XIII.**

The District Family Welfare Officer assisted by the District Training Centres will coordinate with the training institutions to ensure that the health personnel of the district are nominated for the training regularly. He will also coordinate with other related departments and Panchayati Raj system in the district to organise training for their functionaries. He will be required to closely interact with the collaborating training institutions of the State and NIHFW. The district authorities are expected to prepare annual plans for training according to the training needs of health workers. They will be assisted in this regards by collaborating institutions.

INFORMATION, EDUCATION AND COMMUNICATION

30. The importance of IEC activity cannot be over overstated for demystifying the RCH and population issues among public and in advocacy role. Imaginatively produced programmes have a very strong persuasive effect. Therefore, the Department of Family Welfare has been implementing a large IEC programme under which extensive use is being made of Doordarshan, All India Radio, Directorate of Advertising and Visual Publicity, Directorate of Field Publicity, Song and Drama Division and Films Division under the Ministry of Information and Broadcasting. In addition, Mahila Swathya Sanghs, sensitisation of opinion leaders, health awareness units in Nehru Yuvak Kendras are being supported.

Inputs

The IEC Division in the Department has been commissioning some programmes directly. The ongoing projects will continue as per the conditions of sanction in each case and will be valid till the date of completion of such projects. The Department also provides financial assistance for State level and District Level IEC.

i. TV & Doordarshan

Since the primary target for Information, Education and Communication is

middle class and low income group, reliance has to be on Doordarshan because the clientele of the non-government channels is middle class and above. Therefore, it is proposed that other channels will be utilised only to the extent viewership is intended from among middle class and above families. Doordarshan is proposed to be used for :

(a) ***Spots***

For placement of spots, it will be negotiated with Doordarshan that Family Welfare spots should be scheduled 3-4 days a week during the Polio Immunization period and two days a week during rest of the year - each day once in Hindi and second time in English. Attempt will be made to negotiate spots just before the national news and at least once just before the cinema film transmission to ensure maximum viewership. To the extent necessary the Department will agree to pay for time.

Spots will be got produced by non-government professional agencies. Since money will be drawn partly under the Reproductive and Child Health (International) funds, shortlisting of the agencies based on presentation/screening before an expert group and subsequently inviting offers from the shortlisted firms and entering into production agreement will have to be through procurement agency under the RCH programme. The name of the experts will be suggested to them after consulting the Ministry of Information and Broadcasting and one officer at Joint Secretary level from the Department will also be nominated.

The VHS Cassettes of the spots produced by Department of Family Welfare will be provided to the State Governments for dubbing in regional languages and telecast through local channels of Doordarshan/ TV.

(b) ***Films***

Production of films if left to Doordarshan or Films Division tend to be less creative. On the other hand the existing arrangement of inviting scripts in the Department has attracted only mediocre and substandard offers and lot of pressure. In any case the viewership of films through field shows is nominal and on Doordarshan one can show only a few films a year. Therefore, it is proposed to stop the practice of making a large number of films (there are already more than 300 films from the past) and also to stop the practice of entertaining scripts in the Department. Instead it is proposed to approach six to eight creative producers (to be firmed up in consultation with the Directorate of Film Festivals) through Films Division or National Films Development Corporation and invite them to make film of 1 to 1 1/2 hour on any of the themes relating to women's empowerment, population situation and the changes these are bringing about in the lives of the people, issues relating to girl child and reproductive behaviours of men/women. The costing of these films will also be left to these bodies. These films will be telecast on Doordarshan

and then given to field publicity units. Since both Films Division and NFDC will be treated as extension of the Government under World Bank procedures, no other procedural requirement will be there. Also, as part of 50th Anniversary of Independence, Films Division will be requested to make two documentaries about the changes brought about in the life of individuals or in the community by the Family Welfare/Population Control programme.

(c) ***Interactive panel discussions***

These are proposed to be commissioned through procurement agency by considering a shortlist of creative producers. Since these will be at regional level, each will be preceded by 2-3 district level interactive panel discussion as a build up. In each panel there will be of opinion leaders, the anchor person with the invited audience will interact with the panel in regard to population and Reproductive Child Health issues involving attitudes and responses of the citizens. This effort will aim to elicit support of opinion leaders in the Family Welfare programmes and to disseminate awareness above the issues in an informed manner. This will have to be done through the procurement agencies and according to World Bank procedures which essentially means financing on the basis of competitive bidding and two stage clearance of the World Bank first at shortlisting stage and second at the stage of finalising selected parties and their terms.

(d) ***Panel discussions***

This would be on topics where some professional information is sought to be communicated to specialist groups or citizens like in regard to Pre-natal Diagnostic Techniques Act, abortions, and STD etc. This would be done through Doordarshan about once in a month.

ii. RADIO

It is proposed to assign both the production and transmission task to the AIR. The Department will pay the amount which AIR may require for production and sponsorship of programmes (including money for time). It is proposed to sponsor dramas and folk music about two days a week, each day for 20-30 minutes. The spots then can be placed in the beginning, in the middle or at the end of the programme. The sound track of TV messages will be made available to the AIR for their use and AIR will supplement it by their additional recordings to the extent necessary. To maximise the audience only Vividh Bharati and the national channel will be used. Since AIR is a Government agency no other procedural requirement is necessary.

iii. Song and Drama Division

In order to optimise impact of the song and drama shows it is proposed to ask the Song and Drama Division to assign 2-3 districts to each group for intensive coverage. It is proposed to focus these performances in the 275 weakly performing districts. Since this Division is part of the government, no other procedural

requirement will be there.

In addition, it will be negotiated with Ministry of Information and Broadcasting that the Department of Family Welfare would not want to continue to pay for salary of any administrative staff or even of the song and drama troops. The payment would only be on the basis of performances made and Ministry of Information & Broadcasting can do the costing of each performance according to its own systems which should include the cost of salary.

iv. Directorate of Field Publicity

An arrangement similar to one for Song and Drama Division is proposed.

v. Hoardings in Towns

It is proposed to engage professional agencies through the procurement agency for hoardings in Prominent locations in town of more than 10 lakh population to begin with (5-10 hoardings in a town) and similarly to select professional agencies and assigning them the task of designing and painting the hoardings by a new design every quarter. This procedure will be in accordance with the World Bank requirement.

vi. Print Media

(a) Advertisements

Advertisements are proposed to be issued through DAVP on a number of specified annual days. The designs for advertisements will be prepared through professional agencies to be selected according to World Bank procedures through the procurement agency.

It is also proposed to negotiate with some established T-shirts manufacturers to manufacture and market T-shirts with design and messages of Family Welfare. It will be done if there is no cost involved or if the Department is able to get a small royalty for design/name. The designs will be not prepared from professional agencies and supplied to manufacturers of T-shirts. If this succeeds, there will be a few lakh young men and women sporting such T-shirts in a few months time. This could give a boost to the image of the programme particularly among youth.

(b) Printing of IEC material

Department of Family Welfare will continue printing of IEC material centrally whenever required. However, printing in regional languages will be undetaken by the State Government for the respective State.

vii. State level

While the above activities will be undertaken by the Government of India, State Governments may undertake similar local specific IEC activities from the funds allocated to the States for IEC activities. For this purpose, an amount of Rs. 25 lakh

to large States, Rs. 15 lakh to medium States and Rs. 10 lakh to smaller States will be provided annually.

Funds for maintenance of existing about 80,000 Mahila Swasthya Sanghs (MSS) will be provided @ Rs. 1200 per annum per MSS. In addition, each year 30,000 new MSS will be established based on the request of States. An amount of Rs. 1530 for each new MSS will be provided during the first year and in subsequent year funds will be provided as per existing rate. The funds for MSS will be provided through State Government/SCOVA as the case may be.

viii. District programmes

It is proposed to build up a strong component of Information, Education and Communication at district level. It proposed to link up with the National Literacy Mission which works through Zila Saksharata Samitis at district level for Total Literacy Campaign conducted over 1-2 years for each district. The District Samiti is headed by District Magistrate and includes all NGOs, related departments and opinion leaders. Literacy programme has substantially succeeded in mobilising masses and this strategy would be helpful for Family Welfare also. In any case, Education and Family Welfare are mutually supportive and in Total Literacy Campaign, women's literacy is the primary concern which again is relevant for Family Welfare. It is proposed to seek project proposals from each district (involving design and display of posters, wall writings, mass campaigns, local folk songs/ performance etc.) and to sanction individual projects through national literacy mission. This would be also helpful because Total Literacy Campaign is presently continuing mostly in districts which are weakly performing for Family Welfare. National Literacy Mission is also a Government agency and therefore, no other procedural requirement will be necessary and in any case it will be part of the NGO Programme.

An amount of between Rs. 3-5 lakh annually may be provided on the basis of Project proposals to the Zilla Saksharata Samities in the districts where they are functional and for other districts the proposal will be considered as and when Zilla Saksharata Samitis becomes functional.

ix. Evaluation of impact of IEC

It is proposed to follow World Bank procedures and assign the work of concurrent evaluation in a few districts every quarter to specialist communication agencies to asses the impact of IEC in all forms so that the programmes could be reoriented on the basis of results of evaluation.

In the 9th Plan, the IEC Programme will be further strengthened and extended. The main thrust of the Programme in the 9th Plan is to take away direct production responsibility from the Department and to give it the role of coordination, monitoring and commissioning of programmes/agencies. Also, while extensive use will continue to be made of agencies of Ministry of Information and Broadcasting more reliance will be placed on using professional non-governmental agencies for production for increasing innovative-ness.

NON-GOVERNMENTAL ORGANISATIONS (NGOs)

31. The work through the NGOs is not by way of alternative to work through a Government system, it is actually complementary in nature. Both sectors have their own strong points which cannot be ignored and therefore, both the Government Sector and the NGOs should be used in complementary manner for optimum effect. The NGOs have the advantage of flexibility in procedures, rapport with local population and credibility. They are therefore, better placed to try innovations which the Government system is not in a position to even attempt. The Department of Family Welfare has been increasing the involvement of NGOs over the years and currently about 600 NGOs are being assisted for various Programmes. The main thrust of the NGO Programme in the 9th Plan will be to involve NGOs essentially in innovative programmes and not to use them for implementing routine Government Programmes. Also the NGO Programme will be so directed as to not burden the Department of Family Welfare with all the NGO cases of the country which obviously the Department cannot deal with efficiently.

Inputs

In view of the above mentioned policy thrusts, the following NGO Programmes would be implemented in the 9th Plan:

Small NGOs

i. At the village, Panchayat and Block levels, small NGOs will be involved basically for advocacy of RCH and Family Welfare Practices and for counselling to explain the facts and consequences of using or not using RCH/Family Welfare Practices. However, the individual NGOs at this level will be allowed to propose innovative programmes also and these will be considered for sanction if they are found practicable by Mother NGO.

ii. These small NGOs have small resources and they should not in fairness be asked to send their proposals all the way upto Central Government or to come to Delhi. Therefore, assistance to such small NGOs will be organised through Mother NGOs each for 5-10 districts.

Mother NGOs

iii. Mother NGOs with substantial resources and proved competence will be approved. They will be given grants by the Department directly once in a year at the beginning of the year. In subsequent years the annual grant will be given after taking into consideration the performance report for the previous year and utilisation certificate for the grants given earlier.

iv. The Mother NGO will have one nominee of the State Government and one of the Government of India on its Executive Committee. They will screen the credentials of the applicant small NGO, obtain proposal from it, consider it for sanction, release money to it, monitor its work and obtain utilisation certificate from the small NGO. The nominee of the State/Central Governments must be present while sanctioning the Projects otherwise such sanctions may not be valid.

v. The Mother NGO will also provide training to the staff of the small NGOs for both management of the NGO and for management of the Programmes.

vi. The Mother NGO will furnish Annual Report and its audited accounts to the Department every year mentioning the work done by each NGO during the year and the result of periodic verification done by the Mother NGO in the field of the work of small NGOs while claiming grant for the next year.

vii. In order to facilitate easy working, it has been decided that there will be no insistence on any share being contributed for implementation of the Programme by the small NGO or the Mother NGO. Also the annual grant to all NGOs will be released in one annual installment because the system of two installments in the year has been found to be impracticable.

viii. While sanction to small NGO by the Mother NGO will be for the needs of the Programme, the sanction to the Mother NGO by the Department of Family Welfare will be to the extent of financing done by the Mother NGO to the small NGO plus 20% of such financing by way of institutional overheads of the Mother NGO and for providing support services to the small NGOs.

ix. No Mother NGO would be expected to sanction a project to itself for implementation. This applies to any branch or affiliated office of the Mother NGO as well. However, in few cases, if some branch of the National or Mother NGO submit the project for implementation, the same would be got verified from other National/Mother NGO and the project will be sanctioned if all necessary conditions are fulfilled by that branch independently for being a suitable NGO.

x. Annual funds required by a Mother NGOs will be released on quarterly/six-monthly basis and will be based on their performance.

National NGOs

xi. A limited number of national level NGOs will be assisted by the Department on project basis for innovative Programmes. Again, the attempt will be to not involve the NGOs in repeating the Government Programmes. In addition to above mentioned general categories of NGO Programmes, the Department proposes to involve NGOs for some specific areas wherever involvement is expected to yield good results. For example, for introducing Baby-friendly practices in hospitals it is proposed to give projects for individual hospitals in cities to individual NGOs. Similarly for helping in enforcement of Pre-natal Diagnostic Technique Act by detecting offending sex determination clinics and collecting evidence for making specific complaints against them to the designated authorities in the States, it is proposed to involve a number of NGOs in different parts of the country.

xii. A limited number of NGOs may be assisted for mobile clinics having equipped vans offering RCH and spacing methods services including IUD insertions. These clinics will operate in identified areas and visit villages on fixed days of the week or fortnight. The cost of vans, drugs, a lady medical officer and a paramedical worker will be funded under the programme. Initially these clinics will be operationalised at 10 places in the country and extended later based on the experience gained from the projects.

xiii. A large number of hospitals and clinics have come up and are coming up in urban areas which unfortunately are so far not getting adequately involved

in offering facility for contraceptive/terminal methods and for counselling both in regard to RCH and population control measures. The desirability of involving the hospitals/clinics in non-government sector in these activities is obvious. It is proposed to motivate such hospitals/clinics for setting up the above mentioned units by offering them a token one time start-up assistance of not more than Rs. 2 lakh after which they will be expected to maintain these services in any case for not less than 5 years.

xiv. A small number (6 to 8) of national level NGOs/Institutions will be selected to make verfication of credentials of Mother NGOs. Apart from the verification of Mother NGOs, National level NGOs may also be assigned the work of the assessing the performance of some of the Mother NGOs on a regular basis.

Procedure for sanction/conditions regulating assistance

i The following conditions will apply to small NGOs and Mother NGOs :

* NGO should have the character of a registered society or trust or non-profit making company.
* NGO should have been in existence preferably for at least 3 years but this can be considered for being waived in areas which are weak in NGO coverage.
* NGO must have office premises either its own or rented. There should be at least minimum necessary furniture and office equipment.
* NGO should have at least one full time or part-time specialist relating to field of activity and at least one full time/part-time person for administration/financial management. The Governing Body of NGO must have at least 35% members with background in the field of activity.
* National and Mother NGOs must have at least Rs. 1 lakh in fixed/cash assets to ensure that it is an organisation of substance. For field level small NGOs this would be to the extent of Rs. 25,000/-.
* Before the first project is assigned to the NGO its credentials and assets must be verified by an independent agency to establish its bona fides.
* An NGO blacklisted by any Ministry/Department of GOI would not be sanctioned a project by the Department for next 5 years.
* The NGO should have already existing premises/office in the state where it wishes to work.

ii. It will be the responsibility of the Mother NGOs to verify fulfillment of these conditions and to keep a record of the verification made for being made available to the Department of Family Welfare on demand.

iii. In the case of Mother NGOs, the Department of Family Welfare will have their antecedents and credentials verified through a national level NGO before according it the status of Mother NGO and before sanctioning any project to it.

iv. For this purpose, the Department of Family Welfare will enter into an arrangement with one or more national level NGOs like SOSVA or Voluntary

Health Association of India or Family Planning Association of India etc., by agreeing to pay to these national level NGOs for every verification report. Therefore, at the time of first application the sanction to the Mother NGO is likely to take three months after the application is received in the Department.

v. A limited number of national level NGOs will be assisted by the Department on project basis for innovative programmes. Again, the attempt will be to not involve the NGOs in repeating the Government programmes.

* The conditions specified for small and Mother NGOs will apply to the national level NGOs also. Although many of the national level NGOs have established credentials but the NGOs which have not earlier worked for the Department may be subjected to verification through an identified national level NGO before a project is sanctioned to it.

* All such sanctions to national level NGOs will be on project basis which will be generally for 3-4 years. Each project will be for a well defined area with stated objectives to be attained at the end of the project. While the sanction under the individual projects will vary depending on the nature of the project but generally an upper limit of Rs. 50 lakh for a 3 year project will be observed.

vi. All NGO cases at the central level will be considered for sanction by a committee headed by the Secretary, Department of Family Welfare and will include in addition to the Programme Joint Secretary and Financial Adviser of the Department, two NGO representatives, three RCH specialists and representative of the Planning Commission. The Committee will meet atleast every quarter and will consider cases which have been received up to that stage.

vii. The effectiveness of the NGO projects in the area of counselling and advocacy will be assessed on the basis of the improvement in increased CPR, sterilisations and other project related goals. Similarly, while evaluating the performance of National level NGOs and Mother NGOs, their effectiveness will be judged on the the same criterion.

viii. All ongoing NGO projects will continue as per the conditions of sanction in each case and will be valid till the date of completion of such projects.

MANAGEMENT INFORMATION SYSTEM UNDER RCH PROGRAMME

32. RCH approach has been built upon the participatory planning approach that was initiated in 1996-97. The participatory planning approach is intended to identify Reproductive and Child Health needs of the communities and clients and the Target Free Approach manual is an instrument to assist this process. Target Free Manual which has been renamed as Community Needs Assessment Manual has been revised in order to simplify the messages and contents and is being made available to all districts for distribution among all health facilities and workers. On the basis of community needs assessed by the health workers, Sub-centre Action Plan need to be prepared annually. This process will involve discussion and approval of supervisor of the health worker (LHV/MO). Similarly PHC Action Plan incorpo-

rating the Sub-centre Action Plan will be prepared under the supervision of the next supervisory officer. The PHC Plans will form an integral part of the District Plan which will be formulated on annual basis. Availability of the Annual District Plan would be one of the performance indicator

For a complex and extensive programme like RCH, the Management Information System (MIS) needs to be strengthened. The Appraisal Document of the World Bank mentions a number of indicators **(Annexure XIV)** which will be used for monitoring the progress of implementation and information on these indicators are to be provided on a six monthly basis to World Bank. An efficient MIS should provide a regular and reliable information about the implementation of various programmes/ activities initiated under the RCH programme and their impact in improving the health status of women and children.

i. At present the information about the various demographic indicators are being made available through decennial census, National Family Health Survey (NFHS: 1992-93), Sample Registration System (SRS) of Registrar General of India, studies conducted by various agencies like PRCs etc. and routine reporting made for the activities under Family Welfare Programmes by the States. The reliability and authenticity of the information provided by SRS and NFHS is beyond any doubt, however, the information is available either at national level or upto the state level only and that too with a considerable time lag.

ii. The information collected through SRS is only in respect of small numbers of indicators. Therefore, for effectively monitoring the programme activities, the information collected through routine channels of the state system is only available and used for this purpose. The routine information available from the state systems suffers in authenticity to some extent because it involves large number of personnel and most of them may not be aware of the purpose of collection of such information and therefore not meticulous in reporting.

iii. National Family Health Survey (NFHS)-1992-93, was the first survey conducted in the country and it is proposed that henceforth National Family Health Surveys will be conducted at every five years interval. This year IIPS, Mumbai will be conducting second NFHS with the support from USAID.

iv. Under the RCH Programme, the following mechanisms are being proposed for getting information on selected RCH indicators on annual basis with district level estimates of the indicators.

A. ROUTINE REPORTING

In order to improve the routine reporting under the decentralised participatory plans at the PHC level the reporting for all interventions under the Family Welfare Programme have been integrated. Formats for the reports to be submitted at various levels have been revised and are being separately made

Bank. They would also be responsible for receiving expenditure reports from Drawing and Disbursement Officers, the registered society and any other agency to which project funds have been allocated. For any expenditure incurred through the registered society, the society would submit compiled accounts to the Project Director for submission of disbursement applications.

38. Each year the Project Director would be required to arrange for the accounts to be audited by the auditors. In the case of Zilla Parishads, audits by the Examiner/ Director of the Local Fund Audit will be acceptable. Accounts of registered societies would be audited by private auditors in accordance with Registration of Societies Act. The Project Director would arrange for one consolidated audit report to be submitted to MOHFW within the six months after closing of each financial year, covering the project for the respective state as a whole.

ANNUAL PERFORMANCE AND WORK PLAN

39. It has been agreed in principle with World bank to implement performance based funding during the project. Each state would provide annual performance report and Annual Work Plan (for the national wide component as well as for each sub-project separately). These documents will be jointly reviewed by World Bank and MOHFW. MOHFW will be responsible for approving annual budgets after reviewing these documents using agreed criteria **(Annexure XVII).** Since the performance based funding has been introduced for the first time, MOHFW and World Bank from time to time assess appropriateness and effectiveness of this exercise and wherever necessary, revision may be carried out.

SUBMISSION OF STATEMENT OF EXPENDITURE (SOES)

40. All the State Project Directors will coordinate the activity-wise periodic expenditure and prepare the disbursement applications on the prescribed formats and submit the Statement of Expenditure (SOEs) to MOHFW on monthly basis. The Expenditure of "Contractual Staff" may be submitted under two sub-headings of "Full Time" (Doctors, Nurses, ANMs, Lab. Techs.) and "Part Time" (Anaesthetists, PHC Doctors, staff nurse for Midwifery, clearning services). Details of items under which reimbursement for World Bank will be available, extent of reimbursement available, agency which will claim reimbursement and essential document to be submitted while preferring reimbursement claims are at **ANNEXURE-XVIII.**

CONTENTS OF DRUG KIT A

Sr. NO.	Name of the Item	Quantity
1.	Oral Rehydration Salt (O.R.S.)	150 packets
2.	Tablet I.F.A. (large)	15000 tabs.
3.	Tablet I.F.A. (small)	13000 tabs.
4.	Vitamin A solution	6 bottles of 100 ml. each
5.	Tablet Cotrimoxazole (Paediatric)	1000 tabs.

ANNEXURE-II

CONTENTS OF DRUG KIT B

Sr. No.	Name of the Item	Quantity
1.	Tab. Methylergometrine Maleate (0.125 mg.)	500 tablets
2.	Tablet Paracetamol (500 mg.)	500 tablets
3.	Inj. Methylergometrine Maleate [0.2 mg./ml., 1ml. ampoule (for I.M. use) in light resistant amber colour ampoules]	10 ampoule
4.	Tab.Mebendazole 100 mg.	300 tablets
5.	Dicyclomine Hcl 10 mg.	250 tablets
6.	Chloramphenicol Eye Ointment 1% w/w in applicaps. Each applicap to contain 250 mg. of ointment	500 applicap
7.	Ointment Povidone Iodine 5%	5 Tubes
8.	Cetrimide Powder	125 gm.
9.	Absorbent Cotton	1 roll
10.	Cotton Bandage (4 cm width x 4 metres length)	120 rolls

ANNEXURE III

LIST OF EQUIPMENT KITS
A MIDWIFERY KIT A.N.M.

S.No.	Item Description	Qnty
1.	Sphygmomanometer, aneroid, 300mm with cuff	1
2.	Scale, weighing, (baby) hanging type, colour coded, 5kg.	1
3.	Steriliser Instrument, 222 x 82 x 41mm. stainless steel	1
4.	Forceps, spring-type, dressing 160mm, stainless steel	1
5.	Basin, Kidney, 825ml, stainless steel	1
6.	Bowl, sponge set of two sizes, 600ml 1200ml-SS	1
7.	Catheter, uretheral, 12fr, rubber	1
8.	Sheeting, clear, vinyl plastic, 910mm wide x 180mm	1
9.	Can, enema with tubing and clip	2
10.	Thermometer, clinical, oral dual scale, celsius/fahrenheit	1
11.	Thermometer, clinical, rectal dual celsius/fahrenheit	1
12.	Brush, hand, surgeon's with white nylon bristles	1
13.	Mucus extractor	1
14.	Forceps, artery, straight, pean 160mm, stainless steel	2
15	Scissor, cord-cutting, busch, curved on flat, 160mm.-SS	1
16.	Tape, umbilical non-sterile, 3mm wide x 25m spool	1
17.	Nail clipper/file	1
18.	Foethoscope (Stethoscope Foetal)	1
19.	Bag, multipurpose, vinyl, for midwifery kit	1

ANNEXURE IV

SUB-CENTRE EQUIPMENT KIT

Item description	Qty./ Kit	Item description	Qty./ Kit
Kit C-Sub-Centers			
BASIN KIDNEY 825 ML (28 OZ) STAINLESS STEEL, REF IS: 3992	2EA	BASIN SOLUTION DEEP APPROX. 6 LITRE S.S. REF IS: 5764	1EA
TRAY INSTRUMENT/DRESSING W/COVER 310X195X63MM SS, REF IS: 3993	IEA	BRUSH SURGEON'S WHITE NYLON BRISTLES	2EA
FLASHLIGHT BOX-TYPE PRE-FOCUSED 4 CELL	1EA	SPHYGMOMANOMETER ANEROID 300 MM WITH CUFF IS: 7652	1EA
JAR DRESSING W/COVER 0.945 LITER STAINLESS STEEL	1E.A	RACK BLOOD-SEDIMENTATION WESTERGREN 6-UNIT	1EA
HEMOGLOBINOMETER-SET SAHL 1 TYPE COMPLETE	1EA	BATTERY DRY CELL 1.5, 'D' TYPE FOR ITEM 10C	4EA
SCALE BATHROOM METRIC/ AVOIRDUPOIS 125 KG/280 1B	1EA	SCALE, INFANT METRIC	1EA
SHEETING PLASTIC CLEAR PVC CM X 180 CM	2EA	LANCET SS (MAGEDORN NEEDLE) 75 MM PKT OF 6	1EA
FORCEPS TISSUE- 160 MM	1EA	FORCEPS HEMOSTAT STRAIGHT KELLY 140MM SS	1EA
FORCEPS STERILIZER (UTILITY) 200 VAUGHM SS	1EA	FORCEPS UTERINE VULSELLUM CURVED 25.5 CM	1EA
SCISSORS SURGICAL STRAIGHT 140MM S/B, SS	1EA	REAGENT STRIPS FOR URINE TEST	1EA
REAGENT STRIPS FOR URINE TEST	1EA	SPECULUM VAGINAL BI-VALVE CUSCO'S/GRAVES MEDIUM	1E.A
SIMS UTERINE DEPRESSOR/ RETRACTOR	1EA	SPECULUM VAGINAL DOUBLE-ENDED SIMS: ISS MEDIUM	1EA
MEASURE 1 LITER JUG-SS	1EA	MEASURE 1/2 LITRE JUG- SS SOUND, UTERINE, GRADUATED)	1E.A 1EA

PRIMARY HEALTH CENTRE EQUIPMENT

KIT D- PRIMARY HEALTH CENTRES			
BASIN, KIDNEY 825 ML (28 OZ) STAINLESS, REF: 3992	1E.A	IRRIGATOR 1.5 LTR W/TUBING-CLAMP AND STRAIGHT CONNECTOR	1Set
JAR DRESSING W/COVER 310X195X 36MM S/S, REF IS:3993	1EA	TRAY INSTRUMENT/DRESSING W/COVER 310X 195X 63 MM S/S. REF IS: 3993	1EA
SPHYGMOMANOMETER, ANEROID, 300 MM WITH CUFF, REF IS: 7652	1EA	HEMOGLOBINOMETER SET SAHLI-TYPE. COMPLETE	1Set
MICROSCOPE MONOCULAR W/OIL-1MM OBJ WITH ILLUMINATOR	1EA	RACK BLOOD SEDIMENATION, WESTERGREN, 6 UNIT	1EA
MUCUS EVACUATOR	1Set	BATTERY ALKALINE DRY CELL "C" TYPE 1.5 V	2EA
SCALE PHYSICIAN ADULT METRIC 125KGS/100 GMS	1EA	SCALE INFANT METRIC 16 KGS/20 GMS	1EA
REAGENT STRIPS FOR URINE TEST	1 Botl	SPECULUM NASAL. STAINLESS STEEL	1Set
CURETTE UTERINE SHARP/BLUNT, BLUKE 270 MM S/S	1EA	FORCEPS HEMOSTAT, STRAIGHT, KELLY 140MM, S/S	1EA
DILATOR UTERINE DOUBLE-ENDED, HEGAL S/S, SET OF 5	1EA	FOREPs SPONGE - HOLDING, STRAIGHT, 228 MM, S/S	1EA
FORCEPS TISSUE, SPRING TYPE 1X2 . TEETH 150MM S/S	1EA	FORCEPS TISSUE 4X5 TEETH ALLIS 150MM S/S	1EA
FORCEPS, TONGUE HOLDING, YOUNG 170 MM, SOFT RUBBER JAWS, STAINLESS STEEL	1EA	FORCEPS STERILIZER (UTILITY) 280MM VAUGHAN, S/S	1EA
FORCEPS UTERINE VULSELLUM STRAIGHT JACOBS 250 MM	1EA	KNIFE-HANDLE SURGICAL FOR MINOR SURGERY # 3	1EA
KNIFE-HANDLE SURGICAL FOR MAJOR SURGERY # 4	1EA	KNIFE-BLADE SURGICAL FOR MINOR SURGERY # 1 PKT 5	1E.A
KNIFE-BLADE FOR MAJOR SURGERY # 22 PK T 5	1Pkt	NEEDLE SUTURE 3/8 CIRCLE CUTTING, ASSORTED	2 Pkts
RETRACTOR VAGINAL SIMS MEDIUM BLADE 31X 80M S/S	1EA	SCISSORS, SURGICAL CURVED, 140MM SHARP/BLUNT. S/S	1E.A
SPECULUM VAGINAL, BI-VALVE CUSCO'S/GRAVES, SMALL	1EA	SCISSORS SURGICAL, STRAIGHT, 140MM SHARP/BLUNT, S/S	1EA
SPECULUM, VAGINAL, DOUBLE-HANDED SIMS, 165 MM LONG, STAINLESS STEEL	1EA	SPECULUM VAGINAL, BI-VALVE CUSCO' S/GRAVES, MEDIUM	1EA
SOUND UTERINE SIMPSON 300 MM GRADUATED IN 20MM	1E.A	LARYNGOSCOPE FOLDING TYPE MACKINTOSH PATTERN WITH SEPARATELY PACKED BATTERIES	1EA
NEEDLE, SUTURE SURGEON'S . REGULAR 3/8 CIRCLE	1EA	HOLDER, NEEDLE, STRAIGHT, NARROW-JAW MAYO HEGAR, 180MM	1EA
CATHETER, TRACHEAL, DELEE, 16FR, 5/5MM DIA, 400MM OPEN TUP WITHOUT EYE, FUNNEL END 6 MM, SOFT RUBBER	1EA	PUMP, ASPIRATING, SURGICAL PORTABLE, FLOOR OPERATED	1EA
		CONNECTOR 3-IN-1 FOR 6 TO 8MM NYLON TUBING	1EA

E STANDARD SURGICAL SET-1 (INSTRUMENTS) FRU

S. No.	Item Description	Qnty
1.	Tray, Instrument/dressing with cover, 310x200x600mm-ss	1
2.	Gloves surgeon, latex sterilizable, size 6	12
3.	Gloves surgeon, latex sterilizable, size 6-1/2	12
4.	Gloves surgeon, latex sterilizable, size 7	12
5.	Gloves surgeon, latex sterilizable, size 7-1/2	12
6.	Gloves surgeon, latex sterilizable, size 8	12
7.	Forceps backhaus towal -130mm	4
8.	Forceps sponge holding- 228mm	6
9.	Forceps artery, pean straight, 160mm, stainless steel	4
10.	Forceps hysterectomy, curved-22.5mm	4
11.	Forceps, hemostatic, halsteads mosquito, straight, 125mm-ss	6
12.	Forceps tissue, all/is 6 x 7 teeth, straight 200 mm- ss	6
13.	Forceps, uterine, tenaculum-280mm stainless steel	1
14.	Needle holder, mayo, straight, narrow jaw, 175 mm, ss	1
15.	Knife-handle surgical for minor surgery # 3	1
16.	Knife-handle surgical for major surgery # 4	1
17.	Knife-blade surgical, size 11, for minor surgery, pkt of 5	3
18.	Knife-blade surgical, size 15, for minor surgery, pkt of 5	4
19.	Knife-blade surgical, size 22, for major surgery, pkt. of 5	3
20.	Needles, suture triangular point- 7.3 cm, pkt of 6	2
21.	Needles, suture, round bodied, 3/8 circle No. 12 pkt of 6	2
22.	Retractor, abdomimal, Deavers, Size 3,2.5 x 22.5 cm.	1
23.	Retractor, double-ended abdominal, Beltouis, set of 2	2
24.	Scissors, operating curved mayo-blunt pointed 170mm	1
25.	Retractor abdomimal, Balfour 3 blade self-retaining	1
26.	Scissors, operating, straight, blunt point 170mm	1
27.	Scissors, gauze, straight, 230mm- stainless steel	1
28.	Suction tube-225mm, size 23F	1
29.	Clamp Intestinal, Doyen, curved 225mm- stainless steel	2
30.	Clamp Intestinal, Doyen straight, 225mm- stainless steel	2
31.	Forceps, Tissue Spring Type, 160mm stainless steel	2
32.	Forceps, Tissue Spring-Type 250mm stainless steel	1

F CHC STANDARD SURGICAL SET-II

S. No.	Item Description	Qnty	Unit
1.	Forceps, Tissue, 6 x 7 teeth, Thomas-Allis 200mm- SS	1	EA
2.	Forceps, Backhaus Towel- 130mm, stainless steel	4	EA
3.	Syringe anaesthetic (Control) 10ml. luer-glass	1	EA
4.	Syringe, hypodermic 10ml glass, spare for item 3	4	EA
5.	Needles hypodermic 20G x 1-1/2" box of 12	1	Box
6.	Forceps Tissue, Spring type 145mm stainless steel	1	EA
7.	Forceps Tissue spring type 1 x 2 teeth, Semkins 250mm	1	EA
8.	Forceps, Tissue spring, type 250mm stainless steel	1	EA
9.	Forceps, Hemostat curved mosquito haistead 130mm	6	EA
10.	Forceps, Artery, straight pean 160mm stainless steel	3	EA
11.	Forceps, Artery, curved pean 200mm stainless steel	1	EA
12.	Forceps, tissue, babcock, 195mm, stainless steel	2	EA
13.	Knife bandle for minor surgery No. 3	1	EA
14.	Knife blade for minor surgery No. 10 pkt of 5	8	EA
15.	Needle holder, straight narrow-jaw Mayo-Heger 175mm	1	EA
16.	Needle suture straight 5.5 cm triangular point, pkt of 6	2	Pkt
17.	Needle, Mayo, 1/2 circle, taper point, size 6, pkt of 6	2	Pkt
18.	Catheter urethral Nelaton solid-tip one-eye 14Fr	1	EA
19.	Catheter urethral Nelaton solid-tip one-eye 16 Fr	1	EA
20.	Catheter urethral Nelaton solid-tip one-eye 18 Fr	1	EA
21.	Forceps uterine tenaculum duplay dbl-cvd 280mm	1	EA
22.	Uterine elevator (Ranathlbod), stainless steel	1	EA
23.	Hook, obstetric, Smellie, stainless steel	1	EA
24.	Proctoscope Mcevedy complete with case	1	EA
25.	Bowl, sponge, 6000ml stainless steel	1	EA
26.	Retractor abdominal Richardson-Eastman, dbl-ended, set 2	1	Set
27.	Retractor abdominal Deaver 25mm x 3cm. stainless steel	1	EA
28.	Speculum vaginal bi-valve graves, medium, stainless steel	1	EA
29.	Scissors ligature, spencer straight, 130mm. stainless steel	1	EA
30.	Scissors operating straight 140mm blunt/blunt SS	1	EA
31.	Scissors operating curved-170mm blunt/blunt SS	2	EA
32.	Tray instrument, curved, 225 x 125 x 50mm stainless steel	1	EA
33.	Battery cells for item 24	2	EA

IUD INSERTION KIT

KIT G

SETAL STERILIZATION TRAY WITH COVER SIZE 300 X 220 X 70MM, S/S, REF IS: 3993	1EA	TORCH WITHOUT BATTERIES	1EA
GLOVES SURGEON, LATEX, SIZE-6-1/2 REF 4148	6 Pairs	GLOVES SURGEON, LATEX, SIZE- 7, REF: 4148	6 Pairs
GLOVES SURGEON LATEX, SIZE 7⅛, REF 4148	6 Pairs	GLOVES SURGEON, LATEX SIZE 6 REF-IS 4148	6 Pairs
BOWL, METAL, SPONGE, 600 ML REF IS: 5782	1EA	BATTERY DRY CELL 1.5 V `D' TYPE FOR ITEM 7G	1EA
SPECULUM VAGINAL BI-VALVE CUSCO'S GRAVES SMALL S/S	1EA	SPECULUM VAGINAL BI-VALVE CUSCO'S/GREA VES MEDIUM S/S	1EA
FORCEPS SPONGE HOLDING, STRAIGHT 228MMH SEMKEN 200MM	1EA	FORCEPS ARTERY, STRAIGHT, PEAN 160MM	1EA
SOUND UTERINE SIMPSON 300MM GRADUATED UB 20MM	1E.A	SCISSORS OPERATING STRAIGHT 145MM BLUNT/BLUNT	1 Set
FORCEPS UTERINE TENACULUM DUPLAY DBL-CVD 280MM	1EA	FORCEPS UTERINE VULSELLUM CURVED MUSEUX 240MM	1EA
FORCEPS TISSUE - 160MM	1EA	SPECULUM VAGINAL DOUBLE ENDED SIME SIZE # 3	1E.A
ANTERIOR VAGINAL WALL RETRACTOR STAINLESS	1EA		

NORMAL DELIVERY KIT

KIT I

TROLLEY, DRESSING CARRIAGE SIZE 76 C, LONG X 46CM WIDE AND 84CM HIGH, REF IS: 4769/1968	1EA	MACINTOSH, OPERATION, PLASTIC	2EA
TOWEL, TROLLEY 84 CM X 54 CM	2EA	MASK, FACE, SURGEON'S) CAP OF REAR TIES; B) BERET TYPEWITH ELASTIC HEM	2EA
GOWN, OPERATION, COTTON	1EA	TOWEL, GLOVE	3EA
CAP, OPERATION, SURGEON'S 36 X 46 CM	2EA	COTTON WOOL ABSORBENT NON-STERILE 500G	2EA
GAUZE ABSORBENT NON-STERILE 200 MM X 6M, AS PER IS: 171/1985	2EA	DRUM, STERILIZING, CYLINDRICAL - 275 MM DIA X 132MM, S/S AS PER IS: 3831/1979	2EA
TRAY INSTRUMENT W/COVER 450MM(L) X 300MM(W) X 80MM(H)	1EA	TABLE INSTRUMENT ADJUSTABLE TYPE WITH TRAY, S/S	1Set

H CHC- EQUIPMENT FOR STANDARD SURGICAL SET III

S. No.	Item Description	Qnty	Unit
1.	Tray, instrument/dressing with cover 310 x 195 x 63mm.	1	EA
2.	Forceps, Backhaus towel 130mm, stainless steel	4	EA
3.	Forceps, Hemostat, straight. Kelly, 140mm, stainless steel	4	EA
4.	Forceps, Hemostat, curved. Kelly, 125mm, stainless steel	2	EA
5.	Forceps, tissue Allis 150mm. stainless steel, 4 x5 teeth	2	EA
6.	Knife handle for minor surgery No. 3	1	EA
7.	Knife blade for minor surgery, size 11 pkt of 5	10	Pkt
8.	Needle hypodermic, Luer 22G x 11/4", box of 12	1	Box
9.	Needle hypodermic Luer 250G x 3/4", box of 12	1	Box
10.	Needle, Suture straight 5.5cm triangular point, pkt of 6	2	Pkt
11.	Needle, suture, Mayo 1/2 circle, taper point No. 6 pkt of 6	2	Pkt
12.	Scissors, ligature, angled on flat 140mm. stainless steel	1	EA
13.	Syringe anaestbetic control. Luer - 5ml glass	4	EA
14.	Syringe 5ml, spare for item 13	4	EA
15.	Sterilizer, instrument 200 x 100 x 60 mm. with burner. SS	1	EA
16.	Syringe, hypodermic, Lure 5ml, glass	4	EA
17.	Forceps, sterilizer, cheatle 265mm, stainless steel	1	EA

J STANDARD SURGICAL SET- IV

S. No.	Item Description	Qnty	Unit
1.	Vaccum Extractor. Malastrom	1	SET
2.	Forceps, obstetric, Wrigley's- 280mm. stainless steel	1	EA
3.	Forceps, obstetric, Barnes-Neville, with traction- 390mm	1	EA
4.	Forceps, sponge holding, straight 228mm, stainless steel	4	EA
5.	Forceps, artery, Spencer-Wells, straight, 180mm-SS	2	EA
6.	Forceps, artery, Spencer-Wells, straight, 140mm-SS	2	EA
7.	Holder, needle straight, Mayo-Hegar 175mm-SS	1	EA
8.	Scissors, ligature, Spencer 130mm- stainless steel	1	EA
9.	Scissors, episiotomy, angular, Braun 145mm, stainless steel	1	EA
10.	Forceps, tissue, spring-type, 1x2 teeth, 160mm-SS	1	EA
11.	Forceps, tissue, spring-type, serrated ups, 160mm-SS	1	EA
12.	Catheter, urethral, rubber, Foley's 14ER	1	EA
13.	Catheter, urethral, Nelaton, set of five (Fr 12-20) rubber	1	Set
14.	Forceps, Backhaus, towel- 130mm-SS	4	Set
15.	Speculum, vaginal, Sim's, double-ended # 3-SS	1	EA
16.	Speculum. vaginal, Hamilton-Bailey	1	EA

K STANDARD SURGICAL SET-V

S. No.	Item Description	Qnty	Unit
1.	Forceps, obstetric, Neville-Barnes, W/traction 390mm	1	EA
2.	Hook, decapitation, Braun, 300mm, stainless steel	1	EA
3.	Hook & Crochet. obstetric, 300mm, Smellie, stainless steel	1	EA
4.	Bone, forceps, Mesnard 280mm, stainless steel	4	EA
5.	Perforator, Smellie, 250mm stainless	1	EA
6.	Forceps, cranial. Gouss, straight, 295mm-SS	1	EA
7.	Cranioclast, Braun, stainless steel, 365mm long	1	EA
8.	Scissors ligature Spencer 130mm, stainless steel	1	EA
9.	Forceps sponge holding, 22.5 cm straight.-SS	1	EA
10.	Forceps, tissue, spring-type, 1x2 teeth, 160mm stainless steel	1	EA
11.	Forceps, tissue, spring-type, serrated tips, 160mm-SS	1	EA
12.	Forceps, artery, spencer-wells. straight, 180mm-SS	2	EA
13.	Forceps, artery, spencer-wells. strarght, 140mm-SS	2	EA
14.	Forceps, scalp flap. Willet's 190mm.- SS	4	EA
15.	Forceps, Vulsellum, Duplay double curved, 280mm- SS	4	EA
16.	Forceps, Vulsellum, Duplay double curved, 240mm- SS	1	EA
17.	Catheter, urethral, 14Fr, Solid tip. one eye, soft rubber	3	EA
18.	Holder. needle, Mayo-Hegar, narrow jaw, straight, 175mm-SS	1	EA
19.	Speculum vaginal Bi-valve. Cusco-medium. stainless steel	1	EA
20.	Speculum, vaginal Sim's double-ended, size # 3- SS	1	EA
21.	Forceps, Backhaus, towel-130mm, stainless steel	4	EA

L STANDARD SURGICAL SET-VI

S. No.	Item Description	Qnty	Unit
1.	Forceps. sponge holding, straight. 225mm, stainless steel	4	EA
2.	Speculum, vaginal, Sim's double-ended, size # 3 -SS	1	EA
3.	Speculum, vaginal, weighted Auvard, 38 x 75 mm blade- SS	1	EA
4.	Forceps, Tenaculum, Teale's 230mm-SS 3x4	2	EA
5.	Sound, uterine, Simmpson 300mm with 200mm graduations	1	EA
6.	Dilator, uterine, double-ended hegar, set of 5-SS	1	Set
7.	Curette, uterine, Sim's, blunt, 26cm x 11mm size # 4- SS	2	EA
8.	Curette, uterine, Sim's, sharp, 26cm x 9mm. size # 3- SS	2	EA
9.	Forceps, artery, Spencer-Well's straight 140mm- SS	1	EA
10.	Forceps, tissue, spring-type, serrated tips 160mm-SS	1	EA
11.	Forceps, ovum, Krantz, 290mm-stainless steel	1	EA

M EQUIPMENT FOR ANAESTHESIA

S. No.	Item Description	Qnty	Unit
1.	Facemask, plastic w/rubber cushion & headstrap, set of 4	4	Set
2.	Airway, Guedel or Berman, Autoclavable rubber, set of 6	2	Set
3.	Laryngoscope, set with infant, child, adolescent blades	3	Set
4.	Catheter, endotracheal w/cuff, rubber set of 4	3	Set
5.	Catheter, urethral, stainless steel, set of 8 in case	2	Set
6.	Forceps, catheter, Magill, adult and child sizes, set of 2	1	Set
7.	Connectors, catheter, straight/curved, 3, 4, 5mm (set of 6)	3	Set
8.	Cuffs for endotracheal catheters, spare for item 4	4	EA
9.	Breathing tubes, hoses, connectors for item 1, anti-static	4	Set
10.	Valve, inhaler, chrome-plated brass, Y-shape	3	EA
11.	Bag, breathing, self inflating, anti-static rubber, set of 4	2	Set
12.	Vaporiser, Halothane, dial setting	2	Set
13.	Vaporiser, ether or Methoxyflurane, wick type	2	EA
14.	Intravenous set, in box	6	EA
15.	Needle, spinal, stainless, set of 4	2	Set
16.	Syringe, anaesthetic, control, 5ml Luer mount glass	2	EA
17.	Cells for item 3	2	EA

N EQUIPMENT FOR NEO-NATAL RESUSCITATION

S. No.	Item Description	Qnty	Unit
1.	Catheter, mucus, rubber, open-ended tip, size 14 Fr	2	EA
2.	Catheter, nasal, rubber, open tip, funnel end, size 8Fr	2	EA
3.	Catheter, endo/tracheal. open-tip, funnel end, rubber, 12Fr	3	EA
4.	Stilette, curved, for stiffening tracheal catheter-SS	1	EA
5.	Catheter, suction, rubber, size 8Fr	3	EA
6.	Laryngoscope, infant, w/three blades and spare bulbs.	1	EA
7.	Lateral mask, with ventillatory bag, infant size	2	EA
8.	Resucitator, automatic, basinet type	1	EA
9.	Lamp, ultra-violet (heat source) with floor stand	1	EA
10.	Cells for item 6 (laryngoscope)	2	EA

O KIT-SIDE LABORATORY TEST & BLOOD TRANSFUSION

S. No.	Item Description	Qnty	Unit
1.	Rod, flint-glass, 1000x10mm dia, set of two	2	Set
2.	Cylinder, measuring, graduated W/pouring lip, glass 50ml	2	EA
3.	Bottle, wash, polyethylene w/angled delivery tube- 250ml	1	EA
4.	Timer, clock, interval, spring wound, 60 minutes x I minute	1	EA
5.	Rack, slide drying nickel/silver, 30 slide capacity	1	EA
6.	Tray, staining, stainless steel 450 x 350 x 25mm	1	EA
7.	Chamber, counting, glass, double neubauer ruling	2	EA
8.	Pipette, serological glass, 0.05ml x 0.0125ml	6	EA
9.	Pipette, serological glass, 1.0ml x 0.10ml	6	EA
10.	Counter, differential, blood cells, 6 unit	1	EA
11.	Centrifuge, micro-hematocrit, 6 tubes, 240v	1	EA
12.	Cover glass for counting chamber (item 7)- box of 12	1	Box
13.	Tube, capillary, heparinized, 75mm x 1.5mm, vial of 100	10	Vial
14.	Lamp, spirit w/Screw cap. metal 60ml	1	EA
15.	Lancet. blood (Hadgedorn needle) 75mm pack of 10- SS	10	Pkt
16.	Benedict's reagent qualitative dry components for soln	1	Kit
17.	Pipette. measuring. glass, set of two sizes 10ml. 20ml.	2	Set
18.	Test-tube, w/o rim, heat resistant glass, 100 x 13mm	24	EA
19.	Clamp, test-tube, nickel-plated spring wire, standard type	3	EA
20.	Beaker, HRG glass, low form, set of two sizes, 50ml. 150ml.	2	Set
21.	Rack, test-tube wooden with 12 x 22mm dia holes.	1	EA

P MATERIALS KIT- DONOR BLOOD FOR TRANSFUSION			
S. No.	**Item Description**	**Qnty**	**Unit**
1.	Bovidne albumin 20% testing agent, box of 10 x 5ml vials	5	Box
2.	Centrifuge, angle head for 6 x 15ml tubes, 240 volt	1	EA
3.	Bath, water, serological, with racks, cover, thermostat, 240v	1	EA
4.	Pipette, volumetric, set of six 1ml/2ml/3ml/5ml/10ml/20ml	1	EA
5.	Test-tube without rim 75x 12mm HRG	12	EA
6.	Test-tube without rim 150 x 16mm, HRG	12	EA
7.	Cuff, sphygmomanometer, set of two sizes-Child/Adult	1	Set
8.	Needle, blood collection disposable, 17G x 1-1/3 box of 100	1	Box
9.	Ball, donor squeeze, rubber, dia, 60mm	1	EA
10.	Forceps, artery, spencer-wells, straight 140mm, stainless steel	1	EA
11.	Scissors, operating, straight 140mm, blunt/points, SS	1	EA
12.	CPDA anti-coagulent, pilot bottle 350ml for collection	20	EA
13.	Microscope, binocular, inclined, 10 x 40 x 100 x magnificant	1	EA
14.	Illuminator for item 14 (microscope)	1	EA
15.	Slides, microscope, plain 25 x 75mm, clinical, box of 100	1	Box

LIST OF RCH DRUGS AT PRIMARY HEALTH CENTRE
(Essential Obstetric Care Drugs)

S. No.	Name of the drug with specification	Annual qnty. required per P.H.C.
1.	Inj. Diazepam 2ml amp, 5mg//ml	50
2.	Inj. Lignocaine/Xylocaine 2%-30ml	10
3.	Inj. Pethidine 50 mg	10
4.	Inj. Pentazocine 30 mg	50
5.	Inj. Dexamethasone 2ml amp, 4 mg/ml.	100
6.	Inj. Promethazine 2ml amp, 25mg/ml	50
7.	Inj. Methyl Ergometerin 0.5mg/amp	150
8.	Inj. Etophyilline + Theophlline 2ml	100
9.	Inj. Aminophyline 50mg/10 ml	50
10.	Inj. Adrenalin 0.5mg/ml	50
11.	I.V. Fluid-Ringer Lactate	200
12.	Tablet Methyl Ergotamine/Methargine 0.125mg	500
13.	Tablet Diazepam 5mg	250
14.	Tablet Paracetemol 500mg	1000
15.	Tablet Cotrimaxazole	2000
16.	Tablet Nofloxacin 400mg	1000
17.	Cap. Ampicillin- 250mg	2000
18.	Cap. Doxycycline 100mg	500
19.	Tab. Metronidazole 200mg	2000
20.	Tab Salbutamol 2mg	1000
21.	Tab. Penicilin-V 125mg/130mg	5000
22.	Clotrimazole/Cenestin 100mg Vaginal pessary	1000
23.	Gyne. CVP (Tab/Cap)	1000
24.	Inj. Vit. K	200
25.	Inj. Atropine 1ml. amp., 0.65mg/ml	50 amp
26.	Tablet Nalidixic Acid 500 mg	1000
27.	Dextrose, 5% I.V. Solution	50
28.	Normal Saline, 0.9% I.V. Solution	100

ANNEXURE VIII

LIST OF RCH DRUGS AT FIRST REFERRAL UNIT

(Emergency Obstetric Care Drugs)

S. No.	Name of the drug with specification	Annual qnty. required/FRU
I	**CRITICAL DRUGS**	
	I (i) ANAESTHETICS/Preanesthetics	
1.	Halothane 50ml/per bottle	5 bottles
2.	Inj. Atropine- 0.6mg/ml	500
3.	Oxygen Cylinder bulk (M) type	2 with 24 fillings per year
4.	Inj. Thiopentone Sod. 500mg	100
5.	Inj. Bupercaine 0.5%, 25ml vial	50
6.	Inj. Xylocaine 58 amp.	50
7.	Inj. Xylocaine 2% 30ml	50
8.	Inj. Diazepam 2ml/amp, 5mg/ml	100
	I (ii) ANALGESIC	
9.	Inj. Pentazocine 30ml	100
	I (iii) ANTI ALLERGICS	
10.	Inj. Dexamethasone 8mg	100
11.	Inj. Promethazine	50
	I (iv) ANTI DIABETIC	
12.	Inj. Insulin (plain) 10ml vial, 40 IU/ml	10
13.	Inj. Lente Insulin	10
	I (v) ANTI HYPERTENSIVE/C.V. DRUGS	
14.	Cap. Nifedipine 10mg	500
15.	Inj. Mephentine 15mg	25
16.	Inj. Dopamine 20ml vial	25
	I (vi) ANTIBIOTICS	
17.	Inj. Ampicilin 250mg	1000
18.	Inj. Gentamycine 8mg	1000
19.	Cap. Ampicilin 250mg	2000
20.	Tab. Norfloxacin 400mg	2000

ANNEXURE VIII (Contd.)

S. No.	Name of the drug with specification	Annual qnty. required/FRU
21.	Cap. Doxycycline 100mg	1000
22.	Tab. Metronidazole 200mg	2000
	I (vii) DIURETIC	
23.	Inj. Frusomide 40mg/ml, 1ml amp	100
	I (viii) I.V. FLUIDS	
24.	Normal Saline 0.9% 540ml	1000
25.	Ringers Lactate 500ml	1000
26.	Inj. Sod. Bicarbonate	1000
27.	Inj. Dextrose 5%	250 bottles
28.	Haemaceel 500ml	25
	I (ix) OXYTOCICS	
29.	Inj. Ergometrine 0.5mg/ml	500
30.	Inj. Oxytocine 10.14/ml	500
	I (x) DISPOSABLES	
31.	I.V. Infusion Sets	100
32.	Intracath Cannula, No. 18, 20 & 22 (No. 50, 30, 20 Resp.)	100
33.	Syringes & needles	Syringes & Needles
	5ml	2000 & 100
	10ml	500 & 500
	20ml	100 & 2000
34.	Gloves size 7 & 8	3000 & (1500) each size)
	I (xi) OTHERS	
35.	Inj. Deriphylline	100
36.	Inj. Hydrocortisone 100mg/vial	100
37.	Tab. Salbutamol 2mg	1000
38.	Inj. Adrenalin	100

ANNEXURE VIII (Contd.)

S. No.	Name of the drug with specification	Annual qnty. required/FRU
II	**ESSENTIAL DRUGS**	
	II (i) ANAESTHETICS/Preanesthetics	
39.	Nitrous Oxide	2 cylinder with 10 refillings/year
40.	Inj. Scoline 50mg/ml (Suxamethonium)	30
41.	Inj. Ketamine 10ml vial, 10mg/ml.	50
42.	Tab. Diazepam 5mg	250
43.	Inj. Vecuronium 4mg/amp	500
44.	Inj. Paneuronium 4mg/amp	500
45.	Inj. Prostigmine 0.5mg/amp	1000
46.	Salbutamol inhaler	20
	II (ii) ANALGESICS	
47.	Inj. Pethidine, 50mg/ml, 1ml Amp.	100
	II (iii) CARDIO VASCULAR SYSTEM (C.V.S.)	
48.	Tab. Frusmide 40mg.	500
49.	Tab. Digoxin 0.25mg.	500
50.	Inj. Digoxin 50ml.	50
51.	Tab. Methyldopa, 250mg.	50
	II (iv) ANTIBIOTICS	
52.	Inj. Benzyl Pencillin	2000
53.	Inj. Procaine Pencillin 4 lakh units	1000
54.	Inj. Benzathine Penicillin	100
55.	Tab. Cotrimoxozole	5000
56.	Tab. Penicillin V 125mg	5000
	II (v) OTHERS	
57.	Tab. Ergometrine 0.125mg	2000
58.	Tab. Nalixic Acid 500mg.	3000
59.	Inj. Cloxacillin 250mg.	100
60.	Inj. Chloroquine 5ml.	50

ANNEXURE IX

LIST OF NEWBORN CARE EQUIPMENT TO BE SUPPLIED TO HEALTH INSTITUTIONS

S. No.	Equipment	PHC	FRU	District Hospital
		No	No	No
1.	Infant resuscitation bag with mask (capacity 700ml with safery valve set to 70cm of water)	1	2	3
2.	Weighing machine (Pan type 0-10 kg with 50gm sensitivity)	1	2	3
3.	Paddle operated suction machine	1	2	3
4.	Mounted lamp with 200 w bulb (warming device)	1	-	-
5.	Radiant warmer (manually operated with adjustable heat output). Operates at 180-220 volts. Surface on which baby is placed is tiltable to facilitate resuscitation.	-	2	4
6.	Phototherapy Unit	-	1	1
7.	Oxygen hood	-	1	2
8.	Baby bassinet	1	2	4
9.	Neonatal laryngoscope	-	-	2
10.	Endotracheal tubes	-	-	100

LIST OF CONSUMABLE ITEMS FOR RTI/STI LABORATORY DIAGNOSIS FOR F.R.U.

S. No.	Item with specifications	Quantity Per F.R.U.
1.	Microscopic slides & cover slips	50 boxes, each with 100 slides (5000 slides and 5000 cover slips)
2.	Pipette graduated (1 ml.- glass)	10
3.	VDRL slides	10
4.	Petri Dish (glass - 90mm)	10
5.	VDRL Antigen vial including diluent	50 vials
6.	Sterlised Disposable Syringes (5ml.)	2000
7.	Disposable needles	
	size 21 awg	1000
	size 22 awg	2000
	size 23 awg	1000
8.	Disposable glove (size 7)	300
9.	Test Tubes (glass, 15mm x 125mm)	60 dozens (720 tubes)
10.	Gram stain re-agents (ready)	
	a) Gention violet (100 ml. bottle)	5 bottles
	b) Grama iodine (100 ml. bottle)	5 bottles
	c) Actone (100 ml. bottle)	5 bottles
	d) Safranin (100 ml. bottle)	5 bottles
11.	KOH Crystals	50gm.
12.	Distilled water	1 ltr. bottle

ANNEXURE XI

ITEMS WHICH WILL NOT BE FUNDED UNDER THE HEAD MINOR CIVIL `WORKS' IN RCH PROJECT

1. No new construction or expansion of FRUs, PHCs, SCs, STD clines etc. shall be permitted.

2. Minor civil works beyond Rs 4.00 lakh at any single facility shall be made only after specific clearance by GOI.

3. No vehicle shall be procured or maintained under transport.

4. Cost on POL or any other consumables shall not be shown under this head. This should be met by the states/implementation agencies.

5. No. equipment for FRUs/PHCs shall be permitted

6. No addition/deletion in the list of drugs for RTI/STI annexed to guidelines shall be permitted.

7. SHS project districts will not use this fund for any purpose at FRUs. However, they are permitted to use these funds for PHCs/Sub-Centres.

8. Any expenditure on office furnitures/machinery etc. will not be permitted.

Only those type of works/items which are essential and where non-availability of the same hinders the smooth functioning of the health facilities will be permitted.

ANNEXURE XII

URBAN FAMILY WELFARE CENTRES AND URBAN HEALTH POSTS

The MCH and family planning services in urban areas are provided through existing net work of 1083 Urban Family Welfare Centres and 871 Urban Health Posts. Presently there are three types of Urban Family Welfare Centres and 4 types of Health Posts. The population served and the staffing pattern of Urban Family Welfare Centres and Health Posts are given below:-

Type	Population covered	Staffing pattern		
I	10000 to 25000	Auxiliary Nurse Midwife	-	1
		F.P. Field Worker (Male)	-	1
II	25000 to 50000	F.P. Extension Educator/LHV	-	1
		F.P. Field Worker (Male)	-	1
		A. N. M.	-	1
III	Above 50000	Medical Officer (Pref. Female)	-	1
		LHV	-	1
		ANM	-	2
		F.P. Field Worker (Male)	-	1
		Store Keeper cum Clerk	-	1

Type A : For area below 5000 population

B : For area with population 5000-10000

C : For area with population 10000-25000

D : For area with population 25000-50000

If population of the area is more than 50000 then it is to be divided into sectors of 50000 population and Health Posts provided.

STAFFING PATTERN OF HEALTH POSTS

Category of Staff	Staff admissible by type of Health Posts			
	A	B	C	D
Lady Doctor	-	-	-	1
PHN	-	-	-	1
Nurse Midwife	1	1	2	3-4
MPW (male) @	-	1	2	3-4
Class IV women	-	-	-	1
Computer cum Clark	-	-	-	1
Voluntary women health worker @	*	*	*	*.

* One for every 2000 population

@ At present there is a ban on these categories of staff.

Note: Type a to C Health Posts be attached to a hospital for providing referral and supervisory services. Type D Health Post to be attached to a hospital for sterilisation, MTP and referral.

The Urban Family Welfare Centres and Health Posts provide comprechensive integrated services of MCH and family planning and out reach services. The referral support for these centres come from the nearest hospital/Post Partum Centres. The Urban Family Welfare Centres and Health Posts are envisaged to function in close coordination with ICDS (Anganwadis) and urban basic services centres in their respective areas.

The State wise list of Urban Family Welfare Centres and Health Posts are annexed.

DEPARTMENT OF FAMILY WELFARE
NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE (NIHFW)

Subject : Proposal for NIHFW to act as national level coordinating agency for training programmes of the Department of Family Welfare.

1.1 The National Institute of Health & Family Welfare (NIHFW) was set up in March, 1977 (by the merger of National Institute of Family Planning and the Institute of Health Administration & Education) as the national level academic and Research & Development Institution for the Department of Family Welfare. NIHFW is affiliated to Delhi University for Post Graduate courses (MD, CHA and Diploma in HA and undertakes various inservice training programmes for trainers, researchers and health administrators to upgrade their knowledge and skills in relevant areas to promote Health and Family Welfare Programmes in this country.

1.2 The NIHFW is registered as a Society under the Societies Registration Act. Its Governing Body is headed by the Minister for Health & Family Welfare and the Secretary, Department of Family Welfare is the Vice Chairman. Within the provisions of the Societies Registration Act, the Institute is autonomous. It is funded mainly by grants form the Department of Family Welfare and also by Department of Health through International and bilateral agencies. The composition of the Governing Body and important Committees is at **Statement-I**

1.3 The NIHFW has very good campus measuring 32 acres at Munirka, New Delhi. It has a very well porvided administrative and teaching blocks. It has hostel accommodation for 75 persons and it has 166 residential quarters for various categries of staff. The Institute is headed by a Director and it has 9 positions of professors (6 filled up), 11 Readers (8 filled up) and 15 Lecturers. They are supported by various categories of technical and supportive staff. List of faculty members is at **Statement-II**. All the faculty members have qualifications as required for a University level Institution.

1.4 The NIHFW conducts a number of training courses regularly. The course conducted in 1996-97 are listed at **Statement-III**. The, NIHFW is well equipped to take on the responsibility for organising and coordinating training programmes for the Department of Family Welfare.

II. OBJECTIVE

(i) To organise, co-ordinate and monitor training in the country.

(ii) To upgrade the competence of family welfare personnel and managers to provide technically sound client centred and gender sensitive RCH services.

(iii) To create mass awareness on RCH and population stabilization issues by holding orientation training programme.

(iv) To involve other government departments in promotion of RCH programme by team training for convergence of services.

III. SPECIFIC OBJECTIVES

a. To coordinate : (i) training financed by the Family Welfare Department in RCH management, clinical and interpesonal counselling skills and communications (IEC), and (ii) awareness generation and community mobilization (including convergence of related programmes such as ICDS) as requested by MOHFW.

b. To coordinate the development and or adaptation as necessary of model trianing curricula, facilitators, guides, and prototype manuals/materials, and provide such materials to collaborating centres and training centres for local adaptation and use.

c. To assist MOHFW in the development of clinical management protocols for safe motherhood, fertility regulation methods, reproductive tract infections and sexually transmitted diseases and child survival as specified in the essential package of RCH services and ensure that such protocols are integrated into training.

d. To assist MOHFW and national procurement support agency for appointment of suitable collaborating institutions from Government, NGO and private/corporate sector in accordance with World Bank Guidelines and to organise training of trainers of these institutions.

e. To review the work of the collaborative institutions annually and to assist the MOHFW in determining suitability of the institution to continue as a collaborating institution.

f. To assist states, districts through collaborating institutions, in formulation of integrated training plans at State and District levels so as to : (i) avoid unecessary duplication; (ii) ensure there are no critical gaps in the training plans; and (iii) coordinate scheduling of training with other programme inputs such as equipment, civil works, IEC and NGO activities.

g. To assist States in the establishment of system of proficiency certificate award to trainees and monitor and report on state specific achievements on the project performance.

To monitor the implementation, outcome and impact of the training component of RCH programme.

IV. SPECIFIC TASKS AND MECHANISM FOR IMPLEMENTATION OF TRAINING BY THE NODAL AGENCY

1. To coordinate (a) development of model training curricula in accordance with the MOHFW Training Guidelines, 1996 and the Target Free Mannual (as revised from time to time), development of facilitators' guides (b) reviewing and upgrading of training manual/materials currently used, integrating best practice materials produced and used by state specific and NGO specific training programme.

2. For task (a) the nodal agency will constitute an maintain Expert Commit-

tees, ensuring appropriate inputs from MOHFW, States, relevant experts from NGOs, public and private sector institutions, representatives of potential trainee groups and donor representatives. For this purpose a list of agreed suitable experts will be compiled, regularly updated and used and the source from which experts would be drawn to provide inputs for the Expert Committees.

3. To (a) participate in and provide inputs to working groups and similar groups organised by MOHFW for the purpose of developing clinical management protocols and (b) distribute copies of clinical management protocols to collaborating centres and training centres.

4. To (a) review and release funds for state and district training plans with assistance from collaborating centres so as to reduce unnecessary duplication and ensure optimum utilisation of training funds (b) collate and integrate into training plans, requests from MOHFW for specific upgrading or revision to accommodate newer programme directions and priorities.

5. To develop a system of proficiency certification for trainees, by, (a) establishing criteria for proficiency certification for clinical skills training of different categories of health providers (b) designing prototype formats for such certification with the assistance of collabotrating centres (c) providing orientatin as required on the certification process and (d) monitoring of proficiency certificates awarded.

6. To coordinate selection and assist MOHFW and national procurement support agency for appointment of suitable agencies/institutions from Government, NGO and private corporate sector in accordance with World Bank guidelines in respect of the following :

(a) - Selection of Training Institutions for Medical Officers/Specialists for training in :

- Medical Termination of Pregnancy (MTP)
- Mini Laparotomy
- Laparoscopic sterilisation
- No Scalpel Vasectomy

(b) Selection of Resource Person/Institutions for conducting Management Training for Health Administrators at District, Division and State levels.

(c) To prepare a panel of experts to be paid higher rates of honorarium per day for specified number of days in a month for training programmes.

7. To conduct orientation courses for master trainers of collaborating agencies/institutions and specialised training instutitons appointed for this purpose and also to implement some training of trainers courses.

8. Monitoring and Evaluation of Training Programmes:

(a) To moniter the implementation, outcome and impact of the training component of RCH programme.

(b) To review with MOHFW, State representatives and relevant experts the continued relevance of training courses every year and make necessary changes in curricula and training materials.

9. To conduct directly training courses for some of the Health Managers/ Communication Personnel at State/Divisional/District level in regard to RCH concept and management of RCH issues.

10. Disbursement of finances for the training courses to be held under RCH project to the collaborating Institutes and Training Institutes. Also to obtain and furnish to MOHFW accounts duly audited by CA for training courses and utilisation certificates.

11. To conduct on site review of some training institutions every month to review the quality of training and ensure that the financial accounts are being maintained in accordance with the required standards.

V. SCHEDULE FOR COMPLETION OF TASKS

Assignment is likely to continue for five years but the contract will be for one year at a time, to be renewed each year if work continues to be satisfactory.

VI. PROPOSED TRAINING AND ORGANISATIONAL ARRANGEMENTS

A. The training programmes will have two distinct components :

(i) Awareness generation/orientation for RCH programme for all health personnel, functionaries of releated departments and members of elected bodies (Panchayati Raj Institutions and NGOs.), team approach orientation for convergence of services at community level.

(ii) Knowledge, task oriented and technical skill upgradation training for health personnel.

AWARENESS GENERATION/ORIENTAION FOR RCH PROGRAMME

The orientation and awareness generation courses for personnel working in the district, will be ANM/LHV training schools or district training centre.

The State Institute of Health and Family Welfare or collaborating institutions will hold awareness/orientation courses for senior level health professionals, officiers of related departments.

The National Institute of Health and FW will conduct (a) courses for faculty of collaborating institutions to familiarise them about the RCH concepts, issues and the proposed scheme (b) will hold courses for

management of RCH issues for state/Divisional and senior district level officers.

TECHNICAL SKILL UPGRADATION

The skill based courses will be conducted in the district hospitals or sub-district hospitals/CHC/FRU/hospitals run by NGOs/Private/Corporate Sectors selected for the purpose on the basis of sufficient training load and number of trainers.

The Medical Officers will be trained for skill development at the District Hospitals/Medical Colleges/government recognised Centres for specialised skills like MTP/Tubectomy/Vasectomy and IUCD insertion.

Experts from Centres of Excellence will be sent abroad to acquire new skills like No Scalpel Vasectomy to act as trainers for the doctors.

B. RESPONSIBILITIES OF NIHFW :

Select 15 collaborating institutions on regional basis for assisting the NIHFW in providing the support services and supervision required to the peripheral institutions which are likely to be 300-500 in number as per the requirements of the country. The collaborating institutions would be selected on regional basis and could be Government, Non-Government, private institutions. A list of possible institutions for short listing and selection as collaborating institutes is at **Statement - IV**.

The criteria for selecting the collaborating institution will be their capability and consultancy charges quoted by them, per training (actual cost for Government Institutions).

The NIHFW will assist the Department of Family Welfare and procurement agency for selection and appointment in accordance with the World Bank procedures.

C. RESPONSIBILITIES OF COLLABORATING AGENCIES :

(i) To assist the state authorities and the nodal agencies in selection of appropriate training institutions from government, NGO, private/corporate sectors in implementing all types of training envisaged under RCH programme.

(ii) To assist the state government and to provide guidance to the districts in preparation of district training plans in accordance with the MOHFW's "In-Service Training Guidelines 1996".

(iii) To procure the training materials from nodal agencies, translate, adapt and print copies as per requirement of the State Government.

(iv) To distribute the training materials to all selected training institutions.

(v) To conduct training of trainers of the selected institutions and other training courses in the region in accordance with the approved plans.

(vi) To train District Family Welfare Officers in collating information from supervisory check lists (TFA manual) and provide feedback on staff performance gaps to the training institutions.

(vii) To evaluate training carried out by the training institutions in the defined region including on-site visits of the institutions provide evaluation reports to the state authorises and the nodal agencies and take corrective measures.

VII. GUIDING PRINCIPLES OF TRAINING :

1 (i) The training programmes will be conducted in conformity with the Inservice Training Guidelines developed by the Department of Family Welfare, Government of India- 1996.

(ii) The training programmes will have two components - (i) awareness generation/orientation and (ii) upgradation of technical skills of health personnel.

(iii) Each skill upgradation training course will normally have 15 - 20 participants. Whereas the orientation programme will be conducted for 25 participants. The sites mentioned for these training programmes would be as mentioned in para 6 above.

(iv) In specialised skills development programme there will be two to three trainees per trainer.

(v) The skill based training will have a recall after three to six months wherein the trainees will work under the supervision of the trainers for technical assessment of their skills for issuing the validation certificate.

(vi) For each category of training programmes standards for development of necessary skills will be laid down by a group of experts.

(vii) At the end of every training course each training institution will obtain the feed back of each trainee about the quality of each session and its effectiveness. This record will be kept by the training institution and a compiled summary will be submitted to the collaborative institution alongwith the report of the trainee at the end of each course. This will be used for improving the subsequent courses.

(viii) A uniform honorarium will be paid on per session basis to the in-house faculty. There will be provision of one outside expert being invited for training every day as required. There will be one rate of honorarium for district and sub-district level experts and another for state and regional level experts. Similarly the daily allowance for trainees will be uniform for group B, C and D level. Another rate will apply for Group A level trainees. Contingencies including money for teaching material, consumable etc. will be at Rs. 100 per trainee per day. A training institution will receive 15% of the total training expenditure for providing institutional support services. If the institutions wishes to pay something to supportive staff it will be able to make that payment out of the contingencies or out of its institutional support

payment. The scale of these payments is specified in statement-VII. These norms can be changed by the NIHFW with the prior approval of the Department, if required.

The experts for the training programme of the trainers at the National Institute of Health and Family Welfare and State Institutions will be hired at the rate of Rs. 1000/- per day for specified number of days in a month.

2. The NIHFW with the assistance of the collaborating institutions will furnish to the Department every quarter the list of training courses, the list of training institutions for each course and the brief report of courses organised during the quarter alongwith a summary of findings by NIHFW and collaborating institutions during their inspections during the quarter.

3. The list of training courses on the basis of which the NIHFW will operate to begin with is at **Statement - V**.

VIII. OUTPUTS:

a. Selection of 15 collaborating agencies/institutions and 300-500 peripheral training institutions.

b. Integrated Training District Plans.

c. Establishment of mechanism of proficiency certification.

d. Clinical protocols

e. Training modules

f. Training material

g. Customised training packages

h. Facilitators guides

i. Curriculum for integrated training for all categories.

j. Short lists for selection of collaborating agencies/institutions

k. Annual Review Reports on performance of collaborating agencies/ institutions.

l. Quarterly Review Reports on training courses being conducted including training of trainers.

m. Recommendations on various training aspects.

n. Accounts duly audited by CA and utilisation certificate of the funds released by MOHFW to NIHFW.

o. Accounts duly audited by CA and utilisation certificates for the funds released by NIHFW to collaborating institutions and other agencies.

IX. DATA SERVICES AND FACILITIES EXPECTED FROM THE MINISTRY OF HEALTH AND FAMILY WELFARE

- MOHFW will ensure participation of the representatives of the Nodal Agency in all activities that could have implications for training, such

as development of clinical management protocols, expert group meetings, workshops, review of relevant programme monitoring and evaluating meetings etc.

- MOHFW will include representation in relevant committees expert groups etc. established by the Nodal Agency.
- MOHFW will nominate a coordinator who will liaise with appropriate departments and committees set up by Nodal Agency for the project.
- MOHFW will furnish Nodal Agency with necessary data, documents and other inputs necessary for carrying out the assignment by Nodal Agency.
- MOHFW will make available adequate funds to Nodal Agency for carrying out task assigned.
- MOHFW will make necessary arrangement to provide entry/exit passes for visits of Nodal Agency personnel during the course of the assignment.

X. HUMAN RESOURCE STRENGTHENING IN NIHFW AND COLLABORATING INSTITUTIONS

While NIHFW and collaborating institutions are quite well provided generally but the overall range and size of the training programme is very large. The NIHFW and the collaborating institutions will not be able to take on this additional responsibility only with the existing human resource at their disposal. It will be necessary to strengthen the human resource in NIHFW as well as in collaborating institutions to some extent for performing the functions assigned to NIHFW and collaborating institutions adequately. All the proposed additional human resource will be for the project period only and all the appointments against such positions will be contractual. The strengthening required in NIHFW and collaborating institutions will be as (Annexed under H.R.D.) **Statement - VI.**

STATEMENT - I

NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE*

GOVERNING BODY

Mrs. Renuka Chowdhary
Union Minister of State for Health and Family Welfare
Chairman

Mr. Y.N. Chaturvedi
Secretary (FW)
Vice-Chairman

Ex-Officio Members

Ms. Shailaja Chandra
Addl. Secretary (Health),
MOHFW, New Delhi

Dr. S.P. Agarwal
DGHS, New Delhi

Mr. K. S. Sugathan
Joint Secretary,
MOHFW, New Delhi

Shri Vijay Singh
Joint Secretary (F.A.),
MOHFW, New Delhi

Dr. (Mrs.) G.V. Satyawati
Director General,
ICMR, New Delhi

Dr. P. K. Dave
Director,
AIIMS, New Delhi

Dr. K. B. Pathak
Director, IIPS
Mumbai

Dr. (Mrs.) Prema Ramachandran
Adviser (Health),
Planning Commission, New Delhi

Members

Prof. V Ramalingaswami
Ex-Director General, ICMR &
Professor Emeritus AIIMS,
New Delhi

Dr. (Mrs.) Banoo J. Coyaji
Chairman,
KEM Hospital Research Centre, Pune

Dr. Raja J. Chelliah
Chairman,
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Mrs. Kalpana Jain
Journalist
D-26, Gulmohar Park
New Delhi

Prof. S. Chakraborty
Indian Institute of Management
Prabha Nagar,
Sitapur Road, Lucknow

Dr. (Ms.) H. Helen
Director, NIHFW
Member-Secretary

* An Autonomous Body, registered as a Society under the Societies Registration Act XXXI of 1860.

STATEMENT-II

STATEMENT OF FACULTY IN NIHFW

		Teaching Experience
Director :	Dr. H. Helen B.Sc., M.B.B.S., D.G.O. M.D., F.R.C.O.G.	31 Years
Professor :	Dr. I. Murali Epidemiology, M.D., Dip., HSA	23 Years
	Prof. P. L. Trakroo Communication, M.A., Ph.D.	23 Years
	Dr. M. C. Gupta Education & Training, M.D. (Med.), DPH	23 Years
	Dr. M. Bhattacharya Community Health Admn. M.B.B.S., M.D. (PSM)	
	Dr. N. Sethi Planning & Evaluation, M.D. (PSM)	15 years
	Dr. K. Kalaivani Reproductive Biomedicine, M.B.B.S., D.G.O., M.D. (O&G) Dip, N.B.E. (O&G)	
Statistics & Demography,		Selection under process
Social Sciences,		"
Medical Care & Hosp. Admn.		"
Readers :		
	Dr. A.K. Sood Reader in Education & Training M.B.B.S., M.D. (Health Admn.), M.A., Ph.D.	13 Years
	Dr. Pratima Mitra Reader in Nursing Administration, B.Sc. (H) Nsg., M.A. (P.A.) M.A. Health Mgmt. & Planning Policy Ph.D., Training in Health Management	13 Years

STATEMENT-II (Contd)

Readers :	Dr. J.K. Das Reader in Medical Care & Hosp. Admn.	6 Years
	Dr. A.M. Khan Reader in Social Sciences, M.A., Ph.D.	13 years
	Dr. U. Dutta Reader in Health System Research (Gwalior Project), B.Sc., M.B.B.S., DCP, M.D. (C. Med.)	12 Years
	Dr. Vivek Adhish Reader, Education & Training (IPP), M.B.B.S., M.D. (PSM) Trained in Health Management	5 Years
	Dr. M.M. Misro Reader, Reproductive Biomedicine, M.Sc., Ph.D.	Since June 1997
	Dr. T. G. Shrivastav Reader, Reproductive Biomedicine, M.Sc., Ph.D.	Since Sept., 1997
Reader in Reproductive Medicine - Clinic		Recruitment is being done
Reader in Electronic Media		"
Reader in Management Sciences		"
Lecturers :		
	Mr. C. B. Joshi Sr. Lecturer in Evaluation, M.A. (Eco.), M.A. (Soc.), CD	23 Years
	Sh. B.B.L. Sharma Sr. Lecturer in Health Economics, M.A. (PHA)	18 Years
	Dr. I.S. Allag Sr. Lecturer in Rep. Biomedicine, M.Sc., Ph.D.	13 Years
	Dr. (Mrs.) S. Menon Sr. Lecturer in Rep. Biomedicine (Clinic) M.B.B.S., MS. (O&G)	10 Years

STATEMENT-II (Contd.)

Lecturers :	Dr. T. Mathiyazhagan Sr. Lecturer in Communication M.Sc., Ph.D.	10 Years
	Dr. (Mrs.) Neera Dhar Education & Training, M.Phil. Ph. D., M.S.	6 Years
	Dr. Sanjay Gupta Community Health Administration, M.B.B.S., M.D. (PSM)	5 Years
	Mrs. Beena Khillare Biomedical Research, M.S.c., M.Phil.	5 Years
	Dr. (Mrs.) Rajni Bagga Psychology, Deptt. of Soc. Sci., M.A., Ph.D.	5 Years
	Sh. Thaneshwar Bir Anthropology, Deptt. of Soc. Sci., M.A., M.Phil.	5 Years
	Dr. (Mrs. Gita Bamezai Print Media - Communication M.A., Ph.D.	5 Years
	Dr. Y. L. Tekhre Sociology, Soc. Sci. Deptt., Ph.D., LL.B., PG Diploma in Pub. Admn., Dip. in Journalism	5 Years
	Dr. Vijay Kumar Tiwari Statistics & Demography, M.Sc., Ph.D. PG Dip. in Computer Programming & System Analysis.	4 Years
	Dr. (Mrs.) Sajjal Gupta Deptt. of RBM, Clinical Female, M.B.B.S., M.D. (Obst. & Gynae.) D.G.O.	2 Years

STATEMENT III

TRAINING COURSES AND WORKSHOPS - 1996-97

1. Trianing Course in Research Methodology in Reproductive Bio-Medicine (1)
2. Training Course in Maternal and Child Health for Trainers of Health Personnel (Non-IPP VI & VII States) (1)
3. Training Course in Interpersonal Communication for District Media Officers and Faculty from Training Institutions (1)
4. Training Course in Hospital Administration (1)
5. Training Course for Trainers of Statistical Personnel (1)
6. Training Course for Incorporation of Health and Family Welfare Messages for Trainers (1)
7. Development of Curriculum for Panchayati Raj Institutions (1)
8. Training Courses for State and District Level Officers in Health Economics and Financing (2)
9. Training Course in Computer Application in Health and Hospital Management (1)
10. Workshop on Restructuring of Training and Education in Public Health Management for Health Administrators (1)
11. Workshop on Restructuring of Training and Education in Public Health Management for Residents and Post Graduates (1)
12. 11th Health Systems Research Training Course (1)
13. Repeat Workshop of 11th Health Systems Research Training Course (1)
14. 12th Health Systems Research Training Course (1)
15. Repeat Workshop of 12th Health Systems Research Training Course (1)
16. Integrated Training Course in Health and Family Welfare for Trainers of Medical Officers at various levels (2)
17. Integrated Training Course in Health and Family Welfare for Trainers of Peripheral Health Functionaries (2)
18. Training Resource Development Consortium Workshop (1)
19. Orientation Training Course for District Hospital Specialists (2)
20. Integrated Training Course in IEC (IPP VI & VII) (2)
21. Training Course in Hospital Administration for IPP Trainers (IPP VI & VII) (1)

STATEMENT-III (Contd.)

22. Workshop for Project Directors, Directors (SIHFW) for preparation of Action Plan (IPP VI) (1)

23. Workshop for review of Training Courses Conducted by States (IPP VII) (1)

24. Workshop for review of the Epidemiological Research Activities (2)

25. Workshop on Educational Technology (1)

26. Workshop on Health Policy Planning (1)

Training/Research Meetings

27. Functional Group Meeting of Health Systems Research (Northern Regions) (1)

28. Core Group and Functional Group Meeting of Consortium Members of Health Systems Research (1)

Total Number of Training Courses, Workshops and Meetings = 34

Figures in the parentheses indicate the number of Courses/Workshops/Meetings

STATEMENT IV

LIST OF TRAINING INSTITUTIONS - STATE AND CATEGORY-WISE
(Illustrative)

N= National. R= Regional, S= State. D= Disrict

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Andhra Pradesh	Principal, Regional Health & F.W. Training Centre, Sultan Bazar, Hyderabad (S/D) Health & Family Welfare Training Centre, Nallapadu, Guntur-5 (S/D) Principal, Health & Family Welfare Training Centre. Acor TD Hospital. Resapurnipulem. Vishakhapatnam 13. (S/D) Principal. Health & Family Welfare Training Centre, Kurnool. (S/D) Director, State Instt. of Health & F.W., Hyderabad, Andhra Pradesh. (S/D) Reginnal Centre for Urban and Environmental Studies (RCUES), Osmania University, Hyderabad 500007, AP (S/D)	Commissioner. Instt. of Admin. Road No. 25, Jubilee Hills, Hyderabad-34 (N/R/S/D/) Principal, Administrative Staff College of India, Hellavista, Hyderabad. (N/R/S/D) Director General. National Instt. of Rural Development, Rajendranagar, Hyderabad-30 (N/R/S/D)	Catholic Hospital Association of India, PD-2126, Gun rock Enclave, Secundrabad 500003. AP (D)	
Arunachal Pradesh		Director, Administrative Trg. Instt. Itanagar. (SO)		
Assam	Principal Health & Family Welfare Training Centre. New Colony, Guwahati	Director. Assam Administrative Staff College. Jawaharnagar. P.O. Khanapara. Guwahati 781 002		

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Bihar	Principal, Health & Family Welfare Training Centre. Road No. 10-A, Rajendra Nagar, Patna. (S/D) Principal, Health & Family Welfare Training Centre, Jurnachapra, Lane No. 4, P.O. MIT, Muzaffarpur, (S/D) Principal, Health & Family Welfare Training Centre, Bhagalpur (S/D) Principal, Health & Family Welfare Training Centre, Hazaribagh. (S/D) Director, State Instt. of Health & F W., Indira Gandhi Instt. of Medical Sciences Campus Seikhpura Patna - 14. (S/D)	Director Sri Krishna Instt. of Public Admin. Merus Road, Ranchi-8 (S/D)		Dr. D.K. Dey, Tata Iron and Steel Company, Jamshedpur-831001

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Gujarat	Principal, Health & Family Welfare Training Centre, Opp. Govt. Press, Rajkot (S/D) Programme Officer (Trg) & Principal, Health & Family Welfare Training Centre, New Civil Hospital Campus. Opp. T.B. Hospital, Ahmedabad-16. (S/D) Director, State Instt. of Health & Family Welfare Gandhi Nagar, Gujarat (S/D)	Director, Indian Instt. of Management. Vastrapur, Ahmedabad-380015 (N/R/S/D) Chairman, Instt. of Rural Management, P.B. No. 60 Anand 388 001 (S/D) Commissioner of Trg., Sardar Patel Instt. of Public Admin., Opp. ISRO, Satellite Road, Ahmedabad-53. (S/D)	Centre for Health Education, Training and Nutrition Awareness, (CHETNA), Lilavatiben Lalbhai's Bungalow, Civil Camp Road Shahibaug, Ahmedabad-380004. (N/R/S/D) Sewa Rural, Jhagadia, Distt. Barauch, Gujarat-393 110 (S/D) Mrs. Geeta Sabbarwal, Kutch Mahila Vikas Sangathan, 11, Nutan Colony, Bhuj Kutch 370001 Mrs. Merai, SEWA, Opp M. Chaterjee, Victoria Garden Hills Elis Bridge, Bhadra, Ahmedabad 380001 (S/D)	The Operational Research Group Vikram Sarabhai Marg Baroda-39007 National Institute of Design, Ahmedabad.
Haryana	Principal Health & Family Welfare Training Centre, Rohtak Medical College Campus, Rohtak. (D) State Bank Staff College, IDPL Complex, Dundahera, Gurgaon-122001, Haryana, (N/S)	Director, Haryana Instt. of Public Admin. Gurgaon. (S) Chief Executive, Management Dev. Instt., P.B. 60. Mehrauli Road, Gurgaon-1 (N/R/S/D)	Survial for Women and Child Foundation, Sector 16, (near Sanatan Dharam Mandir) Panchkula 134 109 (N/R/S/D)	
Himachal Pradesh	Principal Health & Family Welfare Training Centre, Parimahal Shimla (D)	Director, H.P. Instt. of Public Admin. Fair Lawns, Shimla (HP) (S)		

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Jammu & Kashmir	Principal, Health & Family Welfare Training Centre, Baramulla, Srinagar. (S/D) Director, Regional Instt. of Health & F. W., C/o Project Director, IPP-VII, Health & Medical Education, Govt. of J & K, 344, Shastri Nagar, Jammu. (S/D)			
Karnataka	Principal, Health & Family Welfare Training Centre, Magadi Road, Bangalore 23 (S/D) Principal, Health & Family Welfare Training Centre, KMC Campus, Distt. Dharwar, Hubli 022. (S/D) Kasturba Medical Collage, Manipal 576119 (N/S/D) (S/D) Deptt. of Community Medicine, St. Jhon's Medical College, Sarjapur Road, Bangalore 560034 (N/S/D)	Director, Indian Instt. of Management, Bannerghata Road. Bangalore. 560076 (N/R/S/D) Director, Admin. Trg. Instt. Karnataka. Lalithamahal Rd, Mysore-10.	Community Health Cell. 367, Srinivassa Nilia, Jkkasandra I, main I block: Koramanga, Bangalore 560034. (S/D) SEARCH, 219/26, 6th main, 4th Block, Jainagar Bangalore 560011 (D) Indian Society for Health Administration (ISHA), 104 (15/13) Cambridge Road Cross, Ulsoor, Bangalore-560008	
Kerala	Principal, Health & Family Welfare Traning Centre, Theraud Trivandrum-14 (S/D) Principal, Health & Family Welfare Training Centre, Calicut-9 (S/D)	Director, Instt. of Management in Govt. Vikas Bhawan, Thiruvanthapuram-695033 (N/R/S/D) The Direcor Kerala Instt. of Local Admin. Mulankunathukavu, P.O. Thrissur-81. (S/D)		

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Madhya Pradesh	Principal, Health & Family Welfare Training Centre. Old CRP Lines, Indore (S/D) Principal, Health & Family Welfare Training Centre, Jabalpur 01. (S/D) Principal, Health & Family Welfare Training Centre, Seepat Road, Sarkande, Bilaspur. (S/D) Principal, Health & Family Welfare Training Centre, Palpur Kothi, Kampoo, Gwalior 01. (S/D) Director, State Instt. of Health Management Communication, Gwalior, Madhya Pradesh. (S/D)	Director, M.P. Academy of Admin Arera Colony, Hitkarini Nagar, Bhopal-16 (S/D)		

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Maharashtra	Principal, Health & Family Welfare Training Centre, Aundh Camp, Pune-7. (S/D) Principal, Health & Family Welfare Training Centre, Vaccine Instt. Premises. Sardhanand Peth. Nagpur-22. (S/D) Principal, Health & Family Welfare Training, Centre, New Civil Hospital Compound, Nasik-2. (S/D) Principal, Health & Family Welfare Training Centre, Behind Rama International Hotel, New Aurangabad-3. (S/D) Public Health Department, Municipal Corporation of Greater Bombay, IInd Floor, F/S Ward Office, Parel. Bombay-12 (S/D)	Course Coordinator, Tata Instt. of Social Science, P.B. No. 8313, Deonar, Bombay-88. (N/R/S/D) Director, Tata Management Trg. Centre, 1, Manpal Das Road, Pune-1. (N/R/S/D) Director, Shri Yashwantrao Chavan Instt. of Dev. Admin., Pune-Baner Road. Pune-7. (N/R/S/D)	Aga Khan Health Service India, 905, Raheja Chambers. 231, Nariman Point, Bombay-21 (S/D) Family Planning Association of India, Bijjay Bhawan, Nariman Point, Bombay. (N/R/S/D) Dr. S.V. Gore, Managing Trustee, Sewa Dham Trust, Manoj Clinic, 1148, Sadasiv Peth Pune, Maharashtra. (S/D) HPSA Bombay, SOSVA, Society for Services to Voluntary Agencies Shardaram Parth, A wing 3rd floor, near Jhangir Nursing Home, Pune 411001 Maharashtra	Tata Institute of Social Science, Bombay.
Manipur	Principal Health & Family Welfare Training Centre, Porompat, Imphal. (S/D)			
Meghalaya	Principal Health & Family Welfare Training Centre. Pasteur Hills, Shillong. (S/D)			
Mizoram		Director, Administrative Training Instt., Aizwal. (S)		
Nagaland		Director, Admmistrative Trg. Instt. Officer Hills, Kohima (S)		

STATEMENT IV (contd.)

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Orissa	Principal, Health & Family Welfare Training Centre, Sambalpur. (S/D) Principal Health & Family Welfare Training Centre, Cuttack-7. (S/D)	Commssioner, Gopabandhu Academy of Admin. Sahidnagar. Bhubaneswar-751 007 (S)	TEAM for Human Resource Education and Action for Development (THREAD) Sidharth Village, Post B. No. 9, Jatni, Distt. Puri-752 050 ORRISA (S/D)	
Punjab	Principal, Health & Family Welfare Training Centre, Kharar, Distt. Ropar. (S/D) Director, State Instt. of Health & F.W., Kharar, Punjab. (S/D)	Director, Punjab State of Public Admin., SCO 175-176, Sec. C, Madhya Marg, Chandigarh-18 (S/D)		
Sikkim				
Tamil Nadu	Principal Health & Family Welfare Training Centre, 417, Panthoon Road, Egmore-9 (S/D) Principal, Health & Family Welfare Training Centre, Salem Govt. H.Q. Hosp. Compound Salem-1. (S/D) Principal Health & Family Welfare Trining Centre, P.O. Ambathurai, Anna R.S. Distt., Madurai-9 (S/D) Department of Community Medicine, Christian Medical College, Vellore-632002 (N/S/D)		Gandhigram Institute of Rural Health and Family Welfare Trust, PO : Ambadhurai,R.S. Dindigal. Quaid-e-Milleth Disrtict, Tamil Nadu-624 309 (N/R/S/D) ANITRA, 60, Radhakrishana Road, Chennai-24, Tamil Nadu Ms. Jaya Arunachalam, President, Working Women Forum 55, Bhimasen Garden Road, Mylapore Chennai.	
Tripura				

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
West Bengal	Principal, Health & Family Welfare Training Centre, 235, Bipin Behari Ganguli Street, Calcutta (S/D) Principal, Health & Family Welfare Training Centre, Kalyani, Distt. Nadia. (S/D) Principal Health & Family Welfare Training Centre, P. O. Danguajher, Jalpaiguri (S/D) Calcutta Metropolitan Development Authority, Unnayam Bhawn, Vidhan Nagar, Calcutta-91 (S/D) All India Institute of Public Health & Hygiene, Calcutta. (N/S/D)	Director, Indian Instt. of Management, Joka Diamond Harbour Raod. Calcutta 700027 (N/R/S/D) (West Bengal. N.E.)	Child in Need Institution (CINI), Post Box No. 16742, Calcutta-27 West Bengal. (S D) Shri R. Das, Secretary General, Indian Tea Association, Royal Exchange, 6 Netaji Subhash Road, Calcutta-1 (S/D)	Shri R. Das, Secretary General, Indian Tea Association Royal Exchange, 6 Netaji Subhash Road, Calcutta-700001
A & N Islands				
Chandigarh	Director, State Instt. of Health & Family Welfare, Near Topiary Park, Sec. 6, Panchkula-9 (S/D)			
D & N Haveli				
Daman & Diu				

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Delhi	Principal, Health & Family Welfare Training Centre, Nurses Hostel 2nd Floor, Hari Nagar New Delhi-64. (S/D)	Director, Indian Instt. of Public Admin. I.P. Estate, New Delhi (N/R/S/D)	Indian Society for Training and Development (ISTD). Training House, Behind Kutub Hotel, Institutional Areaa, New Delhi (N/S/D)	The Indian Instt. of Mass Communication, J.N.U. Campus. New Delhi-67 (N/S/D)
	Director, National Instt. of Health & Family Welfare, New Delhi (N/S/D)		Plan International-ROSA/India, J-27, South Extn. Part-I, New Delhi (N/S/D)	The Media Research Group, E 126, Rajouri Garden, New Delhi-110027 (N/S/D)
	Director, Central Health Education Bureau, Kotla Road, New Delhi. (N)		Society for Participatory Research in Asia, 42 Tuglakabad Institutional Area, New Delhi (N/S)	The Mode Research Pvt. Ltd. Kotla Mubarakpur New Delhi. (N/S/D)
	Director, National Instt. of Communicable Diseases, 22, Shamnath Marg, New Delhi. (S/D)		Voluntary Health Association of India, Tong Swasthya Bhawan, Behind Qutub Hotel, 40, Institutional Area New Delhi-16 (N/S/D/)	The Centre for Research & Planning. & Action. 10, Hailey Road, New Delhi. (N/S/D)
	Ms. Adarash Sharma Addl. Director, NIPCCD, Siri Institutional Area, New Delhi (N/S)		Mr. A. Sengupta, Director, Bharat Gyan Vigyan Sanstha, C/o Delhi Science Forum, B-1, 2nd floor, LSE,3 Block,Saket, New Delhi (N/S/D)	The Centre for Social and Techno Economic Research, B 2-235, Paschim Vihar, New Delhi-110063 (N/S/D)
	Department of Community Medicine, Maulana Azad Medical College, New Delhi-1. (N/S)		Smt.Sudhi Tiwari,President, Parivar Seva Sanstha. 28 Defence Market, New Delhi (N/S/D)	The Socio-Economic Research Centre, C 4D 48 A, Janakpuri, New Delhi. (N/S/D)
	Department of Community Medicine, Lady Hardinge Medical College. New Delhi-1, (N/S)		Centre for Information Education and Communication D-332,Defence Colony, New Delhi	Jamia Milia Islamia University, New Delhi. (N(N)

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Lakshdweep				
Pondicherry	Department of Community Medicine, Jawahar Lal Nehru Instt. of Post Graduate Medical Education and Research, Pondicherry-605006 (N/S/D)			
Rajasthan	Principal, Health & Family Welfare Training Centre, Hira Bagh, Sawai Ram Singh Road, Jaipur-4 (S/D) Principal, Health & Family Welfare Training Centre, Jaipur Road, Ajmer. (S/D) Principal, Health & Family Welfare Training Centre, House No. 846. Pawta Mandor Road, Jodhpur (S/D) State Institute of Health & Family Welfare, HCM-RIPA Campus, Malviya Nagar, Jaipur-302015. (S/D)	Director, Indian Institute of Health Management Research (HHMR), 1, Parbhu Dayal Marg, Sangner Airport, Jaipur (N/R/S/D) Director, HCM Rajasthan State Instt. of Public Admin., Malviya Nagar, Jaipur 17. (S/D)	ASTHA., 4 Bedla Road, Udaipur 313 001. (D) Seva Mandir, Fatehpur, Udaipur 313 001 (S/D) ASSEFA, Association for Sarva Sewa Farms Rajasthan	The Human Environment Action Research, 8 C/6 Pratap Nagar, Jaipur-302015 ASSEFA Association for Sarva Sewa Farms, Rajasthan.

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Uttar Pradesh	Director, State Institute of Health and Family Welfare, Indira nagar, Lucknow 226016 (S)	Chairman, (EDP). Indian Instt.of Management Sector 'O', Aliganj Housing Scheme, Phase-II, Lucknow (N/R/S/D)	Mrs. Maithili Himalyan Institute and Hospital Trust, Jolly Grant, Doiwala, Dehradun, UP.	
	Principal, Health & Family Welfare Training Centre, C Block Indira Nagar, Lucknow (D)			
	Principal, Health & Family Training Centre, LLRM Medical College Campus, Meerut. (D)	Director, Lal Bahadur Shastri National Academy of Admin., Charleville, Mussoorie 179 (U.P.) (N/R/S/D)		
	Principal, Health & Family Welfare Training Centre,P.G.I. Building Mental Hospital Campus, Mathura Road, Agra. (D)			
	Principal, Health & Family Welfare Training Centre, Jonti Bhawan, 5.8/119-B Khajuri Varanasi 2. (D)	Director, UP Acedemy of Administration, Nainital (N/R/S/D)		
	Principal, Health & Family Welfare Training Centre,P.O. Geeta Batika, Gorakhpur-66 (D)			
	Principal, Health & Family Welfare Training Centre, Kanpur (D)			
	Principal, Health & Family Welfare Training Centre, Jhansi (D)			
	Principal, Health & Family Welfare Training Centre, Moradabad (D)			
	Principal, Health & Family Welfare Training Centre, Haldwani (D)			

STATEMENT IV (contd.)

STATES	GOVERNMENT TRAINING INSTITUTIONS	ADMINISTRATIVE TRAINING INSTITUTES	NGO	IEC
Uttar Pradesh	Principal, Health & Family Welfare Training Centre, Dehradun (D) Principal, Health & Family Welfare Training Centre, Azamgarh (D) Principal, Health & Family Welfare Training Centre, Allahabad (D) Principal, Health & Family Welfare Training Centre, Faizabad (D) Principal, Health & Family Welfare Training Centre, Bareilly (D)			

STATEMENT-V

PROPOSED LIST OF COURSES FOR TRAINING UNDER REPRODUCTIVE AND CHILD HEALTH PROGRAMME

Awareness Generation Training:

(a) Grass-root functionaries-2 days: Composite groups of ANMs, LHVs, Male Health Workers, Health Assistant (M), Village level workers of Department of Women and Child Development, Education and Panchayati Raj functioaries.

(b) Similarly for Doctors, Sub-divisional Officers (Collectros, Zilla Parishad members and District level (one day)

(a) Awareness Generation and Management Development of State, Division, and District level Health Managers.

(b) Orientation Training, Seminar for all District Medical Staff-one day in RCH Concept and status of RCH/Population Indicators. This may be needed every quarter in all districts for 2 years.

Skill deveopment training of ANMs, Nurses and LHV-Health Supervisors.

RCH skill development of Medical officers.

Specialised courses for Specialists/Medical Officars.

Skill development of Health Workers (M) and Health Supervisor (M).

Vocational courses for Lab Technicians.

Refresher training to Nurses for RCH, obstetric care and communication.

Skill development course for BEEs, DMEIOs and State Medical Officers.

Diploma in Aneasthesia in the Medical Colleges.

ANNEXURE-XV

REPRODUCTIVE AND CHILD HEALTH PROGRAMME-COMPONENT/AGENCY-WISE COSTING

(Rs. in Lakhs)

Activity	IDA Phase I	IDA Phase II	IDA Total	UNICEF	UNFPA	GOI (incl EC and Counterpart	DANIDA	ODA	Total
RTI CLINICS (Districts)	325.80	0.00	325.80	0.00	0.00	121.95	0.00	0.00	447.75
RTI DRUGS	688.80	0.00	688.80	0.00	0.00	1093.20	0.00	0.00	1782.00
EOC FRU (DURGS)	3307.92	0.00	3307.92	0.00	0.00	3251.08	0.00	0.00	6559.00
EOC PHC (DURGS)	2750.48	3185.52	5936.00	0.00	0.00	1656.00	0.00	0.00	7592.00
Addl. ANMs (30%)	7587.32	6962.44	14549.76	0.00	0.00	4112.24	0.00	0.00	18662.00
SM CONSULTANT (2 VISITS p.m.)	3629.55	0.00	3629.55	0.00	0.00	1135.45	0.00	0.00	4765.00
P.H.N. (A.T.PHCs)	1615.60	10244.40	11860.00	0.00	0.00	3066.00	0.00	0.00	14926.00
Lab. Techs (2 Per distt)	536.83	1059.52	1596.35	0.00	0.00	432.65	0.00	0.00	2029.00
Mtp eqpt & spares (PHC level)	1745.90	0.00	1745.90	0.00	0.00	545.60	0.00	0.00	2291.50
Minor civil works (10 lakh over 5 yrs for repairs)	2760.80	1295.20	4056.00	0.00	0.00	1244.00	0.00	0.00	5300.00
Rental (ANM/PHN)	0.00	0.00	0.00	0.00	0.00	2974.00	0.00	0.00	2974.00
Training	8760.00	4500.00	13260.00	10000.00	4250.00	3490.00	0.00	0.00	31000.00
Institutional Development	4380.00	1825.00	6205.00	3000.00	0.00	7295.00	0.00	0.00	16500.00
Indian System of Medicines	0.00	0.00	0.00	0.00	0.00	3000.00	0.00	0.00	3000.00
IEC	1460.00	4388.00	5848.00	6000.00	5500.00	2152.00	0.00	2000.00	21500.00
Equpt. kits C, D, G & I	173.06	6320.00	6493.06	0.00	0.00	3606.94	0.00	0.00	10100.00
Urban RCH	0.00	5840.00	5840.00	0.00	0.00	17160.00	0.00	0.00	23000.00
Tribal RCH	1080.00	6224.00	7304.00	0.00	0.00	2696.00	0.00	0.00	10000.00
LCE	23316.20	20483.80	43800.00	0.00	0.00	10950.00	0.00	0.00	54750.00
Op. cost	7665.00	3832.50	11497.50	0.00	0.00	7202.50	0.00	1300.00	20000.00
NGO & com. part.	1634.80	5000.00	6634.80	9000.00	4000.00	7865.20	0.00	0.00	27500.00
Referral TPT	357.00	963.20	1320.20	0.00	0.00	1479.80	0.00	0.00	2800.00
Mon. & Eva	2920.00	0.00	2920.00	4000.00	0.00	1380.00	0.00	0.00	8300.00
Civil Works (SSN)	0.00	0.00	0.00	0.00	0.00	27500.00	0.00	0.00	27500.00
IUD Ins. kits	0.00	0.00	0.00	0.00	0.00	16800.00	0.00	0.00	16800.00
Cold Chain Eqpt	0.00	0.00	0.00	8000.00	0.00	2700.00	13.00	0.00	12000.00
Vaccines	0.00	0.00	0.00	7500.00	0.00	45800.00	2000.00	4400.00	59700.00
Drug Kits & Bulk	0.00	0.00	0.00	0.00	0.00	36500.00	0.00	0.00	36500.00
Research	0.00	0.00	0.00	2750.00	2000.00	2250.00	0.00	0.00	7000.00
Ref. System for RH	0.00	0.00	0.00	2000.00	500.00	400.00	0.00	0.00	2900.00
Missing Ess. Package	0.00	0.00	0.00	0.00	0.00	19000.00	0.00	0.00	19000.00
Dist. F.W. Bureaus	0.00	0.00	0.00	0.00	0.00	8000.00	0.00	0.00	8000.00
Innovative Scheme	0.00	0.00	0.00	2500.00	2000.00	1500.00	0.00	0.00	6000.00
Contingency	10950.00	9125.00	20075.00	0.00	0.00	0.00	0.00	0.00	20075.00
TOTAL	87645.06	91248.58	178893.64	54750.64	18250.00	248359.61	3300.00	7700.00	511253.25

ANNEXURE-XVI(1)

FORMAT OF PROJECT ACCOUNTS
(by Expenditure Categories)

Year : _____

Investment Item	Expenditure (Rs. M)	Share of funding		Cumulative expenditure to end of the year
		IDA	GOI	
WORKS				
Civil works				
Sub-total				
GOODS				
Vehicles				
Furniture & Non-medical Equipment				
Medical Equipment				
Drugs				
Materials and Goods				
Sub-total				
CONSULTANTS & SERVICE				
Training				
Consultants				
Contractual Services				
Sub-total				
MISCELLANEOUS				
Salaries of Additional Staff				
Rental Costs (Residential staff quarters)				
Incremental Operating & Maintenance				
Referral Transport				
Sub-total				
TOTAL				

TOTAL 87645.06 91248.58 178893.64 54750.64 18250.00 248359.61 3300.00 7700.00 511253.25

Programme for the new districts created before 1st April, 1997 other than the 466 districts and post of Cold Chain Officer and Technical Assistant created in 6 States/UTs, namely Goa, Andaman & Nicobar, Daman & Diu, D& N Haveli, Chandigarh and Pondicherry will be supported by World Bank. The rate of reimbursement will be 80% upto September 30, 1999, 55% from October 1, 1999 to September 30, 2001 and 25% thereafter. For this purpose, the States/UTs would require to submit the following details of quarterly expenditure on salaries of such additional posts, on the basis of which the reimbursement will be filed with the World Bank by the GOI.

Name of post	No. of posts	No. of posts filled after 1.10.1997	Expenditure incurred on salary during the quarter

2. *SCOVAs:* The posts created for strengthening of SCOVAs at the state level will be funded by World Bank for which all the SCOVAs would be required to send quarterly expenditure details alongwith the number of consultants to GOI on the basis of which the GOI will file claims with World Bank. This includes appointments of Accounts Clerks and Statistical Assistants which are to be appointed on contract basis. This component will be funded 100% by the World Bank.

[B] DISTRICT PROJECTS

GOI will release grants for the districts projects as per the projections indicated in the Implementation Plan. The eligible percentage of reimbursement by World Bank will vary from item to item as defined in the Development Credit Agreement. The States would be required to compile item-wise expenditure on this account and prepare disbursement applicaltion and send the same to MOHFW for forwarding to World Bank through DEA

[C] IMMUNIZATION.

1. The vaccines and Drugs in kits A & B will be procured centrally and suplied to the States/UTs. The expenditure on these these items will be funded by Govt. of India except the cost of Polio vaccine for the use in PPI will be funded by ODA, DANIDA, Japan, KFW, Rotary etc.

2. Most of the cold chain equipments including needles and syringes will similarly will be procured centrally out of GOI funds in case no donor support is available.

3. Funds for operational expenses on cold chain maintenance, POL expenses of UIP vehicles, procurement of disposable delivery kits & Dais kits, the World Bank will reimburse 80% through September, 30,1999, 55% from October, 1, 1999 to September, 30, 2001 and 25% thereafter. For procurement purposes, the reimbursement will be 80% of the expenditure. The States are required to furnish

5. The IUD kits for ANMs will be procured centrally and supplied to the districts on the basis of information about training of ANMs on IUD. The funds for this purpose will be borne by GOI.

[E] EMERGENCY OBSTETRIC CARE

1. Equipment kits (kit-E to kit-P) to the districts other than provided under CSSM Programme, will be procured centrally and the claims will be filed by GOI. 80% of expenditure on this account is reimbursable by World Bank. The World Bank will, however, fund for this activity only under the RCH Phase II.

2. Drug kits for emergency obstetric care at FRUs/CHCs will also be procured centrally and claims filed by GOI for 90% reimbursement by World Bank.

3. Expenditure on Laboratory Technicians provided on contractual basis will be reimbursable 100% from World Bank. For this the States are required to furnish quarterly details about number of such contractual staff engaged and honorarium paid to them during each quarter in accordance with guidelines on the subject, on the basis of information furnished by the States. the claims will be filed by the GOI..

4. For training of doctors as Anaesthetists in Medical Colleges, funds will be made available through NIHFW of which 100% expenditure is reimbursable by the World Bank. The expenditure details will be submitted by NIHFW to MOHFW.

5. Laparoscopes will be procured cetrally and supplied to the CHCs which do not have it. This will be funded by GOI, however, expenditure on training is rembursable by the World Bank.

6. The States will make procurement of items like Inj., Pethidine, Oxygen and other gases as per World Bank procedure. 80% of such procurement will be reimbursable by the World Bank. The States are also required to furnish quarterly expenditure details for such procurement on the proforma as indicated in "Para 3 under Immunization" above.

[F] 24 HOURS DELIVERY SERVICES AT PHCs/CHCs

In order to encouraging institutional deliveries the States are required to send proposals in this regard. Such proposals as detailed in the guidelines, will be scrutinized and funds released to the States for which the States are required to send item-wise expenditure details. Funding for this activity will be undertaken under GOI funds.

[G] REFERRAL TRANSPORT TO INDIGENT FAMILIES THROUGH PANCHAYATS

Funds for referral transport will also be provided to the States/UTs. 90% of expenditure on this activity will be reimbursable by the World Bank. The States are required to send quarterly expenditure details in this regard for each district with amount of expenditure. On the basis of the same the reimbursement claims will be filed with the World Bank by GOI.

[H] BLOOD SUPPLY TO FRUs/PHCs

To ensure regular and reliable supply of blood to PHCs/CHCs, pilot projects will be framed in consultation with the States. Funding for this activity will be made by E.C. The States will be required to furnish the actual expenditure details on quarterly basis to GOI.

[I] ESSENTIAL NEW BORN CARE

Essential equipments to be provided at various levels viz. district hospital/ CHCs/PHCs will be procured centrally by GOI. The funding for this will be from GOI.

[J] MEDICAL TERMINATION OF PREGNANCY (MTP)

1. MTP equipments will be procured centrally for supply to CHCs/PHCs where not available. 100% (ex-factory cost) of such expenditure will be reimbursable by the World Bank. GOI will file the claim.

2. Expenditure on need based training arrangements will be made by NIHFW who will furnish the details to MOHFW for filing claim to World Bank. 100% expenditure on this amount is reimbursable by World Bank.

3. Expenditure on contractual fee of Rs. 500/- will be released through the SCOVAs/State Finance Division, as the case may be. The districts are required to give expenditure details along with number of consultants appointed to State Family Welfare Directors i.e. Project Directors (RCH). Who would be responsible for compiling & preparing disbursement application which will be pursued through MOHFW to DEA for onward tranmission to World Bank. 100% of such expenditure is reimbursable by World Bank. The States are required to submit disbursement applications on monthly basis.

[K] REPRODUCTIVE TRACT INFECTION (RTI)/SEXUALLY TRANSMITTED INFECTION (STI) CLINICs

1. RTI/STI drugs, to be supplied in the form of kits will be centrally provided. 90% of expenditure on the amount is reimbursable by World Bank. Claims will be filed by the MOHFW.

2. The expenditure on training for the purpose will be made by NIHFW who will funish details to MOHFW. MOHFW will file claims with World Bank. The eligible percentage for reimbursement is 100% on the amount.

[L] CIVIL WORKS

1. There are 2 components under Civil Work. Under one component called "Minor Civil Works and Repairs", a sum of Rs. 10 lakh will be provided to each district except sub-project district. This component will be funded by World Bank and eligible for 90% reimbursement. State Director (FW) will obtain details from districts and prepare SOE on monthly basis.

2. In addition, for civil work similar to Social Safety Net Scheme will be

given as per the procedure given earlier and will be funded by GOI. However, States are required to give item-wise monthly expenditure report along with following details:

Name of facility with location (SC/PHC/CHC/ District Hospital)	Activity of Work	Name of Agency	Budgeted Amount	Payment made during to month

[M] INDIAN SYSTEMS OF MEDICINE

1. Training to ISM practitioners will be looked after centrally by MOHFW. Funding will be as World Bank programme and 100% expenditure is reimbursable.

2. The project regarding raising nurseries of medicinal plants will be sanctioned by MOHFW. The agency/institution are required to send quartely expenditure details for such expenditure to MONFW. This item of expenditure is to be borne by World Bank/GOI.

3. The Reseacch in ISM will be a part of Survey & Studies and 100% expenditure will be reimbursable by the World Bank. The funds to the agency/ institutions will be provided directly by MOHFW and claims filed to World Bank.

4. Assistance for Vanaspati Van Projects under ISM will be placed through SCOVA/State Governments. Each such projects will provide detailed expenditure reports to the fund releasing agency. Consolidated Vanaspati Van Project-wise expenditure details will be sent by State F.W. Directors to MOHFW. The expenditure for the activity will be brone by World Bank/GOI.

[N] ADDITIONAL PROGRAMME FOR THE URBAN SLUMS

Recommendation of Expert Committee set up for the purpose is yet to come. Keeping in view the Project requirements, the flow of funds will be through SCOVAs/ State Governments if activities are to be implemented by States. Otherwise the funds may be provided by MOHFW directly to any other implementing agency. The monthly activity-wise expenditure reports are to be submitted to MOHFW who will file the claims to World Bank. The percentage of reimbursement will depend upon the type of expenditure.

[O] SPECIAL PROGRAMME FOR TRBAL AREAS

Recommendation of Expert Committee set up for the purpose is yet to come. Keeping in view the Project requirements the flow of funds will be through SCOVAs/ State Govermments if activities are to be implemented by States. Otherwise the funds may be provided by MOHFW directly to any other implementing agency. The monthly activity-wise expenditure reports are to be submitted to MOHFW who will file the claime to World Bank. The percentage of reimbursement will depend upon the type of expenditure.

[P] SPECIAL PROGRAMME FOR ADOLESCENTS

Recommendation of Expert Committee set for the purpose is yet to come. Keeping in view the Project requirements, the flow of funds will be through SCOVAs/ State Governments if activities are to be implemented by States. Otherwise the funds may be provided by MOHFW directly to any other implementing agency. The monthly activity-wise expenditure reports are to be submitted to MOHFW. Funding for this component are likely to come from UNFPA/UNICEF/World Bank.

[Q] RESEARCH AND DEVELOPMENT

The Research under RCH Programme will be sponsored directly by MOHFW and 100% expenditure will be reimbursable by the World Bank. The funds to the agency/institutions will be provided directly by MOHFW and claims filed to World Bank.

[R] TRAINING

Funds for training will be placed with NIHFW, who will coordinate, compile the expenditure from collaborating institution and send the consolidated SOEs to MOHFW for filing reimbursement claims with World Bank/UNICEF/UNFPA as the case may be. 100% expenditure on training is reimbursable.

[S] INFORMATION, EDUCATION AND COMMUNICATION

1. The funding for IEC activities will be through GOI and World Bank. ODA (UK) will provide funds for IEC activities under Pulse Polio Immunization. Expenditure on national level IEC activities will be incurred by GOI centrally.

2. Funds for State specific IEC activities will be placed with the SCOVAs/ State Governments. The State Family Welfare Directors will ensure sending quarterly expenditure details to MOHFW for filing claims with World Bank, ODA etc. 100% expenditure is reimbursable on this amount.

[T] NON-GOVERNMENTAL ORGANISATIONS (NGOs)

Funds to NGOs, under RCH programme will mainly from GOI, however, in the RCH Phase-I, World Bank will provide funding for the Jan Mangal Scheme of the Rajasthan Government in lieu of additional ANMs. Under RCH Phase-II additional support for NGOs and for community participation is likely to be available. For enhanced community participation, suport will be available from UNICEF and UNFPA under district projects (other than RCH). As per schemes given, funds will be provided by GOI to National level NGOs/Mother NGOs and expenditure details will be obtained from them.

[U] MANAGEMENT INFORMATION SYSTEM UNDER THE RCH PROGRAMME

1. MIS related material i.e. forms, registers, manuals etc. will either be provided by MOHFW or funds released to States through SCOVAs/State Government. 80% of such expenditure will be reimbursed by World Bank. Against the funds

released to the States, the States are required to send item-wise expenditure details on monthly basis to MOHFW, who will consolidate and file claims with World Bank

2. Funds relating to District Surveys and concurrent evaluation surveys will be released to the agencies, to be selected by MOHFW and expenditure details will be obtained from these agencies on monthly basis and claims will be filed with World Bank who will reimburse 100% of such expenditure.

FORM 1B

SCHEDULE OF WITHDRAWAL OF PROCEEDS

Details of Payments made from the Special Account 1/

During the period _____ through _____

Date_____

IFC Credit No. No 18-IN

Application No._____

Summary Sheet No._____

For : (i) Expenditures on goods contracts equivalent to US$ 3,00,000 or more
(ii) Expenditures on works contracts equivalent to US$ 3,00,000 or more
(iii) Expenditures on contracts with consulting firm equivalent US$ 2,00,000 or more, and contracts with individual consultants equivalent to US$ 50,000 or more
(iv) Expenditures on vehicles contracts equivalent to US$ 1,00,000 or more

1	2	3	4	5	6	7	8	9	10	11	12	13
Item No	Category No	Brief description of goods or services	Name of Contractor, Address, Contract No. Contract date	Contract Amount	Currency and cumulative amount paid to date	Currency and Amount paid during this period	IDA Financing Percentage from Schedule 1 to the Credit Agreement	Amount eligible for IDA financing (% in column 8 applied to amount in column 7)	Exchange Rate	U.S. Dollar Equivalent charged to the Special Account (Exchange Rate in column 10 applied to amount in Column 9)	Project State	Remarks/No Objection data/Country of origin
									TOTAL			

1/ If this application is not for replenishment of the special Account, leave columns 10 and 11 blank

(Authorized Representative)

FORM 1C

REPROCUTIVE AND CHILD HEALTH PROJECT
STATEMENT OF EXPENDITURES (SOE)

PAYMENT MADE DURING THE PERIOD FROM _____ to _____ 1/

Date_____
IFC Credit No. No 18-IN
Application No._____
Summary Sheet No._____

For expenditures under :

- Goods contracts less than US$ 3,00,000 equivalent
- Works controls less than US$ 3,00,000 equivalent
- Connsulting firms contracts less than US$ 2,00,000 equivalent and Individual consultant contracts less than US$ 50,000 equivalent
- Vehicles contracts under US$ 1,00,000 equivalent
- training and workships
- Surveys and studies
- Referral transport
- Incremental salaries and operating expenses

1	2	3	4	5	6	7	8	9	10	11
Item No	Category No 2/	Country of Supplier 3/	Name and Address of Supplier/ Contractor 4/	Total Amount of Invoices convered by Application (net of retention)	Eligible Percentage Schedule 1 of Credit Agreement	Amount eligible for	Currency & Amount paid from the Special Account (if applicable)	Exchange Rate (amount in Col. 7 divided by amount in column 8)	Project State	Remarks
					TOTAL					

Supporting documents for this SOE retained at _____
(insert location)

_____
(Authorized Representative)

1/ A separate SOE form should be used for retroactive financing.
2/ Items should be grouped by category or alternately, a separate SOE form may be used for each category.
3/ Consolidate payments by country of supplier except for US suppliers.
4/ Column 4 should be filled in respect of all suppliers/contractors from the U.S., the address should include the city and the state.

It is certified that detailed information on expenditures incurred by each district is available at a central location in the State Government.

ANNEXURE-A

DETAILS OF DISTRICT/CITY PROJECTS

S. No.	Name of the State	Project	Cost (Rs. in Crore)	Population (in lakh)
1.	Punjab	Sangrur	12.62	16.85
2.	Gujarat	Baroda	10.61	30.90
3.	Tripura	Tribal Autonomous Districts	11.97	9.42
4.	Orissa	Kalahandi	15.00	11.31
5.	Karnataka	Bellary	15.05	18.90
6.	Mizoram	Entire State	17.31	7.50
7.	Andhra Pradesh	1) 7 Municipalities of Hyderabad	7.72	2.25
		2) Mehboob Nagar	18.96	30.70
8.	Himachal Pradesh	Kinnaur	3.65	0.71
9.	Madhya Pradesh	Rajgarh	12.34	9.93
10.	Maharashtra	Nasik	13.78	38.50
11.	Haryana	(1) Bhiwani	6.18	11.66
		(2) Faridabad	7.83	4.60
12.	Manipur	Tamenglong, Churachandpur & Thoubal	13.91	5.56
13.	Rajasthan	1) Tonk	10.23	9.80
		2) Jaipur	13.10	15.18
14.	Tamil Nadu	1) Madurai (City)	7.90	3.70
		2) Madurai (Distt)	15.24	19.10
15.	Uttar Pradesh	1) Firozabad	4.87	2.70
		2) Rai Barreily	16.33	23.22
16.	West Bengal	1) Asansole	8.57	4.78
		2) Murshidabad	13.53	47.40
17.	Kerala	1) Palakkad	16.87	23.82
		2) Kozhikode	10.31	26.20

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