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# INDIAN SOCIETY OF HEALTH ADMINISTRATORS (ISHA)

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BACKGROUND MATERIAL

STRENGTHENING THE CAPABILITIES OF VOLUNTARY AGENCIES

WORKING IN HEALTH AND FAMILY WELFARE

WORKSHOP ON

INVOLVEMENT OF VOLUNTARY ORGANIZATIONS

IN HEALTH AND FAMILY WELFARE

MAY 25 - 27, 1992

FOR

MINISTRY OF HEALTH AND FAMILY WELFARE

GOVERNMENT OF INDIA

NEW DELHI

WITH THE FINANCIAL ASSISTANCE OF

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

NEW DELHI

ISHA

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ISHA

Workshop on Involvement of Voluntary Organizations
in Health and Family Welfare
May 25-27, 1992

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It is proposed to hold a workshop of three days' duration on 25th to 27th May, 1992 at Bangalore for the officals at the policy levels in the state governments as well as nodal officers of states and certain NGOs. The participants will come from the States of Karnataka, Kerala, Andhra Pradesh and Tamilnadu. The broad objectives of the workshop will be :-

1. To achieve involvement of more and more NGO organizations in the implementation of the family welfare programme.

2. To ensure better cooperation between state government officals and the NGOs and to bring about necessary attitudenal changes to seek increased involvement of the voluntary sector in the family welfare programme.

3. To acquaint the participants with the polices and programme followed at national level for achieving better implementation of the family welfare programme through voluntary organizations.

4. To discuss annual action plans of the state governments for the family welfare programme to be implemented.

5. To develop appropriate monitoring and evaluation mechanisms to ensure proper implementation of such projects through voluntary organizations.

6. To share the experience of the state governments in the implementation of the family welfare programme through voluntary organizations in those states for bringing about further improvement.

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The broad topics proposed to be discussed are as follows:-

1. Methodology and schemes in existence.
2. Implementation of family welfare programme by states and the experience of State Family Welfare Secretaries.
3. Action Plan of States for 1992-93.
4. Better cooperation between NGOs and government officials.
5. Further possible simplification of procedures.
6. Problems of NGOs vis-a-vis the community.
7. Evaluation and accountability of voluntary organizations.
8. Training needs of NGOs.

## II - Record note of discussions of the meeting of Voluntary Organisations/NGOs held on 31-10-1991 in Nirman Bhawan, New Delhi.

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A meeting to discuss policy pertaining to involvement of Voluntary Organisations/NGOs in the F.W.Programme was hela in the Ministry on 31-10-1991 under the chairmanship of Shri K K Mathur, Secretary (FW). The list of participants is at annexure.

The main purpose of the meeting was to discuss the involvement of the Voluntary Organisations/NGOs for the promotion of F.W. programme in the country in the light of various discussions held in the five regional conferences at various places. A number of organisations who have been associating themselves with various schemes in this Ministry had been identified and requested to participate in the meeting. In addition, a number of international donor agencies who have been showing keen interest in the furtherence of the F.W. Programme especially through voluntary organisations/NGOs were also invited.

A brief background paper which incorporated the current thinking in this regard as also the salient points which emerged in the regional conferences was circulated in the meeting.

Welcoming the participants, Mrs. Rita Menon, Director (Media) regretted the short notice given to the participants and thanked them for attending the meeting which was indicative of the interest and concern they have been showing towards this very important national programme. Director (M) highlighted the various steps Government have taken to stimulate participation of voluntary agencies in the Family Welfare Programme and measures taken to reduce the time taken in processing of cases etc. She briefly, mentioned about the current thinking to set-up an Apex body in the field of Voluntary Organisations/ NGOs which could take up the work relating to coordination, sanctioning, monitoring, evaluation etc. of F.W. Programme in their respective areas.

Smt. Suneeta Mukherjee, Joint Secretary in her inaugural discussion gave the background of the apex body intended, as well as an insight into the Government policies relating to funding of Voluntary agencies and laid special emphasis on the funds placed at the disposal of State Governments for training, visits and interactions amongst voluntary agencies. She also announced that Prof. Sontoso had been invited to make a presentation on the F.W. Programme in Indonesia and the role of Government and Non-Government Sectors therein. As is well-known, the concept of community participation has been most fruitfully translated in action in Indonesia.

Shri K K Mathur, Secretary (FW) in his key note address expressed his happiness that representatives of various organisations have come for this very important meeting at such a short notice. He specifically mentioned the benefits of availing of the opportunity of interaction with Dr Sontoso after his presentation on Community Participation in

Indonesia and how far this could be practised in our country. He also mentioned the imperative need for finalisation of well-devised strategies to bring dynamism in the F.W. Programme through Voluntary Organisations/NGOs. He reiterated the government's contention to make F.W. Programmes a People's Movement. For this, participation and cooperation of the voluntary organisations/NGOs was considered to be very essential particularly due to the fact that these organisations are so much a part and parcel of the community itself. The Government on their part have introduced many schemes and are providing services through the Primary Health Centres etc. However, it is an established fact that considerable gaps still remain to be filled and herein comes the importance of Voluntary Organisations/NGOs. It needs to be borne in mind that the efforts made by NGOs/Voluntary Organisations are to be taken as vital and crucially supplemental to Governmental efforts.

Secretary (FW) mentioned about the meeting of State Secretaries incharge of Family Welfare held towards the end of August, 1991. It was observed therein that many of the States did not have clear perception as to the role which could be fruitfully played by NGOs/ Voluntary Organisations in furtherance of the Government programmes.

Referring to the field of communication, Secretary(FW) stressed that IEC activities need to be considerably strengthened at the local level and interface with other activities improved. Our endeavour should be to cover the total population in the field of education, motivation etc. For this also, the effective role of NGOs/Voluntary Organisations was highlightea. Secretary (FW) also mentionea mis-conceptions of the people about Family Planning Education. He desired that we should take up programmes through focus of media which would be accepted by the people.

While congratulating the Voluntary Organisations|NGOs for the good work already being done by them, Secretary (FW) specially mentioned that there existed many smaller organisations which are also really keen to contribute in F.W. Programme in the country. These smaller organisations have certain inherent problems, namely, lack of knowledge about project formulation, existing government schemes, rules, procedures etc. He was of the view that the role of bigger voluntary organisations in educating and assisting their smaller counterparts in this area was of vital importance to the programme. This way there can be more coverage by voluntary organisations/NGOs. This aspect was considered to be a very vital by all present and clear policy in this regard needs to be enunciated.

Secretary (FW) elaborated the current thinking about setting up of an apex body which will be outside Government and will look into all the demands and sanctions for voluntary agencies and NGOs. A final pricture would emerge after getting a feed-back from participants. The participants were requested to give their views. Secretary (FW) hoped that with active co-operation/involvements of voluntary/NGOs Sector, it would be possible to push ahead the family welfare programme in the country, bringing down the growth rate and creating an atmosphere of meaningful socio-economic development in the country.

*Representatives of different voluntary agencies gave various reactions, suggestions to the agenda points and key note address of Secretary (FW). Shri Bunker Roy of Tilonia (Rajasthan) wanted family welfare programmes to be integrated with other rural programmes for action like drinking water, self-employment schemes, rural technology and education. He expressed reservations about state-level committees for assistance to voluntary agencies and stated that certain voluntary agencies could be earmarked for undertaking training of both other agencies as well as schemes implementing personnel in government.*

*Mrs. Wadia of FPAI expressed her request that a responsible feedback for the voluntary sector must be recleared when deciding further government policy on the voluntary sector and there was a need for a Population Commission to enable deliberation at the appropriate level.*

*Mr Srinivasan expressed a view that forming SCOVA's at state-level was a more good decision to enable action at the final level calling for involvement of state government level officers.*

*Various participants then gave their views on the proposal to set the Apex body. A number of procedural changes were also suggested. It was also stressed that Government should seriously and positively think about more direct advertisements through Press/ Radio/Television etc.*

*Another point made was regarding disparities in payscale of workers of voluntary organisations and government employees. It was however, earlier clarified that one of the important plans of the voluntary movement was their credibility and closeness to people at the grassroot. In other countries voluntary organisations function with a considerable level of independence.*

*Secretary (FW), suggested the formation of a group of three members from out of the participants to decide about objective, flexibility, financial aspects, proper utilisation of funds, etc., in a very simple terms and keeping in view the requirements of accountability. The three member group could prepare two or three model schemes at an early date. It was decided that Shri. Roy, Shri Srinivasan and Shri Kulkarani coula form the group.*

*The afternoon session started with a presentation on the family planning movement in Indonesia by Dr Santoso. Various components of the family planning programme in the country, commitment of the Government at the top-most level and full-fledged participation of the community were highlighted in detail in the presentation.*

*Concluding the deliberations, Joint Secretary (M) summarised the various points which emerged during the discussions, <u>particularly in regard to the formation of the Apex-body</u>.*

The following points emerged with reference to the proposal for setting up of the Apex-body.

VOLUNTARY ACTION FOR FAMILY WELFARE AND HEALTH (VAFAH )

Governing Council

* Majority for the Voluntary Sector to be involved.
* Voluntary Sectors should be rural-based.
* Should be action-oriented.
* A gender thrust (with more women involved) with grassroot experience may be stressed.
* Regional Centres - intra-jurisdiction aspect are desirable.

EXECUTIVE BOARD

* Chief Executive on contract (5years).
* Highlight aspects of Health and Family Welfare.
* Other concerned areas - Water, employment, Integrated Programme to be integrated with Family Welfare activities.
* Answerable to highest authority.
* Coordination with Ministries, technical experts, institutions should be built-in.
* Should be non-party political.
* Code of conduct to be drafted by the Organisation.
* Evaluation and deliberation or awarding of grants of old schemes may be included in the brief.

ISSUES WHICH ARE TO BE DECIDED ARE AS FOLLOWS

* VAFAH Constituion.
* Changing attitudes-Long term IEC-total coverage of population
* Three Member Committee consisting of Shri B Roy, Shri Srinivasan and Shri Kulkarni to formulate a few model schemes and submit to Government within a month.
* Sustainability part to be given priority.
* Mother Units concept to be developed and strengthened further.
* Accountability (Financial) will have to be basic.
* Conduct/ethics have to be developed.

The meeting ended with a vote of thanks to the chair.

## III - NOTE ON THE INVOLVEMENT OF VOLUNTARY ORGANISATIONS IN THE FAMILY WELFARE PROGRAMME

### Government Initiatives

The National Family Welfare Programme seeks to promote family planning as a people's movement. The vital role of Voluntary Organisations in promoting the Family Welfare Programme has been recognised and given importance from the very inception of the programme. In a programme calling for change in social and personal attitudes, perceptions and behaviour, the ability of Voluntary Organisations to effect attitudinal changes at the grass-root level is generally expected to be more effective than from Government.

There are many Government schemes for grant-in-aid to Voluntary organisations for the purposes of implementing Family Welfare Programme. The following are the main schemes for financial assistance under the Central Sector Scheme;

1. Innovative and Experimental Schemes.
2. Mini Family Welfare Scheme.
3. Project Linked Model Schemes.
4. Private Voluntary Organisations for Health (PVOH) Schemes.
5. Rolling fund schemes through Mother Units.

### Results so far

Not-withstanding initivatives taken by government and the facilities provided for promotion of activity of the

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voluntary sector under the above mentioned sehemes, the voluntary sector activity is not fully optimised and the funds provided remain unutilised to a large extent. It appears that the potential of the voluntary sector is yet to be fully realised. The following bottlenecks are encountered:

1. Non-Governmental Organisations (NGOs) often perceive Governmental procedures as slow and cumbersome.
2. NGOs are not adequately aware of the financial assistance being provided by the Government of India under various schemes.
3. Grass-root level workers are not aware of, or are unable to utilise the financial facilities available.
4. It has been felt that some voluntary organisations do not know how to formulate schemes or undertake its financial management or monitoring.
5. The existing schemes for providing financial assistance are limited.

Efforts taken by Government to boost the activity of Voluntary Sector

Government has taken the following initiatives to encourage larger participation of and involvement of Voluntary Sector for Family Welfare Programmes:

i) Wide publicity has been given to Government Schemes available for assistance to Voluntary organisations in the field of Health and Family Welfare by advertisements through television and the Press.

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ii) State Level Standing Committee of Voluntary Agencies (SCOVA) Committees comprising of State Government officials, representatives of the voluntary organisations and a representative of the Ministry of Health and Family Welfare are to be constituted. This Committee will recommend projects in family welfare for voluntary sector for funding from the Centre and also impart necessary training to the NGOs in project formulation and financial management with technical and monitoring support. (Annex.I)

iii) It has been proposed that adequate training should be organised for the voluntary sector in each State, atleast in two places - one within the Governmental sector and one in the non-governmental sector. The training will be in the areas of MCH, Spacing techniques, contraception, sterilisation etc., as well as aspects of information, education and communication. Over and above necessary training ~~would~~ be in:

a) Project Management.
b) Financial Management.
c) Project Monitoring & Evaluation.

iv) It has also been proposed to hold workshop/seminars/meetings/study tours of the voluntary sector for sharing experience and ensuring inter-action between the various organisations both in India and overseas. Study tour for workers of the organisations in the States which may have some difficulties in running projects or who want to

effect further professionalism in their activities, may be organised to States where work is being done by NGOs at a sufficiently good level.

v) Nodal Officers have been notified in the States/Union Territories to facilitate speedy action on the proposals of voluntary organisations for financial assistance. A list of the Nodal Officers is enclosed at Annexure-II.

vi) It is also proposed to develop a set of new community based model schemes to involve effectively the smaller voluntary organisations. Schemes with the involvement of Zilla Parishad, Panchayats, Municipal Authorities and private practitioners have been proposed and are under process.

vii) It has been decided to prepare a Directory of Voluntary Organisations to ensure better co-ordination and information. The Family Planning Association of India, Bombay has to undertake the job. A grant-in-aid has been sanctioned to them to prepare a Directory on an All-India-level. They have infact already produced the first volume of the directory.

viii) It has also been proposed to set up an Apex Body viz. Society for Voluntary Action for Family Welfare and Health (VAFAH) to administer all grants in aid of Rs.5.31 lakhs to NGOs. Apart from Government of India funds, External agencies of the United Nations and other donor bodies are expected to help fund it. It is expected that the

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setting up an Apex Body such as VAFAH would constitute a sea-change in the movement, looking at the flexibility and autonomy that would be available. This would mark a watershed in the voluntary sector movement and would go a long way in achieving the goal of making family welfare a people's movement. This proposal is presently under active consideration.

ix) Decentralisation of grant-in-aid procedures through setting up of rolling funds for involvement of small voluntary organisations-

A rolling fund of R.5 lakhs had been placed at the disposal of the Family Planning Association of India, Bombay, to give financial assistance to small voluntary organisations for schemes upto R.1 lakh per annum. The Family Planning Association of India has also been given financial assistance for setting up a Consultancy Unit at its Head-quarters at Bombay to provide consultancy services to other agencies for formulating such projects. Under this scheme, the Family Planning Association of India has approved 30 small organisations so far. The Mother Unit Concept Scheme has been extended to 4 other organisations viz. CIEAR, CINI, and GIRHFWI/CERPA * during the current year to build up a network system of decentralised project-funding spread across the various parts of the country before approval of the project of any organisation, approval of the Government of India is to be obtained by the mother-unit.

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x) To involve more and more organisations in the Family Welfare Programme to acquaint them with Government schemes for financial assistance and for a meaningful exchange of views, five Regional Conferences/meetings of NGOs were held at Patna, Calcutta, Madras, Shimla and Goa between 1990 and 1991, where a large number of NGOs participated and the response had been encouraging. The main points of the recommendations of the working groups of these Conferences/meetings are enclosed at Annexure-III. Action has already been processed or most of the recommendations.

Issues to be decided

i) Improving the skill and motivation of voluntary organisations and their workers through training, greater interaction, conferences, and workshops.

ii) Object of changing the attitude of the community towards family welfare programme through voluntary sector.

iii) Sustainability of the voluntary sector over the long-term.

iv) Extension of mother-unit concept to cover more grass root level organisations.

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v) Community Participation in the programme.

vi) Accountability of the Voluntary Sector and capacity to stand up to financial scrutiny.

vii) Ability of the Voluntary Sector to promote adequate spin-off effects of welfare activities in the regions where they operate.

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* CLEAR ( Centre for Labour Education and Social Research Unit )

CINI ( Child In Need Institute )

GIRHFWI ( Gandhi Gram Institute of Rural Health and Family Welfare )

CERPA ( Centre for Research, Planning and Action )

## STATE LEVEL COMMITTEE

1. A State Level Committee is to be set up for clearing the Projects of voluntary organisations and to guide them in project formulation. The composition and terms of reference of the proposed commitee have also been suggested to the State Governments/Union Territories.

2. An apex level NGO would be set up for providing training and technical support to NGOs regarding Project formulation and monitoring systems.

3. The State Governments/Union Territories should submit their recommendations/comments on the proposals of NGOs within a period of 12 weeks on a reference received from the Central Government. If no reference is received during this period, it would be presumed that the State Government/Union Territory has recommended the Project.

4. Number of instalments for release of grants has been reduced to 1 for the projects upto Rs.1 lakh and to 2 for Projects exceeding Rs. 1 lakh.

5. The period of functioning for eligibility for grant-in-aid and of a minimum 3 years experience for an NGO seeking grant-in-aid has been revised as given below:

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|---|---|
| For Projects for Rs. 5 lakhs & above | 3 years |
| For Projects for Rs. 1 lakh & above but below Rs. 3 lakhs | 2 years |
| Below Rs. 1 lakh | 1 year |

ANNEXURE

LIST OF PARTICIPANTS

| Sl. No. | Name, Designation & Address | Phone No. (O) (R) | Telex/Gram |
|---|---|---|---|
| 1. | Dr. Jogesh Chandra Das,<br>Asstt. Director Health Services,<br>Government of Tripura,<br>Health & Family Welfare Department,<br>AGARTALA (TRIPURA). | | |
| 2. | Dr. Daya Shankar,<br>Joint Director (Urban),<br>Family Welfare Directorate<br>Government of Uttar Pradesh,<br>LUCKNOW (UTTAR PRADESH). | | |
| 3. | Chief Medical Officer (FW),<br>Delhi Administration-Delhi,<br>5, Sham Nath Marg,<br>Delhi -110 054. | | |
| 4. | Dr. Y.S. Sadananda Singh,<br>State Family Welfare Officer,<br>Government of Manipur,<br>Secretariat: Health Department,<br>MANIPUR. | | |
| 5. | Shri Kuldip Kumar,<br>Director Health Services (FW),<br>Government of Haryana,<br>CHANDIGARH. | | |
| 6. | Dr.(Mrs.) Harbir Bajwa,<br>District Family Welfare Officer,<br>U.T. OF CHANDIGARH. | | |
| 7. | Dr. V. RUGMINI,<br>Addl. Dir. of Health Services (FW),<br>Government of Kerala,<br>Thiruvananthapuram (Kerala). | | |
| 8. | Smt. Girija Vaidyanathan,<br>Project Director (IPP-V),<br>Govt. of Tamil Nadu,<br>Health & FW Deptt.<br>51 E.V.K. Sampath Road. Madras-7. | 837386 (R)<br>56755?(O) | |

## LIST OF NODAL OFFICERS

| Sl. No. | Name, Designation & Address | Phone No. | Telex/Gram |
|---|---|---|---|
| 9. | Dr.(Mrs.) N. Mohd. Ali,<br>Chief Medical/Superintendent<br>of G.B. Pant Hospital,<br>Port Blair, A. & N. Island. | 20564 | |
| 10. | Dr.(Miss) Bala Rani Cintury,<br>Jt. Dir. Health & F.W. Deptt.,<br>Government of Sikkim,<br>GANGTOK-737 101. | | |
| 11. | Shri Ved Parkash,<br>Collector,<br>Dadra & Nagar Haveli,<br>Silvasa. | | |
| 12. | Dr. S.K. Senguota,<br>A.C.S. Dy. Secy. to the Govt. of Assam,<br>Health & F.W. Deptt.,<br>Assam Sectt.,<br>Disour. | | |
| 13. | Shri G. Sethuram,<br>Health Education Officer,<br>Directorate of Family Welfare,<br>Govt. of A.P.,<br>Hyderabad (A.P.). | | |
| 14. | Dr. Brij Mohan,<br>Director (Project),<br>Health & F.W. Deptt.,<br>Govt. of H.P.,<br>Shimla. | | |
| 15. | Dr. R.A. Siddiqui,<br>Director,<br>Public Health & FW Deptt.,<br>4th Floor, Satpura Bhawan,<br>Govt. of M.P., Bhopal (M.P.); | | |

LIST OF NON-OFFICIAL OBSERVERS

Sl. No. Name, Designation & Address of Observers. [illegible]

16. Shri Paramananda Pandey,
Jt. Secy., Health & FW Deptt.,
Govt. of Orissa,
Bhubaneswar. 533276

17. Dr. Puran Singh Jassi,
Jt. Dir.(Fw),
Dte of Health & F.w.,
Slo No.419-420, Sec 35-C,
Himalaya Marg,
CHANDIGARH.

18. Dr. D.C. Badade, 145 507(Telex)
Addl. Dir. of Health Services(FW,MCH & SH), FPPN-IN
Family Welfare Bureau, ADDIRRAM(Grams)
(Kutub Kalyan Karyalay),
Kutub Kalyan Bhavan,
Pune.

19. Dr G. Rangaswamy
Deputy Director(FW),
Health & Family Welfare Deptt.,
Govt. of Karnataka,
Bangalore.

20. Dr. Prakash B. Nadkarni,
Chief Medical Officer (FW & MCH),
State Family Welfare Bureau,
Campal, Panaji,
Goa-403 001.

21. Assistant Secretary,
Department of Health & Family Welfare,
Family Welfare Branch,
P-16, India Exchange Place, CIT Buildings., (Annexe)
Calcutta -12.

22. Shri P.R. Ramanathan,
Health Secretary,
Govt. of Pondicherry,
Pondicherry.

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LIST OF NODAL OFFICERS

| Sl. No. | Name, Designation & Address | Phone No. | Telex/Gram |
|---|---|---|---|
| 23. | Dr. B.M. Rana,<br>CMO, Govt. Hospital Daman,<br>Daman & Diu Administration,<br>Daman. | | |
| 24. | Shri ~~G.N. Bahadur~~, Indu Bhushan, Dir (IEC), o/o. Addl Health Services<br>Health Secretary,<br>Govt. of Rajasthan,<br>Jaipur. | | |
| 25. | Shri L. Jamir,<br>Health Secretary,<br>Govt. of Nagaland,<br>Kohima. | | |
| 26. | Shri H.V. Lalringa,<br>Health Secretary,<br>Govt. of Mizoram,<br>Aizawl. | | |
| 27. | Shri G.P. Wahlamg,<br>Health Secretary,<br>Govt. of Meghlaya,<br>Shillong. | | |
| 28. | Shri H.L. Kadalbiju,<br>Health Secretary,<br>Govt. of Jammu & Kashmir,<br>Jammu. | | |
| 29. | Smt. N. Shenoy,<br>Secretary (FW),<br>Govt. of Gujrat,<br>Ahmedabad. | | |
| 30. | ~~Shri G.S. Kang,~~<br>~~Health Secretary,~~ Dr. S.P. Singh<br>Govt. of Biher, Director (F.W)<br>Patna. | | |

Other important recommendations of the Working Group at the Regional Meeting of Voluntary Sector at Goa held on the 3rd and 4th October, 1991

a) Spacing methods should be stressed upon in preference to the permanent (sterilisation) methods.

b) Programmes should be based on felt needs of the community.

c) NGO's Projects may be considered to implement some of the Income Generating Schemes for project areas.

d) NGO's may be made depot holders for distribution of ORS and safe disposal kits.

e) To develop an effective reference system NGOs should share the responsibility and they should coordinate the community and health workers.

f) NGOs should be taken into confidence and actively involved in action planning and policy matters.

g) Consultancy services for smaller organisations by competent bodies should be provided i.e. Government can use NGO's channel to approach the grass root level.

h) NGO's should also have accountability and keep clear records for sanction of grant and schemes.

i) Criteria for release of grants and continuation of Family Planning Schemes need change of targets or criteria for monitoring.

j) Follow-up should be done when time bound schemes are over so that they are sustained further some way.

IV.

# Report on National Workshop on Role of Voluntary Organisations in Health Care Delivery

**New Delhi: January 4-5, 1988**

**DIRECTORATE-GENERAL OF HEALTH SERVICES**
Ministry of Health and Family Welfare
Government of India
Nirman Bhavan, New Delhi: 110 011
and
**THE VOLUNTARY HEALTH ASSOCIATION OF INDIA**
40 Institutional Area, (behind Qutub Hotel)
New Delhi: 110 016

# FOREWORD

The National Workshop on the Role of Voluntary Organisations in Health Care Delivery was organised in January, 1988. The co-operation of voluntary agencies with government organisations to achieve Health For All (HFA) by 2000 A.D. has to be stepped up to ensure and enlarge the scope of community participation. This is an area where voluntary organisations have shown considerable enthusiasm with their motivation and personalised approach. National Health Policy of 1983 by the Government has also emphasised the importance of involving voluntary organisations in health care delivery.

This workshop was convened in order to make best use of the natural strength of voluntary sector in the delivery of health services. Besides, Workshop emphasised the ways and means to promote full participation of the Govt. with the voluntary sector in health care delivery.

RAM NIWAS MIRDHA
MINISTER, HEALTH & FAMILY WELFARE
GOVT. OF INDIA

# BACKGROUND

In India, voluntary organisations have a long tradition of providing health care. Voluntary organisations have many positive aspects: they are close to the people, responsive to their needs, economical, and are able to attune to local conditions quickly and effectively. Not surprisingly, they are popular and most of the health care services especially in remote and underserved areas are provided by them.

The government has realised that voluntary organisations are indispensable allies in the delivery of health care not only because they supplement government resources but also because there is much to be learnt from their experiences, expertise and innovative ventures. The government has also realised that to date no systematic efforts have been made for establishing proper rapport and coordination with voluntary organisations and evolving processes for effectively integrating their efforts and activities into the national health care delivery system. This collaboration between government agencies and voluntary organisations can succeed only if there is open two-way communication. The need to facilitate such a dialogue between representatives from the voluntary as well as government sectors and to work out the mechanisms of future collaborative arrangements between them in the field of health care delivery was also recognised. With this end in view, a National Workshop on "Role of Voluntary Organisations in Health Care Delivery" was organised by the Directorate General of Health Services, Government of India, at Vigyan Bhavan, in New Delhi, on January 4-5, 1988.

# OBJECTIVES

The main objectives of the workshop were:

1. To review the roles of various voluntary organisations working in the health sector engaging in alleviating human suffering and promoting health and quality of life.

2. To identify the priority areas of voluntary participants in the context of health for all by 2000 A.D. and

3. To work out a tentative programme of voluntary participation indicating its nature, thrust areas, role of government agencies in supporting such participation etc.

# PARTICIPANTS

The participants of the workshop were drawn from those voluntary and government sectors which are engaged in the field of health care delivery. Also included among the participants were health administrators, policy planners and representatives from international organisations. (A list of the participants and their addresses is given in Annexure I).

The workshop was organised by Dr. S.C. Sharma, Asst. Director-General of Health Services, (Health Administration), on behalf of the Director-General of Health Services, as the organising secretary of the workshop.

# INAUGURAL SESSION

The workshop was inaugurated by Shri P.V. Narasimha Rao, Union Minister of Human Resource Development and Health and Family Welfare. Dr. G. K. Vishwakarma, Director-General of Health Services, Government of India, welcomed the Chief Guest and the participants. In his welcome address, Dr Vishwakarma gave a brief overview of the present health care system in India. He described the problems in the existing health care delivery system and reiterated that voluntary organisations can play a very important and a significant role in evolving suitable strategies in this area. He referred to the government sector and the voluntary sector as two important pillars on which the entire health care delivery system in India depends. Introducing the theme of the workshop, Dr Vishwakarma raised certain vital issues pertaining to (a) identification of areas of collaboration and cooperation among government agencies and organisations working in the voluntary sector in the health field (b) need for evolving appropriate mechanisms for future collaborative arrangements between them and (c) areas which need priority attention in the field of health care delivery, to be examined in the deliberations of the workshop.

Shri S.S. Dhanoa, Secretary, Ministry of Health and Family Welfare, in his key-note address stated that voluntary agencies have a great tradition of providing health care services and are doing pioneering work in the health field. He also pointed out that the voluntary sector is fulfilling an important role in health care. He stressed the need for encouraging them as they elicit greater people's participation. He then drew attention to a number of well-known health agencies from the voluntary sector viz., Indian Red Cross Society, Hind Kusht Nivaran Sangh, Family Planning Association of India, Bharat Sevak Samaj, etc. which have made many contributions in the health field and are providing health care services to the people in different ways. He then dwelt on the type of services rendered by the voluntary organisations in the field of health viz., (a) advancing health legislation, (b) health education, (c) supplementing work of official/goverment agencies, (d) demonstration/experimentation, and (e) pioneering efforts/innovations. He stated that sincere efforts must be made to understand the message that lack of health education and awareness in our country gets further accentuated due to illiteracy, particularly in the remote rural and tribal areas. Shri Dhanoa reiterated that this is where the role of voluntary agencies becomes crucial for the success of various health and family welfare programmes. He also stressed the need for the voluntary organisations to share the growing burden of the government in efficient implementation of health care programmes. Shri Dhanoa concluded his key-note address by saying "There is no denying the fact that medicine is not entirely an academic, physical or biological science but is intimately related to sociology, economics and indeed politics and in our set-up, the existence and vital role of voluntary health agencies cannot be disputed".

Inaugurating the workshop, the Hon'ble Minister, Shri P.V. Narsimha Rao said:

"I welcome you all to the first ever workshop, and I stress the word 'workshop', organised in the health care sector which I have the honour to inaugurate. I am stressing

the word workshop because we have any number of seminars, we have any number of meetings and so on where excellent ideas and advice, would come, but a workshop, I believe, is a basically different thing. The activity here has to be entirely different and the results which one could expect from such a workshop would naturally be different. While a seminar could be concentrated on a consensus of ideas and work, the workshop would bring out a concrete programme, ready in all respects to identify problems of health care and to be put into action with immediate effect. This is the difference and if this difference is appreciated I am sure you will not spend much time on the inauguration ceremony. You have very little time and the field is so vast. I am not sure you will be able to cover the whole of it. You have to spend usefully, every minute that is available to you and your practical experience in the field has to be brought to bear upon the subject which you are discussing.

We have heard of many voluntary organisations taking up family welfare programmes. In fact, they have played a pioneering role. However, the concept of family welfare has over the years undergone a change. It is not just a matter of asking the couple to adopt a family planning method and so on but it has to become a part of the larger and much more important subject of health of the people itself. So from that point of view the question which you will have to ask is whether the organisations which are engaged in family welfare programmes at the moment are in a position to extend their activity so as to take on the work entailing a wider concept of health of which family welfare is a part

"The second question is how you will get involved in implementing health care delivery programmes because so far the main components of health care were of only two or three kinds and mostly provided by the Government. We have the system of hospitals, we also have the institutions, mainly operated by the Central Government and State Governments at various levels. This has been the pattern so far. Now if I do know the objective of this workshop correctly and if I do know the work also correctly I must say our roles have to be reversed. It is not easy to reverse the roles. It is observed that the non-government organisations have been doing good work in their own limited sphere which has gone to help the efforts of the Government. Thus, the Government happens to be the main doer at the moment. Now government would have to take a different role and so we help you in doing it and you make it your own programme. Is it practicable for you? I am very clear in my mind that if this is possible it is very desirable that it should be done. We have not been able to do it to our satisfaction, in this meaningful form before, but we should think of doing this. I am sure you will give ideas and a concrete Plan of action.

"I would say there are three kinds of programmes. First the institutional programme, even voluntary organisations have been doing these; they have been running hospitals, they have been running dispensaries, they have been holding Eye Camps and all kinds of programmes, programmes of an institutional or semi-institutional nature. The second kind is the promotional programme. Now, a promotional programme is both easy and difficult. The question is : how do you promote a programme, the basis on which to administer the programme etc. Promotional programmes by themselves will not make

an impact unless they are buttressed and followed by actual activities suggested in the programmes. The third is the educational programmes. There is a difference between them. We in the Educational Department, the NCERT and other institutions including the State Governments have now taken up a massive reorganisation of books and curricula. I have been insisting that the health component should figure in a big way there. It is indeed very important that a child knows how to safeguard his health; care of the eyes, care of the ears, care of the teeth, and so on. We had such lessons 50 years ago but it has to be done in a different way now. The NCERT does it by including in the curricula the component of environment. How do you deal with population? How do you deal with small family norms not at a primary stage but in later classes? So these methods are being looked into very seriously by the NCERT, and the Department of Education and they are making it a part of the school curricula directly as well as indirectly. It is not merely a lesson but a very important question on environment. It is not enough that you include one or two lessons on the subject. It is easier said than done; but we are tackling that problem. Now it is not under the Health Ministry or the organisations working in the health field. This is what this School Health Programme for instance is. I have been Minister for both. So I have taken both these in a very serious manner. And we are grappling with them for more than a year and now we have been able to find a frame in which the school health programme can be started and implemented in this country. If that one subject is fully taken care of, I am sure your programme will become easier. So too the education and school health programmes — these are a gist of all other programmes and these programmes are not of just the Health Ministry but also of the Education Ministry. So the coordination and integration between health and educational sectors are of the utmost importance. You will like to liaise with schools in those areas, with students and teachers. Indeed the ICDS programme is again a basic programme. It is not under the Health Ministry. But it is not enough to say that this is not under the Health Ministry. So the whole thing becomes one big subject which the Prime Minister has called Human Resource Development.

"Now we have been asked so many questions with regard to smoking. One poster has come in the newspaper 'Made for Each Other: Smoking and Death'. It is a very effective poster. If one poster can move people, how bad smoking is and how cancer is going to be the result of smoking the same thing can be done by voluntary organisations in a thousand ways. We do not arrogate ourselves all rights to educate the public. This is one thing you have to do. The voluntary organisations should say that for the next two or three years we will take up only education programmes. With the experience available at the field level if you take up at least education programmes in curricula, it will be enough. Doordarshan is giving good coverage. The time has come when you have to diversify the programmes. People do not want to see the same thing again and again. Now Mrs. Rami Chhabra has raked her mind for this. But somebody must rack his mind now on the health side on issues such as vaccines, immunization programmes etc. For instance, if voluntary organisations can help us in the implementation of immunization programmes. If you are a voluntary organisation with few resources, you can go to government hospitals here and there, they have resources, take the children there. You deal with children, we deal with adults. I am giving just one example where Government and voluntary organisations could come together. There need not be a duplication.

"Take a block, depending upon the areas where you are functioning, and try to design location specific and needbased practical action plans of a problem solving nature. I am not in favour of seminar after seminar, workshop after workshop. Let us take the recommendations emerging out of such workshops and put them in action. If you give one concrete idea for developing appropriate health care programme in tribal areas, that alone will do for the present. Tribal areas are the areas where nobody wants to go. So we should begin earnestly in that area. This is what voluntary organisations can do without much money because we do not have so much money. Let us not think of schemes which will immediately cost money. Right now this year and in this Plan, things are very tight. You give me ideas for the next Plan because the planning, the thinking for the Eighth Five Year Plan is starting right now. This is the time when you should say if this programme can be taken in the 8th Plan, it will be very good. Think in terms of what is immediately convertible into a programme at the field level and what we can do. We will certainly call a meeting of the State Ministers, our people can go, liaise with the voluntary organisations in that area. We can get people together and see what can be done to immediately put it into action. That is the real thrust of the workshop. I will not take too much of your time. If anything is going to come as a concrete programme, we would be very happy to put it into action within the budgetary provision we have.

"I am very happy to inaugurate this workshop. I hope we will come out of the workshop with all the paraphernalia of a 'real workshop', coming out of the workshop, not going into a workshop coming out of the workshop with oil, grease, etc. I wish your deliberations all success. Thank you very much."

Dr A.K.Mukherjee, Additional Director-General of Health Services, proposed a Vote of Thanks.

After the inauguration, the workshop was conducted in Plenary Sessions as well as in Working Groups.

# PLENARY SESSIONS AND WORKING GROUPS

## Plenary Sessions

Three plenary sessions were organised, two sessions on the forenoon of 4th January, 1988 and the third session on the forenoon of 5th January, 1988. Each plenary session was addressed by eminent scientists/experts/workers actively engaged in that specific field. Each address was followed by discussions and clarifications. The first plenary session was addressed by Dr Harcharan Singh, Prof. D.Banerjee, Dr Samir Choudhury, Shri E.P.G. Haran and Dr A.K.Mukherjee. The session was presided over by Prof. Ashish Bose. The second plenary session was presided over by Mr Bunker Roy and was addressed by Smt Avabai B. Wadia, Shri Alok Mukhapadyay and Shri P.K. Uma Shankar. The third plenary session was addressed by Dr (Mrs) Shanti Ghosh, Prof. B.N.Tandon, Mr Bunker Roy, Dr Almas Ali, Dr M.I.D. Sharma and Mrs Rami Chhabra. The session was presided over by Smt Avabai B. Wadia. (See Annexure II for the details of the procedings).

## Reference Materials

The participants were provided with reference material. Considering the time limitation in covering the plenary sessions in detail, it was considered important to provide some relevant reading material (See Annexure III).

## Working Groups

After the two plenary sessions of the first day, the participants were divided into three working groups and were assigned the following tasks :

*GROUP I: Working Group for drafting plan of action and modalities of cooperation between the Voluntary Organisations and the Government of India.*

(i) To identify priority areas of cooperation for Family Welfare and Primary Health Care Programmes.

(ii) To identify inputs – materials, manpower, etc; and

(iii) To formulate plan of action indicating guidelines, format of proposals, periodic reporting, nature of feedback etc.

*GROUP II : Working Group on training requirements*

(i) To identify the topics and areas of training

(ii) To identify trainers/core-faculty from voluntary organisations for various topics

(iii) To specify provisions of Scholarship/Fellowship for training of personnel of Government and Non-Government organisations

(iv) To explore the possibilities of financial assistance to training institutions for imparting training in specific courses; and

(v) To suggest ways and means of procuring and preparing publications, technical reference materials, books, manuals etc

*GROUP-III : Working Group on administrative matters*

(i) To identify and consider administrative problems and make suggestions for remedial measures

(ii) To indicate norms of grant-in-aid to the voluntary organisations; and

(iii) To work out a uniform service pattern in voluntary organisations with regard to the Primary Health Care Programme

These three working groups deliberated separately on the afternoon of 4th January '88 and forenoon of 5th January '88 and drafted reports/recommendations in respect of the themes mentioned above. Major emphasis was laid on group discussions to thrash out relevant recommendations about the directions and modalities in which future relations between the government and voluntary organisations should be developed.

## Pre-valedictory Session

At the plenary session preceding the valedictory function on January 5, 1988, the group reports along with their recommendations were presented and discussed. This session was presided over by Smt Avabai B. Wadia.

## Valedictory Session

The Valedictory function was held at 4 pm on January 5, 1988 and was presided over by Prof. S.N. Choudhury. The valedictory address was to have been delivered by Ms Saroj Khaparde, Minister of State for Health and Family Welfare, Government of India. As she could not be present, a representative from the Directorate of Health Services, Government of India, read the address on her behalf. The address, which constituted a fitting finale to the deliberations of the workshop is as under :

"I would like to express my pleasure in addressing the Workshop On Role of Voluntary Organisations in the field of Health Care Delivery.

"India is a vast country, and has several distinct diverse geographic zones. Multiple ethnic groups add to the complicity of the situation. It is perhaps more than a Herculean task to make available comprehensive health care delivery services to its entire population of 776 million through the Government machinery alone. The task has become all the more difficult in view of our commitment to reach Health for All by 2000 AD – a target which is being monitored by the entire nation if not the entire world. I am absolutely clear that until or unless wider and universal voluntary participation is forthcoming our aim to achieve Health for All by 2000 AD will prove to be a mirage ever receding from the aspirations of the people. The organisation of this workshop is a small but important step in the gigantic task of providing our rural millions a package of comprehensive health care delivery services.

"As you know health has been given high priority in our daily life and the concept of health, including physical, mental, social and spiritual well being dates back to the Vedic period. This cherished value regarding health is enshrined in the ancient Sanskrit words 'Sarve Santu Niramayaha' which means 'let all be free from disease and let all be healthy'. Here I would like to quote our beloved late Prime Minister Smt Indira Gandhi's words: 'Life is not mere living but living in health. The health of the individual as of nations is of primary concern to us all. Health is not the absence of illness but a glowing vitality, a feeling of wholeness with a capacity for continuous intellectual and spiritual growth....."Health for All by the Year 2000" envisages strengthening of the public health programmes of developing countries, where most diseases are concomitants of economic backwardness.

"In this perspective, we have to understand that the health delivery system should not mean treatment of diseases alone. The concept of positive health must percolate to all so that the people are no longer dependent on the present day curative health centres and hospitals.

"The task before us is gigantic. The health movement has to be generated in order to educate and involve people to create an environment free of disease. It is in this area that voluntary agencies can play the most vital role. They have to educate and be the watchdog of the people's health problems. There are so many interventions which can be carried out by the individuals and the community in the health field at a negligible

cost. Our people are intelligent and capable of following good advice as has been shown in the agricultural sector where rural people have been very quick in adopting new techniques in agriculture, leading to the green revolution. I am confident that if proper attention and results are shown with dedication in health fields, a great breakthrough will take place in the health scenario.

"The State Governments have already established a vast infrastructure for the health care delivery system. However, the benefits have accrued only to a few people as the health workers are lacking the motivation, the skills and the knowledge to function in the communities where they are posted. This gap has to be bridged. Voluntary agencies can play a vital role in this area. Training programmes suited to the local conditions can be formulated and taken up for the improvement of the health delivery system.

"Another major thrust needed is change in the attitudes and beliefs of the communities. This change can be brought about only by a band of dedicated voluntary workers outside the rules and regulations of the Government system. It involves a total involvement with the community, speaking their language, eating their food and living with them which can be possible only if this challenging role is taken up by the voluntary agencies.

"We must not confine ourselves only to the health field but must broaden our vision to the health related sectors which have a direct bearing on the health of people, like family welfare, immunisation programme, income generation, potable drinking water, sewage disposal and literacy, specially amongst women. Voluntary agencies can take up integrated projects for community upliftment with health as one of the components. If the income level of the people improves, automatically there will be an impact on the health status.

"We should not neglect our own traditional methods of treatment of ailments and indigenous systems of medicine should also be encouraged in areas where people have faith in these systems. Yoga should also be encouraged, specially in schools, to keep the young healthy. Health education should be taken up in a big way to provide information on prevention of diseases as prevention is better than cure and with limited resources, this would be the best approach. Voluntary organisations can play a crucial role in spreading the messages of health, specially in the rural and remote areas.

"I would urge voluntary agencies to take up integrated programmes of income generation, creches, school health programmes, and formation of youth and mother clubs. I would also urge voluntary agencies to sincerely draw up programmes to supplement and compliment the efforts of the Government of India and State Governments in the delivery of health care.

"I have been told that there have been group deliberations on this important subject and some important recommendations have been framed. I hope all these aspects have been taken care of in the deliberations and group work. I would like to assure that these

recommendations will be given due consideration by the Government of India. We now need to evolve a machinery and methodology so that the energies and expertise of voluntary organisations could be channelised through approved schemes of logistic, financial and technical support so that Government machinery and voluntary organisations can go hand in hand to ensure wider and universal voluntary participation in all areas of health care and delivery."

At the plenary session of the valedictory function the consolidated report embodying the recommendations of all the three working groups were presented by the rapporteur-general Dr Almas Ali, and discussed.

The recommendations, as approved by the plenary session, are as follows.

# RECOMMENDATIONS

1. Voluntary organisations (VOs) can assist in identifying needs and priorities of people at the grassroots level and help communicate them to policy makers and planners in the Government. Forums should be made available so that on the one hand, planners have access to ideas about people's needs, and on the other hand, grassroots level workers are able to influence and shape policies with regard to their own health. Voluntary Organisations can thus play an advocacy role, presenting people's needs and interests to the Government.

2. Government should understand, collaborate and co-operate with and support all V.os activities which reflect people's aspirations and relate to the goal of health for all. Under no circumstance should the Government try and impose its policies, programmes and targets on V.os. A mutually acceptable and flexible approach should always be worked out. Broader goal of health for all should be kept upper most in all efforts of Government and V.os collaboration.

Target-oriented terms for the award and release of grants should not be made a pre-condition. The voluntary organisations should be given freedom to operate in their own style within the confines of the national objective of achieving health for all by 2000 A.D.

3. Selective core funding should be made available to V.os so that they can maintain a minimum staff for long-term security and continuation of activities initiated. Maintaining an up to-date register of all V.os could be one method of ensuring that all V.os including small ones and those in remote areas, have equal access to this funding. Priority for this core funding should be given to V.os working in remote, under-served areas, and with the poorest and most backward communities (e.g. tribals, hill people, women, Harijans).

## 4. Identification of Inputs

(i) Basic core funding support should be available to V.os from the Government, as maintained earlier.

(ii) Voluntary agencies (Volags) can assist in selection and training of health personnel at the community level.

(iii) Volags can help to develop curricula and training programmes suited to community needs. They can also assist in in-service training.

(iv) Government and Volags networks and inputs can be used to develop effective referral systems at the grassroots level.

(v) Volags can work towards developing a base of health awareness in the community through health education. This should be undertaken especially among the most disadvantaged groups (e.g. women, tribals).

(vi) Volags can contribute their organising skills to spread health awareness about specific local health problems (eg. guinea-worm, goitre, leprosy etc.). In this they can involve educational institutions like schools.

(vii) Volags can help to disseminate information about existing government programmes and facilities. For people at the grassroots level, this would include information on people's rights, specially with regard to their health.

(viii) Government can set up a mechanism to provide volags with up to-date information on existing national and State programmes, policies and facilities. Information generated at various levels by Health Services Research and Primary Health Care workers and volags should be passed on to a national centre for health literature information, namely the National Medical Library (NML) which in turn will repackage it for wider dissemination.

(ix) Government can provide grants to volags to produce health education material which are locally relevant and suited to people's needs. Volags can help to develop new locally relevant ideas on health education, communication and programmes.

## 5. Formulating a Plan of Action

The group felt that it was unable to develop detailed action plans, guidelines and systems due to lack of time. It was felt that further representation from more volags working in rural and tribal areas of States would be necessary. However, a few issues that were raised are outlined below:

(a) A small group of representatives from a wide range of volags should be considered to assist Government in developing a plan of action for further collaboration and cooperation. This would also include examination of current policies, plans and programmes. It will also serve a kind of "listening post".

A separate small group of a few voluntary organisations, Government agencies and other institutions may be formed to work out the modalities of administrative relationship between the Government and voluntary organisations in matters such as release of grant-in-aid, accountability etc.. This may be completed within a period of six months.

(b) Funding should be decentralised and procedures simplified, so as to ensure easier co-operation.

(c) Volag networks or nodal agencies at the State level, with contacts in remote regions can assist the government in identifying volags who are also working in primary health care and toward the goal of health for all. This identification would help both for funding purposes and for collaboration in various primary health care programmes.

(d) In the light of the present problems in the matter of coordination and collaboration, Government should encourage better State level coordination between volags working for primary health care and the State Government.

(e) Volags should assist the Government in developing a more broadbased approach through health care delivery as opposed to the current target-oriented care.

6. Health for All as a social goal has to be integrated with social and economic goals and hence health strategies should be dovetailed with overall social development strategies. It is thus important that there is effective coordination between health and its closely related sectors like education, agriculture and food, safe drinking water supply, environmental sanitation and other rural development activities. Government should therefore encourage voluntary organisations to undertake integrated health and development projects with multi-sectoral approach towards fuller and complete socio-economic development. Mechanisms should therefore be evolved to have standing interministerial committees within the overall responsibilities of Ministry of Human Resources Development. This will ensure a "single window" approach as well as ensure receiving support for the activities of the organisation by pooling the resources of various ministries under the Human Resource Development Ministry.

This integrated approach should be made applicable at the State, District and also Block levels.

7. A follow-up meeting to this workshop should be held after a period of about six months to review the progress with regard to implementation of the above mentioned recommendations.

8. It was brought out that in the Coordination Committee meetings on particular project of collaborative nature, attendance is either very inadequate or nil. As a result of this, decisions are kept pending and the programme objectives suffer. The recommendations in this regard is that the attendance of Government members should be made obligatory. Coordination Committees at the district and State levels should be attended by the Director of Health Services. If he is not available then a senior officer should be deputed. Such Coordination Committees at the district level should be represented by all voluntary organisations of that district.

9. Possibility of holding regional workshops should be explored.

10. Annual meetings of voluntary organisations may be held at the national level for general review.

11. Possibilities to allocate definitely prescribed areas for voluntary organisations could be considered as is done in Maharashtra and Gujarat in small scale, not with an idea of privatisation of health services but with a view to communitise the health programmes and make them more participative in future.

12. There is a need to review the norms for giving grants-in-aid, keeping in view the inflation and the norms being practised in a particular State. The budget for a block period of three to five years should be approved at the stage when the project is cleared. Seventy-five percent of annual grant should be released directly in advance to voluntary organisations and the remaining twenty-five percent be released on fulfilling other conditions. Wherever the funding has to be routed through the State, to eliminate delay, the Centre and States should work out a streamlined process for quick release of the funds.

13. A cell in the Directorate General of Health Services (DGHS) should be created to coordinate with the voluntary organisations.

14. A Directory of Resource Profile of voluntary organisations indicating the area of activities, manpower, expertise, source of funding etc. could be prepared at the cost of the DGHS.

## 15. Training

(a) The following categories of personnel need to be trained:

*Health Sector:* Dais, village health guides, multipurpose workers, trainers of multi-purpose workers.

*Education Sector:* Adult education teachers, non-formal education of teachers, early childhood Care Centres and Creches.

*Social Welfare Sector:* CDPO supervisors, Anganwadi workers.

*Panchayats and Zila Parishad:* Village level workers and Members of Panchayats and Zila Parishads.

*Community Organisations:* Members of Youth Clubs and Mahila Mandals, adolescent girls, young women and opinion leaders.

*Development Department:* Functionaries at village and Tehsil level, Public Health engineers and low cost sanitation workers, Officials of agricultural department and extension workers.

(b) Topics will vary with the types of department workers, nature of functionaries, their job description and responsibilities. However, topics of health care elements, concept of health and medi-care elements of socio-economic development, National Health Programme/Health Policy, community based rehabilitation should be covered. In addition topics like managerial aspects viz. communications skills, leadership, motivation, team building, materials management, personnel management and logistics should receive special emphasis.

(c) Voluntary organisations involved in field level training should have to their credit service programmes, which are current and also have considerable past experience in the field of primary health care. They should share experiences of their own as well as make available the experiences of other service groups in the area. The training agencies should be competent with considerable experience and should have requisite number of qualified personnel for training. Such training institutions should have effective and appropriate linkages with service and training organisations within the regions both governmental and non-governmental in nature.

(d) The groups having realised that equal opportunities to voluntary organisations are not available in the form of fellowships, and scholarships for training within the country and abroad, it is strongly felt that adequate provisions be made, both monetary and procedural, so that trainers from the voluntary organisations would have equal opportunity to get exposed to the educational technology and experiences in primary health care workers training programmes within the country, as well as abroad.

(e) Some voluntary organisations have developed the competence to organise training programmes of a specific or general nature for various levels of functionaries involved in primary health care in an innovative and anticipatory manner. Full utilisation of such facilities should be made for training of government functionaries as well. This would lead to appropriate change in the orientation of government functionaries and expose them to various important elements of primary health care in the form of community participation, leadership, team building and skills etc. They would indirectly develop a positive attitude to the contributions made by the voluntary organisations so as to provide them equal partnership in the health care delivery at the peripheral levels.

(f) The group felt that adequate and effective support to voluntary organisations for organising training programmes in which they have competence and capability has not yet been sufficiently available from the State and Central Governments. Training being an essential integral part of the health manpower development, needs provision of increasing resources both at the Central and State levels to augment and strengthen the voluntary organisations training capabilities. This will not only include financial allocation from the Central and State Sectors but would also imply provision for availability of material resources from the international agencies at par with the Government system running similar programmes.

(g) A number of members observed that educational material and other publications required for training programmes are available with different voluntary organisations. However, proper mechanisms for sharing of this training material have not yet been developed. Similarly though the voluntary organisations have the appropriate expertise to prepare educational material required for training of primary health care workers, they do not have enough support and opportunities to a very large extent for getting involved in preparation of such material. The group felt that the Central Government should make specific provisions for promoting interaction between voluntary organisations and Government training centres for sharing the education material already available and to

innovate, develop and prepare new education material for training purposes. This would help in identifying voluntary organisations involved in preparation of education material of a specific nature which could be useful at regional and sub-regional levels in a manner that would avoid duplication of efforts and resources. In addition to these, a separate provision for developing educational material and training of trainers in educational technology so that voluntary organisations interested in getting involved in such activities could be provided sufficient amount of funds. Training materials are indispensable for the success of any training programme. Government should offer substantial financial assistance both at the Central and State levels for facilitating the publication and training requirements relevant to primary health care.

V.

# NATIONAL CONFERENCE OF VOLUNTARY ORGANISATIONS ON FAMILY WELFARE

( 25th September, 1986 )

AGENDA

MINISTRY OF HEALTH AND FAMILY WELFARE
DEPARTMENT OF FAMILY WELFARE
NEW DELHI

MINISTRY OF HEALTH AND FAMILY WELFARE
(DEPARTMENT OF FAMILY WELFARE)

# AGENDA NOTES

FOR

NATIONAL CONFERENCE OF VOLUNTARY ORGANISATIONS

ON

25.9.1986

AT

9.30 A.M.

AT

VIGYAN BHAWAN NEW DELHI

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AGENDA ITEMS FOR THE NATIONAL CONFERENCE OF VOLUNTARY ORGANIIONS TO BE HELD AT VIGYAN BHAVAN, NEW DELHI ON 25.9.1986

1. Review of action taken on the decisns of the last Conference held on 4.9.1985.
2. Involvement of Voluntary Organisations for motivational, educational Communication and service delivery aspects for the promotion of Family Welfare Programme in rural /less-served areas and urban slums.
3. Need for grants to be given for flexible programming but with defined goals.
4. Integration of Family Welfare with Social Welfare and Developmental Programmes.
5. Provision of training facilities for Voluntary Workers.
6. Streamlining the procedure for grants-in-aid to Voluntary Organisations.
7. Revision of the prescribed rates of grant-in-aid as per the approved pattern.
8. Evaluation and feed-back in respect of the work done by Voluntary Organisations.
9. Making the latest research findings reports available to Voluntary Organisations for more effective implementation of the Family Planning Programme.

NOTES ON AGENDA ITEMS FOR THE CONFERENCE OF VOLUNTARY ORGANISATIONS TO BE HELD AT VIGYAN BHAVAN, NEW DELHI ON 25.9.1986

ITEM NO.1: Review of action taken on the decisions of the last Conference held on 4.9.1985.

1.1. At the last Conference held on 4th September, 1985 the participating Voluntary Organisations were unanimous in recommending:

(i) Expansion of activities at grass-root levels.

(ii) Taking the Family Welfare Programme to the interior rural areas and urban slums by the Voluntary Organisations.

(iii) Participation of more and more Voluntary Organisati in the Programme.

(iv) Integration of Family Welfare with other Social, Welfare and Developmental Programmes.

The Voluntary Organisations hopefully would have put these suggestions into action.

1.2 Various other important suggestions made at the last Conference have also been given due consideration by the Government, and, whereever feasible, suitable action has bee taken:

(i) A Standing Committee for Supporting Voluntary Acti in Family Welfare, consisting mostly of voluntary workers, has been constituted (vide Notification at Annexure-I). The Committee would provide consultancy services, identify Voluntary Organisations which could promote F.W. activities in ru areas and urban slums and recommend financial and other support.

(ii) The State Governments would be advised to set up similar Committees at the State level. This set-up will be institutionalised by constituting similar Committees at the District level also.

(iii) The Family Planning Association of India to whom grants had been released to set up a small consultancy and have a rolling fund of Rs. 5 lakhs for inducting smaller Voluntary Organisations into the F.W. Programme, have sanctioned two projects under the Scheme. (This scheme can be considered for extension to other National Level Organisations after analysing the experience of the outcome of the grants released to the FPAI).

(iv) Voluntary Organisations are being encouraged to take up the Maternal and Child Health (MCH) and Immunization Programme as a part of the Family Welfare Counselling along with their Family Welfare activities.

(v) Series of meetings with other Ministries/Departments engaged in Social, Welfare and Developmental Programmes have been taking place to identify the areas of useful activity in relation to Family Welfare. A Technical Committee has been set up to draw appropriate models for inclusion of the F.W. Component in the training programmes of the functionaires of these Ministries/ Departments. They have also been requested to consider the desirability of issuing suitable instructions to the Voluntary Organisations engaged in their programmes so that they may use a certain amount of money, say, upto 5% of the total expenditure towards Family Welfare Programme.

(vi) The Scheme of instituting National Awards to Outstanding Voluntary Organisations (Rs. 1 lakh) and Workers (Rs.50,000) dedicated to promote Family Welfare is under consideration.

ITEM NO.2: Involvement of Voluntary Organisations for motivational, educational communication and service delivery aspects for the promotion of Family Welfare Programme in rural and less served areas.

2.1 A point has been reached now where the Family Welfare Programme is progressing steadily and promises to gather further momentum. This has been due to educational and motivational activities undertaken by the Governmental infrastructure and with the collaboration of Voluntary Organisations. In fact, it is envisaged to make Family Welfare a People's Programme duly accepted by the people in increasing numbers. Voluntary Organisations have a vital role in achieving this objective. They have participated in the past and demonstrated their effectiveness in the areas in which they have been serving. Problems emanating from infant mortality, ignorance and misconceptions about family planning methods, lack of scientific information about preventive and promotive measures to ensure health to all in the family, inaccessibility of services to the remote corners and concentration of the voluntary organisations in urban areas need to be considered for designing future action plans by the Voluntary Organisations.

2.2 The need for Family Welfare work and motivating the people to accept family planning services is much more in the village and in slums than in the cities. It is necessary that services to the rural and less-served areas are made available in the matter of health and family welfare education, information and motivation, provision of supplies, M.C.H. services and rudimentary medicines for common ailments; IUD insertions/sterilisations services/supply of contraceptives and immunisation services should also be made available in an acceptable and accessible manner. Voluntary Organisations should consider to extend their activities to the rural and less-served areas and plunge themselves into the country-side to reach the unreached. The leaders of village communities, despite their enthusiasm, are very often unable to take up programme and sustain their efforts for the welfare of the community due to paucity of resources, limitation of mobility and inadequacy of access to services. Many of them

are illiterate but with proper guidance from the Voluntary Organisations they can be made more useful to the community and also helpful in furthering the message under the family welfare programme.

2.3 The coverage of the rural and other less-served areas is limited at present perhaps due to organisational and financial constraints. It is necessary that there is greater interaction between the Government and the Voluntary Organisations so that the valuable experience and the knowledge gained by the Voluntary Organisations could benefit the entire Health and Family Welfare Programme undertaken by the Government. Where the Voluntary Organisations have resource constraints, financial support can be extended by the Government for expansion and consolidation of their activities.

2.4 The participants may discuss ways and means for expanding their activities to the rural and urban slums areas. Given hereunder are some suggestions for consideration:-

i) Many of the bigger Voluntary Organisations are running Mobile Clinics. They may be encouraged and persuaded to ado certain rural/slum area and extend their activities initiall through Mobile Clinics and, subsequently through rural Famil Welfare Outposts/Clinics.

ii) The Voluntary Organisations may be encouraged to adopt some remote and difficult areas for an all-round developmen and extension of Health and Family Welfare Programme. (The areas to be covered may be earmarked for coverage according to geographical jurisdiction by Voluntary Organisations, wh may be willing to undertake and carry on this work. No pat need be developed for such Voluntary Organisations but a lumpsum provision may be made by the Government for activit which may be specified.)

iii) N.S.S. Camps, which the people now perceive as a joi cooperative effort of the local community and the students

Association of India, Working Women's Forum etc. who have the potential to provide such services to the newer and smaller Voluntary Organisations, can play a great role in this matter. Much in this field is expected from the recently constituted Standing Committee for Voluntary Action (SCOVA) which shall provide the requisite consultancy services to draw up project proposals by the organisations working at grass-root level. A rolling fund of Rs. 5 lakhs has also been placed at the disposa of Family Planning Association of India to provide consultancy services and also to fund smaller organisations.

Item No.3:- Need for grants to be given for flexible programming but with defined goals.

3.1 The Family Welfare Schemes for financial assistance to Voluntary Organisations are mostly patterned schemes i.e. schemes under which grants-in-aid are given for specific Family Planning activities and in accordance with a pattern of assistance prescribed by the Government e.g. Sterilisation Camps Schemes, Post Partum Centres, etc. On the demand of the Voluntary Organisations engaged in the programme for giving some flexibility to them in their approach and implementation, a new scheme called 'Experimental/Innovative Projects Scheme' was started during the year 1981-82. Financial assistance is given under this scheme for projects not conforming to any particular pattern but which are viable and aim to provide motivation, communication, educational activities and services, or are otherwise of innovative nature. The keeness of the Government to popularise this scheme can be judged from the fact that the annual budget provision for this scheme which was Rs. 20 lakhs during 1983-84 and Rs. 40 lakhs during 1984-85, was raised to Rs. 90 lakhs during 1985-86 and a still larger amount of Rs. 140 lakhs, has been provided for this scheme during the current financial year.

3.2 The participants may discuss as to how best they can make use of this scheme. Certain suggestions mentioned in item-2 for extending the activities to rural areas and urban slums can also be considered to get grants under the scheme. The newly constituted SCOVA will also help the Voluntary Organisations in drawing up project proposals (costing Rs. one lakh and below).

3.3 Care should, however, be taken to ensure that the Projects are cost-effective. The Committee set up by the Government to draw up model schemes for the guidance of the Voluntary Organisatio is already working upon a model for intensive MCH/Immunisation Programme in urban slums. The objective of the Programme will be to extend the services under MCH/Immunisation Programme beyond the outreach areas. The Scheme when approved will be given wide publicity and tried on a pilot basis. The participants may like to discuss the areas in which they can successfully implement the Family Welfare Programme.

Item No. 4 : Integration of Family Welfare with Social Welfare and Developmental Programmes.

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4.1. The great strength of the voluntary sector is their voluntariness, commitment, dedication in the services they provide and closeness to the people they serve. They are also more responsive to the new ideas because they enjoy more flexibility in functioning as compared to the Government set-up. They are more effective in the community because of their relatively close contacts with the people and working in relatively informal setting while the programme put by the Government machinery is likely to be taken as a more formal programme and the corresponding acceptability may accordingly be relatively poor. Furthermore, the Voluntary Organisations enjoy greater confidence of the community because of the help they render in their socio-economic upliftment: this results in greater acceptability of the programmes by the community.

4.2. The number of Voluntary Organisations working for the welfare of the community is very large. Besides, Health and Family Welfare they are working in the fields of education, rural development, uplift of women, child care, etc. To quote some examples, Voluntary Organisations are actively associated with Adult/Non-formal/Early Childhood Education Programmes Development of Women and Children in Rural Areas (DWCRA), Training of Rural Youths for Self-Employment (TRYSEM), Integrated Child Development Service (ICDS) and various Employment Programmes etc.

4.3. These schemes in the main aim at poverty alleviation of people in the rural areas and improvement of habitat and physical quality of life and majority of the beneficiaries of these schemes are illiterate. The schemes require potential beneficia-ries to come to one place for either acquiring a skill or to work. The opportunity of their coming together could be utilised to reach the message and facilities of the F.W.Programme to these target groups. Various Voluntary Organisations of

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different types, working for different purposes and providing different types of services, have one thing in common viz., their reach to the community is very large. Because of the useful services that they provide, their workers have earned credibility and are in a position to spread the message of Family Welfare and motivate and pursuade the couples through their organisations.

4.4. The Voluntary Organisations are in a better position to promote social acceptance of later age at marriage, child spacing among couples where the wife is in her 20's, limitation of the number of children to two, preferably to be reached before the wife is 30 and, immunisation of mother and child/ children. Influencing social and cultural norms and tradition in order to prevent early marriages, reform of marriage customs including dowry and bride's price, promotion of female education and functional literacy, health education & child care (leading to higher child survival) and promotion of small family norm would also be easily attempted by the Voluntary Organisations.

4.5. The Voluntary Organisations engaged in different types of activities may discuss ways and means for integrating the F.W.Programme with their own activity with marginal inputs. It is not necessary that all Voluntary Organisations should provide clinical services; there are other activities like information, education and communication, population education etc. The main intention is to create awareness in the masses about the advantages of a "Small Family" norm and guide them to avail of the existing infra-structure of Health and Family Welfare. It would be ideal if they could become the outlets for the various contraceptives being supplied by the Government. Since the voluntary workers would be available within the vicinity and reach of young couples, they will be able to provide advice more frequently and intimately and guide the motivated couples to the Family Welfare Service Centres.

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4.6. Financial and/or technical support may be provided by the Government to such Organisations for integration of the F.W. Programme with their regular activities at the grass-root level. Help of SCOVA may also be taken to draw the project proposals.

Item No. 5 : Provision of Training facilities for Voluntary Workers.

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5.1. Training forms perhaps the most important component of the Family Welfare Programme. Family Planning intimately touches the most sensitive areas of individual's personal life. It is, therefore, necessary to orient the functionaries at all levels to understand their role and to develop necessary skills to be able to make the programme a success.

5.2. The problem of extending the available training facilities has to be examined from two angles. The Voluntary Organisations at present engaged in Health and Family Welfare activities, mainly in urban areas, have to extend their activities to rural and less-served areas like urban slums and, therefore, they will require more trained workers. Secondly, the Voluntary Organisations engaged in various social, welfare, developmental etc. activities have also to carry a message on family welfare and, it would not be feasible to involve them in Information, Extension, Communication (IEC) Programme without proper orientation on objectives of Family Welfare Programme and without outlining their expected role in the Programme.

5.3. For providing the training facilities for the workers of the Voluntary Organisations already engaged in Health and Family Welfare Programmes, the following suggestions may be considered:

I) Health and Family Welfare Training Centres (HFWTCs) being run by the Union Ministry of Health and Family Welfare and other similar Government Institutions may accept nominees of such Voluntary Organisations in their training programmes. They may organise short-term need based courses for the workers of these Voluntary Organisations for which the curriculam may be standardised. The areas of training may be identified by

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the Voluntary Organisations. Necessary financial support may be provided for strengthening these institutions. At the same time, the projects developed by the Voluntary Organisations may include the training components so that requisite funds are built in for this purpose in the project proposals.

II) Leading/large Voluntary Organisations, who are conducting training programmes for their own workers, may also undertake training of workers of newer and smaller Voluntary Organisations who do not possess such facilities. Necessary financial assistance may be provided to these Voluntary Organisations for strengthening/enlarging their faculty and other training facilities to undertake the training responsibility of training other voluntary workers.

5.4. For the workers of the Voluntary Organisations engaged in social welfare, socio-economic etc. activities, training teams could be formed which will be imparting training on family welfare topics. These teams would comprise trained members from amongst several other Voluntary Organisations. Such teams could go from place to place and organise short duration training workshops at the venue available in the local areas or the workshops could be held in State capitals or District Headquarters which are easily accessible and can be reached by over-night journey. To carry out such training workshops, these organisations could be provided funds on the basis of number of workers to be trained by them. Thus, for a batch of 40 workers' training for one day, a sum of Rs.400/- may be provided. These workshops may be limited to one or two days' duration as facilities of stay and lodging may not be available everywhere.

5.5. The participants may consider the above views and suggest measures to draw up a precise plan of action indicating inter-alia their specific comments on the following points:

i. Identification of the different categories of the workers of Voluntary Organisations who require orientation training.

ii. The contents of the syllabus and topics for orientation training.

iii. The duration of training/orientation for different categories of workers.

iv. The necessity of refresher courses from time to time.

v. How to expand the available facilities and the plan for training at different levels.

vi. Quantum of funds or other types of assistance required for all the above activities.

5.6. It may be added that a series of meetings have already taken place with the Ministries/Departments of Rural Development, Cooperation, Education etc. to examine whether the component of Family Welfare could also be included in the training programmes of the functionaries of these Departments.

Item No. 6 : Streamlining the procedure for grants-in-aid to Voluntary Organisations.

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6.1. It has been the endeavour of the Government to ensure that the Voluntary Organisations engaged in the Health and Family Welfare Programmes do not face any unnecessary hurdles or bottlenecks in the implementation of the Programme. However, difficulties do arise at times. Various remedial measures taken by the Government on the suggestions made by the Voluntary Organisations are briefly narrated below:

i) The major and recurrent complaint of the Voluntary Organisations has been the delay in the release of grants to them by the State Governments for the implementation of the Government sponsored schemes. It has been impressed upon the State Governments on more than one occasion that the Voluntary Organisations - especially the smaller ones - have limited financial resources and are virtually dependent on grants-in-aid for the implementation of these schemes and, that they should take immediate remedial action in the matter of release of grants. With a view to avoid delay in the release of grants, the powers of the State Governments to sanction Grants-in-aid for the pattern schemes have been enhanced. The State Governments can now release grants-in-aid upto a ceiling of Rs.5.00 lakhs per annum to each unit instead of the earlier ceiling of Rs.2.50 lakhs. Similarly, the State Family Welfare Officer has been empowered to release grants upto Rs.2.00 lakhs, instead of Rs.50,000/- in urgent cases. It is expected that with the issue of these orders, funds for the Voluntary Organisations can be released more expeditiously by the State Governments as the need for references to the Central Government for administrative approval would almost be totally eliminated.

ii) The State Governments have also been advised to take the following steps:

(a) Holding of meetings of the State Grants Committee regularly and periodically.

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(b) Association of one or two representatives of the Voluntary Organisations and Social Welfare Boards of the Grants Committees constituted at various levels in the State.

(c) Holding of the meetings of the Voluntary Organisations in the State frequently to identify other problems faced and to find out solutions to them.

(d) Adequate training to the staff dealing with release of grants to the Voluntary Organisations in the procedure thereof.

6.2. It may also, however, be noted that the Government sometimes finds it difficult to release the grants on account of the short-comings on the part of the Voluntary Organisations also, especially in the proper maintenance of accounts of the funds utilised. The Government's Financial Rules are very strict in this respect and, any lapse on the part of the Government gives rise to audit objections. It is, therefore, necessary that the Voluntary Organisations also extend their cooperation in the matter of proper utilisation of funds and maintenance of their accounts. For this purpose, the staff of the Voluntary Organisations need to be properly trained in matters pertaining to Accounts.

6.3. The participants may discuss as how best such training may be imparted to their workers, and what further remedial steps are necessary to remove the delays in the release of grants.

Item No. 7 : Revision of the prescribed rates of grants-in-aid as per the approved pattern.

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7.1. Representations are received from the Voluntary Organisations from time to time in regard to the inadequacy, and short comings of the pattern of grants-in-aid released to them as per the approved pattern of schemes. Some of the points mentioned by them are as follows:

i) The salary and allowances allowed to be paid to the staff are less than the corresponding pay allowed to the Government staff, as a result of which it is difficult to recruit dedicated workers. There are also no avenues of promotion to the staff recruited by the Voluntary Organisations inasmuch as the patterns of grants-in-aid do not provide for such contingencies. No extra payment is made for the appointment of a substitute whenever any voluntary worker proceeds on leave. There is also no provision of extra funds for the grant of Contributory Provident Fund by the Voluntary Organisations, which themselves depend on public donations and have no extra sources of income and as a result, several Voluntary workers, who have dedicated their entire life to social service, are forced to retire without any pension, gratuity and sense of security in old age.

ii) The rates of grants-in-aid prescribed for various schemes viz., Sterilization Beds Scheme, Post-partum Centres etc. are very low on account of the increased cost of living all round.

iii) The requirement of appointment of minimum staff as per the approved pattern for some of the schemes like Urban Family Welfare Centres needs to have a second look inasmuch as qualified staff is not available within the meagre grants released for the purpose.

7.2. The difficulties experienced by the Voluntary Organisations in all these matters may be discussed to devise ways and means as to how they can be overcome so that fresh guidelines for the release of grants can be worked out. But it may also be noted that Government funds are limited and Voluntary Organisations should not depend entirely on grants-in-aid but supplement their efforts by their own services and also a percentage of their own funds raised by Public donations. It may be noted in this connection that on a suggestion made by some Voluntary Organisations, the case for having more liberalised income-tax exemptions on the donations made to the Voluntary Organisations engaged in Family Welfare activities is under the active consideration of the Government. However, even under the existing exemptions, it is felt that it should not be difficult for the Voluntary Organisations to attract funds from philanthropic subscribers.

Item No. 8 : Evaluation and feed back in respect of the work done by Voluntary Organisations.

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8.1. Over the various plans, the Government have been providing funds to Voluntary Organisations to secure their involvement in accelerating the speed of performance under the Family Welfare Programme to meet the national goals set for achievement by the turn of the century. There is, however, no scientific feedback on the evaluation of their activities and as a consequence, on the right utilisation of the funds provided to them for such activities. In the absence of the feedback, it is also not possible to consider how an innovative Family Welfare Project being carried out by a Voluntary Organisation in a particular area can be suggested for trial in other areas also. It is imperative that we shall have an appropriate system for monitoring the activities and getting regular feedback on these Voluntary Organisations some of which are getting sizeable funds on a regular basis. Besides, there is also a necessity for adequate manpower both at the Central and State levels to monitor the activities of these agencies on a regular basis. To supplement the monitoring, it may also be desirable to have evaluation of their activities to find out the weak points as well as the strong points in the implementation of the programme by them so as to reorient further strategy. Such evaluation could ideally be taken up by autonomous bodies like the International Institute for Population Sciences, Bombay and the National Institute of Health and Family Welfare, or by Population Research Centres etc.

8.2. The immediate need is, therefore, to systematise the collection of data about the activities of these Voluntary Organisations at the national level and State levels and standardisation of records and returns to be maintained by these agencies. Some key indicators for monitoring purposes to assess their activities also need be worked out. As a matter of fact, a proper monitoring and evaluation machinery need be provided for.

8.3. The participants may like to make suitable recommendations in this regard. Some of the specific issues which could be considered may be:

i) Standardisation of records and returns to be maintained and furnished by these agencies, and working out key indicators which could be utilised for monitoring purposes.

ii) The possibility of undertaking external evaluation by independent organisations like I.I.P.S., Bombay, NIHFW, New Delhi at an interval of 3 to 5 years.

iii) Providing suitable staff contingent both at Central and State levels to coordinate and monitor the additional aspects of evaluation in Voluntary Organisations.

Item No. 9 : Making the latest research findings report available to Voluntary Organisations for more effective implementation of the Family Planning Programme.

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9.1. At present, 17 Population Research Centres located in different parts of the country besides State D&E Cells and other research agencies, undertake Demographic Research and Evaluation of Family Welfare Programme. The reports of Research Studies completed by these PRC's are received in the Ministry and summary findings which are considered important from the programme point of view are prepared and circulated among the Programme Officers for appropriate follow-up action and reorientation of strategies. A Population Research Bulletin containing the important findings from various research studies with the Policy/Programme implications emerging out of these research findings is prepared on a regular basis. This bulletin can be circulated to the interested voluntary organisations so that they also may derive benefits from such studies.

9.2. Suggestions regarding the other ways through which the services of the PRC's can be utilised by the voluntary organisations, are solicited.

(To be published in the Gazette of India Part I, Section 1)

No.R.17011/34/85-C&S
Government of India
Ministry of Health & Family Welfare
(Deptt. of Family Welfare)

New Delhi, dated 17/6/1986.

RESOLUTION

The President has been pleased to decide that a Standing Committee for support to Voluntary Organisations should be constituted with immediate effect.

2. The composition of this Committee will be as under:-

1. Shrimati Sasmeeta Srivastava, - Chairman
Chairman, Central Social Welfare Board,
Jeevan Deep Building, Sansad Marg,
New Delhi.

2. Mrs. Vidya Ben Shah, - Member
Chairman, Indian Council of Child Welfare,
4-Deen Dayal Upadhya Marg, New Delhi.

3. Dr. (Mrs.) Lalita Rao, - Member
Ex-President, Indian Medical Association,
141, Kailash Sion (West), Bombay.

4. Mrs. Jaya Arunachalam - Member
President, Working Women's Forum (India),
55-Bhimasena Garden Road, Mylapore,
Madras.

5. Shrimati Verna W. Ingty, - Member
Chairman,
Meghalaya State Social Welfare Advisory Board,
"Thule Cottage", Lmmawrio,
Laitumkharah, Shillong (Meghalaya)

6. Dr. (Mrs) Ragini Behn, - Member
Banwasi Seva Ashram, Mirzapur (UP)

7. Mrs. Nalini Nayak, - Member
P.C.O. Centre,
Spencer Junction, Trivandrum (Kerala)

8. Smt. Rami Chabra, - Ex-officio Member
Adviser (Mass Media & Communication),
Ministry of Health & Family Welfare,
New Delhi.

9. Miss Mira Seth, - Ex-officio Member
Additional Secretary & Commissioner (FW),
Ministry of Health & Family Welfare,
New Delhi.

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10. Shri R.M. Bhargava, Joint Secretary (FA) Ministry of Health & F.W., New Delhi. - ex-officio Member

11. Shri Palat Mohandas, Joint Secretary (MD), Ministry of Health & F.W., New Delhi. - Convener & Member Secy.

3. The terms of reference of the Committee will be as under :-

i) To consider applications received from voluntary organisations (agencies) working at the grass-root level in the rural and urban slums for setting up Family Welfare Projects relating to MCH, Family Planning, Improvement in Health standards and those which integrate the present activities of voluntary organisations with Family Welfare and recommend these found feasible to Government for release of grant-in-aid.

ii) To encourage community action to generate new ideas and approached that will ultimately lead to the improvement of health standards of the people at reduced costs and create greater self-reliance in the rural and unserved areas.

iii) To entertain and consider projects adopting the traditional systems of medicine for achieving the desired purpose.

iv) To document and list all voluntary organisations (agencies) working in specific areas concerned with the Ministry of Health and Family Welfare.

v) To prepare case studies/profiles of voluntary agencies to draw lessions from such grass-root experiences which could be used to influence policy and draw up new schemes more suitable for target groups living below the poverty line.

4. The grant-in-aid recommended for a project shall not exceed Rs. 1 lakh for the project period which may vary from one to three years.

5. The term of office of non-official members will be for a period of 3 years with 1/3rd of the members relinquishing office every year.

6. The Committee will hold its meetings as often as necessary.

7. T.A. and D.A. to non-official members for attending the meetings of the Committee shall be regulated in accordance with the provitions of S.R. 190 and orders of the Government of India thereunder as issued from time to time.

8. The expenditure involved will be met from within the sanctioned budget grant under the Major Head of Account 281-Family Welfare, A.7-Other Services and Supplies, A.7 (10)-Other Schemes, A.7(10)(6)-Involvement of Voluntary Organisations, A.7(10)(6)(1)-Grant-in-aid under Demand No. 46 Family Welfare for the year 1986-87. The expenditure is to be booked as 'Plan Expenditure'.

Sd/-
( Lata Singh )
Joint Secretary to the Govt. of India

No.R.17011/34/85-C&G

Ordered that a copy of the notification be communicated to all State Governments/U.Ts. and that the Notification may be published in the Gazetee of India for general information.

Sd/-
( Lata Singh )
Joint Secretary to the Govt. of India

To

The Manager,
Govt. of India Press,
Mayapuri, Delhi

Copy to:

i) All Members.

ii) All Ministries/Departments of Govt. of India

iii) All Health Secretaries of State Govts./U.Ts.

iv) All Officers/Sections of Ministry of Health and Family Welfare, New Delhi.

v) D.P.I.G./P.I.B.N.D. for wide publication

vi) P.S. to HFM/M.S./D.M.(FW)/Secretary/ A.S.&C.(FW)/A.S. (FW)/A.S. (H).

Sd/-
( K.K. Saxena )
Under Secretary to the Govt. of India

VI.

## Guidelines for Financial Assistance under Rolling Fund (Mother Unit) Scheme

1. The nodal organisation approved under the Scheme will identify the NGOs for assistance under the Scheme and will also help smaller organisations, if need be, to formulate their projects. Before sanctioning grants to such organisations, approval of the Government of India will be obtained by the Nodal Organisation in each case.

2. The grants to be given by the nodal organisation to any NGO under this Scheme should not exceed Rs. 1 lakhs during a financial year.

3. A Quarterly statement of expenditure incurred under the Scheme will be submitted to this Ministry by 30th of the month following each quarter for recoupment of funds to the Rolling Fund, so that it does not fall short of Rs. 5 lakhs at any stage.

4. Quarterly progress report submitted by the NGOs may also be sent to this Ministry in a Consolidated Form for information/review. These will also be reviewed by the nodal organisation to provide guidelines to NGOs for improvement of performance, wherever considered necessary.

5. The nodal organisation will monitor/evaluate the project periodically, provide Technical assistance and also collect Annual Audited Statement of Accounts from NGOs and furnish the same to the Government of India in a consolidated form duly audited to this Ministry within six months of the close of the Financial Year.

6. A separate Bank Account will be maintained for the purpose. These accounts will be open to inspection and the Government of India reserves the right to have the accounts of the Nodal Organisation audited by the Comptroller and Auditor General of India, if and when occasion demands, in order to satisfy themselves regarding the manner in which the affairs of the Nodal Organisation are being managed.

7. The above Rolling Fund shall not fall short of Rs. 5 lakhs at any time.

8. The nodal organisation will be responsible for the proper utilisation of the amount advanced to it for disbursement to NGOs and due safeguards will be observed while releasing the amount to NGOs.

9. The amount will be utilised for furtherence of the Family Welfare Programme only including MCH & Primary Health Care.

10. The nodal organisation will be provided assistance for maintenance of a small NGO Cell for implementation of the Rolling Fund Scheme.

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VII



## PERSPECTIVES

India became a signatory to the Alma-Ata declaration in 1978 committing itself to achieving Health for All by the Year 2000. In 1982, the revised National Health Policy was adopted in the Parliament. The National Health Policy (NHP) lays considerable emphasis on preventive and promotive aspects of health care, greater decentralization of services, self reliance through greater transfer of skills to and participation by the community and development of an effective health care system. Therefore, programmes involving the active participation of Voluntary Organisations and mounting of a massive Health Education movement should be accorded priority.

Keeping the above goal in view the Government of India has evolved various schemes, under which financial assistance is being given to projects undertaken by Voluntary Organisations for expansion of Health, Family Welfare and Nutrition services in various parts of the country. To ensure effective implementation of the project at state level a nodal officer for NGOs is identified. The present workshop broadly aims at sensitising and orienting the nodal officers on the need for involving NGOs in health care projects, providing the participants with insights into the concept, approach, scheme description, scope of activities eligible for grant, processing proposals, disbursing grant and follow-up etc.

## OBJECTIVES

The specific objectives of the workshop are:

1. To sensitise the state level nodal officers on the need for involving Voluntary Organisations in health care projects.
2. To appraise them with the concept, approach, scheme description and scope of activities eligible for grant under various health schemes for Voluntary Organisations.
3. To analyse and understand the areas where Voluntary Organisations could be involved and where they need support etc.
4. To provide orientation to the participants on scrutiny of project proposals, disbursing of grant and follow-up etc.
5. To identify the ''training needs'' of nodal officers for effective implementation of various schemes for Voluntary Organisations.
6. To determine the support structure required by the nodal officers for effective Co-ordination between voluntary organisation and government.
7. To develop appropriate monitoring and evaluation mechanisms to ensure proper implementation of such projects and
8. To initiate Voluntary Organisations into sustainability Planning.

## Background



The National Family Welfare Programme seeks to promote family planning as a peoples' movement. The vital role of voluntary organisations in promoting the family welfare programme has been recognised and given importance from the very beginning. They have been participating in many schemes and bridging the gap between the community and the Government Services. These organisations having their root in the community and due to the fact that they encounter less of cultural and geographical barriers, have far greater acceptance than the Government functionaries. However, inspite of various initiatives taken in this direction, participation of voluntary organisations has not been to the extent desired. Reasons are many. Some are enumerated as under:

1. Lack of knowledge of Government schemes.
2. Lack of knowledge of Government procedures.
3. Lack of resource mobilisation and sustainability.
4. Lack of ability to do financial management and monitoring.
5. Inadequate inter-mingling with Government personnel.

It often happens that even Government personnel in Health and Family Welfare are involved in day to day crisis and epidemics and do not get an opportunity to look into the problems of voluntary sector.

With a view to boosting the activities of the voluntary organisations for meaningful participation in the national programmes, a number of initiatives have been taken by the Government in the recent past. A few are indicated below:

i. Publicity is being done through TV/Press about schemes existing at present.

ii. State level committees comprising of the representatives of State Governments, Voluntary Organisations and Ministry are being constituted. These committees will recommend projects in family welfare for funding and also arrange necessary training to voluntary organisations in project formulation and management.

iii. Adequate training facility for voluntary sector will be developed in each State at least in two places - one within the Governmental Sector and the other in Non-Governmental sector. Various aspects of family welfare including services/ education, etc. are to be covered. In addition, training will also be imparted in project formulation, financial management/ monitoring/ evaluation/ sustainability.

iv. It has also been proposed to hold periodical training/ meetings/ seminars/ study tours of the voluntary sector for sharing experience and ensuring interaction between various organisations.

*v.* Action is being taken to set up an apex body viz. VAFAH to administer all grants to voluntary sector. This body at the centre will also have regional bodies and will enjoy sufficient flexibility and autonomy. Through these bodies the goal of making family welfare a people's movement may be greately achieved.

*vi.* Grant-in-aid procedures have been sufficiently de-centralised through setting up of rolling funds for involvement of small voluntary organisations.

*vii.* To involve more and more organisations in the family welfare programme, to acquaint them with Government schemes for financial assistance and for meaningful exchange of views, five regional conferences of voluntary organisations were held last year in Patna, Calcutta, Madras, Shimla and Goa. A large number of Voluntary Organisations participated and there were useful interaction.

Through various new initiatives, there has been sufficient awareness among the voluntary organisations about the various schemes running at present. However, there is still hesitation among many of them. One of the reasons may be the strict procedures/ limitations within which the Government functionaries are to work. Also in the absence of specific levels in the State Government which are responsible for dealing with and providing guidance to voluntary sector, response from the voluntary sectors has not been adequate. With a view to removing this impediment, all States/Union Territories have nominated Nodal Officers (Government officials) who will be primarily responsible to receive proposals from voluntary organisations and for rendering necessary guidance to them. However, because of the situation under which those officials work, often there is lack of understanding towards the voluntary organisation sector. It has been considered that the Nodal Officers themselves may need some orientation about the schemes which are running for voluntary sector and the difficult condition under which they are working. Only when these are realised properly, our attitude towards the voluntary organised sector will undergo the desired changes. This will greatly help in effective implementation of national Health and Family Welfare Programmes. Following are the main schemes for financial assistance under the Central Sector:

*1.* Innovative and Experimental Scheme

*2.* Mini Family Welfare Scheme.

*3.* Performance Linked Model Scheme.

*4.* Private Voluntary Organisations for Health (PVOH Schemes).

5. Guidelines for financial assistance under the Rolling Fund Mother Unit Scheme.

# Specific Areas Needing Attention of Nodal Officers

## *Project Formulation*

A number of Voluntary Organisations are working in various parts of the country. Most of them are working on their own. A numbr of these organisations are desirous of availing assistance available under various schemes in the field of Family Welfare and Health. The Nodal Officers have special role in guiding the organisations in proper formulation of project proposals. The guiding factors may be *(i)* selection of proper area with a view to avoid duplication; *(ii)* adequate survey of the area to assess the actual need; *(iii)* mobilisation of existing resources, manpower, etc.

## *Financial Management*

Adequate care is to be taken to make the projects cost-effective, as far as possible. The voluntary organisations have to be told clearly that they should not compare themselves with Government organisations in the matter of pay-scales of their employees, creation of infrastructure, etc.

## *Monitoring and Evaluation*

These components are necessarily to be built in the project, periodical monitoring, both physical and financial, at different stages of running of a project are as important as any other component. Based on developments, it may be necessary many a time, to modify a project design to suit to any shift in policy or otherwise. Although the organisations are to run projects within certain defined parameters, they should not be subjected to rigid rules. The experience gained in a particular project may also be suitably utilised for similar other projects. The Nodal officers neeed to develop flexible attitudes.

## *Sustainability*

This is a very important aspect which needs to be given special attention. The sustainability element needs to be properly nurtured from the very beginning of the project as also at different stages of running of the same. The ultimate aim is benefit of the community. Different aspects, such as income generation activities, exchange of experiences, changing project design with changes in policy, etc. have to be constantly kept in view. Another important aspect is cost benefit analysis. This exercise has to be undertaken regularly and necessary changes made to make the project really sustainable.

### *Recommendations of State/Union Territories*

Voluntary organisations are required to work in close co-operation with respective State Governments/Unior Territories. As such, specific recommendations of States/Union Territories are very essential. The nodal officers being Govt. officials themselves, it is expected that necessary clearance from States/Union Territories will be expedited.

## PRIVATE VOLUNTARY ORGANISATIONS FOR HEALTH (PVOH-II) SCHEME

*1.* The PVOH-II Scheme which is a sequel to PVOH-I Scheme was formulated on 31.8.1987 by virtue of an Agreement signed with the USAID who agreed to fund this Project with 10 million. The Project Assistance Completion Date which was earlier 30.9.95 has now been extended to 30.6.1997. The unique feature of the Scheme is the 25% contribution of the Voluntary Organiation towards the total cost of the Project.

*2.* The Project seeks to reduce morbidity, mortality and fertility among the rural and urban poor in the country. The pupose of the Project is to expand and improve basic and special preventive health, family planning and nutrition services for the poor by strengthening the private and voluntary sector with special attention to less well served areas and deprived population.

*3.* About 40 sub-projects are to be accomodated under this Scheme and so far 18 Projects have been sanctioned. The life of the sub-projects is approximately 5 years.

*4.* The National Institute of Health and Family Welfare has been entrusted with the task of regular monitoring/mid-term and final evaluation. The Instiute also provides necessary guidance in Project formulation/revision, baseline survey, preparation of action plan, setting up of operational targets, recording, reporting and supervision.

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# SCHEME OF 'MINI FAMILY WELFARE CENTRES' AS A MODEL UNDER INNOVATIVE SCHEME OF GRANT-IN-AID ASSISTANCE TO VOLUNTARY ORGANISATIONS FOR PROMOTION OF MCH, IMMUNISATION AND SMALL FAMILY NORM

## OBJECTIVE

1. The basic approach of the model is to establish Mini Family Welfare Centres to promote MCH, Immunisation of Family Welfare programme amongst the section of population resistant to Family Welfare Programme and having high birth rates. This will be applicable to town and city upto population of 1,00,000 and rural areas. Preference under the Scheme will be given to such districts as have not achieved Couple Protection Rate (CPR) of 40% as on 31.03.1989. A list of these districts is attached at Annexure-1.

2. The objective of the Scheme will be entirely motivational to create a link between the infrastructure of Health and Family welfare facilities and the community to promote responsible and healthy motherhood and small family norm. As one of the major problems confronting the implementation of the Family Welfare Programme is that inspite of the existence of a network of facilities, the communities are not fully aware of the need for services and in this regard the workers under the Scheme can be utilised as effective link workers to create awareness, generate demand for services and ensure utilisation thereof.

3. **The salient features of the Scheme are:**

3.1. The Scheme of Mini Family Welfare Centres will be operative amongst the population group resistant to Family Welfare Programme. For urban areas, it will be limited to slum and unauthorised areas, in towns with population ranging upto one lakh. In the rural areas the thrust of the Scheme will be in areas having very low CPR. (i.e. in districts with CPR upto 40%).

3.2. The objective of the Scheme will be entirely motivational to serve as a link between the infrastructure of Primary Health Centres, Sub-Divisional Hospitals and Family Welfare Centres, Voluntary Organisations Hospitals/Clinics and the Community.

3.3 The population to be covered in urban areas will be 25,000 divided into five field units of 5000 each. In rural areas the population to be served by each unit will be 15,000 consisting of five field units of 3000 each.

3.4 **Structure:**

Each project will consist of a Mini Family Welfare Centre (MFWC) with a Unit Coordinator as Incharge. Each Mini Family Welfare Centre will have five field units. In each field unit there will be five saheliies to be selected from Anganwadi workers, Balwadi Teachers or any instructor under these Schemes located in the area of operation of these projects. The lady workers from community can also be appointed as saheli (i) if above named workers are not willing, (ii) due to special requirement of the segment of population to be covered. One of the saheli workers will be selected as Group Leader after ascertaining the leadership quality and watching their work for about three months.

3.5 The Mini Family Welfare Centre and the field units will be formally attached to the nearest primary Health Centre in the rural areas, and to the local hospital/dispensary run by the Government or a Voluntary Organisation in the urban areas.

4. This Scheme is both for urban and rural areas. Through this model, attempt is to reach the grass-root levels and create awareness in the community served in a phased manner step by step from the very beginning of family formation i.e.marriage. In a gradual and step by step method the need for MCH and family planning is generated as the family develops keeping a continuous touch with the bride developing into a young mother. She is also trained in the art of motherhood by the grass-root level Voluntary worker known as 'saheli' in this model. This trained mother becomes an agency herself for passing these traits to the new brides in her family and those in close proximity. Thus,gradually the MCH, Family Welfare motivation would progress in a chain like manner and in due course the worker will have to concentrate on lesser number of families and contact with trained mother would be of maintenance character.

5. **Mini Family Welfare Centre :**

The Mini Family Welfare Centres will have five field units and each unit will serve a population of 3000 in rural areas and a population of 5000 in urban areas. The following conditions have to be fulfilled;

(i) The Mini Family Welfare Centre will be situated in the area of population served by it. Its five field units will be disbursed around in the area of operation.

(ii) The Mini Family Welfare Centre will be attached for clinical and referral services to the nearest PHC or Community Health Centre or Urban Centre in city area or Voluntary organisation Hospital/Clinic to be specifically earmarked in this project.

(iii) the Mini Family Welfare Centre will serve as a Depot for supply like contraceptives, condoms and oral pills.

(iv) The Mini Family Welfare Centre will serve as a Unit for Community uplift by (i) Imparting Health Education, (ii) training married young women in the art of motherhood, (iii) immunisation in children and mothers; (iv) motivating the community specially the target couples the community norm and (v) ensuring proper sanitation and hygienic conditions.

(v) The staff should be employed from the community to be served specially the grass-root level worker the Female Voluntary Worker 'Saheli'.

6. The basic principle involved in the success of model is to create rapport with the newly wed bride and follow the couple through their reproductive phase including first pregnancy, delivery, post-natal care, spacing of pregnancy, second pregnancy and finally sterlisation. During this follow-up she will be educated and helped as the need arises in various phases step by step, ensuring a healthy marital life, healthy pregnancy period, safe delivery, healthy and trained motherhood and finally ensuring spaced small family. This step by step approach will provide complete MCH cover and Family Planning. This approach will produce well trained mother who can help other newly weds in her family and neighbourhood.

(a) **Methodology:**

In average there are three to four marriages performed in each marriage season in a village/cover area of an average 800 to 1000 population.

(b) **First Step:**

To establish rapport with the Newly Weds and their family and this is done by Saheli' (Family Female Voluntary Worker) by ensuring her presence in the marriage and creating closeness to the family. This primary rapport with family of newly wed and the bride herself will open the path for consequent visits.

(c) **Second Step:**

The worker pays a casual visit to know the welfare of the newly wed and creating personal friendship with her. This may be done at a convenient and congenial time.

(d) **Third Step:**

During the casual visits 'Saheli' (Family Welfare Female Voluntary Worker) may come to know about the conception accruing in the newly wed. From this, the visits of the worker is goal oriented and purposeful. The Worker should start educating the would be mother regarding the conception, pregnancy, nutrition, for mother and child and few do'S and don'ts in sanitation. During this visit the Worker should congratulate and encourage the would mother and take her into confidence. This is the best period when the young mother is most receptive and inquisitive to learn about motherhood in confidence through a friend.

(e) **Fourth Step:**

The would-be mother is gradually prepared to come to the primary Health Centre/Hospital with the help of elder family members specially the mother-in-law. Thus to routine ante-natal help is provided and would be mother is told about healthy motherhood, protection of self from tetanus, nutritive value of specific feeds to be taken and role of sanitation in pregnancy and delivery. She is educated for preparing cloths for delivery and the child to come. Complete checking is done at the nearest Centre and if she is a risk case, she should be referred to Community Health Centre. Thus at one side the would-be mother is educated for motherhood and at the other side she is given full ante-natal services and care.

(f) **Fifth Step:**

'Saheli' (Female Family Voluntary Worker) thus fully prepares the would-be mother to have safe healthy delivery, physically and mentally. She should be motivated for delivery at home or Community Health Centre or a Hospital as the case may be. The Voluntary worker should, as far as possible, attend the delivery for providing psychological confidence in the mother-to-be.

(g) **Sixth Step:**

The new mother is now prepared to listen about spacing methods and be made interested in the use of Nirodh, Copper 'T', oral pills. The need of spacing be generated through knowledge about the healthy development of baby if spacing is adopted. Also, Family planning is talked casually and if the need is generated services are provided.

(h) **Seventh Step:**

If the need for second child is shown in a strong manner the Worker should wait and help her through the second pregnancy. But usually for the second pregnancy the mother is fully prepared. Gifts may be repeated for the second delivery to create a final approach to sterlisation after second delivery.

Thus, it is seen that step by step the young lady is approached as per need creation and helped and educated gradually when she is fully receptive. A person is not receptive for everything, every time but she becomes very receptive at the time of need and this is the key of success in above methodology.

Secondly, this Scheme ensures a creation of trained mother who can become a natural trainer in future.

Third advantage is that the image of the 'Saheli' (Female Family Voluntary Worker) gradually grows and in this way she is herself sought for reducing her work gradually and also the number of visits in the later period.

Fourthly, it may be seen that in operation-wise the scheme may look as slow and cumbersome but practically after proper scheduling the visits it is not difficult to follow in a small population of 1000 people in urban areas/600 in rural areas.

(i) Besides this, step-by-step approach in respect of newly weds, the 'Sehali' should include all the eligible couples, in particular, of the younger group, in her target group. Her services may be utilised as Depot Holder for distribution of contraceptives so that these become available to the eligible couples at their door-step. The Saheli should also ensure that all the children including the new-born babies and pregnant ladies in her area are provided proper immunisation services. Another area in which the Saheli can play an important role is maintenance of proper sanitation and hygienic conditions in her area.

7. The most important points for the success of the scheme are:

i) Proper selection of 'Saheli' (Family Female Worker) which may be easier for a Voluntary Organisation to do due to their close proximity with the community. The Saheli should be necessarily selected from the project area itself and from the target community. This requires to be ensured particularly in respect of the communities which are traditionally resistant to family planning.

ii) Continued and proper education of 'Saheli' who is the key person of the scheme is very important.

iii) Besides the remuneration admissible, the motivational and other benefits for sterlisation, IUD and Copper 'T' insertion will be according to the rates prescribed by the state government in addition. She will also have to promote sale of commercial variety of condoms as per rates specified.

iv) Arrangement for training of sahelies, unit coordination will be made at nearest PHC or Postpartum Centre or Urban Centre/Hospital according to prescribed curriculum. They will also receive field orientation as a continuous process to be arranged by the organisation in consultation with the Directorate of Family Welfare of State.

V) A spirit of healthy competition among the workers and the members of the target community will be fostered by instituting gifts/rewards to the best workers selected under the project and to the best mother, the best couple and the most healthy child selected in the project area.

vi) The annual get-together of the eligible couples in the area will be held for distribution of the prizes. This occasion will be utilised for a free and frank exchange of views in regard to the Family Welfare and MCH programme in the area. Although funds have been provided in the scheme for this function, the implementing organisation may raise money from other sources such as corporate Bodies to enable themselves to find adequate funds for organising the get-together.

8. **Project Period:**

The minimum period of each project sanctioned under the scheme will be three years. Each project will be subjected to a mid-term evaluation by the Ministry and a final evaluation by an External Agency at the end of the three years period and based thereon a decision will be taken to discontinue financing the project or to extend as the case may be.

9. **ANNUAL FINANCIAL IMPLICATION :**

A. **Staff**

(i) **Mini Family Welfare Centre**

| | | |
|---|---|---|
| Unit Coordinator (Full-time Employee) on Salary | Rs. | 1000/-pm |
| Conveyance allowance | Rs. | 50/-pm |
| Postage/Contingency | Rs. | 50/-pm |
| | | 1100/-pm |

Per annum = Rs. 13,200/-

(ii) **Field Unit**

| | | |
|---|---|---|
| Sahelies - 5 - | Rs. | 100/-pm |
| Extra honorarium for Group leader | Rs. | 75/-pm |
| Total : | | 575/-pm |

Per annum = Rs. 6,900/-

(iii) **Annual Expenditure**

Recurring - Salary of the staff of Mini Family Welfare Centre = Rs. 13,200/-
5 Field Units @ Rs. 6,900/- per Unit = Rs. 34,500/-

B. **Administrative Support cost to**

| | | |
|---|---|---|
| Voluntary Organisation @ Rs. 250/-pm | Rs. | 3000/- |
| Building rent @ Rs. 250/-pm per project | Rs. | 3000/- |
| contingencies | Rs. | 2000/- |

C. **Non-recurring expenditure**

| | | |
|---|---|---|
| Furniture and educational aid - | Rs. | 2000/- |
| Training of Unit Coordinator and Sahelies | Rs. | 5000/- |
| Sub-total - Rs. 7000/- | | |

D. **Prizes & Annual Get-together :**

**Prizes**

i) **Best Saheli Prize**

| | | |
|---|---|---|
| First Prize | Rs. | 500/- |
| Second Prize | Rs. | 250/- |

ii) **Best Group Leader Prize**

| | | |
|---|---|---|
| First Prize | Rs. | 700/- |
| Second Prize | Rs. | 350/- |

| | | |
|---|---|---|
| iii) Best Mother Prize | Rs. | 400/- |
| iv) Best eligible couple prize | Rs. | 400/- |
| v) Most Healthy Child Prize | Rs. | 400/- |
| Total prizes | Rs. | 3000/- |
| Annual Get-together Function | Rs. | 1000/- |
| Total | Rs. | 4000/- |

GRAND TOTAL FOR THE PROJECT = Rs. 66,700 per annum

10. **Unit Coordinator/Group Leader/Saheli**

(a) The Unit Coordinator will coordinate and supervise the project and keep a regular liaison with the field unit. She/He will spend one day each with 5 units and will be at headquarter on the 6th day. She/He will maintain records and monitor the whole project, and undertake correspondence.

Unit coordinator will be a full time employee and primarily Extension Educators and will be required to develop rapport with the Primary Health Centres, Sub-Divisional Hospitals, Family Welfare Centres and Voluntary Organisations, Hospitals/Clinics where he will be required to send the motivated persons. In case of male unit coordinator, he will also try to motivate the men in his areas for adopting a small family norm and terminal and spacing methods of family Planning.

Unit coordinator will have a degree in Science or Social Science and Biology from a recognised University. Preference will be given to persons having two years experience in health care/family planning activities.

(b) **Group Leader**

Group leader will primarily be a Saheli but she would also be given an additional responsibility to assist the Sahelies and act as Group leader of the Unit. She will establish rapport with the Primary Health Centre. Sub-Divisional Hospital and other Hospitals/Clinics and maintain basic records to be passed over to the Unit Coordinator. She will help to develop a programme for motivation of women in reproductive age group for a small family norm. She will extend support to sahelies by visiting family etc. She will ensure that well-designed Family Cards are maintained by the Sahelies for each of the target family in her Field Unit.

(c) **Saheli**

There will be one Saheli for a population of 1,000 in urban area and 600 in rural area. The Saheli will be opted from the Anganwadi Workers/Balwari Workers or instructors or other Child Survival Scheme from the units located in the area of operation of the project. The lady workers from community can also be appointed as Saheli (i) if above named workers are not willing (ii) due to special requirement of the segment of population to be served. Besides the honorarium of Rs. 100/-pm motivational and other benefits for sterilisation and IUD cases will be admissible to the Saheli in addition in accordance with the rates prescribed by the respective State Governments.

## 11. Monitoring and Evaluation

11.1 The monitoring will be done each quarter at the level of PHC in rural set up and at District level in city set-up by M.O., PHC/CMO respectively in their regular meetings. Project Manager will present the report regarding the work of the Centre under various heads like :-

1. Referral Cases.
2. MCH Work
3. Motivation
4. House visits
5. Educational Programme
6. Training Programme
7. Area Profile

11.2 There will be a mid-term evaluation of the project by the Ministry. The final evaluation will be done by an External Agency at the end of the three year period.

## 12. Release of Funds

Release of funds will be under the Central Sector Schemes for grant-in-aid to Voluntary Organisations. The amount of Rs.66,700/- for meeting the cost of implementation of the scheme during the first year period will be paid in two installments. The first installment for the six months will consist of full non-recurring expenditure and 50% of recurring expenditure. The second installment will be given when the project starts operating after completion of three months of the project life on receipt of the progress report and expenditure statement for the first quarter. Grant-in-aid for the second year of the project will also be released in two installments, the first installment at the beginning of the second year of the project, and the second installment after the mid-term evaluation and will be subject to production of audited statement of accounts for the last year by the organisation. The third year installment will also be in two parts with a gap of six months. The second part will be subject to production of audited statement of accounts by the organisation for the last year.

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## APPLICATION PROFORMA FOR APPLYING GRANT-IN-AID ASSISTANCE UNDER THE MODEL SCHEME 'MINI FAMILY WELFARE CENTRES'.

Name of (i) President
(ii) Hony. Secretary

1. Name of the organisation

2. Registered Address

3. Registration No.
(with Act/Statute under which registered)

4. Financial Status of the organisation

   (i) Total income during the year ended..... Rs. .....

   (ii) Total Expenditure during the year ended..... Rs. .....

   (iii) Total Assets during the year ended..... Rs. .....

5. Details of Health/Family Welfare Infrastructure presently available with the Organisation.

6. Health/Family Welfare Workers presently in employment — FULL TIME — PART TIME

7. Previous activities of the Organisation, especially in relation of family welfare.

8. Amount of Grant-in-aid requested Item wise
   (i) Recurring
   (ii) Non-recurring

9. Duration of project.

10. Project Area : **Urban**
   (i) Name of City/town & District
   (ii) Name of Mohallas/Number of Municipal Wards, with their population, to be covered under the project.
   (iii) Name of Mohallas/Number of Municipal Wards to be included in each field unit.
   (iv) Location/address of each field unit
   (v) Location/address of MFWC

| | | |
|---|---|---|
| | **Rural** | (i) Name of Block & District |
| | | (ii) Names of Villages, with their populations, to be covered under the project. |
| | | (iii) Names of Villages, with their populations, to be included in each field unit. |
| | | (iv) Location/address of each field unit. |
| | | (v) Location/address of MFWC |
| 11. | Population of the Project Area | (i) Number<br>(ii) Economic Status<br>(iii) Literacy Status<br>(iv) Attitude towards :<br>(a) Small Family Norm<br>(b) Mch/Immunisation |
| 12. | Total Number of eligible Couples/women/children (0-6 yrs.) in the project population | |
| 13. | Source from which information against column 12 above has been taken. | |
| 14. | Name of PHC/Hospital/Dispansary Which will provide MCH immunisation. Oral Pills and Family Welfare Services. | |
| 15. | Methodology to be used for achieving the stated objectives, (refer to para 5-6 of scheme) | |
| 16. | Target to be achieved. (please specify number of eligible couples, women & children (0-6 yrs.) expected to benefit under the project) | |
| 17. | Whether the Organisation is already running any scheme under Family Welfare Programme with assistance from State Govt./Government of India. | |

18. (a) Are ICDS/Balwadi/Creche /Child Survival functioning in the area of project.

(b) If answer to 18(a) above is 'yes' please state the number of workers from these Balwadis/ anganwadis/creches to participate in the project.

(c) Number of Sahelis to be associated from the general target area/community.

19. Any other relevant information.

**Signature**
**(with stamp)**

Annexure - I

## LIST OF DISTRICTS HAVING COUPLE PROTECTION RATES LESS THAN 20% AS ON 31/03/1989

| S.No. | States | District | CPR as on 31/03/89 |
|---|---|---|---|
| 1. | Assam | 1. N.C.Hills | 18.9 |
| | | 2. Sonitpur | 18.8 |
| | | 3. Darrang | 18.7 |
| | | 4. Cachar | 14.5 |
| | | 5. Dhubri | 13.9 |
| | | 6. Nalbari | 10.8 |
| | | 7. K.Anglong | 10.7 |
| | | 8. Karimganj | 9.6 |
| | | 9. Barpeta | 9.1 |
| | | 10. Kokrajhar | 6.1 |
| 2. | Bihar | 1. Siwan | 17.8 |
| | | 2. Munger | 17.9 |
| | | 3. Gopalganj | 19.4 |
| | | 4. Bhagalpur | 19.7 |
| | | 5. Palamu | 19.8 |
| | | 6. Samastipur | 19.9 |
| 3. | Jammu & Kashmir | 1. Kupwara | 9.2 |
| | | 2. Doda | 11.9 |
| | | 3. Kargil | 12.0 |
| | | 4. Badgam | 12.3 |
| | | 5. Poonch | 15.3 |
| | | 6. Baramulla | 16.2 |
| | | 7. Kathua | 16.8 |
| | | 8. Udhampur | 17.5 |
| | | 9. Rajouri | 19.3 |
| 4. | Rajasthan | 1. Barmer | 15.4 |
| | | 2. Jaisalmer | 19.8 |
| 5. | West Bengal | 1. Maldah | 19.1 |

## VI. SCHEME FOR EXPERIMENTAL/INNOVATIVE PROJECTS UNDER FAMILY WELFARE PROGRAMME

Financial assistance can be provided for projects not conforming to any particular pattern but which are viable and aim to provide motivation, communication, educational activities and services, or are otherwise innovative in nature in the field of Family Welfare. Because of the nature of the schemes, proposals have to be prepared by the NGO's themselves keeping in mind their own objectives and capabilities. Essential components of the scheme include a baseline survey and end of project survey to evaluate the impact of the scheme. Financial assistance will be provided for such survey as also for such components as training (where necessary) motivational activities, services for Family Planning, MCH staffing etc. Assistance for supply of Family Planning equipment like laparoscopes, IUD, Oral Pills, Condoms, etc. could also be provided in cash and kind. Supply of Family Planning Services like Oral Pills, Condoms, IUD, could be arranged with State Governments and Union Territories.

The project should preferably serve rural areas, urban slums taking into consideration the facilities already available with the NGO/State Government/Union Territories in the area. There is no bar to utilising services delivery facilities already in existence whether belonging to Government or Private agencies.

A provision of Rs. 7 crores exists in the 7th Plan for this Scheme and those mentioned at S. Nos. VII and X.

**Procedure for submission of Application:**

There is no prescribed application form for submitting a proposal for grant-in-aid under this scheme. However, besides the details of the proposed project, the following documents/information are required to be furnished by the Voluntary Organisations for considering their request for financial assistance:—

1. Whether the organisation has been registered under the Societies Registration Act, 1860, if so, a copy of the Constitution of it with the Memorandum and Articles of the Organisation alongwith a list of members of the Managing Committee.
2. Certified copies of the audited statements of accounts for the last three years.
3. Annual Report or other documents giving details of activities of the organisation, especially in relation to family welfare programme.
4. Whether the organisation is receiving any assistance from other Departments of the Central Government or State Government for Family Welfare Programme or any other scheme.
5. A copy of the reports of the previous activities.

The application should be submitted to Under Secretary (OS), Ministry of Health & Family Welfare, New Delhi-110011 in duplicate and a copy of it may be sent to the Family Welfare Department of the State Government concerned for onward transmission to the Government of India with their comments/recommendations.

# VII. MCH & IMMUNISATION PERFORMANCE LINKED MODEL FOR ASSISTANCE TO VOLUNTARY ORGANISATIONS IN URBAN AREAS

**Background**

This model is applicable to a population of 25,000 in un-served or under-served urban areas and particularly slums and urban fringes in towns/ cities with a population of less than 2 lakhs. The events and activities have been identified on the basis of population range of 25,000 for 100% coverage in MCH and Immunisation activities and 20% annual coverage in family welfare services. This favourably compares with the D-type urban family welfare centres which covers a population of 50,000 but the performance level is about 50%. Therefore, in terms of the performance this unit can be treated as equivalent to type D urban family welfare centre.

**Staff Requirement**

The optimum level of staff required to render the services outlined in this project is indicated in the Annexure-I. This is necessary to maintain the professional level of performance of MCH and Immunisation services. The Voluntary Organisations will have to keep the staff, as indicated in this Annexure. The Voluntary Organisations will however, have flexibility in the matter of appointment of the staff on part time or full time basis as suitable for the proper functioning of the project and can even engage staff for fixed hours. The Voluntary Organisations will also have flexibility in terms of the emoluments to be sanctioned to staff subject to the Minimum Wages Act Rules applicable in this regard.

## I. ELIGIBILITY

(1) An urban area chosen should have population of 25,000. This population is a unit for consideration for assistance.

(2) The area should be such that it is not being served by any existing urban family welfare centre or is under-served.

(3) The population living in the area should be of low socio-economic status.

## II. Regimen and norm of payment for MCH and Immunisation Services

| *A & D-1 Children Services | Payment norm by regimen (Rs.) |
|---|---|
| (i) DPT (3 shots) | 2,3,5 |
| (ii) BCG | 2 |
| (iii) Polio | 2,3,5 |
| (iv) Measles | 2 |
| (v) Maintenance of Growth Chart | 2 |
| *B 1—5 Children | |
| (i) DT (2 shots) | 2,2 |
| (ii) Vit. 'A' | 2,2 |
| (iii) Iron and Folic Acid (3 times) | 2,2,2 |

| | |
|---|---|
| *C Pregnant Women | |
| (i) T.T. (2 shots) | 5,5 |
| (ii) Urine examination (3 times) | 2,2,2 |
| (iii) Haemoglobine ,, | 2,2,2 |
| (iv) BP ,, | 2,2,2 |
| (v) Weight ,, | 2,2,2 |
| (vi) Iron & Folic Acid ,, | 2,2,2 |
| (vii) Delivery | 10 |
| (viii) Post-natal care | 10 |

*Note :—Wherever, the activity is to be completed in two or more stages, the payments for first/sceond stages (will only be admissible) after all stages are completed. No payment will be permitted for incomplete activity.

**Family Planning**

The family planning activity to be promoted by the organisation would primarily be in the following sectors :—

(i) Motivation of the eligible couple for a smaller family norm and adoption of a family planning technique acceptable to them.

(ii) The sterilisation operation tubectomy/vasectomy will be undertaken at the recognised centre being run by the Voluntary Organisations, Primary Health Centres or Government/Local body hospitals which have been authorised to undertake this work.

(iii) The IUD work for this unit will include both motivation and insertion and follow-up.

(iv) The distribution of the oral pills will be done by ANM after filling the check list. But the acceptor will be got examined from the medical doctor within three months. The payment will only be admissible after 12 months continuous use (13 cycles) by the acceptor.

(v) *Nirodh Supply* :—It has be to ensured that there would be 6 months continuous use and payment will only be admissible after the expiry of the 6 months period.

(vi) The incentive for the motivation both for sterilisation and IUD insertion will have to be claimed by the Voluntary Organisations from the State Governments as per pattern prescribed by them.

(vii) The claim for sterilisation operation will be as per pattern laid by State Government for private practitioners.

| **Family Planning Activities** | (Rs.) |
|---|---|
| (i) Sterilisation (motivation)<br>(ii) Sterilisation (service)<br>(iii) I.U.D. Insertion | Claim for these to be made from the State Government as explained above. |
| (iv) Nirodh (six months of continuous use) | 10 per case. |
| (v) Oral Pills (for 13 continued cycles). | 25 per case. |

III. Target No. of events in the population (25,000)

| Events | Number |
|---|---|
| (i) Births | 800 (32/1000 birth rate) |
| (ii) Pregnant women | 880 |
| (iii) Deliveries | 800 |
| (iv) Post-natal care | 800 |
| (v) Children (1—6 years age) | 3250 (13% of the population) |
| (vi) Eligible women | 4250 (170 per 1000 population) |
| (vii) Distribution of women by number of children ever born % | |

| | % | Number |
|---|---|---|
| 0 | 10.5 | 446 |
| 1 | 11.0 | 468 |
| 2 | 11.0 | 468 |
| 3 | 11.0 | 468 |
| 4+ | 56.5 | 2401 |

IV. Total Cost for Total coverage (Immunisation and MCH)

| 1. D-1 Children | No. of events | × cost per service | Total cost Rs. |
|---|---|---|---|
| DPT | 800 | × 10 | 8000 |
| BCG | 800 | × 2 | 1600 |
| Polio | 800 | × 10 | 8000 |
| Measles | 800 | × 2 | 1600 |
| Maintenance of growth chart | 800 | × 2 | 1600 |
| Sub-total | | | 20000 |
| 2. 1—6 Children | 813 | | |
| DT | 3250 − 800 = 1613 | × 4 | 6452 |
| Vit. 'A' | 4 | 1613 × 4 | 6452 |
| Iron & Folic Acid | | 1613 × 6 | 9678 |
| Sub-total | | | 22582 |

| 3. **Pregnant Women** | |
|---|---|
| TT | 840 × 10 = 8400 |
| Urine Examination | 840 × 6 = 5040 |
| Hb | 840 × 6 = 5040 |
| BP | 840 × 6 = 5040 |

| | |
|---|---|
| Weight | 840 × 6 = 5040 |
| Iron and Folic Acid | 840 × 6 = 5040 |
| Delivery | 800 × 10 = 8000 |
| Post-natal care | 800 × 10 = 8000 |
| Sub Total | 49600 |
| **4. Family Planning** | |
| Nirodh | 4113 |
| Oral Pill | 2285 |
| Sub-total | 6398 |
| Cost MCH | 93082 |
| FP | 6398 |
| | 99480 |

Or Rs. 99500

V. This total cost is comparable to the standard pattern approved by the Government of India for D type Urban Family Welfare Centre.

**Release of funds**

Release of funds will be made under the Central Sector Schemes for grant-in-aid to Voluntary Organisations. An amount of Rs. 99,500/- has been computed to be admissible to each Voluntary Organisation for the activities, events identified in this project. An advance for the contingent and non-recurring expenses will be paid in the first instance for procuring equipment. Later to meet the other recurring expenses advance will become due on quarterly/six-monthly basis as may be decided.

Voluntary Organisations will get the amount specified for each activity under the three heads identified in the project viz. MCH, Immunisation and Family Planning Services. These rates have been worked out after taking into consideration the anticipated scales of salary, contingencies and non-recurring expenses on equipments. The Voluntary Organisation will get charges in terms of the rates prescribed for each activity. Grants will be admissible only when the full staff is employed on the project. The amount of Rs. 99,500/- per year has been worked out to cover the expenditure on the suggested activities.

**Evaluation:**

Periodical evaluation of the project would be necessary to draw up the necessary feed back and make modifications, if necessary, in the scheme. Effort will be made to arrange the evaluation through reputable organisations in the field who could make frank and independent assessment.

ANNEXURE —I

| 1. Staff | No. |
|---|---|
| Part-time Medical Officer (lady) | 1 |
| LHV | 1 |
| ANMs | 2 |
| Female Helpers | 2 |

| | |
|---|---|
| Clerk-cum-Compounder . . . . . | 1 |
| Sweeper . . . . . | 1 |

2. **Non-Recurring**

| | |
|---|---|
| Equipment . . . . . | Rs. 12000/- |
| Refrigerator . . . . . | Rs. 5000/- |
| Furniture . . . . . | Rs. 5000/- |
| 3. Contingencies . . . . . | Rs. 20000/- |
| 4. Overheads (15%) . . . . . | Rs. 17820/- |

The application should be submitted to Under Secretary (OS/Desk Officer (SCOVA), Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi-110011 in duplicate and a copy of it may also be sent to Director of Family Welfare of the State Government concerned.

VIII

# ACTION PLAN FOR REVAMPING THE FAMILY WELFARE PROGRAMME IN INDIA

## 1. DEMOGRAPHIC SCENARIO

1.1 According to 1991 Census, the country's population is 843.93 million- a substantial rise from 342 million in 1947 and 684 million in 1981. The annual addition to the population is 16 million. The all-India average annual growth rate during the 1981-91 decade has been of the order of 2.11%-marginally lower than 2.22% during the preceding decade. The Statement at Annexe-I brings out the comparative position in regard to decadal variation in population, change in decadal variation and average exponential growth rate of population in different States/UTs.

1.2 The latest available Sample Registration System (1989) estimates indicate All-India birth rate of 30.6, death rate of 10.3 and Infant Mortality Rate of 91. Two important parameters influencing fertility behaviour are female literacy and age at marriage for women. Couple Protection Rate (CPR) also indicates the level of efforts made for birth control. The Statement at Annexe-II brings out the comparative position of different States/UTs in regard to several selected indicators.

1.3 The long term demographic goals as laid down by the National Health Policy (1983) is to achieve the birth rate of 21 per thousand, death rate of 9 per thousand, natural growth rate of 1.2%, infant mortality rate below 60 per thousand live births and couple protection rate of 60% by the year 2000 A.D. It has already been recognised that given the current level of achievements, the goals may not be achieveable at the National level before 2006-2011 A.D.

## 2. FUTURE STRATEGIES

Faced with grim prospects of population explosion, it is necessary to devise innovative strategies for imparting new dynamism to the Family Welfare Programme. While the population control programme has to essentially evolve as a multi-sectoral programme comprising many aspects which go beyond family planning, a result-oriented Action Plan has been developed. The broad framework is summarised below:-

### 2.1 National Consensus and Efforts

The population control programme should emerge as a national consensus with willing participation of all segments of the society cutting across political, religious and cultural barriers. It has to be backed by strong political commitment and will not only at the national level but also at the level of States/UTs, which are primarily responsible for implementation of the programme. Political leaders, religious leaders and other opinion leaders at different levels will have to be approached for their active involvement in moulding public opinion.

2.2 Improvement of quality and outreach of services

A vast network of institutions has come up in the country for delivery of health and family welfare services over the successive plan periods. It has, however, been recognised that the quality of service delivery extended to the people is not satisfactory. Besides, the outreach of services is also not adequate for the people in remote rural areas and urban slums. The following steps would be taken:-

a) Keeping in view the general constraint of resources (financial, administrative and managerial) for pushing the family welfare programme, the thrust during the 8th Five Year Plan would be first to consolidate the existing infrastructure. There is no point in going for opening of new sub-centres etc. in the future, if the existing sub-centres are not functioning properly. However, keeping in view the norms fixed during the 7th Five Year Plan, new institutions will be sanctioned if adequate, funds are made available. Special attention will be paid to creation and strengthening of infrastructure in the urban slums where these are particularly deficient.

b) Integrated training modules for training and re-training of medical and para-medical personnel involved in the delivery of family welfare services will be developed and adequate funds made available for organising different training programmes in the institutions already set up for the purpose.

c) As motivation is a key factor in improving the quality of delivery of services, it will form a key element in the training modules for medical and para-medical personnel at all levels.

d) Special attention shall be paid by the State Govts./UT Administrations to have a proper organisation for maintenance of equipments, vehicles and buildings and, wherever possible, train even the existing family welfare workers for doing small repairs. This would ensure proper utilisation of vital equipments and valuable assets created under the programme.

e) The supervision at all levels will have to be vastly improved. This will primarily focus on identification of problems, finding solutions thereto and improving understanding and capabilities of key functionaries involved in the delivery of services.

f) Special attention shall be paid to the construction of buildings for Primary Health Centres and sub-centres through Area Development Projects and under the Minimum Needs Programme of the States Plans.

g) The State Govts. and UT Administrations would look into the practical problems of the workers like ANMs in the field conditions such as their place of stay, mobility and travelling expenses etc. as inadequate attention to these problems seriously hampers the working of the main propagators and service providers of the family welfare programme at the grass root level.

2.3 Special Strategy for 90 Districts

The demographic and health profile of the country is not uniform. Examination of the statewise data regarding behaviour of the important demographic and health indicators shows very clearly that any operational strategy, to be successful, will have to be based on disaggregated approach. The 4 States of Bihar, Madhya Pradesh, Rajasthan and U.P. which constitute about 40% of country's population, have IMR and MMR level distinctly higher than the national average. These are also the States where female age at marriage, female literacy and share of women in the non-agricultural employment are distinctly lower than the national average. Unless special efforts are made to bring up the profile and performance of these States in regard to health and family welfare, it would be well-nigh importance to accelerate the achievement of demographic and family welfare goals at the national level. Special Area Development Projects have already been launched in these States with the help of World Bank, UNFPA and other funding agencies. The pace of the implementation of these projects primarily designed to strengthen the infrastructure and to improve the training of their staff requires to be speeded up with due attention to quality of implementation.

2.3.1 The relevance of the disaggregated approach does not stop at the identification of the four States. An analysis of demographic indicators at the district level indicates that there are 90 particularly bad districts where the CBR is above 39 per thousand (1981 Census). A list of these districts is placed at Annexe-III. The following steps would need to be taken to improve the programme performance in these districts:-

a) Micro-level planning by the States to identify the needs on a realistic basis for reduction in birth rate in these districts. Resources will be allocated for strengthening of infrastructure and provision of other essential inputs after taking into account the inputs already provided in these districts through Area Development Projects and other special projects, if any.

b) All posts at grass root level of family welfare workers and supervisory officers would be filled up and only motivated officers with excellent record in these districts would be posted.

c) Priority for construction of sub-centres and buildings for other health institutions would be given in these districts under the Area Development Projects.

d) Intensive training of medical and para-medical personnel would be organised.

e) Since many of the low performance districts have large minority populations, minority community leaders at local levels would be involved in launching imaginative IEC programmes designed to increase family planning acceptance by all sections of the society through methods best suited to individual needs.

f) In order to improve the inter-personal communication efforts at the

grass root level, a scheme of link volunteers would be tried out in some of the districts on a pilot basis. Deptt. of Woman and Child Development would be requested to cover all the 90 districts with ICDS programme and suitable linkages developed at the delivery level with ICDS functionaries to delivery health, nutrition and family welfare services as a package.

g) The District Collectors would be fully involved in coordination/supervision of family welfare programme related activities in these districts.

## 2.4 Package of Incentives/ Disincentives

2.4.1 The present scheme of compensation for loss of wages to acceptors of sterilisation/IUD, places great emphasis on target achievement with the result that the quantity has taken precedence over quality and some specific methods seem to have over-shadowed others. It has increasingly been recognised that we should get rid of "tyranny of targets" altogether. Targets based on micro-level planning suiting the local specific needs may, however, continue to be fixed for monitoring of the programme.

2.4.2 The above scheme will be modified to provide for greater flexibility to the States and to cover younger age couples with greater fertility potential under spacing methods. The resources meant for the purpose would be provided to the States/UTs in relation to their overall birth rate reduction efforts. In order to work out a suitable formula for devolution of resources under the scheme, a Committee under the chairmanship of Shri S.B. Mishra, Joint Secretary in the Ministry of Health & Family Welfare will be constituted which will have 4 State Health Secretaries as its members-two from good performing States and two from poor performing States. The Committee will finalise its recommendations within 3 months of its constitution.

2.4.3 No more incentive to Govt. employees will be considered. A suitable package of disincentives will be developed for this section of the society for adoption by the State Govts. as well. It will also be recommended to the employers in the organised sector.

2.4.4 Motivators fee etc. presently being paid to service providers will not be paid any more as it also leads to emphasis on achievement of specific methods of contraception.

2.4.5 States Award Scheme already decided to be scrapped retrospectively w.e.f. the financial year 1988-89, would not be revived as it had been leading to falsification of figures and unhealthy competition. However, suitable incentives to encourage good performance shall be built in the proposed modified scheme of compensation.

2.4.6 An innovative package of incentives/disincentives would be formulated with emphasis on community based incentives and social security measures for individuals adopting small family norm. The community based incentives would be linked to various benefits being

made available to the public under different socio-economic development plans of the Government.

2.5 Promotion of Different Contraceptive Methods/Devices

2.5.1 Sterilisation procedures were the mainstay of the programme in the past. However, acceptors have generally been the higher age and the high parity couples who have already completed the desired family size. The contribution of sterilisation to the fertility decline, therefore, has been less than anticipated. While sterilisation would continue to play an important role in the population control efforts, it would be ensured that the profile of the acceptors would be of the right quality in terms of age and number of children already born.

2.5.2 Spacing methods will be vigorously pushed for adoption by the younger age couples with high fertility potential. This would require good follow up services for acceptors of IUD insertions to bring down the drop out rates, improvement in the distribution arrangements of conventional contraceptives and oral pills in rural areas and urban slums through strengthening of schemes for social marketing of contraceptives and launching of community based distribution of contraceptives. The free distribution schemes which are somewhat wastage-prone would be gradually curtailed and limited only to such areas where these are actually needed for economic reasons or for lack of outreach of social marketing/community based distribution programmes.

2.5.3 The quality of contraceptives would be improved. In this regard supply of dry condoms under the free distribution scheme would be gradually phased out and only lubricated condoms made available.

2.5.4 The production arrangements for weekly oral pills (Centchroman) and oral contraceptive pills (Mala N and Mala D) shall be gradually improved so as to make these easily available across the length and breadth of the country in greater numbers.

2.5.5 In order to give a wider choice of contraceptives to the acceptors, new contraceptives such as Norplant-6 and injectibles shall be introduced under the programme, initially under controlled conditions and gradually on a wider scale.

2.6 - Universal Immunisation Programme and MCH Programme

2.6.1 Consistently high coverages are being now reported from most of the States in the UIP. However, there still remain areas where the coverage levels are low. Special attention would be focussed on such areas during the coming years, while sustaining the high level of coverage achieved elsewhere.

2.6.2 All such cases where reported coverages are more than 100% of the target fixed, the reasons for high coverages would be routinely investigated to ensure that no over-reporting is allowed as this would otherwise lead to a sense of complacency leading to outbreak of the vaccine preventable diseases.

2.6.3 The ultimate objective being reduction of vaccine preventable diseases, the priority in the coming years would be to concentrate on the quality aspects of the services delivery and on documenting reduction in disease incidence. The following activities in this context would be strengthened:-

a) Initiate active surveillance in areas where low incidence has been recorded in the last two years. List of cases, particularly of Polio and neo-natal tetanus would be the lead diseases under monitoring.

b) Set up network of Polio Virus Isolation Laboratories while increasing the number of field samples of Oral Polio Vaccine to ensure that atleast one full sample is lifted from every Primary Health Centre area in a year.

c) Time-bound investigation of all adverse reactions following vaccination.

2.6.4 For overall improvement in the management of the programme, all supervisory posts created so far particularly that of the District Immunisation Officers and Refrigeration Mechanics would be filled up by the States/UTs.

2.6.5 All States/UTs would also take priority action to take over the maintenance of the cold-chain created over the last 4-5 years and further planned to be strengthened in the coming years.

2.6.6 About 1.5 million children below 5 years of age die because of Diarrhoea in the country every year. Even though the Oral Rehydration Therapy Programme is being implemented for quite some time now, it has met with only partial success. There are still many medical practitioners who are not propagating it or prescribing ORS. The programme would be more vigorously promoted through the training of medical and para-medical personnel and through health education to people, particularly mothers.

2.6.7 Keeping in view the Health for All goal by 2000 A.D. a new Child Survival and Safe Motherhood Programme is proposed to be implemented with IDA/UNICEF assistance in a phased manner. It would provide for universalisation of IFA to cover all pregnant mothers, universalisation of Vit. 'A' to all children upto the age of 3 years, expanding the pilot project on control of Acute Respiratory Infections and strengthening primary health care infrastructure coupled with an intensified training of traditional birth attendants in the higher IMR/MMR States of Assam, Bihar, Orissa, Madhya Pradesh, Rajasthan and U.P. It is expected that this Project would not only help in lowering the IMR/MMR and child mortality rate but would also contribute significantly to improve the family welfare services.

## 2.7 Urban Area Schemes

2.7.1 The Schemes like Post-Partum Centres, Urban Family Welfare Centres, Health Posts are designed to provide Family Planning and

Maternal and Child Health Care services to population living in the urban areas including slum areas. While the post-partum centres have generally become hospital based programmes and are not effectively catering to the areas/populations attached to them, the quality and outreach of services being provided by the Urban Family Welfare Centres/Health Posts are also not satisfactory. This has resulted in a situation in which the F.P. and MCH services are not effectively reaching the urban slums population which is an area of major concern. The following steps would be initiated:-

a) With a view to strengthen infrastructure and services, Urban Revamping Schemes covering towns with 2 lakh population and above with special focus on slum areas are already being developed. The operationalisation of these schemes would be expedited with adequate funding support from central budget and external agencies.

b) The involvement of voluntary organisations in catering to the needs of slum population will be enhanced. Preference would be given to voluntary groups already active in such areas.

c) The urban institutions whether under the Government or in the voluntary sector will be closed down or shifted elsewhere in case an optimum level of performance is not recorded. It would be ensured through proper monitoring and supervision mechanisms that these institutions do seriously endeavour to meet the respective programme objectives, particularly those related to serving the target population assigned to each. Adequate flexibility would be given to States/UTs to meet these objectives.

d) Suitable coordinating mechanisms would be developed to ensure that the urban institutions function in an integrated manner and not in total isolation of each other and the overall programme objectives.

2.8 - Village Health Guide Scheme

There is a general impression that this important scheme designed to provide for the basic linkage between the community and the Health & Family Welfare service delivery system, is not working well. VHGs are presently getting only Rs. 50/- p.m. as honorarium and in most parts of the country, they are not rendering much service to the community. Some States (J. & K., Tamil Nadu, Kerala) did not implement the scheme from the very beginning and some others like Assam and Haryana have scrapped it. The decision to replace male health guides with female health guides has also led to a plethora of writ-petitions in different High Courts. The general experience has been that wherever female health guides are in position, the ground situation of service delivery is much better.

2.8.1 The following steps would be taken:-

a) All the pending court cases would be effectively followed up and got decided on a priority basis.

b) The existing number of Village Health Guides shall be fully utilised by States/UTs with reduced functions, if necessary. Their services may primarily be utilised as motivators and depot-holders for contraceptives, Oral Rehydration Salts, IFA tablets etc.

c) The possibility of revitalisation of the scheme to make it more effective or alternatively of disbanding it would be examined further taking into account the varied implications including from the legal angle.

2.9 Continuation of ANM/LHV Training Schools

There are a large number of ANM/LHV/MPW (M) Training Schools in different parts of the country. As regards ANM/LHV training, many States/UTs have already fulfilled targets of recruitment and basic training of workers. In so far as the scheme of training of Health Worker (Male) is concerned, most States have stopped training as fresh recruitment is not taking place. There is a large number of vacancies of MPW(M) in different States/UTs which has caused serious concern.

2.9.1 The following steps would be taken

a) The existing infrastructure of ANM/LHV Training Schools would be thoroughly reviewed for each State/UT to ensure its proper and effective utilisation. Schools without buildings and those being run through voluntary organisations shall be closed down gradually. The remaining schools will be utilised for running integrated training modules for para-medical workers, including of voluntary sector, and for continuing education programmes.

b) States/UTs would initiate action to create posts of MPW(M) to meet the existing gaps in a phased manner and effectively utilise the available training infrastructure.

c) Net working arrangements of training institutions at different levels would be developed with a view to ensure uniformity in training modules, avoid duplication and bring about effective coordination.

2.10 Information, Education, Communication

Information, Education and Communication (IEC) inputs need to be revitalised not only to propagate the Family Welfare Programme but also to bring about attitudinal changes so as to cover a part of the ground which should be normally prepared through education and social work. The new IEC strategy would have the following key elements:-

a) The IEC message would be to associate Family Welfare with planned parenthood and not just with the adoption of contraception.

b) The messages would be positive with thrust on quality of life issues and removal of ignorance, apathy and misgivings about the Family Welfare Programmes.

c) In order to involve the community in generating demand for Family Welfare services, the Scheme of Mahila Swasthya Sangh which has been

recently introduced in some selected districts would be further strengthened in case the results are found to be encouraging.

d) The messages through the Mass Media would be of a balanced nature so that these do not harm sensibility in our socio-cultural ethos.

e) In order to cover 40% of the population which is not covered by any mass media presently, special attention shall be paid on traditional art forms, folk-lore, field publicity and inter-personal communication. Feature films with entertainment value would be developed for being shown on 16 mm projectors for conveying the required messages in a suitable manner.

f) Increased emphasis would be laid on development of media material in a decentralised manner so that these are produced taking into account the regional diversities in the country and local specific needs.

g) Regular training of IEC staff at different levels would be undertaken to expose them to latest IEC techniques, improving their motivation and administrative/managerial abilities.

h) The funds provided for media activity would be in no case diverted as is happening in some States presently. The importance of IEC activities in achieving the desired goals would need to be fully realised by the States/UTs.

i) IEC efforts would increasingly focus on the need for participation of males in adopting contraception with a view to remove misgivings about the vasectomy, which is a much simpler procedure than the female sterilisation.

j) The Rajasthan experiment of integrating the IEC activities of the entire H&FW Sector and developing linkages with other sister Departments for a coordinated IEC effort has been noted to be leading to better achievements. Other States/UTs may like to study this experiment for possible replication.

## 2.11 Involvement of Non-Governmental Sector

For supplementing the efforts of the Government, it is necessary to involve the non-Governmental organisations and voluntary agencies in a very big way. Even though the need for this has been realised for quite some time with a view to make the Family Welfare Programme a people's movement, harsh reality is that so far the contribution from the non-Governmental Sector is rather limited and the programme is perceived by the people as the Government's programme. Voluntary sector and NGOs can not only supplement the family welfare services provided by the Government but also it is expected that they would have a better understanding of how to bridge the communication gap with the people and take the message of small family and Maternal and Child Health to them in the language they understand.

2.11.1 Instead of waiting for a voluntary agency to approach the Government for assistance, it would be necessary to identify local level individuals (youths in the villages, panchayat level leaders, private medical practitioners including ISM practitioners, ex-servicemen, retired Govt. servants with a social conscience etc.) to motivate them to participate in the family welfare programme, impart training to them and involve them either individually or collectively for generation of demand for the family welfare services and propagation of small family norm.

2.11.2 The network of cooperative sector institutions, organised sector, trade unions, Zilla Parishads, municipal corporations, panchayats, etc. would be fully involved in the implementation of family welfare programmes in a systematic manner.

2.11.3 Increased powers to sanction schemes for non-Governmental sector would be delegated to the States/UTs which may further be delegated to the district level with a view to expedite the sanction of schemes and also because the actual work of identifying and encouraging the voluntary workers at grass root level, necessarily will have to be done by the district officers and other officers of the State Governments in this field.

2.11.4 In view of the fact that the NGOs in some States/Areas have achieved exceedingly good results, visits of NGO workers from the poor performance States/Areas would be arranged to a good performance State/Area. Further, the available infrastructure would also be utilised for training of voluntary sector workers to improve their administrative, financial and managerial abilities.

2.11.5 In order to have the desired impact of the eliciting participation of voluntary and NGOs, a suitable organisation would be evolved at central level which will have the desired degree of flexibility in sanctioning schemes and ensuring smooth flow of funds.

2.11.6 Increased allocations would be made in the Central Budget for implementation of Family Welfare Programmes through NGOs/voluntary sector and receipt of external assistance for this sector would be considerably stepped up.

2.12 Inter Sectoral Coordination

One of the key points which always needs to be kept in view is the distinction between the Family Welfare activities and the population control programme. Control of population is dependent on a variety of factors, many of which go beyond the sphere of the family welfare sector, but which have an equal and perhaps even more important bearing on the birth rate. In fact, the Family Welfare Department in the Centre and the Health & Family Welfare Departments in the State Governments are organisations which should be essentially viewed as Supply Departments for making available the family welfare services, but the demand for these services and the motivation for population control comes from factors such as female literacy rate, age at marriage of girls, the status of women, position of employment of women, social security and general level of economic development. These are well beyond the pale of activities of Department of Family Welfare.

2.12.1 There is need to have an institutional mechanism at the centre for inter-sectoral coordination particularly between the Ministry of Health & F.W., Ministries of Human Resources Development, Finance, Information & Broadcasting, Environment & Forests, Labour, Deptt. of Woman & Child Development and the Deptt. of Rural Development. A suitable institutional mechanism would be evolved at the central level to achieve the desired level of inter-sectoral coordination and similar mechanisms would be developed at the State level.

2.12.2 At the State level, the Chief Secretaries would be involved personally in making the Family Welfare Programme a success. At the district level, Deputy Commissioners, Chief Executive Officers of the Zilla Parishads, would be involved in a greater way not to push the target achievements in a routine manner but to achieve inter-sectoral coordination of different Departments whose activities have a direct bearing on family welfare programme performance.

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